

E9 | ABORIGINAL COMMUNITY-CONTROLLED HEALTH SERVICES IN AUSTRALIA

Aboriginal community-controlled health services (ACCHS) have been the torch-bearers for Comprehensive Primary Health Care (CPHC) in Australia and have been one of the key vehicles through which the Aboriginal community has been able to engage in the struggle for health. This struggle has, from its inception, combined collective action to gain greater access to primary medical care and social and preventive programmes with addressing the broader, underlying social determinants of health.

Development of Aboriginal community-controlled health services (ACCHS)

Following a long colonial period characterized by conflict, dispossession, marginalization and large-scale decimation from massacres and communicable diseases that Aboriginal people had previously not been exposed to, in the 1960s a grassroots Aboriginal movement formed in collaboration with non-Aboriginal activists. This social movement led to the successful 1967 referendum and subsequently a new positive period in Aboriginal affairs was established – the era of self-determination (Anderson 1997: 123). The 1967 referendum gave Aboriginal people citizenship for the first time and also gave the Commonwealth government constitutional power to make laws in relation to Aboriginal people. As citizens, Aboriginal people were better able to advocate for their citizenship rights, including access to healthcare, education and government transfer payments that had previously been denied to them.

Aboriginal community-controlled health services developed within this context with the first ACCHS being established at Redfern in Sydney in 1971. This was inspirational to many Aboriginal communities around the country and many similar services were established in the following few years (Bartlett and Boffa 2005).

These new ACCHS were initially started with either no government funding or small seeding grants. The Central Australian Aboriginal Congress (Congress), for example, was established in 1973 as an advocacy body and initially focused on the lack of shelter for Aboriginal people living around the small, remote, mainly non-Aboriginal town of Alice Springs. People were living in humpies (temporary shelters made from tree bark and branches) and the provision of tents was the beginning of action to properly address poor living conditions that were so much part of the poor health at that time. Within eighteen months Congress had established a community health programme,

including a medical service as a response to the high levels of ill health in the community and the fact that the mainstream hospital system was seen as part of the colonial state and had been implicated in the forced removal of Aboriginal children. At this time there was no primary care, and general practitioners became the main or only source of primary medical care for both Aboriginal and non-Aboriginal people (Bartlett and Boffa 2001).

Following the initial wave of establishment of Aboriginal health services, by the mid-1970s these services formed the National Aboriginal and Islander Health Organization (NAIHO) as their umbrella body. It was realized that in order to gain greater strength in political advocacy for change there was a need to network and join forces. In 1977, NAIHO developed a National Black Health Plan that advocated for a coordinated and collaborative approach to the project of improving Aboriginal health (Foley 1982). While this plan was never adopted by governments, it was a crucial document in terms of uniting health services around a vision of better health, strengthening their input into government policies and influencing those policies. It was one of the first expressions of the critical role that ACCHS were to play in the struggle to improve Aboriginal health through better-informed Aboriginal health policy development.

Flag-bearer of Comprehensive Primary Health Care

Seven years after the emergence of ACCHS in Australia, international commitment to primary healthcare (PHC) as a policy model was formalized in 1978 with the Alma Ata declaration on PHC (WHO 1978). The significance of the Chinese model of barefoot doctors in inspiring the Declaration is well known; less well known is the participation of Aboriginal NAIHO representatives in the drafting of the Declaration. When PHC was further endorsed as a key strategy by the World Health Assembly in 1981, the Aboriginal community-controlled health service model in Australia was already a powerful expression of the Alma Ata vision for CPHC.

However, from the beginning, in Australia as in other First World nations, there was ongoing tension between the delivery of selective PHC programmes targeting particular areas, such as medical care, immunization and maternal and child health, on the one hand, and resourcing communities to deliver comprehensive PHC programmes according to their own priorities on the other (Baum 1995). Australia had not developed a national primary healthcare policy and had very much retreated from the commitment given at Alma Ata to CPHC (NCEPH 1992). Resourcing the capacity of Aboriginal communities to use their health service as vehicles for the broader political struggle on these types of issues was not something that government was comfortable with, and there were attempts to restrict the role of Aboriginal health services to primary medical care with some selected programmes.

It was in this context that NAIHO was defunded in the mid-1980s by the

Commonwealth minister for Aboriginal affairs, following extensive criticism of the government of the day for its failure to make progress on key Aboriginal health priorities. However, NAIHO continued the struggle for Aboriginal health improvement with funding from philanthropic institutions. In 1991 it ceased functioning to make way for the new National Aboriginal Community Controlled Health Organization (NACCHO), which was established as part of the implementation of the National Aboriginal Health Strategy. Since then ACCHS have gone on to develop umbrella organizations at the state and territory levels, such as the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) (Bartlett and Boffa 2005).

It is Aboriginal people and their communities who have most vigorously and consistently developed the PHC model in Australia through the ACCHS. These services were instrumental in lobbying for the National Aboriginal Health Strategy (NAHSWP 1989), built on the principles of the PHC policy model for Aboriginal health advancement.

The struggle to be part of the 'mainstream' health system

However, by the early 1990s ACCHS around the country became frustrated about the lack of focus on health service development, the failure to implement the National Aboriginal Health Strategy, the lack of effective joint health planning, and an almost exclusive focus on environmental health to the detriment of resourcing primary healthcare services. There was a strong view at the time that health services of all types, including primary healthcare services, would make no difference to Aboriginal health advancement compared with environmental health issues. In the Northern Territory (NT), Aboriginal health services had a long history of an informal alliance, and in 1994 this alliance was formalized with the formation of the Aboriginal Medical Services Alliance, NT (AMSANT). A major focus for AMSANT was how to advocate for more appropriate administrative and funding support to Aboriginal community-controlled primary healthcare services. At that time the role of Aboriginal health services was seen as 'supplementary' to that of the mainstream health system, which did not provide CPHC to anyone, let alone Aboriginal people (O'Donoghue 1995).

However, ACCHS saw their role in delivery of PHC to Aboriginal communities as central and not merely supplementary. Indeed, the NAHS embraced a strategy intended to have ACCHS established in all communities, and was seen as an important aspect of addressing Aboriginal health disadvantage. Further, many ACCHS were the major (and sometimes only) providers of PHC services to their communities, but they were not getting specific funding support.

As a result of these concerns, Congress and the National Centre for Epidemiology and Population Health published a monograph that analysed the Aboriginal health system, identified barriers to progress, and suggested

how these could be addressed (Bartlett and Legge 1994). This provided a basis for AMSANT and NACCHO to further develop their lobbying campaign to highlight the problems with existing practices, and to call for the transfer of administrative and funding responsibilities to the Commonwealth Department of Health (Bartlett and Boffa 2005).

Welfare colonialism

One of the key problems with the administrative arrangements for Aboriginal health at that time was that they perpetuated a type of ‘welfare colonialism’ whereby funding for Aboriginal health came only from a special Aboriginal-specific programme and not from the much greater mainstream funding sources within the health department. In addition to this, the funding arrangements were such that Aboriginal organizations from different sectors were forced to compete with each other for the same funds, and this undermined the previous community-level collaboration that had existed in advocacy on the broader social determinants of Aboriginal health. Intersectoral collaboration was replaced by intersectoral conflict (Bartlett and Legge 1994). As the then director of Congress explained (Delaney 1994): ‘... when you are at a negotiating table you have to look after your own organisation or your interest. And sometimes that can create ill feeling ... It is all designed to take the heat off the minister ... and point it at the blacks. We’re blaming our own mob. And I think that’s a brilliant strategy, for the government to make us fight ourselves.’

Administrative responsibility for funding for Aboriginal health was transferred from the Aboriginal affairs portfolio to the health portfolio in 1995, and it was this transfer which then enabled the key health policy decisions that led to the Aboriginal health improvement that is now occurring quite rapidly in the Northern Territory. The key policy changes were:

- 1 The establishment of a special section of the Commonwealth Health Department that focused on Aboriginal health with special expertise, especially in primary healthcare.
- 2 The establishment of a specialist umbrella Advisory Council to advise the health minister of the day on Aboriginal health issues.
- 3 The adoption of a national plan to improve Aboriginal health through the National and Torres Strait Islander Strategic Framework and a national approach to reporting on progress in Aboriginal health through the Aboriginal Health Performance Framework.
- 4 The development of the Framework Agreements in Aboriginal Health which included the establishment of the state and territory joint planning fora involving all levels of government and the Aboriginal community-controlled health sector as partners. An era of partnership with Aboriginal health services in health planning rather than conflict began.
- 5 Much greater access to mainstream health funding systems for Aboriginal

people, including the Australian health insurance scheme known as Medicare and the Pharmaceutical Benefits Scheme for access to essential medicines. The total level of funds for Aboriginal health, including health services, has increased from around \$54 million per year prior to the transfer in 1994 to more than \$1 billion per year now.

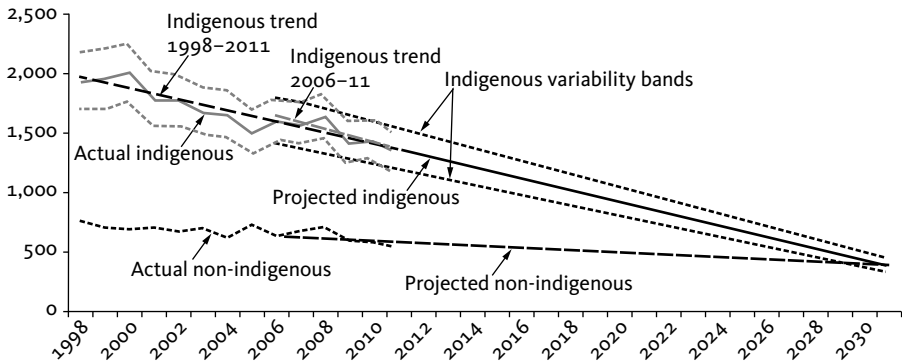
- 6 Improvement in the inter-sectoral relationships between Aboriginal community-controlled health services and Aboriginal community-controlled organizations in other sectors, which have led to more effective action on the social determinants of health (Hogan et al. 2006).
- 7 The establishment of a range of special programmes that were fully integrated into comprehensive PHC, including eye and ear health, the Social and Emotional Well Being programme, the Stolen Generations Counselling programme, the Sexual Health and Blood-borne Viruses programme, quality improvement, chronic disease and many others.
- 8 The establishment of national reporting tools such as the national Key Performance Indicators (nKPIs).

A less tangible outcome of these changes was a greater recognition of the need to respect the special expertise that had developed within Aboriginal communities in different sectors. This helped lead to clearer articulation of Aboriginal perspectives in national dialogue, the opening up of Aboriginal participation in the mainstream government departments and also in mainstream culture and economy, and a stronger expression of solidarity of non-Aboriginal Australians with the Aboriginal struggle. While institutional racism remains widespread and economic interests continue to press for further dispossession (particularly in northern Australia), the improving health status of Aboriginal people speaks of slow but real (albeit uneven) progress in confronting the social determinants of health. This progress has been informed and in some degree driven by the ACCHS but it is largely now carried in a much more dispersed way by achievements by individuals and organizations in many sectors.

Improvements in health outcomes

The Northern Territory especially was able to utilize all of these key changes to transform the health system, primarily because much of the thinking that led to these health system reforms came from within the Aboriginal community-controlled health sector in the NT, which was led by AMSANT. Figure E9.1, from the recent Council of Australian Governments (COAG Reform Council 2013) Indigenous Reform Council report, shows that there has been a more than 30 per cent decline in all-cause mortality for Aboriginal people since 1999 and the NT is now on track to close the Life Expectancy Gap by 2031.

In this period, in the Northern Territory, there has been improved access to primary healthcare, with average per capita funding increasing from \$700 per person in 1999 to more than \$3,000 per person in 2013 (ibid.).



Eg.1 Death rates per 100,000 standard population, Northern Territory

Another part of the progressive realization of the CPHC vision has been the increasing iterations of what has become known as ‘core primary healthcare services’. There have been three iterations of the core primary healthcare services model with the most recent and comprehensive version produced in 2011 in which there are five service domains (Northern Territory Aboriginal Health Forum 2011):

- 1 Clinical Services
- 2 Health Promotion
- 3 Corporate Services and Information
- 4 Advocacy, Knowledge, Research, Policy and Planning
- 5 Community Engagement, Control and Cultural Safety.

Defining core services is part of defining the progressive realization of the right to health as the obligation on governments to ensure access to evidence-based services and programmes according to need is made more explicit. Australia has the resources to ensure all of the services and programmes outlined in this core services model are accessible through Aboriginal community-controlled health services. This includes services and programmes in areas such as early childhood, family support, alcohol and other drug treatment, and aged and disability care, along with the more familiar clinical, maternal and child health, chronic disease and other services. Resourcing all of the core services will enable CPHC to make its maximum contribution to closing the gap.

This health improvement story for Aboriginal people demonstrates the important role that ACCHS have played in the broader struggle for Aboriginal health improvement and in the progressive realization of the CPHC care vision of health for all in Australia. They still remain the torch-bearers for CPHC in a nation where this service model has been undermined in all other areas. They continue to work to promote health across sectors and not just treat illness (Baum et al. 2013).

New challenges

The struggle for Aboriginal health improvement now faces a new challenge as the Australian government, along with those of many other rich nations, responds to the global financial crisis with tough new austerity measures that may make it hard to maintain the current investment in primary healthcare services and will certainly make it hard to secure increased funding. It will be important over the coming years to advocate for a more evidence-based approach to the economic crisis using the evidence that ‘austerity kills’ in public health terms as well as the reality that countries that adopt more progressive taxation and redistributive policies have a stronger economy with greater employment, as well as better health and education systems (Marmot et al. 2014). Now more than ever the struggle for health equity within and between countries is embedded in the political economy of health on a global scale and this reinforces that part of the Alma Ata declaration that states: ‘Gross inequalities in the health status of people, both between and within countries are politically, socially and economically unacceptable and require a new world economic order dedicated to achieving more equitable health outcomes’ (WHO 1978).

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