Community Control:

The changing landscape of Indigenous health

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.
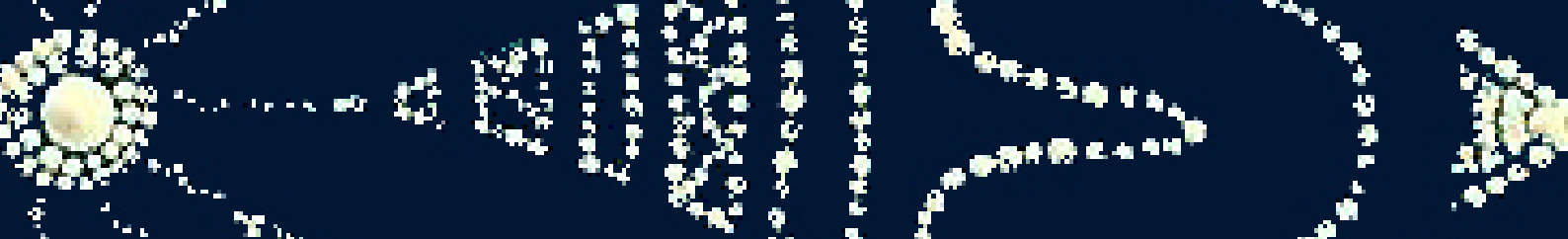
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Cover Image

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.
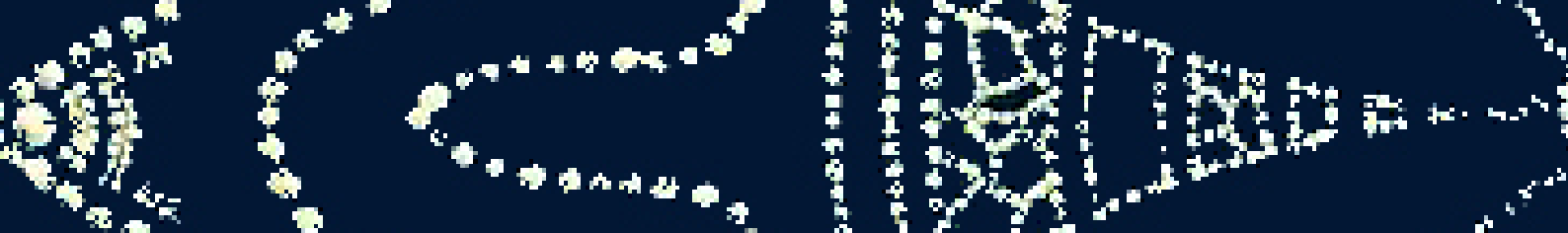
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"The thing is [...] that we own the bloody thing and it is something that we can't — I can't explain about the ownership and the pride that it actually brings.

"We used to be blamed for being the same as the mainstream, well, I can tell you [...] we're nowhere near the same as mainstream. Mainstream would love to do some of this stuff, but they can't. I don't know why, but that's why we're here…"

- Dr Puggy Hunter, 2001

Introduction

The increasing urban shift of Australia's Indigenous population has not yet heralded significant improvement in social disadvantage and health. While recent substantial urban growth ought to signal renewed political will for investment into these communities, it would appear that government responses have thus far been inadequate.

When examining the health of urban Aboriginal and Torres Strait Islander populations, two things become clear. First, that mainstream health system failure to Indigenous Australians is unmistakable, and even more so in our cities, where it is now obvious that proximity to services is not translating into health equity. And second, that urban Indigenous communities - in both historical and contemporary contexts - are actively working towards health improvement.

This is the third monograph in a series on urban Indigenous health. As a case study, South East Queensland – the largest and fastest-growing Indigenous community in Australia – offers considerable scope for understanding the health of the urban population. The region is well-positioned to demonstrate the impact of targeted primary health care services on efforts to 'close the gap' in Indigenous disadvantage.

Indigenous health policy and outcomes

Current health policies under the nationally-coordinated 'Closing the Gap' strategy indicate a focus on remote Indigenous communities at the cost of the health needs of Indigenous Australians in urban areas. Due to their greater numbers, the non-remote Indigenous population constitutes 60% of the overall Indigenous health gap. Under the present funding model for Aboriginal and Torres Strait Islander health, Indigenous-specific services are prioritised for remote localities, while strategies for increasing access to mainstream primary health care are preferred for urban Indigenous communities.
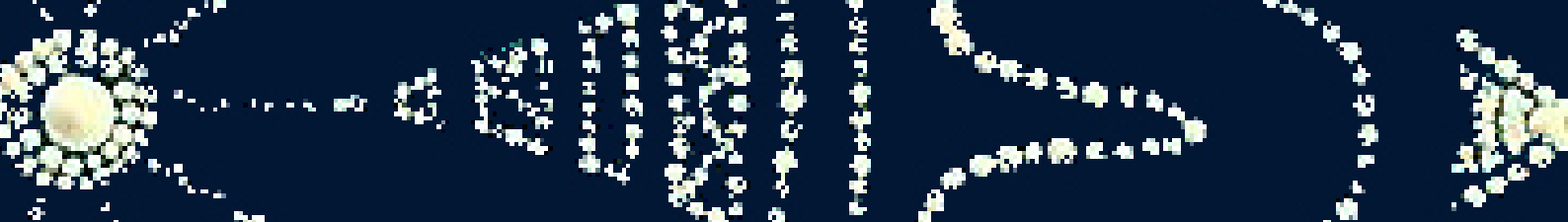
Urban-dwelling Aboriginal and Torres Strait Islander people are often thought to have the same access to services as the non-Indigenous urban population. The implication is that their health outcomes should also be similar.

However, the statistics tell a different story.

With higher rates of chronic disease and injury compared to their non-Indigenous neighbours, Australia's 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). Access patterns to primary health care also negatively differ between urban Indigenous and non-Indigenous groups (Scrimgeour & Scrimgeour, 2008). And across some indicators, the urban population is worse off than those living remotely (Eades, 2010; Vos et al, 2003).

It is abundantly apparent that the increasing rates of Indigenous urbanisation is not diminishing the healthy inequalities they experience relative to the rest of the population. What's more, it refutes the common assumption that 'remoteness' is the root cause of Indigenous ill health. The disparities in health status and life expectancy in urban areas indicate that Indigenous health disadvantage is more complex than geography.

Australia consistently ranks highly among the world's health care systems, and Australians are often at the top of the list of the world's healthiest populations.

One would like to presume that Indigenous Australians would be beneficiaries of this world class system.

The mainstreaming of urban Indigenous health services has been part of government health strategies for some time. However the inequity between Indigenous and non-Indigenous populations in our cities remains, and across some indicators, is deepening (Holland, 2016). Arguably it is the inadequacy of mainstream services and inequitable access that lies at the heart of Indigenous health disadvantage (Australian Government, 2013).

Indigenous-led responses

Urban Indigenous communities have been responding to deficiencies in mainstream health services for over 45 years. Under the banner of self-determination, the Indigenous community in inner-city Sydney in the early 1970s had pioneered community control in legal, medical, housing, and women's and children's services (Foley, 1991). This model of community control quickly spread across the country. Successful outcomes in community-controlled Aboriginal and Torres Strait Islander health saw Queensland's first Indigenous-managed health service open in inner-city Brisbane in 1973.

"Community control is about self-determination, reconciliation and providing culturally appropriate services. But it is also more than that; it is about cultural history, cultural identity and a having a 'place' to identify with."

– VACCHO executive, 2015

The community controlled health service movement

The social movement of the early 1970s that called for Indigenous community control of health services was very much an urban phenomenon (Scrimgeour & Scrimgeour, 2008). Situated more broadly within the policy era of self-determination, the movement came at a time of increased political activism and consciousness for Indigenous Australians following the 1967 Referendum (Aird, 2001; Foley, 1991). It was also firmly located in cities.

With the closure of missions and reserves, the flow of Aboriginal and Torres Strait Islander people to cities and large towns began to steadily increase in the 1960s. Yet new arrivals frequently faced poor conditions. Discrimination in regards to housing and employment led to high instances of overcrowding in urban areas, as well the proliferation of fringe camps on the edge of town. These living conditions often exacerbated the health problems of the urban Indigenous population. Not only was the cost of treatment out of reach for many Indigenous Australians, but the racism they encountered in the health system meant that health care was largely inaccessible (Gillor, 2012).

In response to this ongoing mainstream denial of health care, Aboriginal and Torres Strait Islander people took their health into their own hands. In 1971, the first Aboriginal Medical Service (AMS) was formed in the Sydney suburb of Redfern, which at the time was Australia's largest Indigenous community (Morgan, 2008). Controlled and run by Indigenous people for Indigenous people, the Redfern AMS was the frontrunner for the community controlled health service movement (Weightman, 2013; NACCHO, 2012). A decade after opening, it was regarded as the nation's best example of an Indigenous self-help program (Foley, 1991). Following the success of the model in Redfern, other AMSs were quickly established across

the country. There are currently 150 AMSs – also now commonly known as CCHSs – operating nationwide, overseen by the umbrella organisation, National Aboriginal Community Controlled Health Organisation (NACCHO).

It is important to note that CCHSs are not advocates for separatist 'special treatment', but advocate for best-practice model of care.

History of CCHS in South East Queensland
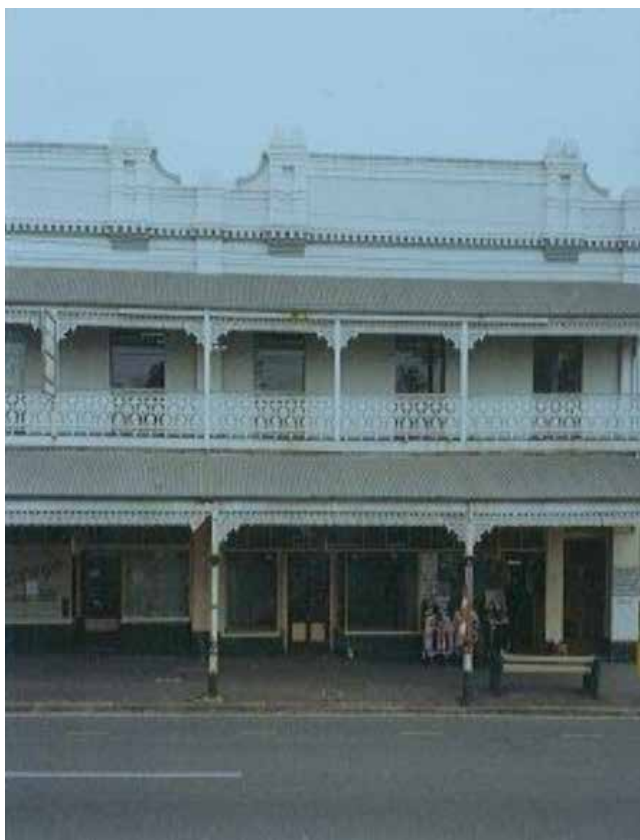
AICHS Red Hill. Image courtesy of ATSICHS Brisbane.

The first CCHS clinic in Queensland was located in Brisbane, opening less than two years after the establishment of Redfern AMS. The Aboriginal and Islander Community Health Service officially commenced operations in February 1973. Initially operating out of a converted shopfront in the inner-city suburb of Red Hill, ATSICHS (as it is now known) adopted an innovative primary health care approach to cater to the needs of Brisbane's Indigenous community.

From the collective work of a small group of volunteers from the Indigenous community and concerned GPs, the clinic in Red Hill was born out a specific set of South East Queensland circumstances. The early 1970s was a time of protest for the Brisbane Aboriginal and Torres Strait Islander community (Ward, Fredericks, & Best, 2014).

The political issues Indigenous residents of the wider Brisbane area were grappling with were often localised: venues refusing Aboriginal and Torres Strait Islander people service, landlords refusing to rent to Indigenous families, schools refusing to enrol Indigenous children, police harassment, and racism in GP clinics and hospitals (Aird, 2001). Church groups and the Brisbane chapter of the Black Panthers also played key roles in galvanising the Brisbane community into action, promoting the community control movement as self-determination made manifest (Ward et al, 2014; Aird, 2001). As communities organised and rallied themselves around specific incidents, the Indigenous community controlled services movement had its beginnings (Aird, 2001; Ward et al, 2014).

It was at this time that the Tribal Council of Queensland set up separate organisations to deal with three areas of concern: law, housing and health. Ward, Fredericks and Best (2014) observe that "in Queensland, this was the birth of community controlled Aboriginal and Torres Strait Islander services".

After opening at Red Hill, ATSICHS was soon providing a range of services to the community, including general medical and dental, social work, mobile clinics, outreach to homeless people and a transport service (Ward et al, 2013). Brisbane's Indigenous community supported others in Queensland to establish their own AMSs, just as Redfern AMS supported the establishment of new services, including in Brisbane itself. (ATSICHS, 2013). There are now more than 25 CCHSs located across the state, represented at a national level by the

Queensland Aboriginal and Islander Health Council (QAIHC).

By 2009, four independent CCHSs were operating 10 clinics in the wider South East Queensland region. At that time, these CCHSs were ATSICHS, Kalwun Health Service, Kambu Aboriginal and Torres Strait Islander Corporation for Health, and Yulu-Burri-Ba Aboriginal Corporation for Community Health.

The CCHS model

"When the community is in control of the resources and facilities, and the people of the community are the ones who determine priorities and policies, it is possible to alleviate the problems confronting that community."

– Dr Gary Foley, activist and historian

Community Controlled Health Services (CCHSs) provide a patient-centred platform for primary health care, where Aboriginal and Torres Strait Islander clients run the service through an elected board of Indigenous directors. This structure is unique within the Australian health system. Here, not only is the service catered to the specific health and cultural needs of Indigenous Australians, but also to the needs of the community. Community ownership and management aims to enable the local community to decide on its priorities, policies, management structure, staff and service profile (Dyer, 2003). This allows communities to be more responsive in addressing their needs. The first National Strategic Framework for Aboriginal and Torres Strait Islander Health for 2003-2013 highlighted the role of the CCHS sector as:

- Providing an established mechanism for increasing Aboriginal control over management of primary health care services

- Representing a major source of education, training, achievement and pride, and have developed a pool of knowledge and expertise about Aboriginal health issues
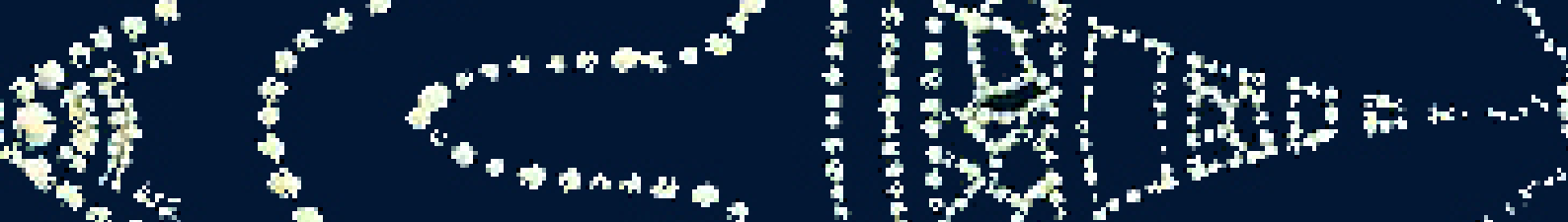
- Being an integral part of the health system, participating as partners with governments in policy, planning and through the Framework Agreements

- Ensuring a range of primary health care services are available in one place

The community-ownership approach pioneered by the CCHS sector recognised the need for accessible, effective and appropriate primary health care for Indigenous Australians. Since that time, CCHSs have also become key sites for Indigenous urban community development (Weightman, 2013). The typical CCHS has evolved to become an incorporated Indigenous organisation initiated by Indigenous communities (Ward, Best, & Fredericks, 2014). From the outset, there have been strong linkages between communities and their health services. On a national scale, the presence the peak body NACCHO and state and territory networks like the QAIHC have allowed CCHSs to lobby governments for funding and engage in advocacy for the Indigenous communities they serve (Scrimgeour & Scrimgeour, 2008; NACCHO, 2013).

CCHSs generally provide comprehensive primary health care, including access to GPs, nurses, allied health professionals, social and emotional wellbeing staff, and medical specialists (AIHW, 2014). The often facilitate access and coordination with mainstream service providers. Frequently these services are broader, reflective of the sector's holistic outlook, and include a range of health and community-related activities and programs to address social determinants of health.

This model of care is needed because of the earlier onset of illness, greater burden of chronic disease, and greater levels of co-morbidity in Indigenous Australians, with a high level of social disorder which compounds this (Close the Gap, 2015). CCHSs aim to provide a prevention and early intervention approach

that communities require. These services – accessible and culturally-appropriate – are crucial in order to meet the targets of 'Closing the Gap'.

In urban parts of Australia the provision of culturally-safe primary health care is paramount (NATSIHP 2013). As a service for Indigenous communities – holistically addressing the whole of a person's health needs, including the health of the community – CCHSs "provide the space to receive health care where culturally security is respected" (Scrimgeour & Scrimgeour, 2008). This is achieved through the ability to:

- Attract and retain Indigenous staff with expertise in Indigenous health

- Provide Indigenous employees and the wider community with meaningful control over services

- Deliver culturally-appropriate holistic care in a welcoming environment

- Through community ownership, foster a sense of pride in the services

- Provide logistical means of access – whether by community drivers to transport clients or staff going out of their way to get the services to clients

- Advocate for Indigenous rights and empowerment

- Function as a hub for urban Indigenous communities and their networks

- Identify critical health issues in the community and address these in a rapid manner

- Facilitate preventative programs, support networks, social health teams, education groups and management plans, tailored to the needs of specific communities
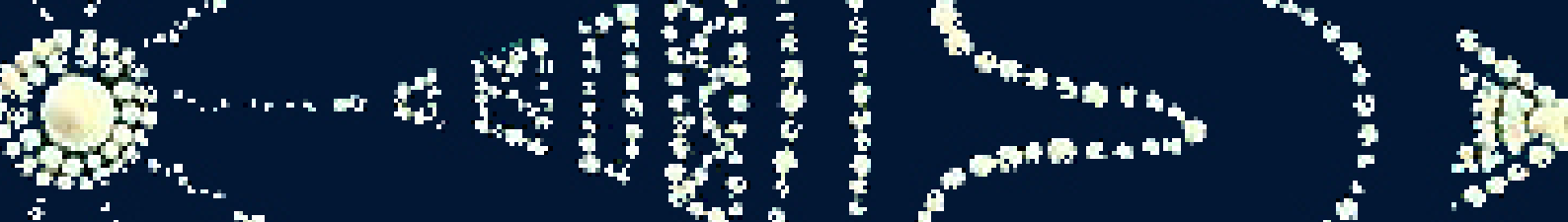
The community controlled sector also addresses the health impacts of discrimination in urban areas (Baba, Brolan & Hill, 2014). Racism in the mainstream public health system was one of the instigating factors for the CCHSs movement (Foley, 1991; VACCHO, 2007). Today, Aboriginal and Torres Strait Islander people in urban areas still experience racism as a barrier to health care and as a contributing factor to their poor health outcomes (Close the Gap report, 2016; Paradies, Harris & Anderson, 2008). Histories of oppression and discrimination have understandably made some Indigenous Australians wary of the health system. Thus urban CCHSs play a key role in providing opportunities for culturally-safe health care.

Of course, not all Indigenous Australians in urban areas use CCHSs as their primary health care provider. Sometimes they choose to use a mainstream service, or sometimes there is no nearby CCHS available. Overall, though, there is strong evidence to suggest that many Indigenous people in urban areas prefer to use Indigenous-specific and community-controlled services for their primary health care needs (Mackey, Boxall, & Partel, 2014; Alford, 2014; Baba et al, 2014). Alford (2014) observes that:

"A pervasive assumption that mainstream health services are an acceptable substitute in urban Australia is not supported by evidence. Ignoring the strong preference for ACCHS jeopardises the precarious health of Aboriginal people resulting from deferred access to health services and under-utilisation of mainstream primary health services. The strong preference for 'own culture', 'own system,' 'own community control' primary health care services is indicated by 6.3% annual increase in demand for these services, notwithstanding supply and fiscal constraints on ACCHS" (pg. 10).

The proliferation of CCHSs across remote, rural and urban Australia attest to the fact that the model is well-regarded by Indigenous clients. However, with providers typically reliant upon

additional government grants to top-up Medicare income, urban CCHSs often face uncertainty about the future of their funding. Under 'Closing the Gap' initiatives, urban mainstreaming policies are increasingly focused on enhancing Indigenous-specific services run by providers from outside the community controlled space.

This places pressure on local CCHSs to demonstrate their relative effectiveness in improving health outcomes, and undermines the hard-fought gains achieved by CCHSs to close the gap.

Cost-effectiveness of the CCHS sector

More recent policy announcements have highlighted the contested role of CCHSs in the health system (Panaretto, 2014; Dennis et al, 2015). In a political landscape dominated by evidenced-based policy, the community control model routinely comes under scrutiny. Due to the availability of health services in metropolitan areas, the community controlled sector's cost-effectiveness in comparison to general practice is of key interest to policymakers. In urban areas, where the emphasis is on mainstream investment, it is increasingly necessary for CCHSs to demonstrate their services' value for money (Ward et al, 2014).

As government policies target the cultural capacity-building of mainstream providers in urban areas to encourage Indigenous access, the separate existence of local CCHSs is challenged. An evidence brief issued by the Deeble Institute surmises that there is currently a lack of evidence around the cost-effectiveness of CCHSs compared with mainstream health services (Mackey et al, 2014). For instance, consider two cost-effectiveness studies identified by the brief:

One study found a CCHS-delivered midwifery service reduced strain on the mainstream antenatal service, as mothers who attended the CCHS program had shorter hospital stays. The goal of reducing tertiary costs was achieved.

Another study on the impact of clinical intervention delivered through both CCHS and mainstream services found that although CCHSs are thought to deliver greater health benefit, they also cost more due to a model of holistic and comprehensive primary health care (Mackey et al 2014).
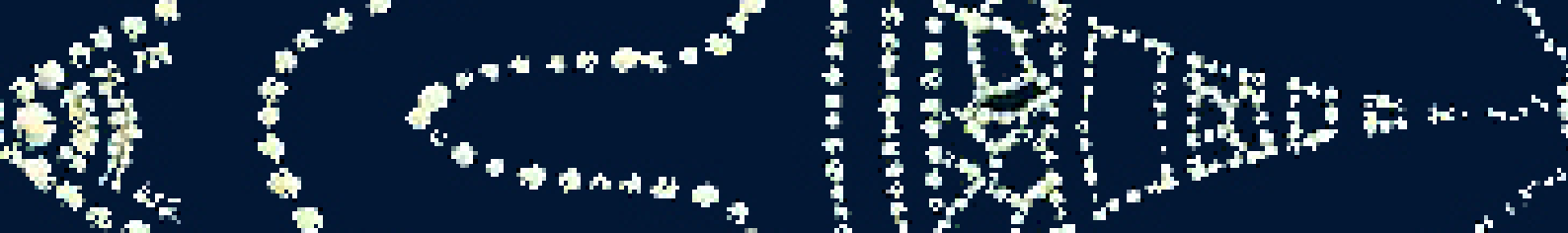
In addition, the available data on clinical outcomes across the two service types is also inconclusive. The literature indicates a number of programs successfully run and monitored in CCHSs, showing improved health outcomes in sexual health, maternal and child health, smoking cessation and cardiovascular programs (Panaretto et al, 2014).

At the same time, there are comparative studies that have found no significant difference in clinical outcomes, or instances of mainstream services outperforming CCHSs (Mackey et al, 2014).

The Deeble Institute notes that the differences in caseloads of CCHSs and mainstream services mean that it is difficult to directly compare the outcomes of each service type (Mackey et al, 2014). This is compounded by community health problems that are complex and multifaceted: tracking health outcomes as a result of specific interventions under an equally multifaceted model of care is difficult at best. CCHSs frequently have significantly more patients at high risk, and accordingly have more time-intensive and budget-sensitive activities (Scrimgeour & Scrimgeour, 2008).

Broadly, though, the holistic model of care that makes CCHSs more acceptable to Indigenous Australians is considered to lead to improved individual health outcomes (Mackey et al, 2014; Close the Gap, 2016).

While acknowledging the evidence on CCHS-based health outcomes is inconclusive when

compared with mainstream services, the Deeble brief authors note that:

"Generally, the improvements in outcomes for Aboriginal people can be attributed to sociocultural factors, including an apparent preference by Aboriginal people to attend ACCHS, as well as increased patient satisfaction, adherence and compliance with treatment regimens. These factors, therefore, are important because they have a positive influence on access to care and the quality of the services delivered. Given the high needs of the population increasing access and quality are central to achieving longer term improvements."

As Australian governments solidify their commitments to 'closing the gap', consideration of the role of the CCHS sector is vital. Yet while governments acknowledge the strengths of urban-based CCHSs described above, it is paradoxically the difficulties with securing funding – often short term and from multiple sources – that limit their effectiveness (Lavoie, 2004).

Policy and funding history: urban Indigenous health services

"Governments have come and gone, departmental responsibilities have been reshuffled and their names changed; there have been centralisation-regionalisation oscillations, fads in health financing reforms, numerous reports commissioned, all-of-government commitments and international covenants signed – truly a paradox of innovation without change."
NACCHO, 2012

In the four decades of CCHS operations, the relationship between community providers and governments and the mainstream health system has been dependent upon revolving Indigenous health policies (NACCHO, 2013). Certainly the Whitlam government's official position of self-determination – intrinsic to the expansion of the

CCHS sector – has been considerably diluted over time.

Approaches to funding Indigenous urban service delivery, too, have shifted. For at least the first ten years, CCHSs in Australia were funded largely by donations and scattered Commonwealth grants, as state governments argued that urban-based Aboriginal and Torres Strait Islander people already had access to mainstream health services (Foley, 1991; Baba et al, 2014). This demonstrates that the myth of mainstreaming has been around for some time.

Presently the bulk of the funding amount is Commonwealth funds directed through the Office of Aboriginal and Torres Strait Islander Health (OATSIH). State and territory governments are the other major source of funding.

The early decades of CCHSs saw gradually increasing support for their programs, but various waves of policy reform have seen government priorities focus on top-down, large-scale, whole-of-government approaches (NACCHO, 2013). In urban areas, where the CCHS movement has its roots, policies of mainstreaming health services for Indigenous people have become prominent. While community controlled Indigenous health services have continued to receive government funding, rotating political ideologies (with particular regards to mainstreaming) and funding cycles have caused a great deal of uncertainty in the sector (NACCHO, 2013; Institute for Urban Indigenous Health, 2015). The current grants process for CCHSs has also been blamed for compromising efforts to close the gap (Lowitja Institute, 2015). Hence while the Australian Government has recently confirmed the availability of ongoing funding for CCHSs, urban communities are naturally concerned about policies of mainstreaming and the sector's future.

The risk of mainstreaming and the urban CCHS

Recent reforms to Indigenous health policy and funding agreements have pushed the community controlled health sector into uncertain territory. COAG's 'Closing the Gap' and the Australian Government's Indigenous Advancement Strategy exemplify the new mainstreaming of mass coordination and consolidation. Part of this consolidated approach has seen pooled funds increasingly focussed on program and service delivery in discrete remote communities, with urban community controlled Indigenous health commitments sidelined. In non-remote Indigenous communities, investments in Indigenous health have largely been in the mainstream sector (Panaretto et al, 2014).

Health services that cater to Indigenous communities are changing. The challenge for urban CCHSs, then, has been two-fold. In part it is underpinned by the fact that the consolidated mainstreaming approach threatens any sense of Indigenous control in the health sector. And on a local scale, the encroachment of mainstream services targeting Indigenous clients has put enormous pressure on community organisations. Both of these factors have been made more urgent with the rapid rise of the urban Indigenous population: Only 15% of Indigenous-specific health services are located in major cities – where about 35% of the Indigenous population reside (Department of Health, 2009).
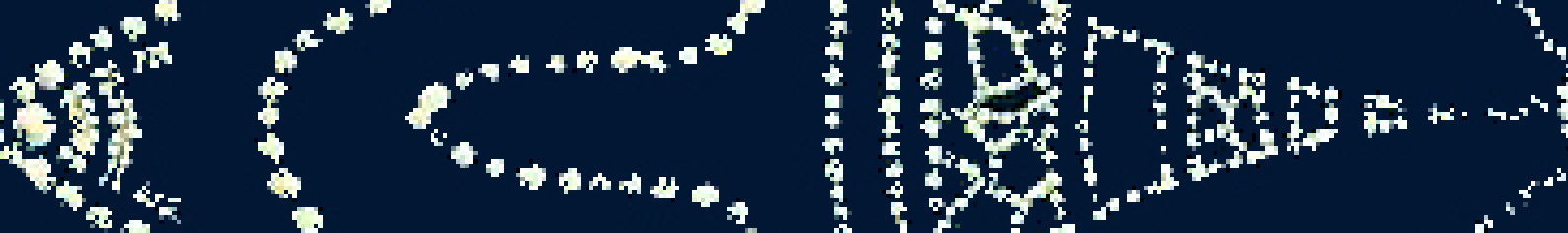
"Mainstream alternatives"…

Governments recognise that urban-based Aboriginal and Torres Strait Islander people may have difficulty accessing mainstream services for a range of complex cultural, historical and socioeconomic reasons (Ware, 2013). Yet rather than acknowledging the important role of CCHSs within the health system, the emphasis is on mainstream services improving their cultural competency. This commonly takes the form of sensitivity training, hiring of Indigenous staff, the creation of an Indigenous advisory board, and so on. The mainstay of this policy agenda is the Department of Health's $84 million Improving Indigenous Access to Mainstream Primary Care Programme (IIAMPC).

While this approach can be viewed as a step forward in improving health system responses to Indigenous health, it minimises the value that communities place in CCHSs. It also erodes the choice that Indigenous Australians ought to have in seeking a health care provider. Of course mainstream providers should provide culturally appropriate health care for Indigenous people: the existence of CCHSs should not absolve them of that responsibility (Scrimgeour & Scrimgeour, 2008). Many urban-based Aboriginal and Torres Strait Islander people use mainstream health services for their primary health care. Their interactions with hospitals and specialist services should ideally be culturally safe. At the same time, mainstream commitments to quality Indigenous primary health care should not come at the expensive of the CCHSs. Rather, these commitments to improve the accessibility and effectiveness of mainstream providers must take place alongside the expansion of the community controlled sector (VACCHO, 2007).

It is worth noting the demarcation between the initial designation of 'AMS' and the contemporary styling of 'ACCHS' or 'CCHS'. This is to distinguish community controlled services from government health facilities that also provide services for Indigenous clients. In some cases, particularly in rural and remote areas, they are run by larger NGOs (Ward et al, 2014). Hence 'Indigenous-specific health services' are not necessarily community-controlled, and this difference is significant. While government Indigenous-specific services regularly employ Indigenous health workers and

other Indigenous staff, up until more recently it was rare for the local community to be entrusted with decision-making powers (Baba et al, 2014). In cities and large towns, these services are typically attached, or act as a pipeline, to larger mainstream structures. In the mid-2000s, 'urban brokerage' was floated as a model for Indigenous health services. Here, Aboriginal Health Workers were employed as part of the health brokerage service to guide Indigenous clients and non-Indigenous clinicians through culturally-appropriate mainstream health services (Dennis et al, 2015).

Government funding for this model has since ceased, but it serves as an example of the new ways that urban CCHSs are facing increasing pressure to exist alongside (or compete against) mainstream structures. While policy developments that make the delivery of Indigenous health services more user-friendly are welcome, the issue is that funds are diverted away from the vital services that urban-based CCHSs provide (Rollins, 2014).

Funding for services

In addition to Medicare income, individual CCHSs rely on significant government grants to maintain some services, which has ramifications for sustainability. In 2007-8, Commonwealth and State governments were responsible for up to 99 per cent of total grant funding. These funding arrangements are increasingly demanding of outcomes: wanting to see demonstrable improvements and value for money, often in overly-ambitious, if not impossible timeframes (VACCHO, 2007; Scrimgeour & Scrimgeour, 2008; Ward et al, 2014). The standards by which both service types are measured have also been shown to differ. Henry, Houston and Mooney (2004) cited an instance where a Perth CCHS had its funding cut when an overspend arose due to success in attracting new clients. At the same time, the Perth teaching hospitals' overspend was up to 120 times as great as the

CCHS: The hospitals were given an extra $100 million to cover their budget overspend.

There are multiple concerns with the present funding arrangements for the sector. Using a survey of 28 community controlled organisations in the 2007/2008 financial year, a report from the Lowitja Institute identified an "onerous and complex system of accounting and reporting faced by ACCHSs" (Martini et al, 2011). Many grants are one-offs, short-term or program-based (Martini et al, 2011). While all of the CCHSs surveyed in 2009 received core funding, security and duration of funding was a concern. For some providers, the proportion of core funding was as little as 13% of their total funding. This lack of core funding is troubling as it limits the flexibility of local priority-setting enshrined in the CCHS model (Martini et al, 2011; Lowitja Institute, 2011). Some of the main findings from the Lowitja study were as follows:

- CCHSs are funded in more complex ways and from more sources than most other health organisations. They are the only sector of the health system that provides comprehensive primary health care services from a base of short-term fragmented contracts from multiple sources.

- Providers struggle to pull together a comprehensive primary health care package from multiple specific-purpose grants (with separate reporting requirements).

- These reporting requirements consume an amount of time and effort from CCHS staff and boards disproportionate to the amount of funds received. Often the mandates attached to funds differ from how services are delivered on the ground, increasing the reporting burden.

- Insecurity of funding is an issue for the sector, with nearly 70% of grants received for use in 2007-2008 being for a period of less than three years.

- Significant funding continues from period to period and is treated by both parties as ongoing, however, contracts are time-limited and regularly require new submissions. In this way, the vast majority of CCHS funding is considered to be ongoing in practice, despite being packaged as short-term contracts.

- The complex contractual environments in which CCHSs operate are not consistently monitored or managed, as they have emerged on an ad hoc basis.

The Lowitja Institute and other organisations, including NACCHO and the AMA, have called for more robust funding arrangements for the community controlled sector (Rollins, 2014; Martini et al, 2011). We know that long-term programs deliver the best health outcomes (Close the Gap, 2016). For local CCHSs, the fragmented nature of funding contracts has an undeniable impact on service delivery, operations and their overall effectiveness. And in urban areas, the current funding model heightens insecurity and uncertainty, contributing to instances of CCHS providers under strain. It is quite clear that a CCHS sector operating below capacity puts progress towards 'Closing the Gap' in jeopardy.
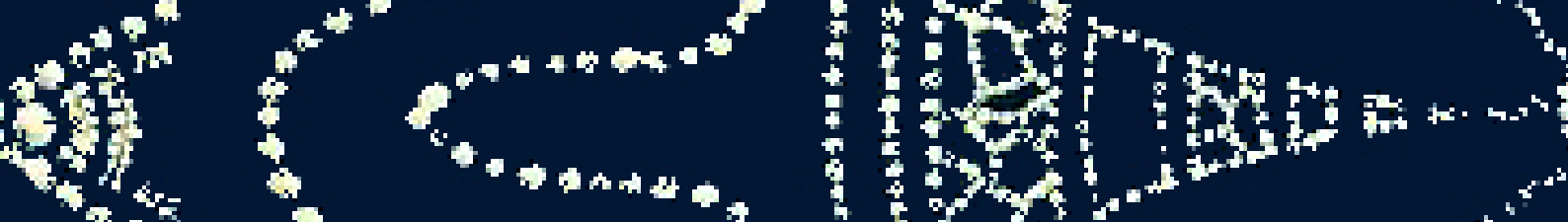
Urban CCHSs under pressure

Across the Indigenous affairs sector, changes to funding allocation models, typified by the current Indigenous Advancement Strategy (IAS), are trending to competitive tenders. A 2016 Senate inquiry found that the shift towards competitive processes "appeared to disadvantage Indigenous organisations", particularly those that were smaller and under-resourced. Here, the organisation that is able to write the best proposal may not be the same organisation who can provide the best services across quality, access and outcomes (Close the Gap, 2016).

These processes wholly ignore the strong preference for CCHSs among Aboriginal and Torres Strait Islander clients. In their submission to the Senate Standing Committee, NACCHO expressed concern over: the reductions in IAS funding to the community controlled sector; the high proportion of grants awarded to the for-profit sector; lack of consultation which meant that half of the 90 CCHSs surveyed did not apply; high proportion of NACCHO members who had their applications rejected (41/90 surveyed); and the reduction of IAS funding for essential services (NACCHO, 2015). This is happening alongside the $500m funding cut in the Indigenous Affairs portfolio (NACCHO, 2015). Under current policy processes, the IAS fails to capitalise on the sector's extensive knowledge and experience of providing services to Aboriginal and Torres Strait Islander communities – to the detriment of their health (NACCHO, 2015).

The closure of Western Sydney AMS in 2015, which went into liquidation after 3 decades of operation, highlights a number of issues with the current policy environment. While not all specific to this particular CCHS, the following concerns have emerged about the viability of urban CCHSs under present funding arrangements:

- Short term contracts make it difficult for CCHSs to engage in long term strategic planning or recruit and retain experienced staff. Providers are disempowered to make sustainable changes to the health of their community. Simultaneously, both funders and providers often act as though they are in long-term funding partnerships, despite the prominence of short-term contracts (Lowitja Institute, 2011).

- When 'competing' with the mainstream, CCHSs are often disadvantaged with higher caseloads. They often require greater "resources, time and evidence base to manage more problems of greater complexity" than would generally be expected in mainstream general practice (Larkins, Geia, & Panaretto, 2012). Thus

their operations are often characterised as ambitious programs with inadequate funding.

- Funding for capacity building of mainstream services and other urban Indigenous health organisations often means that CCHSs experience increased funding competition (VACCHO, 2007; Close the Gap, 2016).

- Traditionally CCHSs have been located in inner-city locations. As the sector has expanded, more providers are operating in outer-suburban areas. However, trends show that unprecedented growth in urban Indigenous populations does not match CCHS coverage, even in these city fringe areas. Providers find it difficult to grow client numbers when they are out of reach.

- Policies such as the Medicare rebate freeze (and other proposed changes to Medicare, such as the $7 co-payment, and privatisation) also have a profound impact on community controlled service delivery, in addition to the stressors of mainstreaming and competitive tendering.

Yet as urban-based CCHS providers grapple with these new challenges – on top of the challenge of providing quality effective health care to the most disadvantaged population group in Australia – the sector's model of care is being adopted in the mainstream. This can be seen in through the development of Primary Health Networks (PHNs) and hospital and health service networks (Panaretto et al, 2014).

CCHS models in the mainstream

PHNs, replacing Medicare Locals in 2015, are part of a reform to the primary health care system. Part of their agenda is to understand the health needs of communities, with greater involvement in population health, and they are managed by a local board. In many ways, CCHSs can be viewed as the prototype for this model of care (Panaretto et al, 2014).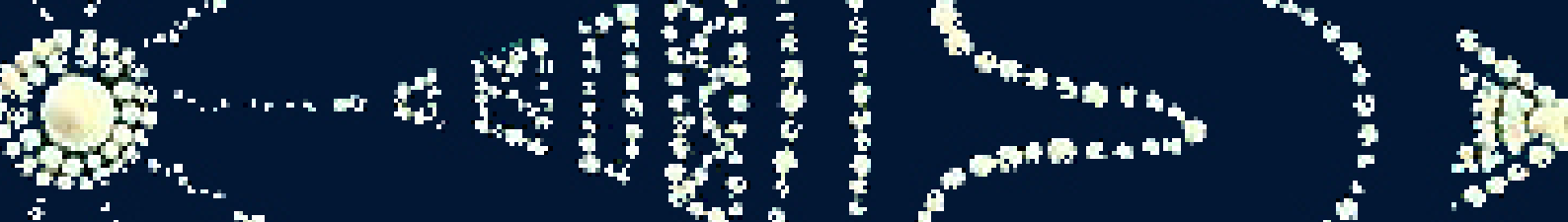 Here, the adoption of a community-based model for mainstream primary health care signals an opportunity for urban CCHSs. PHNs were also established with the intention of coordination with local CCHS providers under 'Closing the Gap' strategies. Significantly, then, PHNs both increase capacity for coordinated care and validate the existence of CCHSs in urban areas. However, without meaningful partnership with the CCHS sector, PHNs could exacerbate funding inequities and inefficiencies in the health system (Close the Gap, 2016).

Despite positive outcomes to stem from well-managed partnerships with PHNs, CCHSs face further uncertainty within this model. PHNs could potentially burden an already stretched CCHS sector. One prevailing consequence of mainstreaming is the increased demand on CCHSs to provide consultation, advice and coordination with governments and mainstream service providers. Simultaneously, CCHSs see cuts to funding and are disadvantaged by unworkable funding arrangements.

Responses to mainstreaming

If there is to be a continued policy focus on mainstream services at the expense of CCHSs, the burdens on community providers will increase substantially (VACCHO, 2007). A destabilised community controlled health sector means that local CCHSs will be less effective at meeting the health needs of their communities, and Indigenous health will be worse off for it.

Given the incentives intended to encourage Indigenous access to urban mainstream services, urban-based CCHSs are particularly at risk. The irony is, of course, that the CCHS movement was an urban response to the mainstream's historical inability to provide primary health care to Indigenous communities. The community control sector has a long history of providing primary and preventative health care to Aboriginal and Torres Strait Islander people in urban areas. The evidence of this

model's effectiveness is visible in the roll-out of community-based models like PHNs. CCHSs are distinguished by their commitment to the ethos of self-determination. Community control ensures that Indigenous Australians are able to take charge of their own health and the health of their communities.

In the early 1970s, when the health system was failing Redfern's Aboriginal and Torres Strait Islander population, the community responded with their own AMS (Foley, 1991). Unsurprisingly, contemporary urban communities have responded to these new challenges in a similarly pragmatic way. In recent years, CCHSs have begun to organise themselves into regional alliances built around common interests (Ward et al, 2014). One example is the Institute for Urban Indigenous Health (IUIH) in South East Queensland.

The IUIH was established in 2009 as a strategic response to significant Indigenous population growth and distribution in South East Queensland. Not oblivious to the policy environment described above, the IUIH was formed with the aim of an integrated and efficient approach to Indigenous health care in the region. Today, the IUIH supports the growth of the CCHS sector in South East Queensland with a network of 18 primary health care clinics, through the ownership of its 5 CCHS members.

The IUIH model will be examined as a case study in the next paper in this series.

Conclusion

"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 […] 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".
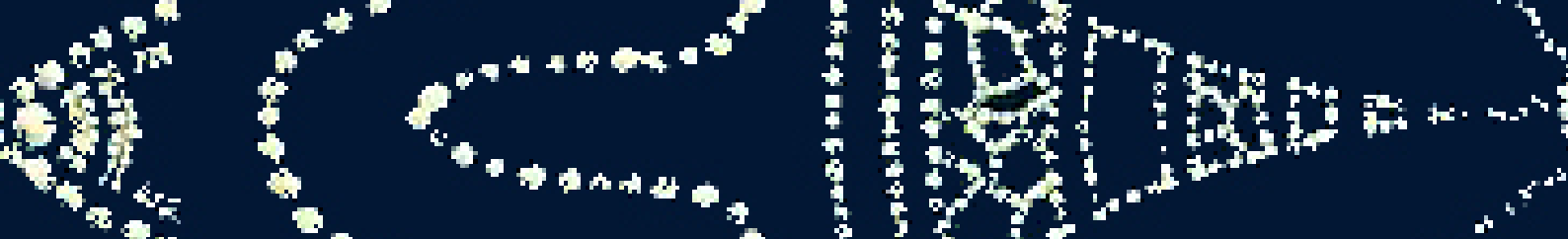
– Dr Michael Weightman, 2013.

Since the establishment of the first AMS in 1971, successive governments' revolving policy frameworks have frequently threatened the viability of the urban CCHS. The irony is, of course, that the first CCHSs were the urban Indigenous response to barriers in the mainstream health system.

The community control sector has a long history of providing primary and preventative health care to Aboriginal and Torres Strait Islander people in urban areas. The evidence of this model's success is visible in the roll-out of community-based models in the mainstream, such as Primary Health Networks.

Yet increasingly policymakers expect that Aboriginal and Torres Strait Islander people living in urban areas should use mainstream health services. This is embodied by higher-allocation of funds for mainstream providers in order to improve their cultural competency and encourage Indigenous access in cities and regional centres, and the redirection and reduction in funds for urban CCHSs.

The existence of the community control sector does not alleviate responsibility of mainstream services to Indigenous clients; nor does community control ethos require their isolated operation. However, it is becoming quite clear that the prioritising of mainstream structures has compounded the pressures that urban CCHSs

face around complex and insecure funding cycles.

In spite of the challenges, urban-based CCHSs will continue to respond to policy and service delivery barriers in order to achieve better health for Indigenous Australians. The success of a coordinated regional approach like the Institute for Urban Indigenous Health is reflective of the continuing resilience and innovation of Indigenous people in urban areas in ensuring access to care. The coordinated regional approach of IUIH also demonstrates the potential of CCHSs to strategically position themselves in State and Federal objectives of 'closing the gap'.

CCHSs have always had a vital role to play urban Indigenous health. However the community control sector's capacity to close the gap is inhibited by funding models that undermine the work and successes of these critical primary health care providers.

CCHSs are distinguished by their commitment to the ethos of self-determination. Central to this struggle, community control ensures that Indigenous Australians are able to take charge of their own health and the health of their communities. While the sector's future remains uncertain under present models, its history of innovation and pragmatism ensures that it must continue to be a key player in improving Indigenous health.

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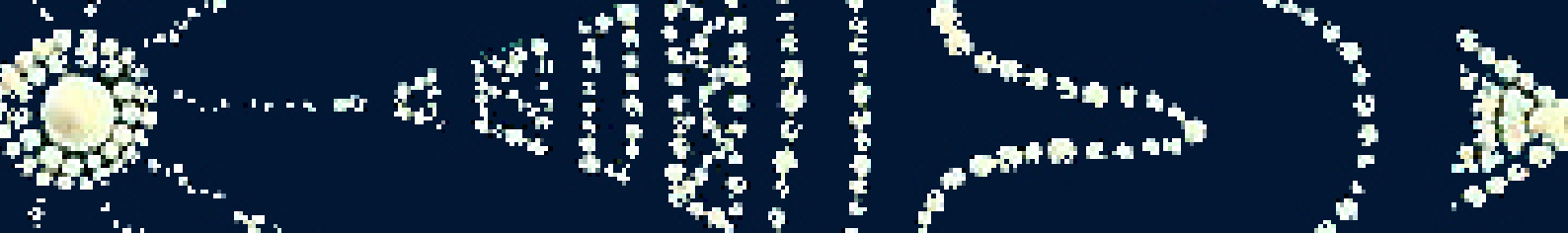National Aboriginal Community Controlled Health Organisation. (2012). NACCHO History. Retrieved from http://www.naccho.org.au/about-nacho/naccho-history/

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