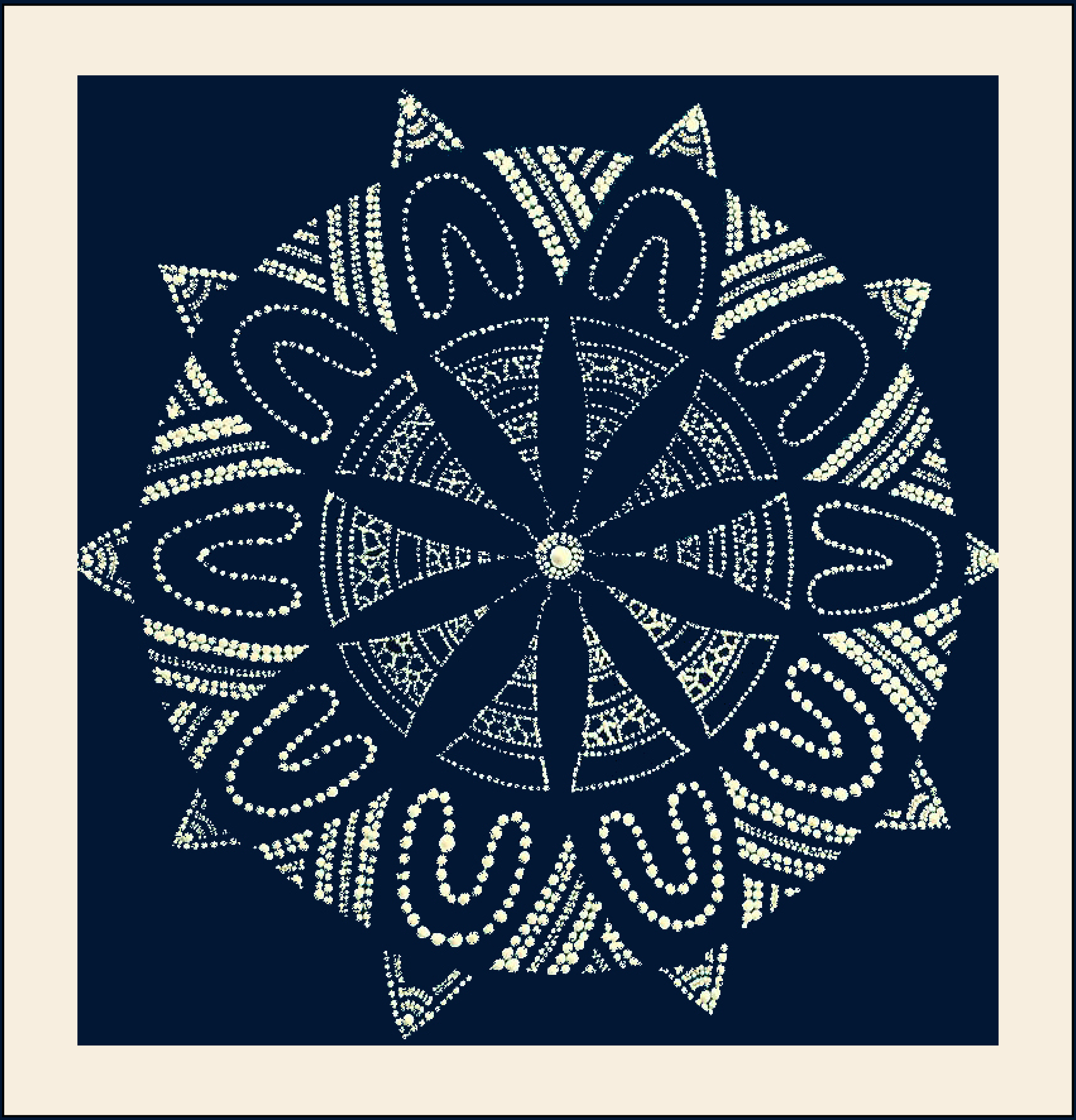
Urban Indigenous Health:

Opportunities and challenges in South East Queensland



UQ Poche Centre for Indigenous Health

The University of Queensland
Australia

Create change

Acknowledgements

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The authors wish to acknowledge the traditional owners of the land on which our cities are built, and pay respect to all Elders, both past and present. In talking about Aboriginal and Torres Strait Islander peoples' presence and movement in urban spaces, we also recognise that, wherever they live, Aboriginal and Torres Strait Islander people maintain deep and ongoing relationships to country.

We use the term 'Indigenous' when referring to both Aboriginal and Torres Strait Islander people. We recognise that Aboriginal and Torres Strait Islander peoples are two distinct and diverse cultural groups.

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Cover Image

Potential by Sid Domic, Outreach and Engagement Program Co-ordinator, the Aboriginal and Torres Strait Islander Studies Unit, The University of Queensland, as commissioned for UQ Poche Centre for Indigenous Health.

Potential represents the potential in all of us. The plant doesn't reach its full potential until it flowers: a symbol of its expression and growth. In the image, the U shapes represents the UQ community (staff, students, Indigenous community, our partners, everyone). From the UQ community comes their individual growth, directed towards the centre circle, which represents a focal point of all this knowledge and energy. This creates the flower, which is symbolic of our potential as a community working together. *Potential* is also a reflection of a DNA cross-section, which makes us what we are.

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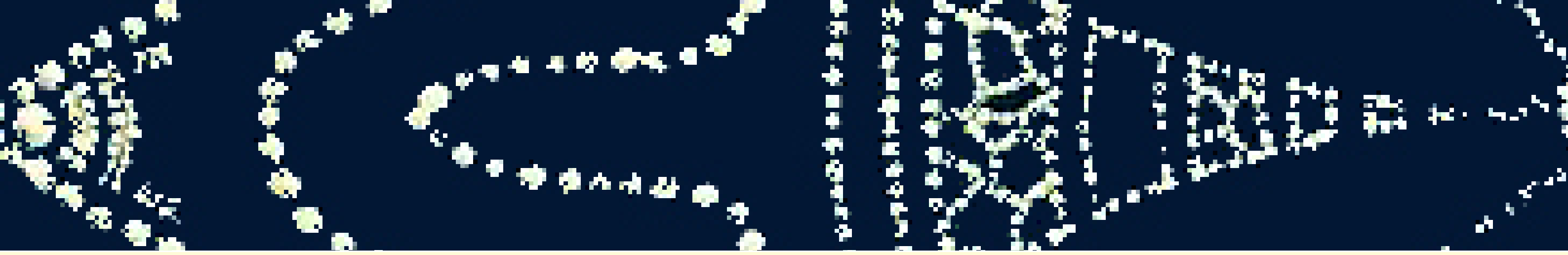
Contents

Figures



> *“The effects of invasion and colonisation on Aboriginal peoples impacted earlier and have been impacting for longer, in what are now urban areas. It is therefore hardly surprising that dispossession and alienation, poverty and disadvantage are felt as keenly by Aboriginal people in urban areas as elsewhere.”*
>
> NACCHO, 2001.

Australian urban Indigenous communities

Globally, the growing rural-urban shift of indigenous peoples has attracted considerable attention from UN agencies, governments, and human rights organisations. Despite their increased proximity to services and facilities, indigenous peoples are often among the most vulnerable and marginalised groups in the world’s cities.

In Australia, the past two decades have seen substantial growth in the urban Aboriginal and Torres Strait Islander population.

Approximately half of all Indigenous Australians now live in major cities and inner regional areas, with implications for planners, policymakers and service providers alike. Yet for many Indigenous Australians, the outcomes of urbanisation are complex.

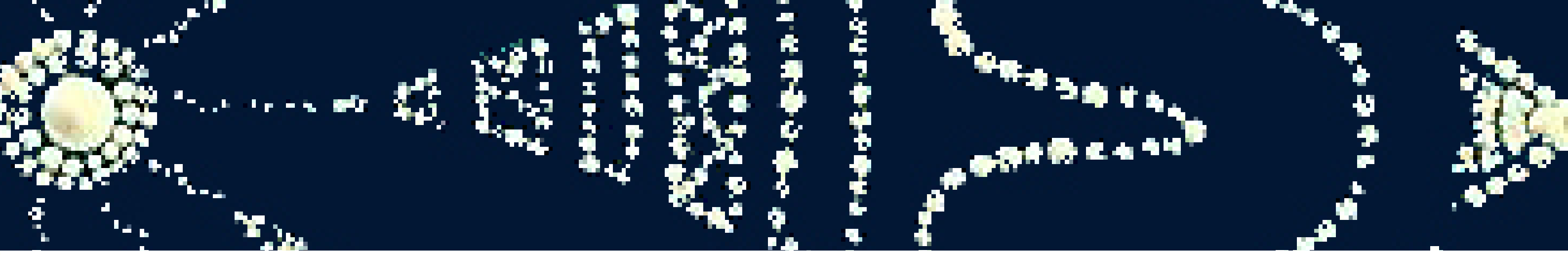
While Aboriginal and Torres Strait Islander people in urban areas are generally in better circumstances than their remote and rural counterparts, compared to their non-Indigenous neighbours, they are significantly disadvantaged across a range of socioeconomic indicators, including higher unemployment rates, lower education attainments, and higher rates of disease and injury.

The case study

South East Queensland is the largest and fastest-growing Indigenous community in Australia. Since the 1980s, the region has seen a marked increase in Indigenous migration, and by 2031, the population is projected to exceed 130,000 people. This burgeoning urban population has a long history of Indigenous-driven services and initiatives.

Using the South East Queensland region as a case study, this paper will unpack the significance of urban Indigenous health outcomes in meeting State and Federal Government aims of ‘closing the gap’. An exploration of the community’s health needs raises questions about how best to meet them, and highlights the tensions that exist between ideologies of mainstream and community-controlled health sectors.

The crux of the argument for prioritising urban Indigenous health is that the disparity between Indigenous and non-Indigenous health outcomes is not confined to remote areas. In cities and towns, Aboriginal and Torres Strait Islander people experience health problems at greater rates than their non-Indigenous counterparts, including a significant burden of mortality, injury and risk factors. And since large numbers of the Aboriginal and Torres Strait Islander population live in urban localities,



they represent a sizable target to close the Indigenous health gap.

The urban population constitutes the majority of this gap across a range of indicators, and are vastly overrepresented in mental health issues. Hence the inequality that Indigenous Australians experience cannot solely be attributed to distance from urban centres (Biddle, 2009).

By now, it is apparent that urban centres with large Indigenous populations like South East Queensland, with a large share of the overall health equity gap, have a stake in national health outcomes. However, it is equally apparent that this will require strategic investment in, and engagement with, urban Indigenous communities.

South East Queensland Demographics

Size and location

The South East Queensland region includes the greater Brisbane, Logan, Ipswich and Gold Coast areas. A large part of this area is covered by the former ATSIC boundary of the Brisbane Indigenous Region, which is the largest such region by population in Australia (ABS, 2012).

In the 2011 census, the South East Queensland region's Indigenous population was roughly 50,000 people. With adjustments for undercounting, and a projected average annual growth rate of 3.7%, current estimates could put the population at upwards of 75,000 (Biddle, 2013).

Not only does this growth rate far outstrip South East Queensland's overall population growth, it also makes the region home to the fastest-growing Aboriginal and Torres Strait Islander community in the country.

The Indigenous population of the South East Queensland region is greater than the total Indigenous population of Victoria and South Australia, and is more than two-thirds of the total Indigenous population of the Northern Territory. Roughly 1 in 3 Aboriginal and Torres Strait Islander Queenslanders live in the relatively tiny South East pocket.

The region[1] covers the local government areas (LGAs) of Brisbane, Ipswich, Logan, Gold Coast, Moreton Bay, Redland, Somerset, Scenic Rim and Lockyer Valley. In 2011, the LGAs with greatest share of the Indigenous population were Brisbane, Moreton Bay, Logan, Ipswich and Gold Coast, with the fastest growth projected for the Logan area.

Population

The South East Queensland Indigenous community itself is a culturally diverse population derived from all over Queensland and other parts of Australia (Fredericks, 2008). As can be observed in other regional centres and major cities of Australia, South East Queensland remains the traditional homelands of Indigenous people who still live in the region, as well as Indigenous people who have come from elsewhere. With Brisbane being the state capital, as well as a centre for tertiary education and specialist medical services, the wider Indigenous community experiences temporary migrants and short-term visitors in significant numbers. Alongside this mobile population are networks of families who have established themselves in certain areas for generations, interspersed with more recent migrants who have settled permanently in South East Queensland.

Many Aboriginal and Torres Strait Islander people living in the region maintain close cultural and kinship ties to their traditional lands or communities of origin. For some people, where they live now is their country. Others may not have a particular Indigenous nation to which they can readily refer, due to legacies of

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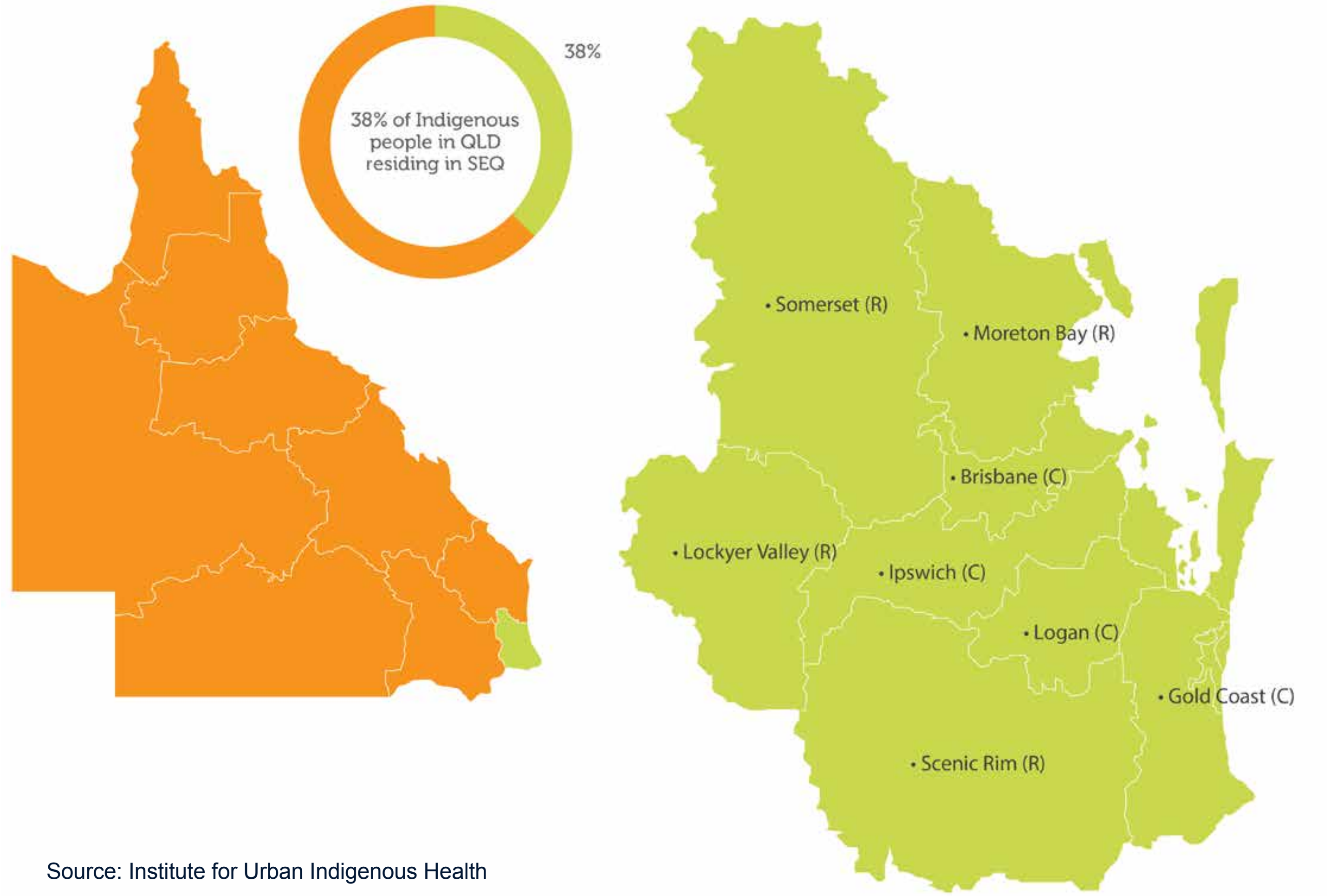
[1] 'South East Queensland' in this monograph series excludes Sunshine Coast.

Figure 1: South East Queensland



Source: Institute for Urban Indigenous Health

colonisation. The displacement of Aboriginal and Torres Strait Islander people from all over the state can be seen in the make-up of the South East Queensland community. Yet it is not just urban Indigenous populations that are highly diverse. Many non-Indigenous Australians often assume that all remote discrete communities are monocultural. However, due to practices of displacement under the Act, it is not uncommon for remote communities to be home to Aboriginal and Torres Strait Islander people from dozens of different groups.

Historical Distribution

Indigenous people have always been a part of the social fabric in South East Queensland, despite various approaches to have them removed.

By the end of the 19th Century, white residents had largely regulated the presence of the South East Queensland Indigenous population in towns. This was frequently by violent means, but also enshrined in legislation through the ‘Protection Act’ (1897). Throughout the 20th Century, government policies actively discouraged the presence of Indigenous people in urban areas. Part of this drew on racist ideologies that suggested that cities were harmful to Indigenous people. In this ideology, urban poverty and fringe camps were not seen as symptoms of racism, oppression or colonisation, but rather as an inherent unsuitability to city conditions - with the presence of Indigenous people a threat to the civility of white peopulations.

The result of this was missionisation and the emptying out of Indigenous people from city areas (Aird, 2001).

Those that managed to remain despite the policies against them included people who had obtained exemptions from the Act, people who were sent out from missions and reserves as domestic servants or employed under work contracts, and Indigenous children removed from their families and adopted by white families in the city.

Towards the end of the 20th Century, however, the tide was beginning to turn. From the 1960s onwards, South East Queensland has experienced increased permanent migration from other areas, as gradual relaxation and eventual repeal of the Act prompted a drift from reserves and missions to urban centres such as Brisbane, Logan, Ipswich and the Gold Coast (Aird, 2001; Fredericks, 2008).

Under the Act, an Indigenous community was always present in South East Queensland (Aird, 2001). Historically, there was a strong sense of community among Indigenous families in the inner suburbs of Brisbane . Over the course of the 20th century, this would translate into active community-making, with high levels of participation, volunteerism and activism (Aird, 2001). This continued as Indigenous people shifted to the outer suburbs and newer communities emerged.

Dispersion

In the 1980s and 90s, gentrification was occurring in inner-city areas that were previously regarded as Indigenous places. As these suburbs became less viable (both with regards to increased racism and increased rents), there was an inevitable drift to outer suburban areas. Increasingly, these suburbs are located further away from the Brisbane CBD and are typically ranked as lower socioeconomic status. Indigenous residents of South East Queensland tend to be unevenly distributed across these neighbourhoods.

The narrative of the outer-urban shift becomes more compelling with the Indigenous growth rate being greatest in these suburbs. Often one of the implications of this is that Indigenous service providers are left playing catch-up in terms of their reach and capacity. This undermines their ability to meet the needs of communities.

Disadvantage in the suburbs

There is a common misconception that the gap in socioeconomic circumstance we see at a national level can largely be explained away by the poor conditions in remote communities (Biddle, 2009). However, the scenario that commonly plays out in Indigenous communities in South East Queensland's outer-suburban rings refutes this entirely. Across the region's cities, suburbs and neighbourhoods, the gap between Indigenous and non-Indigenous neighbours persists (Biddle, 2009). In some suburbs, the gap is more pronounced than in others.

More affordable housing available, including higher concentrations of social housing, can explain the draw of these outer-ring suburbs. An additional factor is the racism and housing discrimination reported both historically and more recently (Aird, 2001; Brough, Bond, & Hunt 2004). However, there is a tendency of Aboriginal and Torres Strait Islander urban migrants to move to areas that already have a high concentration of Indigenous people (Taylor, 2006).

While Aboriginal and Torres Strait Islander people have a history of living on the margins, in contemporary times there is often less of a sense of being pushed to the outer suburbs than there is a sense of choice about it. Certainly affordability has influenced Indigenous presence in the urban periphery, but there are tremendous social resources for Indigenous people living in neighbourhoods with a high proportion of Indigenous residents. Research shows that there is value in these communities, and people desire to remain there (Brough, Bond, & Hunt, 2004; Greenop, 2012).

Community profile

Australian cities have long been sites for Indigenous activism and community-building. Across the country there are a number of well-known contemporary urban sites of significance for Aboriginal and Torres Strait Islander people. Among the most prominent of these Indigenous places is Musgrave Park in Brisbane's West End. Often these sites, such as Musgrave Park and Sydney's Redfern, had been Indigenous meeting places since before colonisation.

Many major Indigenous rights movements have roots in cities, including the Day of Mourning, the Tent Embassy movement, Reconciliation marches, among countless others.

Urban Australia has also been the birthplace of Indigenous community controlled services, beginning in Sydney's Redfern with the Aboriginal Legal Service and branching out to include the Aboriginal Housing Company and the Aboriginal Medical Service. Since the early 1970s, these services have represented urban Indigenous solutions to urban Indigenous problems. In South East Queensland, the spectrum of Indigenous services has included primary health care, schools and kindergartens, and legal, housing and media services, through the establishment of various Aboriginal and Torres Strait Islander corporations. Despite the structural visibility of Indigenous community organisations and initiatives, non-Indigenous outsiders often have misleading interpretations of the community as being inaccessible or hidden (Scrimgeour & Scrimgeour, 2007). Tellingly, researchers and public health advisors often classify urban Indigenous populations as a hard-to-reach group.

There are a number of reasons for this. The first is the common misconception that 'real' Aboriginal and Torres Strait Islander people live in remote communities undertaking 'authentic' and traditional lifestyles. This often has a racist underpinning: that urbanisation means assimilation into non-Indigenous (white) Australian society, as well as the loss of Indigenous identities. Despite their vibrancy and strength, urban communities, such as those that exist in South East Queensland, are frequently rendered invisible by non-Indigenous eyes simply because they don't resemble the stereotype. This also contains notions of Aboriginal and Torres Strait Islander people being incompatible with urban spaces, which historically was the basis for their exclusion from colonial Brisbane.

The second is a perception that the community is scattered or widely dispersed – geographically indistinguishable from the non-Indigenous population (Eades, 2010). In this sense, 'community' is not tangible in the same way that discrete remote communities are. While it is true that the entire Indigenous community does not all live in the one small area, there are certainly suburbs of high concentrations all over the region, both historical Indigenous spaces and more contemporary markers. Of course, 'community' also follows along lines of family and kinship ties, identity systems, community organisation and structural connections (including sporting clubs, schools, arts, media and culture, and health services), activism networks and so on, connecting smaller communities to much larger ones. The sheer size of the region and subsequent population distribution requires non-Indigenous outsiders to look beyond geographical proximity as a marker of community.

Finally, there are observations of segregation that impact on 'Indigenous invisibility' and accessibility. While the Indigenous population is commonly conceptualised as dispersed, Biddle's (2013) research demonstrates that Brisbane is moderately segregated. However, the city is the least segregated of the large capital cities in Australia: Melbourne, Sydney, Perth and Adelaide all have comparatively higher levels of segregation between Indigenous and non-Indigenous Australians (Biddle, 2013).

To unpack this a step further, it was not too long ago that Aboriginal and Torres Strait Islander people in the region were legislatively segregated from the white population. Early European settlements in South East Queensland had boundaries and curfews enforced on local Aboriginal people. A cursory glance at the number of Boundary streets and roads – indicating the town boundaries where Aboriginal people were forbidden – reveals this not-so-hidden history.

The first non-Indigenous settlements in the region actively and violently discouraged the presence of Aboriginal people (Greenop, 2012). This reinforced a racist colonial ideology that revolved around the claim that Indigenous people do not belong in cities. Of course, it also played out against the backdrop of a long era of segregation and protection in the state of Queensland.

Part of reclaiming an urban Indigenous identity has involved challenging dominant histories that erase the presence of Indigenous people in urban settings and dispute claims to Indigeneity.

Health challenges and opportunities

The continued growth of Indigenous populations, coupled with a myriad of socioeconomic limitations, ensures that discrepancies in health status between Indigenous and non-Indigenous Australians is not confined to remote areas.

In South East Queensland, this is exacerbated further, with the shift of population blurring existing Indigenous health service area boundaries. In recent years, the region's four existing community controlled health services have struggled to meet the needs of the Indigenous community with the fastest population growth occurring away from traditional service areas. In 2009, the four providers were serving a population of approximately 50,000. This meant that a large proportion of the population went unserviced.

Simultaneously, the focus of successive governments on Indigenous-specific investment in remote communities has put these already limited services in urban areas at risk of being mainstreamed.

The poor health status of Indigenous Australians is embedded in enduring colonial legacies of dispossession and disruption. It is important to recognise that these factors affect Aboriginal and Torres Strait Islander communities across remote, rural, regional and metropolitan settings.

The motif of remote Indigenous ill-health ignores the fact that effects of colonisation on Indigenous people impacted earlier and have been impacting for longer, in what are now urban areas (NACCHO, 2001). This is what underscores the gap in health equity experienced by Indigenous Australians in cities, despite their proximity to health services. Unfortunately, this aspect of Indigenous poor health in cities and suburbs is often overlooked.

While it is assumed that Aboriginal and Torres Strait Islander people should access health care in the same way as their non-Indigenous neighbours, the statistics show that this is not the case (AIHW 2013; Queensland Health, 2010; Eades, 2010). Historically, mainstream services in urban areas have not effectively met the health needs of Indigenous communities (NACCHO, 2001). As the urban share of the Indigenous population grows, this only becomes more apparent.

The identification and qualification of Aboriginal and Torres Strait Islander health needs, as well as effective approaches to improving urban Indigenous health, is crucial at this juncture.

In South East Queensland, the challenge of meeting the health needs of a large Indigenous population is closely linked to the growth experienced in outer suburban areas with poor access to services, especially primary health care, and particularly Indigenous-specific primary health care.

South East Queensland Indigenous Health Profile

While the rate of burden of disease may be higher in remote areas, the bulk of the burden of disease is experienced by Aboriginal and Torres Strait Islander people in urban areas. As a large proportion of Queensland's Indigenous population live in major cities and regional centres, the health status of Queensland's urban Indigenous population contributes significantly to the overall burden of disease (Queensland Health, 2010). Nationally, 60% of the health gap between Indigenous and non-Indigenous Australians is attributable to those living non-remotely (Eades, 2010; Vos et al, 2003).

Urban-dwelling Aboriginal and Torres Strait Islander people carry the burden of the Indigenous health gap in mental disorders. They are also over-represented in chronic respiratory disease, cardiovascular disease and diabetes.

Other risk factors for disease and injury, such as unsafe sex practices, illicit drug use, high blood pressure, high cholesterol and higher rates of tobacco use, are greater among the urban population (Vos et al, 2003). Additional indicators include:

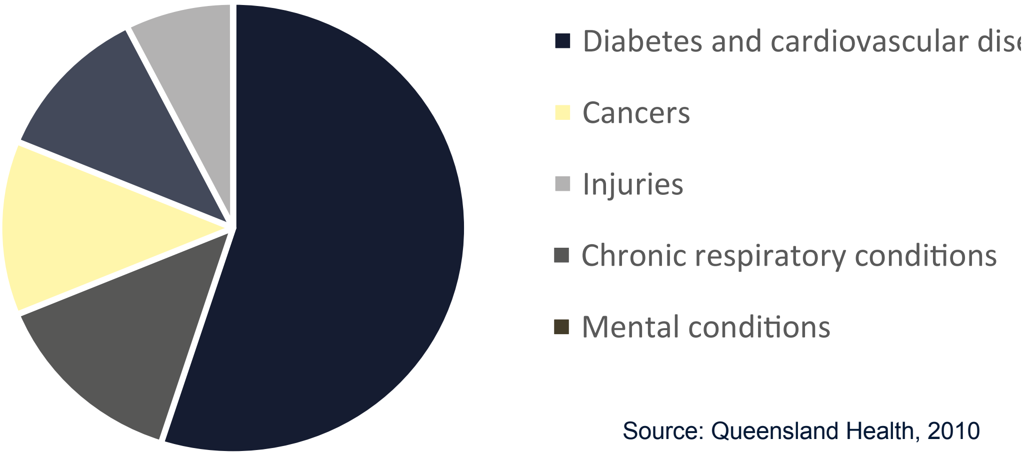
- Indigenous children in urban areas experience higher rates of asthma, dental decay and mental health issues (Eades, 2010).
- In 2008, nearly half of the Indigenous population in urban areas were regular smokers (ABS, 2009).
- In urban areas of Queensland, the health-adjusted life expectancy for Indigenous Australians is 11.9 years less than the Queensland average (Queensland Health, 2010).

A 2010 Queensland Health report outlined the major contributors to the gap between Indigenous and non-Indigenous Queenslanders in urban areas, namely:

- Diabetes and cardiovascular disease, together accounting for 44% of the gap
- Chronic respiratory conditions (11%)
- Cancers (10%)
- Mental conditions (9%)
- Injuries (6%)

Together they account for 80% of the health gap between Indigenous and non-Indigenous

Figure 2: Major causes of the urban health gap



Source: Queensland Health, 2010

residents of urban areas, which is 11.9 years of the health-adjusted life expectancy (Queensland Health, 2010).

This demonstrates the extent to which the gap remains between Indigenous and non-Indigenous Queenslanders, even in regional centres and major cities.

Yet while urban-based Indigenous Australians suffer significant health problems, expenditure on health services for this population is not only less than for their rural and remote counterparts, but less than urban non-Indigenous Australians (AIHW, 2015; Scrimgeour & Scrimgeour, 2008).

As Australia's largest and fastest-growing Indigenous community, the South East will require targeted and effective services in order to meet targets of the 'closing the gap' on a national scale.

Despite some gains in Indigenous health, there is evidence to suggest that intensified efforts will be needed to 'close the gap'. The needs of the urban population are quite clear, and improving the community's health will have a substantial impact on closing the gap.

While the impetus for action on Indigenous urban health may well be clear, within the policy framework there are competing ideologies on how to meet community health needs effectively. More recently policy has centred on improving Indigenous access to mainstream health services in urban areas, however there are arguments for a more community based approach.

Urban Indigenous Health Services and the risk of mainstreaming

Across Australia, the growth in urban Indigenous services frequently lags behind the growth in population. There are a number of reasons for this. For one, 'Indigenous invisibility' makes accessing the urban Indigenous community a difficult task for non-Indigenous outsiders (Fredericks, Leitch, & Barty, 2008).

Secondly, planners and policymakers tend to prefer and encourage mainstream services for Indigenous people in cities. This is due to their perceived ease of access compared to rural and remote areas, where mainstream service delivery is often out of reach geographically. Historically, however, mainstreaming for the Aboriginal and Torres Strait Islander community in urban areas has proved largely unsuitable.

Tied into this predilection for mainstreaming for communities in urban areas is an increased focus on remote service delivery. Recent scaling-up of services has prioritised Indigenous-specific and community-controlled services in health care in places where Indigenous Australians are in the majority (discrete communities'), largely in remote areas.

Funding for Indigenous health care and service delivery remains skewed towards remote areas. In 2011, per person health expenditure for remotely-located Indigenous Australians 1.7 times that of those living in major cities (AIHW, 2015). While the Federal Government recognises the fact that their aim of 'closing the gap' will not be met without targeted strategies for urban areas, funding for Indigenous-specific health service delivery is increasingly directed towards remote areas (*Crikey*, 2008). Only 15% of Indigenous-specific health services are located in major cities – where about 35% of the Indigenous population reside (AIHW, 2013).

Despite the availability of mainstream health services, there remains a solid case for Indigenous-specific and community-controlled health services in urban areas. The poor health status of Indigenous Australians relative to their non-Indigenous neighbours is illustrative of this.

Recently, the Close the Gap Campaign has called on the Government to instigate a national inquiry into institutional racism in the health system. With a reported preference for

Community Controlled Health Services (CCHS), and a reluctance to engage with mainstream services, it is apparent that proximity alone does not constitute a means to improve health equity in Australian cities (Mackey, Boxall, & Partel 2014).

Rather, there is a need to understand why mainstream health services have historically fallen short in providing the same level of care for both Indigenous and non-Indigenous Australians.

Mainstream failure

Across the sectors of health, housing and employment, there have been various policy eras and waves of reform that alternately support community controlled services or promote mainstreaming (Milligan, Phillips, Easthope, & Memmott, 2010; Behrendt, 2005). The demise of ATSIC in 2005 has since ushered in an era of the ‘new mainstreaming’: national coordination – the COAG ‘closing the gap’ framework is a significant example. The top-down, one-size-fits-all approach that is the ideology of mainstreaming has had a jarring effect on Indigenous health services.

The challenge of recognising urban Indigenous communities seems to coincide with government preferences for mainstreaming.

A belief that Indigenous Australians should be serviced by mainstream providers underpins the mainstreaming policy agenda. This agenda disregards the persistent health gap between Indigenous and non-Indigenous people in urban areas as being demonstrative of the failure of mainstream health service provision.

Altman (2004) highlights the main findings of mainstream failure identified by the Commonwealth Grants Commission in their 2001 inquiry into Indigenous funding as follows:

- It is clear from all available evidence that mainstream services do not meet the needs of Indigenous people to the same extent that they meet the needs of non-Indigenous people;
- Indigenous Australians in all regions access mainstream services at a much lower rate than non-Indigenous people;
- The mainstream programs provided by the Commonwealth do not adequately meet the needs of Indigenous people because of barriers to access; and
- Commonwealth Indigenous-specific programs are intended to provide targeted assistance to Indigenous people to supplement the delivery of services through mainstream programs […] the failure of mainstream programs to effectively address the needs of Indigenous people means that Indigenous-specific programs are expected to do more than they were designed for.

There is evidence that Indigenous Australians in urban areas are less satisfied with their access to health care than remote-dwelling Indigenous Australians (Scrimgeour and Scrimgeour 2008). The evidence is that where CCHSs exist Aboriginal and Torres Strait Islander people prefer to use them (Panaretto et al, 2014).

For those living in urban areas, there are particular accessibility issues that affect their ability and willingness to utilise mainstream services. These barriers are centred on availability, affordability, appropriateness and acceptability. In urban areas, the mainstream health services that Aboriginal and Torres Strait Islander people are expected to access often lack cultural sensitivity (AIHW, 2013). What’s more, Indigenous Australians report experiencing racism in health care settings at disturbing rates, and 1 in 10 report difficulties in

> *“The failure of mainstream services, and Aboriginal and Torres Strait Islander people’s ability to access mainstream services, lies at the heart of continuing health disadvantage.”*
>
> - Participant, Australian Government Health Systems Thematic Roundtable, 18 March 2013, Canberra

understanding or being understood by service providers (Scrimgeour & Scrimgeour, 2008).

There is also compelling evidence for culturally safe primary health care provision. Internationally, New Zealand, Canada and the United States have long recognised the need for distinct Indigenous services. In Australia, Aboriginal Medical Services (AMSs) or Community Controlled Health Services (CCHSs) have been a part of the urban Indigenous health care scene since the 1970s, and are overwhelmingly preferred by Indigenous clients (Mackey et al, 2014). They were set up in response to inadequacies and racism in the mainstream health system, and were aimed at reducing the significant financial, cultural and social barriers to health care experienced by Aboriginal and Torres Strait Islander people, particularly in urban areas (Anderson, 2006).

The existence of the community control sector should not absolve mainstream providers of their responsibility to ensure culturally acceptable healthcare is available for Indigenous people, and indeed for all Australians (Scrimgeour & Scrimgeour, 2008).

However, the major health issues that urban Indigenous communities continue to face indicates that mainstreaming primary health care services is unlikley to bring about the vastly improved health outcomes that are needed to improve Indigenous health inequality.

Conclusion

There is an expectation that the needs of urban-based Indigenous Australians will be met primarily through accessing mainstream services. They are often assumed to have the same level of access to services as the non-indigenous urban population. The implication is that their health outcomes should also be similar.

However, the statistics tell a different story.

With higher rates of chronic disease and injury compared to their non-Indigenous neighbours, urban Indigenous communities are also burdened by a life expectancy gap that equates to an average difference of 10.9 years less than the non-Indigenous urban average (ABS 2013). Despite the fact that urban Aboriginal and Torres Strait Islander people suffer significant health problems, expenditure on health services for this population is not only less than for their rural and remote counterparts, but also less than for urban non-Indigenous people (Scimgeour and Scrimgeour, 2008).

Access patterns to primary health care also negatively differ between urban Indigenous and non-Indigenous groups (Scrimgeour and Scrimgeour 2008). There are a number of barriers that urban-based Indigenous Australians face when accessing mainstream health services. These are often multifaceted and involve issues of availability, affordability, appropriateness and acceptability. Despite proximity to service, Indigenous Australians don’t utilise health services in the same way as the non-Indigenous population. Consequently their health outcomes differ accordingly.

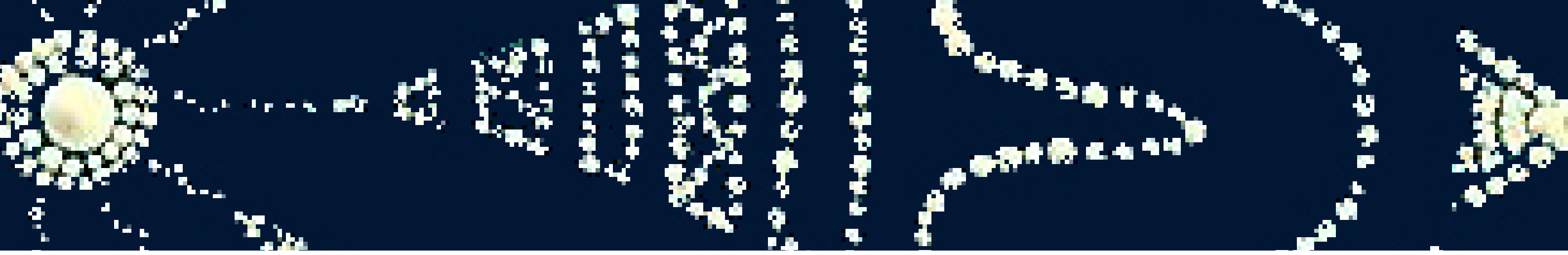
CCHSs had their beginnings in the policy era of self-determination. However, current policy – and the policy for some time now – has indicated strong government preference for Indigenous use of mainstream health services in urban areas (Panaretto, Wenitong, Button, & Ring, 2014). The policy shift and resultant Closing the Gap framework has also seen the direction of Indigenous-sepcific health funding to rural and remote areas, at the expense of the vast majority who live in urban areas.

While reforms to the mainstream sector aimed at increasing providers' ability to provide culturally-safe health care to Indigenous Australians are welcome and needed, they should not come at a cost to CCHSs. With the unprecented Indigenous population growth in Australian cities, and the health gap between Indigenous and non-Indigenous neighbours, their expertise is needed more than ever.

In South East Queensland, this is especially concerning due to the size, growth and dispersion of the Indigenous community. A combination of poor health and poor community-controlled service coverage, without the proportionate investment, puts the efforts thus far of closing the gap at risk of going backwards.

With the continued growth of Aboriginal and Torres Strait Islander communities in outer-suburban areas, meeting their significant health needs has become a challenge for Indigenous service providers. It is becoming increasingly apparent that mainstream efforts of improving urban Indigenous health in the South East are not sufficient, and that a shift in service delivery is desperately needed.

For further reading on the Indigenous CCHS sector, this series continues with an exploration of the history and emerging policy contexts of community control.



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