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The role of Aboriginal Community Controlled Health Services in Indigenous health

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"Our right to take back responsibility." Noel Pearson, 2000 [1]

This emotive aphorism by Pearson embodies the struggle of Australia's Indigenous people to gain control of their destiny, which for generations has been wrested from them into the power of governments. Although his statement was primarily directed toward welfare, the same right of responsibility can be applied to health, perhaps the gravest challenge facing the Aboriginal population. As Pearson alluded to, the only way to solve the health crisis is by enabling local communities to take charge of their own affairs. This principle of self-determination has led to the creation of Aboriginal Community Controlled Health Services (ACCHS), which has allowed over 150 Aboriginal communities throughout Australia control over their healthcare. [2] This article describes the founding principles behind community controlled health centres in Aboriginal communities through considering several different ACCHS and the unique challenges they face.

The fundamental concept behind each ACCHS – whether metropolitan, rural or remote – is the establishment of a primary healthcare facility that is both built and run by the local Aboriginal people "to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it." [2] This is based upon the principle of self-determination and grants local people the power to achieve their own goals. From the beginning ACCHS were always intended to be more than exclusively a healthcare centre and each ACCHS has four key roles: the provision of primary clinical care, community support, special needs programmes, and advocacy.

ACCHS endeavour to provide primary healthcare as enshrined by the World Health Organization in the 1978 Declaration of Alma-Ata. This landmark international conference defined primary healthcare as:

> "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain… in the spirit of self-determination." [3]

Although conceived subsequent to the advent of the community controlled healthcare movement in Australia, this definition echoes many of the underlying principles upon which ACCHS were founded, including the most important aspect – local control. Indeed, it is widely accepted throughout the literature that the community itself must identify its needs and problems so an effective and appropriate course of action can be undertaken. [4-7]

This principle is espoused in the National Aboriginal Health Strategy's frequently quoted statement that "Aboriginal health is not just the physical well-being of an individual but the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well-being of their community." [8] The notion of 'community' is an essential component of the Indigenous view of the self and therefore strongly related to health and well-being. Accordingly, ACCHS have a holistic view of healthcare, recognising that Indigenous healthcare needs to be multi-faceted and focus on cultural complexities that may not be appreciated by mainstream health services. As each Aboriginal community across the country has a distinct culture and language, [9] local control is paramount.

The concept of community control is not new. It can be traced back to early nineteenth-century America, where such services were used with success for improving the health of the poor and recent migrants. [4] The first ACCHS was established in the inner city Sydney suburb of Redfern in 1971. [10] Known as the Aboriginal Medical Service (AMS), it pioneered the concept of community controlled healthcare in Australia and, from modest beginnings, has now expanded into a major, versatile healthcare facility that provides free medical, dental, psychological, antenatal and drug and alcohol services to the large Aboriginal community in Sydney. Redfern's AMS overcame struggles against an initially distrustful and paternalistic government through the dedication of visionary Indigenous leaders and support of benevolent non-Indigenous Australians. [10,11]

Specialised Indigenous policies are essential, as it is impossible to apply the same approach that is used in health services for non-Indigenous patients. Many Indigenous people are uncomfortable with seeking medical help at hospitals or general practices and therefore are reluctant to obtain essential care. [12] In addition, access to healthcare is often extremely difficult due to either geographical isolation or lack of transportation. Many Indigenous people live below the poverty line, so the services provided by practices that do not bulk bill are unattainable. Mainstream services struggle to provide appropriate healthcare to Aboriginal patients due to significant cultural and language disparities; [5,13] the establishment of ACCHS attempts to overcome such challenges.

For example, the Inala Indigenous Health Service in south-west Brisbane performed extensive market research to determine the factors keeping Aboriginal patients from utilising the mainstream health service. The results showed that several simple measures were highly effective in engaging the local community, such as employing an Indigenous receptionist and making the waiting room more culturally appropriate through local art or broadcasting an Aboriginal radio station. [12] In the five years following implementation of these strategies, the number of Indigenous patients at Inala ballooned from 12 to 899, and an average of four consultations per patient per year was attained, compared to the national Indigenous average of fewer than two. [14] A follow-up survey attributed patient satisfaction to the presence of Indigenous staff and a focus on Indigenous health. [12]

Nevertheless, the consequence of longstanding obstacles to Indigenous access to mainstream healthcare is manifest in the stark inequity between the health outcomes of Indigenous and non-Indigenous Australians. The most recent data from the Australian Institute

of Health and Welfare (AIHW) shows that the discrepancy in life expectancy between Aboriginal Australians and their non-Indigenous counterparts remains unacceptably high, at 11.5 years for males and 9.7 for females. [15] Moreover, studies demonstrate that Aboriginal people have significantly worse outcomes in key health indicators, including infant mortality, diabetes, heart disease, infectious disease and mental illness. [5,12,13,16] Such disparities indicate that a novel, tailored approach to Indigenous health is required.

Cultural understanding is essential, as demonstrated by the example of the Anyinginyi Health Aboriginal Corporation in the Northern Territory. Anyinginyi serves the twelve remote Aboriginal communities within a 100km radius of Tennant Creek and its name comes from the local Warumungu language, meaning 'belonging to us' [17] emphasising the community's control of, and pride in, this service. Anyinginyi has always strived to be more than just a health service and has evolved to deliver many other community programmes. This is embodied by Anyinginyi's insistence on 'culturally appropriate' healthcare for Aboriginal people. In addition to medical advice, the local Aboriginal community is offered support through various programmes that range from employment services to cultural and spiritual activities promoting Indigenous language and culture. One such social service is the 'Piliyintinji-Ki Stronger Families' initiative, which assists community members through access to support services relating to issues such as family violence and the Stolen Generations. [17] Indeed, ACCHS such as Anyinginyi have the additional benefit of providing employment opportunities for community members, as the vast majority of the employees are Indigenous. All new staff members participate in a Cross Cultural Workshop, as one of Anyinginyi's goals is to ensure that the local Aboriginal cultures are respected and continue to thrive.

The other important arm of healthcare in ACCHS relates to population health, with initiatives ranging from education campaigns to immunisations and screening for diseases. [2] One of the first large-scale community health promotion campaigns run specifically for Aboriginal people was conducted by the Redfern AMS between 1983-1984 to encourage breast-feeding among the local Koori mothers. [11] It achieved such stunning success that it set a precedent for all future ACCHS to continue in the important area of preventative medicine, with similar campaigns for sexual health and safe alcohol consumption having been undertaken subsequently.

Moreover, each ACCHS runs special services that are dictated by local needs and priorities. In some instances, there is a specific health problem that needs to be addressed, such as poor nutrition or substance abuse. Other programmes are directed at specific groups, such as young mothers or the elderly. The flexibility of these special services allows each ACCHS to identify and address the most significant problems within its area – problems that can only be identified by the community itself. For example, the Danila Dilba Health Service in Darwin runs a programme called 'Dare to Dream' that provides support and counselling for young Indigenous people suffering from mental illness. [18] It is an early intervention programme that intends to identify and support adolescents exhibiting early signs of both behavioural and mental health problems. To this end, school visits are undertaken to promote awareness of mental health issues to students and staff, as well as the services that Danila Dilba has to offer. A 'chillout' centre has been set up in Darwin as a safe place for young people to come and allows the community workers to refer those who present to appropriate counselling services. As such, Danila Dilba is empowered to proactively address an important local issue in the most culturally-appropriate way.

ACCHS are also active in the area of advocacy. This involves providing a voice for the community so that their needs can be expressed. Although each ACCHS operates autonomously, they form a national network with their collective interests represented both on a state/territory level and also nationally. Each of the eight states and territories has a peak representative body that acts on behalf of all ACCHS within that jurisdiction. [2] Examples of these organisations include the Aboriginal Health & Medical Research Council of New South Wales and the Aboriginal Medical Services Alliance Northern Territory. At the national level the umbrella body overseeing all the different stakeholders across the country is the National Aboriginal Community Controlled Health Organisation (NACCHO). [2] Individual ACCHS, as well as NACCHO and the affiliated state or territory peak bodies, lobby all levels of government for increased funding and greater recognition of the issues facing Aboriginal communities. The collective weight of NACCHO as a national advocate allows each community's needs to be heard.

Inevitably, the scope of the services each ACCHS can provide is restricted by funding, most of which comes from the Commonwealth or State and Territory Governments. [2] More money continues to be spent per capita on mainstream health services than on Aboriginal health, despite the great dichotomy in health outcomes. Indeed, the 2012 Indigenous Expenditure Report published figures showing that for every dollar spent on healthcare subsidies for non-Indigenous health, only $0.66 is spent on Aboriginal health. [19] This statistic covers all the key areas of healthcare expenditure, such as Medicare rebates, the pharmaceutical benefits scheme (PBS) and private health insurance rebates. Therefore, Indigenous patients are not receiving the same level of health service delivery, including clinical consultations and treatment, compared to their non-Indigenous counterparts. However, it is propitious to note that the funding bodies have recognised the value of the public health efforts of ACCHS, as the spending in this area is a $4.89 to $1.00 ratio in favour of Indigenous health. [19] Nevertheless, the priority needs to be placed on ensuring that sufficient funding exists to allow Indigenous patients to access health care subsidies as required.

In addition to inadequate funding, another major obstacle that ACCHS face is the difficulty in attracting and retaining doctors and allied health professionals. According to the AIHW's most recent report, only 63% of Indigenous health services currently employ a doctor. [20] Consequently, a significant increase in the number of general practitioners working with Indigenous patients is required simply to provide adequate services. There is additionally a severe lack of Aboriginal medical students and general practitioners, which limits the opportunities for Indigenous professionals to provide culturally-appropriate care to their own communities. Census data from 2006 found that there were 106 Indigenous doctors nationally, accounting for only 0.19% of all medical practitioners. [21] These shortages are compounded further for ACCHS in rural and remote areas. By 2011, further data from Medical Deans demonstrated that the numbers had increased to 153 Indigenous medical practitioners nationally, along with 218 enrolled Indigenous medical students. Although promising, these numbers remain grossly inadequate to fulfil workforce demand. [22]

Services become stretched due to perpetual resource inadequacies. Understandably, the remoteness of some communities makes service delivery challenging, yet even major metropolitan areas with large Indigenous populations can struggle to adequately provide for those in their catchment area. Under-resourcing places major constraints on service delivery and different ACCHS throughout the country exhibit significant variation in the level of services offered. Some are large, employ several doctors and provide a wide range of services; others are much smaller and operate without doctors. [20] These rely on Aboriginal health workers and nurses to provide the bulk of primary healthcare.

As such, the success of the ACCHS concept would not have been possible without the contribution of Aboriginal health workers. The role of Aboriginal health workers, who are often sourced from the local community, is to provide the primary healthcare that ACCHS offer. [23] This involves assessing patients and then coordinating or providing the medical attention required. Health workers are able to treat certain conditions with the help of standard treatment guidelines and provide a selection of important medications to patients. Importantly,

Aboriginal health workers have a liaison role between medical professionals and Aboriginal patients. They are often required to act as an interpreter between the patient and health professional, thus providing an intermediary for cross-cultural interactions, and therefore improving the quality of healthcare provided to the local community.

Due to the often quite remote locations of ACCHS and the scarcity of doctors and nurses, Aboriginal health workers perform many clinical tasks that would be provided by a medical professional in mainstream health services. Aboriginal health workers bear much greater responsibility than their colleagues in the public sector and often learn a wide range of procedural skills including how to perform standard health checks, vaccinations and venepuncture. [23] Indeed, some choose to specialise in a specific area (such as diabetes, pregnancy or infant care) thus gaining additional skills and responsibilities. Still others take on managerial responsibilities. This is in contrast to the public sector, where health workers are often fixed to one routine area or even to non-clinical work such as transportation or social assistance. [23] Without Aboriginal health workers performing these additional tasks, ACCHS would not be able to provide a sufficient level of service for the community. For this reason, Aboriginal health workers are rightly considered the backbone of community controlled health services.

As one example, the Pika Wiya Health Service in the South Australian town of Port Augusta runs two outreach clinics for communities in Copely and Nepabunna. Due to the shortage of doctors, these clinics are staffed entirely by Aboriginal health workers. Their invaluable contribution is evident, with 695 clinical encounters performed by health workers during 2008, [24] ensuring that the absence of doctors did not deny the local people the chance to receive healthcare. Whilst the major health issues faced by Indigenous people are broadly similar between urban and remote communities, these problems are often compounded by the remoteness of the location. Although these are challenges that Copely and Nepabunna will continue to have to face, the empowerment of Aboriginal health workers has helped redefine the direction of Pika Wiya's outreach health services.

Aboriginal health workers face many difficulties. Perhaps the most significant is that, until recently, there had been no national qualifications or recognition of the skills they developed. [23] The introduction of national registration for Aboriginal health workers (from July 1 2012) and the new qualification of Certificate IV in Aboriginal and Torres Strait Islander Primary Health Care (Practice) have revolutionised the industry. [25] This has had the benefit of standardising the quality and safety of the Aboriginal health worker labour force. However, as the changes will increase the required length and standard of training, there is the potential for current or prospective health workers to be deterred by the prospect of undertaking study at a tertiary level, particularly if they have had limited previous education. Nevertheless, national registration is a positive step for recognising the important work done by Aboriginal health workers, and in providing them with the training to continue serving their communities.

In addition to doctors, nurses and health workers, medical students are also important stakeholders in Indigenous health. First, much has been done in recent years to increase the numbers of Indigenous medical students. For example, the University of Newcastle has been the first medical school to make a dedicated attempt at training Indigenous doctors and has produced approximately 60% of Australia's Indigenous medical practitioners. [26] This achievement has been based on a "strong focus on community, equity and engagement by the medical profession." [26] Encouraging community members to enter the profession can be an important way of addressing both the lack of doctors in Indigenous communities and paucity of doctors of Indigenous background. The benefits are broader than this, as Indigenous doctors provide strong role models for young Indigenous people and also have the opportunity to contribute with advocacy and leadership within Indigenous health.

Secondly, the medical student population as a whole is exposed to increasingly more Indigenous health as part of the core curriculum at university following adoption of the updated Australian Medical Council accreditation standards from 2007. [27] Additionally, some students even have the opportunity to spend time in an ACCHS and experience first-hand how the system works. There has been some criticism of these 'fly in, fly out' medical electives, where students are sent to ACCHS for short periods and then leave. [28] Whilst this model may be beneficial for the student, it fails to engage the local community as they are unable to build meaningful or lasting relationships with the student.

Better models allow for a longer-term placement and immersion in the community. These include the John Flynn Placement Programme where some students are able to spend a fortnight annually in an ACCHS in the Northern Territory over a period of four years. [29] Another example is the Northern Territory Clinical School, which allows third-year medical students from Flinders University to spend a whole year of study in Darwin, providing the opportunity for increased contact with local Indigenous communities. [30] Initiatives such as these help to build a relationship with the community, and allows for increased acceptance of the medical student. Additionally, the student is able to make a more meaningful contribution to various client's healthcare. Prolonged or longitudinal attachments have also been shown to increase the likelihood of students returning as a doctor. [31] Certainly, there is much scope for the contribution of medical students to be harnessed more effectively.

It is abundantly apparent that any solution to address the health inequalities of Aboriginal people will only be effective if it recognises that the local Aboriginal communities must control the process of healthcare delivery. This is the principle upon which ACCHS were founded and can be attributed to their many successes, as demonstrated through the examples of Redfern's AMS, Inala, Anyinginyi, Danila Dilba and Pika Wiya. In spite of the challenges posed by inadequate funding, under-staffing and often remote locations, these organisations strive to uphold the ideals of self-determination and community control. It is hoped that wider adoption of these principles by national governing bodies together with improved financial support will enable Indigenous Australians control over their lives and destinies, leading to better health outcomes.

Conflict of interest

None declared.

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