

Aboriginal community controlled health services: good work largely unsung

Supporting Aboriginal community-controlled health services is AMA policy and **Dr David Scrimgeour** puts a strong case for health services run by Aboriginal communities. He gives an overview of the development of Aboriginal community-controlled health services since 1971 and calls for greater recognition of the advances made.

STORIES about Aboriginal health are not often good news stories. There is, however, an ongoing good news Aboriginal health story which is not sufficiently recognised, by government or by the general public. In recent years particularly, the lack of recognition of this story by the Commonwealth government is arguably one of the contributing factors to the ongoing poor health status of Aboriginal people – that's the not-so-good part.

The good part is the story of Aboriginal community-controlled health services themselves. These organisations arose from a social movement involving Aboriginal people taking control of their own health services, which commenced forty years ago and persists today.

The first Aboriginal community controlled health service (ACCHS), also sometimes referred to as AMS, (or Aboriginal Medical Service) was established in 1971 in the inner Sydney suburb of Redfern. Redfern then had the largest Aboriginal community in Australia, and the establishment of the health service was a response to the difficulties experienced by urban Aboriginal people in accessing mainstream health care, both for financial reasons and because of discriminatory practices in medical institutions.

Over the following few years many other Aboriginal communities in metropolitan and provincial cities established their own health services. In the early years, many ACCHSs relied on voluntary work and donations from aid organisations, but eventually funding from the Commonwealth government was usually

forthcoming. One of the earliest was the Aboriginal Community Centre in Adelaide, which later became Nunakuwarrin Yunti, now a well-established Aboriginal health service for Aboriginal people living in Adelaide

The establishment of ACCHSs in rural and remote areas of South Australia came later, starting in the late 1970s. One of the first remote ACCHS in Australia was the Pitjantjatjarra Homelands Health Service, established in 1978 in the far

Port Lincoln Aboriginal Health Service, and Umoona Tjutagku Health Service at Coober Pedy were established. More recently, Pangula Mannamurna Health Service in Mount Gambier, and Nunyara Wellbeing Centre in Whyalla, have brought the total number of ACCHSs in South Australia to ten. All these services are represented on the Board of their South Australian peak body, the Aboriginal Health Council of SA (AHCSA), and are members of the National

Aboriginal Community-Controlled Health Organisation (NACCHO).

ACCHSs employ health staff, including general practitioners, nurses, Aboriginal health workers and frequently other health professionals, working as a multi-disciplinary team providing comprehensive primary health care under the direction of an Aboriginal Board. The fact that these services are provided in spaces in which Aboriginal people feel comfortable, and are able to access health care provided in appropriate ways, means that ACCHSs must be seen as an important component of any policies aimed at 'Closing the Gap'.

The development of ACCHSs, and other Aboriginal and Torres Strait Islander community-controlled organisations has been the most significant manifestation of the policy of self-determination, which became official Australian government policy in 1972. The important role of ACCHSs in providing comprehensive primary health care to Aboriginal people in urban, rural and remote environments has been widely acknowledged, despite the fact that difficulties with funding, especially the short-term, fragmented nature of contracts from multiple funding



north-west of South Australia, to provide services to small communities on both sides of the SA and WA border. Later, in 1983, all communities on the Anangu Pitjantjatjarra Yankuntjatjarra Lands assumed control of their health services with the establishment of Nganampa Health Council.

In following years, Pika Wiya Health Service in Port Augusta, Ceduna-Koonibba Aboriginal Health Service, Yalata-Maralinga Health Service (later divided into Tullawon Health Service at Yalata and Oak Valley Health Service),

sources, have limited the effectiveness of the services provided.

Over the past decade, while the policy of self-determination has not been officially repudiated, a number of commentators have suggested that the self-determination policy has failed, and both the Howard and Rudd governments have introduced policies which place less emphasis on self-determination.

In recent years, while ACCHSs have continued to receive funding from the Commonwealth government, the emphasis has been more on 'mainstreaming' of health services, despite the evidence that ACCHSs are the most effective way of ensuring that Aboriginal people have access to health care. Mainstreaming policies also ignores the evidence, contained in reports, commissioned by governments but not widely publicised, that there are significant obstacles to the utilisation of mainstream services by Aboriginal people.

Evidence from other countries supports the importance of separate Indigenous-specific services. In New Zealand, Canada and the USA, countries with an Indigenous minority which have been able to achieve better Indigenous health outcomes, there has been a recognition that separate Indigenous services have a place; this has often been seen as a way of governments fulfilling their obligations under the conditions of treaties. The USA, for example, has had

a federally-funded Indian Health Service for decades, providing an integrated system of health care which has been a major factor in the reduction of health inequalities between Indigenous and non-Indigenous Americans.

Separate Aboriginal services do not absolve mainstream providers of the responsibility for providing high quality and culturally appropriate services for Aboriginal people. Aboriginal-specific services should be seen as additional services to help overcome identified inequalities, and to meet the particular needs of Aboriginal people which are in general not well met by mainstream services. Aboriginal-specific services also provide Aboriginal people with a greater choice. To provide the required level of health care, these services need adequate levels of funding and support.

The Council of Australian Governments (COAG) has committed \$1.6 billion over five years to 'close the gap' in life expectancy between Aboriginal and non-Aboriginal people. Unfortunately, most of these funds are being allocated to poorly planned programs, and provided to mainstream organisations and government departments, rather than to the Aboriginal organisations with the experience and track record in providing appropriate comprehensive primary health care to Aboriginal people. Consequently, the significant funding commitment is unlikely to have the effect of improving health outcomes which might otherwise have occurred.

The AMA Position Statement on Aboriginal and Torres Strait Islander Health (2005) states:

that within the health system, the crucial mechanism for improving Aboriginal and Torres Strait Islander health is the availability of comprehensive primary health care services; that Aboriginal community control must be supported and appropriately resourced in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context; and that all health services provided specifically for Aboriginal peoples and Torres Strait Islanders should be designed, developed and controlled by the communities they serve in collaboration with mainstream processes.

Supporting Aboriginal community-controlled health services is AMA policy. In the current political environment, with successive Commonwealth governments taking a bureaucratic, managerialist approach to Aboriginal health, rather than an approach which supports the involvement of Aboriginal people and their organisations, Aboriginal community-controlled health services need all the support they can get.

Dr David Scrimgeour AM is the public health medical officer for the Aboriginal Health Council of SA Inc and a part-time senior lecturer in public health at the University of Adelaide.

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