

RAUCHS

Research Alliance for Urban Community Controlled Health Services

State of Play Report 2026: Aboriginal and Islander Community Controlled Health Services and the health and wellbeing of Aboriginal and Torres Strait Islander people living in capital cities of Australia

Prepared by

UQ Poche Centre for Indigenous Health

State of Play Report 2026: Aboriginal and Islander Community Controlled Health Services and the health and wellbeing of Aboriginal and Torres Strait Islander people living in capital cities of Australia

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UQ Poche Centre for Indigenous Health, The University of Queensland.

April 2026.

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Suggested citation: Leske, S., Wallace, J., & Ward, J. (2026). State of Play Report 2026: Aboriginal and Islander Community Controlled Health Services and the health and wellbeing of Aboriginal and Torres Strait Islander people living in capital cities of Australia. Prepared by the UQ Poche Centre for Indigenous Health, The University of Queensland, for the Research Alliance for Urban Community Controlled Health Services.

Published by the UQ Poche Centre for Indigenous Health.

National Library of Australia cataloguing-in-publication entry

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UQ Poche Centre for Indigenous Health.
Title: State of Play Report 2026: Aboriginal and Islander Community Controlled Health Services and the health and wellbeing of Aboriginal and Torres Strait Islander people living in capital cities of Australia.

Dewey Number: 305.89915

Acknowledgement of Country

This report was prepared in Magandjin. This report acknowledges the Yuggera and Turrbal People as the custodians of this Country since time immemorial. This Country has long been a place for gathering, teaching, learning, and research.

The report has been developed with Aboriginal and Torres Strait Islander people from across Australia, with deep connections to Country and place. We acknowledge traditional owners and custodians of Country of all the lands for people who were involved in the development of this report.

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Glossary

Term	Definition
Aboriginal and Torres Strait Islander Community Controlled Health Services	These can also be known as Aboriginal and Torres Strait Islander Community Controlled Health Services, Aboriginal Community Controlled Health Services, Aboriginal Community Controlled Health Organisations, Aboriginal Medical Services, or Community Clinics. We use the term AICCHS to include both Torres Strait Islanders and also other Islanders who may require treatment on the mainland. The National Aboriginal Community Controlled Health Organisation (NACCHO), the national peak body for all ACCHOs, defines Aboriginal community controlled health as: *'a community-run primary healthcare service that provides comprehensive, culturally informed care for Aboriginal and Torres Strait Islander people. These services address not only physical health but also the social, emotional, and cultural wellbeing of individuals, families, and communities, aiming to support healthier, happier lives.'*[1]
Age-standardised rates	An age-standardised rate is an adjustment made to account for differences in age structures over time, in different areas, or between different population groups.[2]
Greater Capital City Statistical Areas	Greater Capital City Statistical Areas (GCCSAs) refer to the Australian Bureau of Statistics' geographical boundary of Greater Capital City Statistical Areas. They represent the functional area of each of the eight State and Territory capital cities, including populations who regularly socialise, shop or work within the city, but may live either in the city or in the small towns and rural areas surrounding the city.[3]
Relative standard error	The standard error, expressed as a proportion of its estimated value.[4] A higher relative standard error indicates less confidence that an estimated value is close to the true population value.

Abbreviations

Term	Full name
ABS	Australian Bureau of Statistics
AEDC	Australian Early Development Census
AICCHS	Aboriginal and Islander Community Controlled Health Services
ASR	Age-standardised rates
GCCSA	Greater Capital City Statistical Areas
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
RAUCCHS	Research Alliance for Urban Community Controlled Health Services

Executive summary

This is the inaugural report of the Research Alliance for Urban Community Controlled Health Services (RAUCCHS), a consortium of capital city Aboriginal and Islander Community Controlled Health Services (AICCHS) and the Poche Centre for Indigenous Health, based at The University of Queensland. The report draws on publicly available data, scans of literature as well as consultations conducted with members of RAUCCHS. This Report will become an annual publication that aims to elevate issues impacting urban AICCHS and the health and wellbeing of Aboriginal and Torres Strait Islander people living in capital cities.

This State of Play Report provides a snapshot of health and wellbeing outcomes for urban Aboriginal and Torres Strait Islander people, as well as providing rationale for a greater focus on the health and wellbeing of urban Aboriginal and Torres Strait Islander peoples. It also highlights some of the work urban AICCHS conduct as well as some of the issues they are currently facing. In doing so RAUCCHS members and the authors of this Report aim to bring greater attention to issues that affect urban AICCHS, and the health and well-being of urban Aboriginal and Torres Strait Islander people. The Report is not intended to diminish efforts or resources needed in other regions of Australia, but instead argue that greater recognition is required of the issues that capital city AICCHS are currently facing and the unique issues that they are addressing.

This Report presents data disaggregated by Greater Capital City Statistical Areas (GCCSAs)[3] as defined by the Australian Bureau of Statistics (ABS) in each of Australia's state and territory capitals. These areas align closely with the main AICCHS service delivery footprints in each of the capital cities. The authors of this report also acknowledge that there are many other Aboriginal and Torres Strait Islander people living in the 11[a] areas the ABS has classified as "Major Cities of Australia", that are not the focus of this inaugural report, but consideration will be given to these in future iterations.

We look forward to working on this annual report in coming years, some of which will have a specific focus on contemporary issues. The report will be housed on the UQ Poche Centre for Indigenous Health website and many of the urban AICCHS own websites for downloading. This Report accompanies other pieces of work, that RAUCCHS members have been involved in.

[a] All capital cities except for Darwin and Hobart are considered "Major Cities of Australia". Other areas classified as Major Cities of Australia include Geelong; the area around Bacchus March, Darley and Maddingley; the area surrounding Wollongong; the NSW North East Coast, and the Gold Coast.

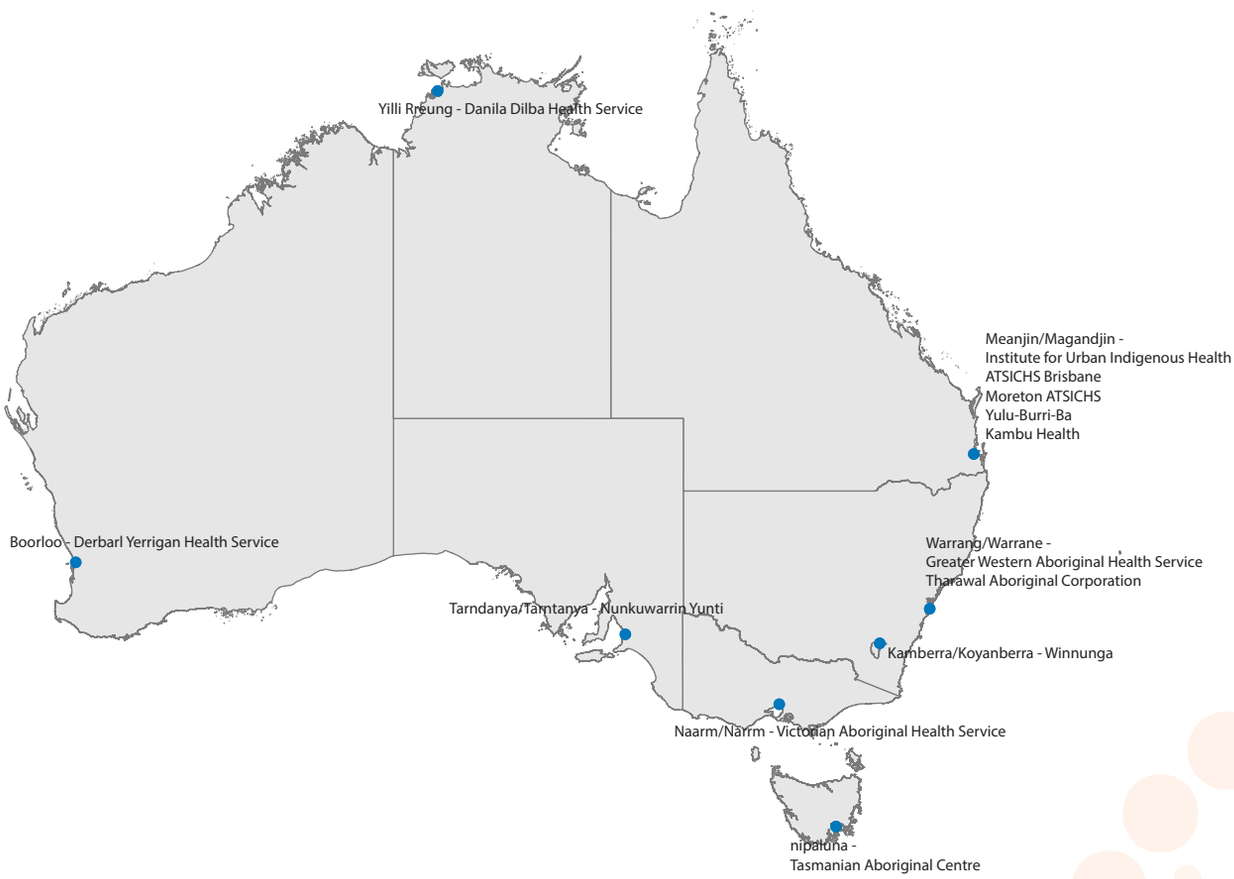
These include a Urban Aboriginal and Torres Strait Islander Health and Wellbeing Research Framework as well as a national health equity dashboard prepared in partnership with the AIHW. The dashboard provides social determinants and health and wellbeing outcome data by capital city and by Aboriginal and Torres Strait Islander status and will be a valuable asset for future advocacy, research, policy and program responses.

Part 1: Introduction

The Research Alliance for Urban Community Controlled Health Services (RAUCCHS) was formed to bring together researchers and urban Aboriginal and Islander Community Controlled Health Services (AICCHS) together to discuss issues impacting urban AICCHS and to develop an Australian first national Urban First Nations Research strategy. The objective of RAUCCHS, is to capitalise on the expertise and capacity of members to achieve transformational changes in urban First Nations primary health care research infrastructure, capacity, research policy, and program outcomes.

The UQ Poche Centre for Indigenous Health provides strategic coordination and research support, reflecting its commitment to community-led approaches and health equity. This Inaugural report will be an important asset to inform governments, and the broader health and research sectors about the growing health needs of Aboriginal and Torres Strait Islander communities in capital cities, and the critical role of capital city AICCHS in delivering culturally safe, effective, community-driven and cost-effective care.

This Report is focused on the eight capital cities of Australia: Brisbane, Sydney, Canberra, Melbourne, Hobart, Adelaide, Perth and Darwin.



Each city has one or more AICCHS organisations, with most providing satellite primary health care clinics across the greater capital city footprint. It should be noted that not all AICCHS in every capital city are a member of RAUCCHS at this stage.

Urban AICCHS play a critical role in delivering culturally safe, holistic, and community-led care. Many AICCHS are providing care to people who not only are residents of the city, but also to Aboriginal or Torres Strait Islander people who are residents from other areas, either, visiting, working, or living temporarily in a capital city. This creates additional service demands for urban AICCHS. As such, each AICCHS seeks to innovate with models of care that improve care delivered to as many people as possible, as well as to improve health outcomes.[5] Success stories of AICCHS ranging from vaccination campaigns[6] to prison health services[7,8] and award-winning clinical excellence,[9] show their capacity to deliver results for their people and are highlighted in this Report.

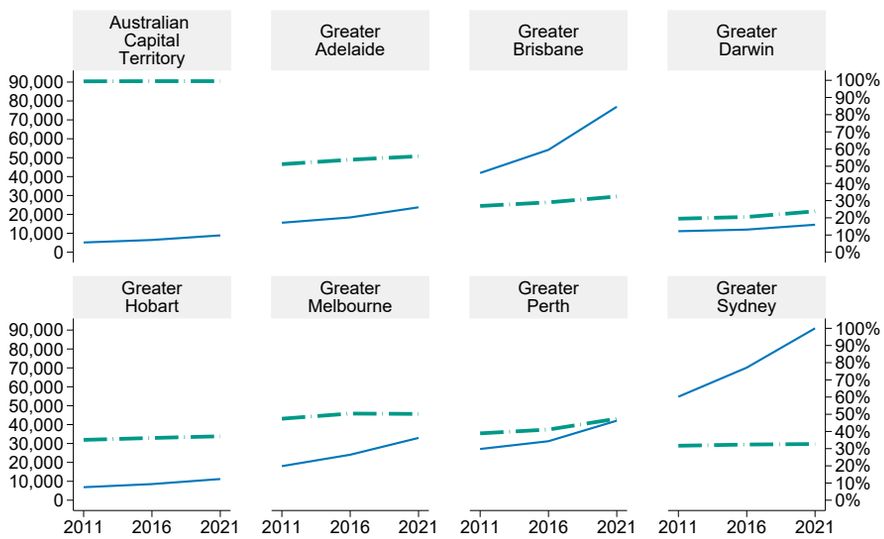
Urban Populations and Urbanisation

Aboriginal and Torres Strait Islander people living in Greater Capital City Statistical Areas (GCCSAs) comprised 37% (365,909/983,709)[10] of the total Aboriginal and Torres Strait Islander population in the final census-based estimated resident population for 2021. Urbanisation is a global phenomenon, disproportionately impacting Indigenous peoples. Here in Australia that trend is occurring among Aboriginal and Torres Strait Islander peoples at a rapid rate. Between 2011 and 2021, the overall population of Aboriginal and Torres Strait Islander people living in capital cities increased by 67%.[11] Relative population growth in each capital city over the ten years ranged from 31% in Greater Darwin to 84% in Greater Brisbane.[11] This compares to an overall population increase among non-Indigenous people in capital cities of 28% in the same period, ranging from 19% in Greater Adelaide to 33% in Greater Perth.[11]

The impact of rapid urbanisation means significant pressures are exerted on existing capital city AICCHS, because they have not been able to expand proportionately. The 2022-2023 National Aboriginal and Torres Strait Islander Health Survey highlighted the unmet health care needs of urban First Nations peoples. In this survey 55% of First Nations peoples (86,200) in capital cities stated they would like to go to an Aboriginal Medical Service or AICCHS for their own health care but usually go somewhere else.

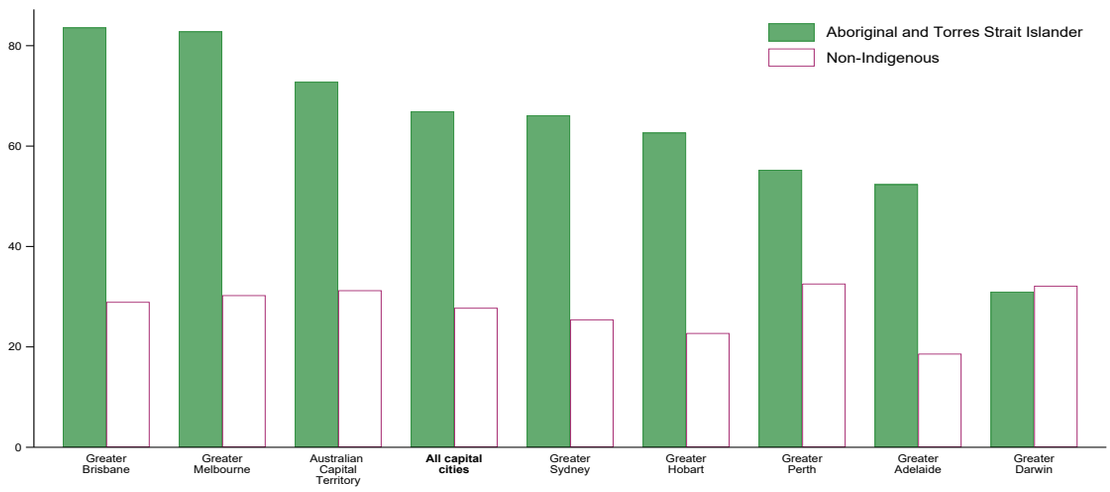
Figures 1 and 2 highlight population estimates as recorded in the last three Australian Population Censuses as well as population growth in each capital city for Aboriginal and Torres Strait population.

Figure 1. Aboriginal and Torres Strait Islander population growth, number and percentage, by capital city, 2011-2021.



In all panels, solid lines show population counts (left axis) and dashed lines show percentages over time (right axis). Axes are scaled to show change over time within each capital city, and are consistent across city panels.
Source: Australian Bureau of Statistics (ABS), Census of Population and Housing, 2011, 2016 and 2021.

Figure 2. Relative population growth of Aboriginal and Torres Strait Islander people and non-Indigenous people living in Greater Capital City Statistical Areas, 2011-2021



Bars use both colour and pattern to support accessibility.
Source: Australian Bureau of Statistics (ABS), Census of Population and Housing, 2011, 2016 and 2021. Proportions calculated by authors.

The impact of rapid urbanisation means significant pressures are exerted on existing capital city AICCHS, because they have not been able to expand proportionately. The 2022-2023 National Aboriginal and Torres Strait Islander Health Survey highlighted the unmet health care needs of urban First Nations peoples. In this survey 55% of First Nations peoples (86,200) in capital cities stated they would like to go to an Aboriginal Medical Service or AICCHS for their own health care but usually go somewhere else.[12]

Health and Wellbeing Status of Urban Populations

The health status of Aboriginal and Torres Strait Islander people living in urban areas is understated, and requires more attention.[9] Even though health disparities between Aboriginal and Torres Strait Islander people and non-Indigenous Australians are often greatest in remote areas, there is a critical need to provide greater focus on urban Aboriginal and Torres Strait Islander peoples' health and wellbeing. Health outcome data related to urban Aboriginal and Torres Strait Islander people, is seldomly reported. However, we highlight some data here to highlight inequities and disparity in health outcomes for Aboriginal and Torres Strait Islander peoples' living in capital cities.

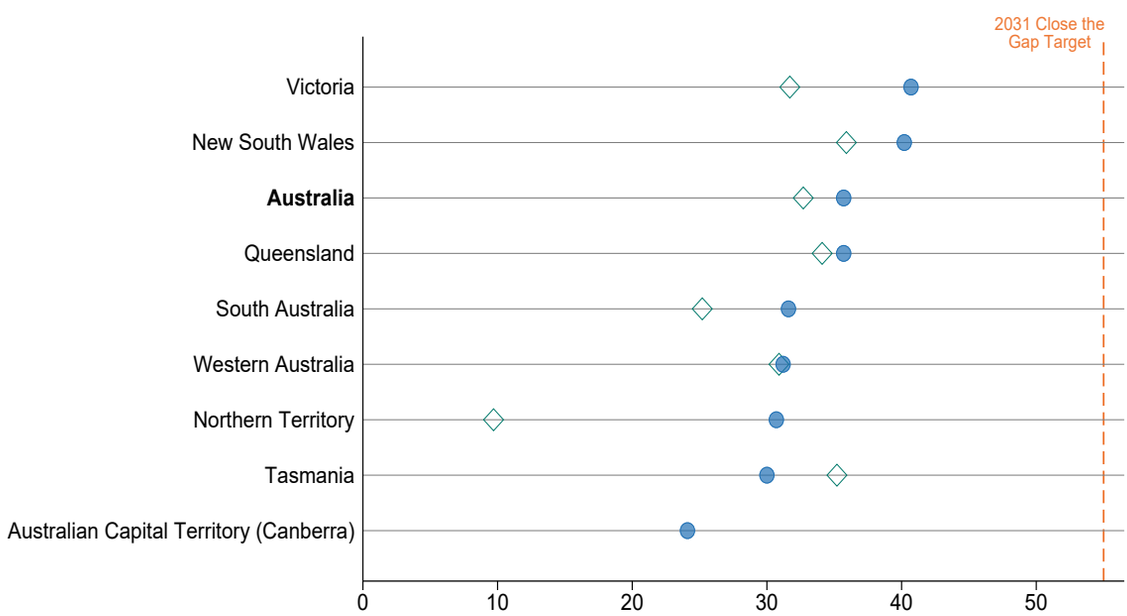
The largest share of fatal (32%), non fatal (36%) and total (34%) burden of disease among all First Nations People occurs among urban residents.[13] In five capital cities (Sydney, Brisbane, Adelaide, Perth, and Darwin), the median age at death for First Nations peoples from 2018 to 2022 was on average 21 years younger than for non-Indigenous peoples living in the same areas.[14]

In 2022–2023, almost a third of Aboriginal and Torres Strait Islander people aged 18 and over, living in cities, self-reported high/very high levels of psychological distress ref and only 44% of people living in cities reported their health status as excellent/very good.[15] The rate ratio of potential preventable hospitalisations between urban First Nations peoples and non-Indigenous peoples living in capital cities was 1.93 in the period, 2017/18-2019/2020.[14] Between 2015 and 2024 there has been a 340% increase in infectious syphilis rates in Major Cities of Australia[16] and from the COVID-19 pandemic, 44% of all cases diagnosed among Aboriginal and Torres Strait Islander people were in Major Cities of Australia.[17]

The outcome for Closing the Gap Target 4 is for Aboriginal and Torres Strait Islander children to thrive in their early years.[18] CTG 4 target is that by 2031, 55% of Aboriginal and Torres Strait Islander children are to be assessed as developmentally on track in all five domains of the Australian Early Development Census (AEDC).[18]

Figure 3 shows the proportion of Aboriginal and Torres Strait Islander children in each capital city on track in all five domains. In capital cities, the proportion of Aboriginal and Torres Strait Islander children developmentally on track in all five domains ranged from 30% in Greater Hobart to 35.7% in Greater Brisbane.

Figure 3: Developmental vulnerability: Aboriginal and Torres Strait Islander children on track in all five domains, Greater Capital City Statistical Areas, 2024



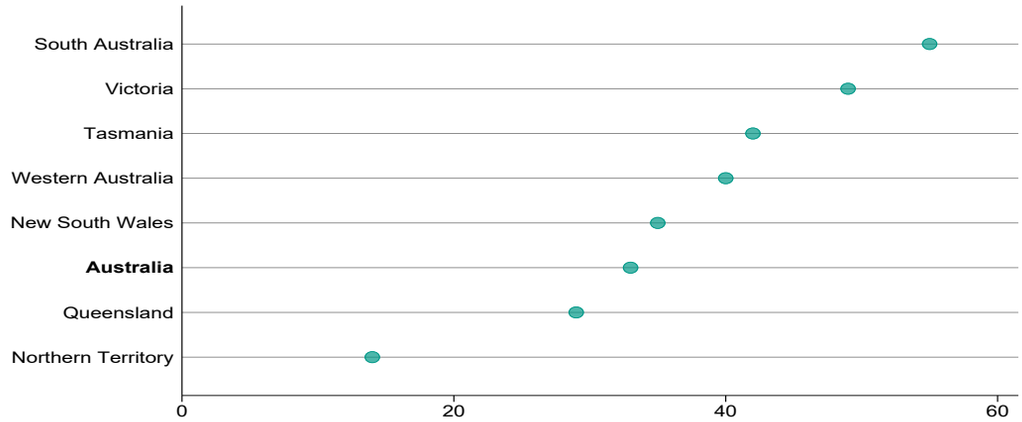
Blue filled circles represent Greater Capital City Statistical Areas. Hollow green diamonds represent the rest of each state or territory.
Note: There is no rest-of-territory estimate for the Australian Capital Territory.
Source: Public Health Information Development Unit (PHIDU), Torrens University Australia, using data from the Aboriginal and Torres Strait Islander Social Health Atlas of Australia: Indigenous Area data (online), published December 2025. Accessed 10 April 2026.

Housing

Housing is a social determinant of health. Overall, 26% of Aboriginal and Torres Strait Islander people living in crowded dwellings in Australia were in capital cities with a range of 8% in Greater Darwin to 45% in Greater Adelaide and Greater Melbourne.[10]

In 2021 there were significant proportions of Aboriginal and Torres Strait Islander households requiring extra bedrooms. Overall a third of all Aboriginal and Torres Strait Islander households requiring extra bedrooms were located in capital cities, ranging from 14% in Greater Darwin to 55% in Greater Adelaide.[10]

Figure 4. Percentage of dwellings with Aboriginal and Torres Strait Islander households requiring extra bedrooms in Greater Capital City Statistical Areas, by jurisdiction, 2021



There is no estimate for the Australian Capital Territory.
Source: Public Health Information Development Unit (PHIDU), Torrens University Australia, using data from the Aboriginal and Torres Strait Islander Social Health Atlas of Australia: Indigenous Area data (online), published September 2025. Accessed 9 October 2025.

Connection to Community, Country and Culture

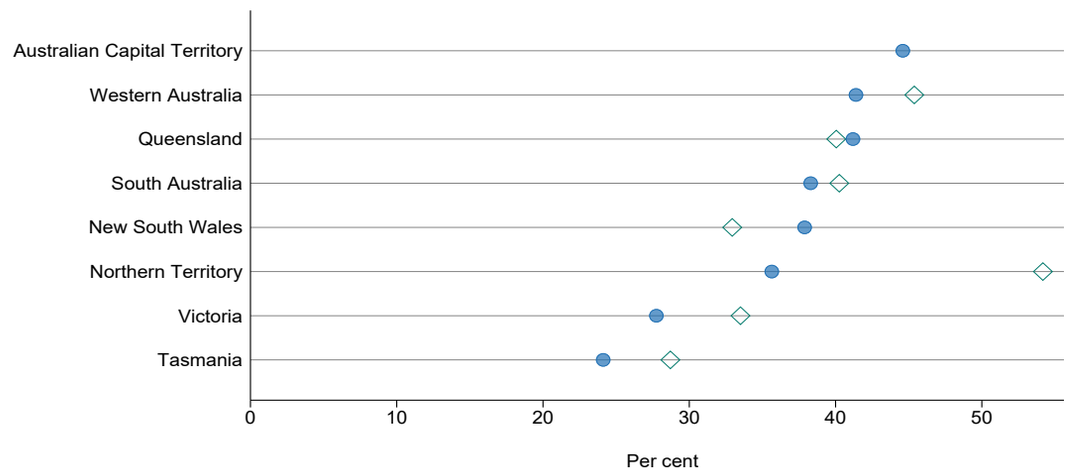
Connection to Community, Country and Culture are important protective factors for Aboriginal and Torres Strait Islander people. However, these connections can be lost or disrupted for people who have historically been displaced to capital cities.

The 2022-2023 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) asked several questions about cultural identification. While not ideal measures of connection to Community, Country and Culture, the NATSIHS nevertheless enables looking at variation between capital cities and the rest of state or territory estimates.

Data on whether Aboriginal and Torres Strait Islander people identified with a tribal group, language group, clan, mission or regional group is in its set of indicators on cultural identification. Figure 11 shows the differences in responses on this item within and across jurisdictions by capital cities.

As can be seen, a larger proportion of Aboriginal and Torres Strait Islander people do not identify with a tribal group, language group, clan, mission or regional group in all capital cities except for Magandjin (Brisbane) and nipaluna (Hobart). These differences illustrate not only the complex identity challenges that Aboriginal and Torres Strait Islander people living in capital cities experience, but also the great variation within and across states in the proportion of people not identifying.

Figure 5. Identification with a triabl group, language group, clan, mission, or regional group

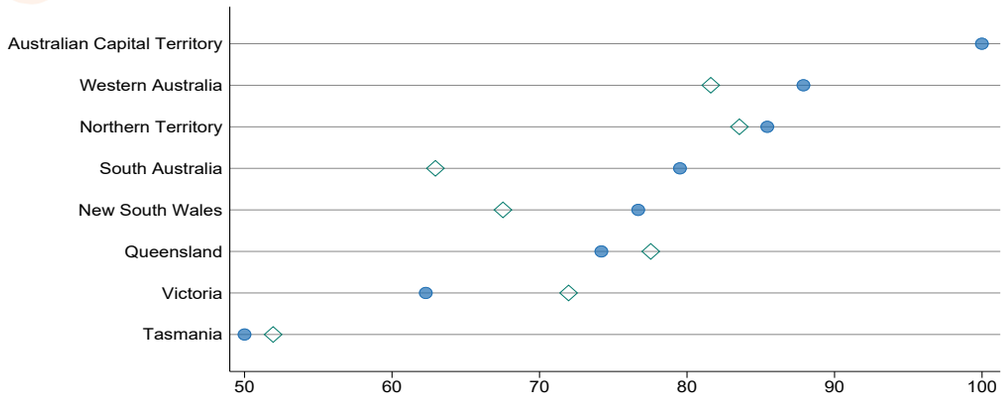


Blue filled circles represent Greater Capital City Statistical Areas. Hollow green diamonds represent the rest of each state or territory.
Note: The estimate for the Australian Capital Territory have a relative standard error greater than 50% and are considered too unreliable for general use. There is no rest-of-territory estimate for the Australian Capital Territory. Percentages represent the proportion of people who identify with at least one tribal group, language group, clan, mission or regional group. Values are calculated as the residual of the total population after excluding people recorded as not identifying, having an unknown response, refusing to answer, or for whom the question was not applicable.
Source: Australian Bureau of Statistics (ABS), National Aboriginal and Torres Strait Islander Health Survey, 2022–23. TableBuilder.

The 2022-2023 NATSIHS also collected information on whether people aged 18 years and over recognised an area as homelands/ traditional Country (Figure 6). This question indicates not only connection to Country, but to the Culture and Community of people living in or from that Country.

The figure shows that there is wide variation both within and across Australian jurisdictions. In 4 of 7 jurisdictions with comparisons available, the proportion of people who recognised an area as homelands/traditional Country was higher in the capital city.

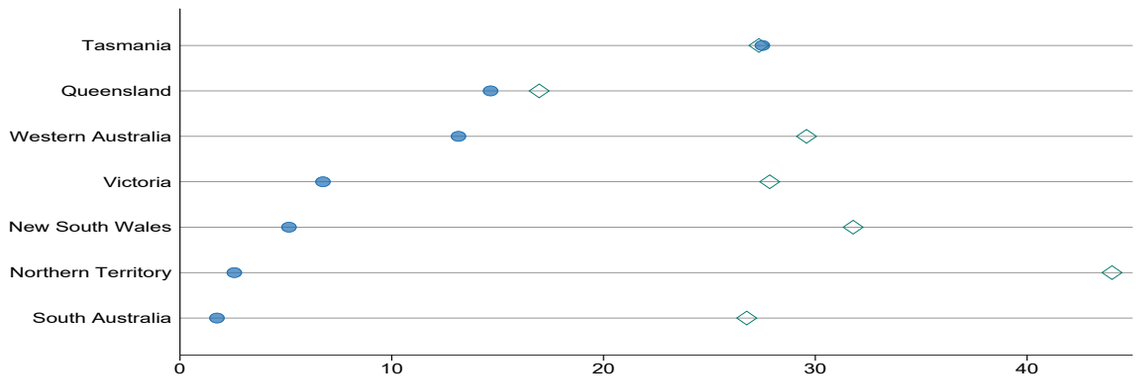
Figure 6. Persons aged 18 years and over who recognised an area as homelands/traditional Country, by Greater Capital City Statistical Area, 2022 to 2023



Blue filled circles represent Greater Capital City Statistical Areas. Hollow green diamonds represent the rest of each state or territory.
Note: The estimate for the Australian Capital Territory has a relative standard error greater than 50% and is considered too unreliable for general use. There is no rest of territory estimate for the Australian Capital Territory. Percentages represent the proportion of people who identify with at least one tribal group, language group, clan, mission or regional group. Values are calculated as the residual of the total population after excluding people recorded as not identifying, having an unknown response, refusing to answer, or for whom the question was not applicable.
Source: Australian Bureau of Statistics (ABS), National Aboriginal and Torres Strait Islander Health Survey, 2022–23. TableBuilder.

Figure 7 shows the percentage of people aged 18 years and older who recognised an area as their homelands/traditional Country but did not currently live there, by capital cities. As can be seen, except for Tasmania, a greater percentage of people outside the capital cities who recognised an area as homelands/traditional Country currently lived there. These differences are quite stark, and given that connection to Country is a protective factor for good health, they illustrate the challenges that Aboriginal and Torres Strait Islander people face in capital cities to maintain their social and emotional well-being.

Figure 7. Persons aged 18 years and over who recognise and live on homelands or traditional Country, Greater Capital City Statistical Areas, 2022-2023



Blue filled circles represent Greater Capital City Statistical Areas. Hollow green diamonds represent the rest of each state or territory.
Note: The estimate for the Australian Capital Territory has a relative standard error greater than 50% and is considered too unreliable for general use. Percentages represent the proportion of people who identify with at least one tribal group, language group, clan, mission or regional group. Values are calculated as the residual of the total population after excluding people recorded as not identifying, having an unknown response, refusing to answer, or for whom the question was not applicable. There is no rest of territory estimate for the Australian Capital Territory.
Source: Australian Bureau of Statistics (ABS), National Aboriginal and Torres Strait Islander Health Survey, 2022–23. TableBuilder.

As Aboriginal and Torres Strait Islander researchers have highlighted[19-21], an increased focus on urban Aboriginal and Torres Strait Islander health must not detract from existing regional or remote health efforts. Instead, there must be an increased focus on urban Indigenous health (research, policy, AICCHS, resource allocation and investment).

This must be proportional to the population, the health burden, and gaps in social determinants of health impacting health and wellbeing. The gaps that exist in research[19-23], policy[19,20], and evaluation of policies and programs[19] focused on urban Aboriginal and Torres Strait Islander populations, means stakeholders working to improve the health of Aboriginal and Torres Strait Islander people in capital cities often rely on insufficient data to plan services and progress clinical and public health practice, policy and research.

This report reinforces the need for increased investment, particularly for AICCHS, and reinforces the need for disaggregated data to inform tailored service delivery. It presents compelling economic evidence on the value of services delivered by AICCHS. AICCHS like Danila Dilba Health Services and models of care like Birthing in Our Community run by IUIH show high returns on investment[24,25] and cost savings[26] and reinforce the value of expanding urban AICCHS.

This report concludes that adequately resourcing AICCHS in capital cities is essential to achieve health equity and fulfil the commitments of the National Closing the Gap Agreement and Strategy. Without additional investment, health gaps will persist and even worsen, and governments at all levels will lose opportunities to support thriving, self-determined Aboriginal and Torres Strait Islander communities and health services in cities.

Part 2: Urban Aboriginal and Islander Community Controlled Health Services (AICCHS)

Unmet need for AICCHS

The 2018-19 NATSIHS estimated that 49,100 people in capital city areas who usually saw a doctor / general practitioner (other than at an AICCHS) would prefer to see an AICCHS[a], a figure increasing to 65,800 in the 2022-23 NATSIHS.[12] The total number of people who would like to see an AICCHS but usually go somewhere else in capital cities increased from 56,600 in 2018-19 to 80,200 in 2022-2023.[12]

Improving primary care

The need to focus on AICCHS in urban areas is consistent with the 2020–25 National Health Reform Agreement[27], which specifies that "The Commonwealth and the States will work in partnership to implement arrangements for a nationally unified and locally controlled health system which will improve the provision of general practitioner and primary health care services, including Aboriginal and Torres Strait Islander community controlled health organisations".[27] AICCHS are especially important in this regard since Aboriginal and Torres Strait Islander clients value their unique accessibility, their welcoming social spaces and additional services, and their culturally safe and appropriate care that is responsive to holistic needs.[28]

Reducing pressure on hospitals

The intersection between primary and tertiary care is paramount for this sector to support better-coordinated care and prevention and reduce pressure on hospitals. Aboriginal and Torres Strait Islander people residing in capital cities accounted for 29% (53,560 / 185,996) of all potentially preventable hospitalisations among Aboriginal and Torres Strait Islander people in Australia from 2017/18 to 2020/21.[10]

[a] The two most recent National Aboriginal and Torres Strait Islander Health Surveys ask people 'Where would like to go for own health' and 'Where usually go if problem with health' to an 'Aboriginal Medical Service / Community Clinic'.

Financial returns on investments in capital city AICCHS and their models of care

The available economic evidence has suggested that building the urban community controlled health sector is worth investing in. Each dollar invested in Danila Dilba Health Service in Darwin in 2016, which serves the Yilli Rreung (Greater Darwin) region, generated a benefit to society of $4.18, a return on investment of 318%.[24]

An updated cost-benefit analysis of Danila Dilba Health Service conducted in 2019 found that the benefit-cost ratio was 4.0, indicating an expected return of $4 for every $1 spent with a return on investment of 297%,[25] with no key data concerns identified in an independent review of this cost-effectiveness analysis.[29]

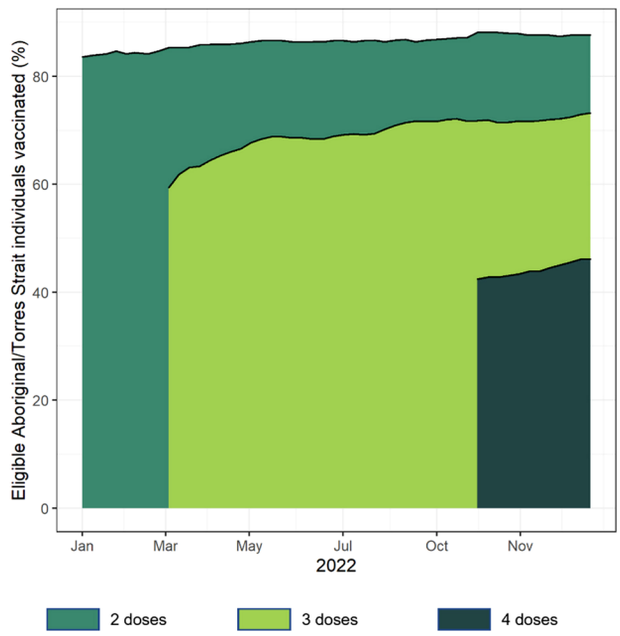
For the Birthing in our Community service run in Brisbane, the cost-effectiveness analysis found that relative to standard care, this service was associated with cost savings of -AU$4,810.02 for each mother-baby pair.[26] Based on this cost, replicating the Birthing in our Community service nationally could have saved almost $87 million ($86,994,021) in Australian health expenditure in 2019.[26]

A review of the cost-effectiveness of interventions to prevent cardiovascular disease in Aboriginal and Torres Strait Islander people found that all pharmacological interventions produced more health benefits when delivered via Indigenous community controlled health services rather than mainstream general practitioner services.[30] Interventions delivered via AICCHS provided up to 50% more health gain than if those same interventions were delivered via mainstream general practitioner practices.[30] Although cost-effectiveness ratios were lower in AICCHS due to greater health service costs, cost-effectiveness was higher in non-remote areas than in remote areas.

The need for community to lead in capital cities during crises

Responses by AICCHS in capital cities during the COVID-19 pandemic have been well documented. The Victorian Aboriginal Health Service (VAHS) mobilised existing resources to remove transporation and geographical barriers to COVID-19 vaccination by re-purposing dental vans and visiting communities.[31] Respected community leaders spoke up to encourage youth and others to get vaccinated. VAHS also extended the availability of Yarning SafeNStrong, their emergency counselling service, during the high-rise lockdown in Naarm.[32] VAHS championing vaccination uptake contributed to high vaccination rates in Naarm (Greater Melbourne) in 2022 (Figure 8).

Figure 8. Trends in COVID-19 vaccination uptake among the Aboriginal and Torres Strait Islander people living in Naarm (Greater Melbourne), 2022

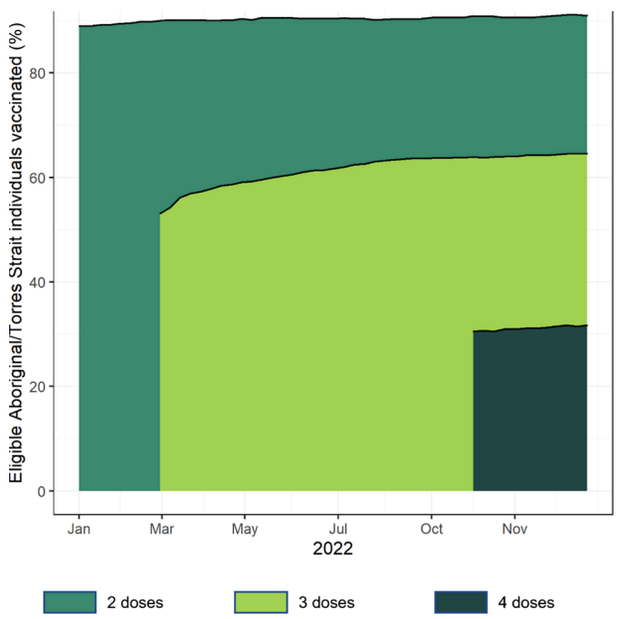


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Tharawal Aboriginal Corporation in Sydney enabled Elders to stay home and protected during the pandemic by partnering with Reiby Juvenile Justice Centre to prepare and deliver hot meals and hampers containing essential items.[6] To promote connection to the community, they ran online cooking and exercise classes.[6] Tharawal ran a drive-in COVID-19 testing area that Elders also used as a safe place to have a clinical yarn.[33]

Clinical yarning sessions were also used to answer all community questions and concerns before members got vaccinated.[33] Tharawal also organised a vaccination event promoted by Aboriginal and Torres Strait Islander social media influencers to raise awareness and encourage youth to vaccinate.[34] This undoubtedly contributed to the high vaccination uptake in Campbelltown in 2022 (Figure 9).

Figure 9. Trends in COVID-19 vaccination uptake among Aboriginal and Torres Strait Islander people living in Tharawal (Campbelltown), 2022



Source: Reproduced without changes from Poirier et al. (2023), First Nations Health and Wellbeing – The Lowitja Journal, under a CC BY NC ND 4.0 licence. https://doi.org/10.1016/j.fnhli.2023.100008

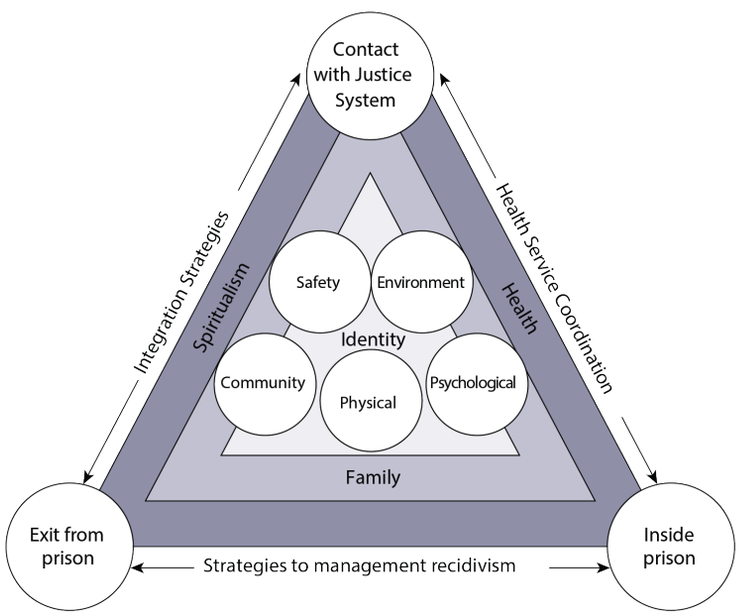
Innovative yet underfunded models of care

While COVID-19 was a crisis that capital city AICCHS mobilised resources and efforts for, over a more extended period, they have developed innovative systems and models of care that provide holistic treatment to Aboriginal and Torres Strait Islander people. These include the universal primary health care approach employed in the Institute for Urban Indigenous Health's System of Care Version 2[35] and the Winnunga Alexander Maconochie Centre Health and Wellbeing Service.[7]

For the Institute for Urban Indigenous Health's System of Care Version 2, after implementation of the patient-centred medical home model, the number of regular clients within health services increased from 1,186 pre-implementation to 1,606 post-implementation, while the proportion of people with sufficient data to calculate the risk of cardiovascular disease almost doubled, from 26% pre-implementation to 51% post-implementation.[35]

Winnunga Alexander Maconochie Centre Health and Wellbeing Service was the first prison health service operated by an AICCHS in Australia.[7] Winnunga has developed a holistic health care prison model (Figure 10) for Aboriginal and Torres Strait Islander prisoners.[7] In a patient experience survey, 75% of patients were satisfied with the waiting time to see staff at this service most or all of the time, all reported that Winnunga staff always treated them with dignity and respect, and of 14 patients who identified as Aboriginal, nine felt that they were treated better by staff because of their Aboriginal identity.[8] Thus, the patient experience survey found that Winnunga clients felt that the service provided highly satisfactory, timely, respectful, and culturally safe care.[8]

Figure 10. Holistic health care prison model at Winnunga Nimmityjah Aboriginal Health & Community Services[7]



Source: Shukralla et al. (2020), Australian and New Zealand Journal of Public Health, 44(4), p. 324. https://doi.org/10.1111/1753-6405.13007

Derbarl Yerrigan Health Service, which services Boorloo (Perth), continues to expand its multi-disciplinary paediatric model of care. This model of care provides early diagnoses, treatment and interventions to children and young people. This model of care had a 100% attendance rate in the 2021 to 2022 financial year,[36] more than 98% in the 2022 to 2023 financial year,[37] and a 98% attendance rate in the 2023 to 2024 financial year.[38]

Despite these high attendance rates for much-needed services, this model of care operates on short-term research, philanthropic and non-recurrent government funding,[38] relying on pro-bono paediatric services for children and families at times.[36]

Better attendance at urban AICCHS

In the 2023 to 2024 financial year, Derbal Yerrigan Health Service had 14 visiting specialists delivering 1,861 specialist services to 1,167 patients.[38] Access to these specialists was facilitated through specialists coordinators, who scheduled and triaged patients and minimised barriers to accessing care such as lack of transport. The attendance rate at Derbarl Yerrigan's specialist clinics was more than 80% in the 2022 to 2023 financial year, compared to as low as 20% in hospital outpatient clinics.[37]

Improved health outcomes from the work of urban AICCHS

In addition to their innovative models of care, capital city AICCHS have conducted successful health education and promotion initiatives. Health education activities conducted at the Institute for Urban Indigenous Health's Deadly Choices™ community health events[39] were associated with significant increases in knowledge of types of chronic diseases, risk factors, types of physical activities, conditions from smoking, sugar in soft drinks and addictive substances in cigarettes from before to after the health education.[39] Among the largest increases, knowledge of the amount of sugar in soft drinks increased from 41% before the workshop to 95% after in 472 people.[40]

Regarding the Birthing in Our Community service mentioned earlier, a study of 1,867 Aboriginal and Torres Strait Islander babies born in Brisbane found that women receiving the Birthing in Our Community service had odds of attending five or more antenatal visits 54% higher, odds of having an infant born preterm 38% lower, and odds of exclusively breastfeeding on discharge from hospital 34% higher than those receiving standard care.[35]

Proper resourcing of capital city AICCHS

The final report of the *Select Committee into the Provision of and Access to Dental Services in Australia*,[41] published in November 2023, contained 35 recommendations, of which 3 concerned Aboriginal and Torres Strait Islander dental health. In Recommendation 32, the committee recommended that the Australian Government adequately recognised 'the need for Aboriginal Community Controlled Health Organisations to:

- train general health care providers in delivering basic and preventative oral health care; and
- recruit and retain dentists, and other oral health practitioners, to work in regional and remote areas of Australia.

Dental care is an area where capital city AICCHS could greatly improve health outcomes, provided that their dental services have funding models that meet the demand for dental services, are not fragmented, and do not impose disproportionate and duplicate reporting requirements.

Secondly, while further training is valuable, capital city AICCHS already operate within significant resource constraints. Beyond recognising that this is a need where AICCHS must lead, there must be proper resourcing of this to alleviate the significant demand for dental services from Community that currently cannot be met.

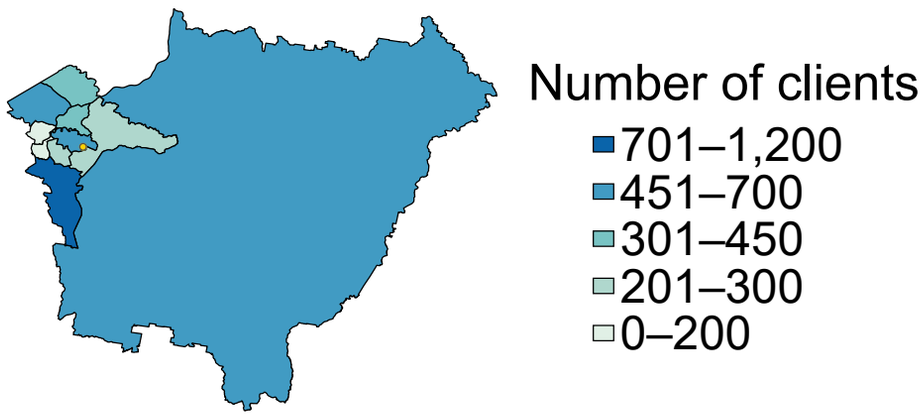
Resourcing and supporting Blak Excellence

Capital city AICCHS also showcase Blak Excellence, Loudly and Proudly. Derbarl Yerrigan Health Service has won multiple awards for its practice environment, especially for the commitment of its Aboriginal doctors in training. This includes Yaru man, doctor and scholar Dr Daniel Hunt being awarded the 2022 Royal Australian College of General Practitioners' award for Western Australian General Practitioner in Training of the Year.[9] Also, Arrernte man and Derbarl General Practitioner Registrar, Doctor Corey Dalton, was named the Western Australian and National Royal Australian College of General Practitioners' 2023 General Practitioner in Training.[9] Additionally, the Royal Australian College of General Practitioners awarded Derbarl Yerrigan Health Service General Practice of the Year for Western Australia in 2023.[9]

Seeing clients from here, there and everywhere

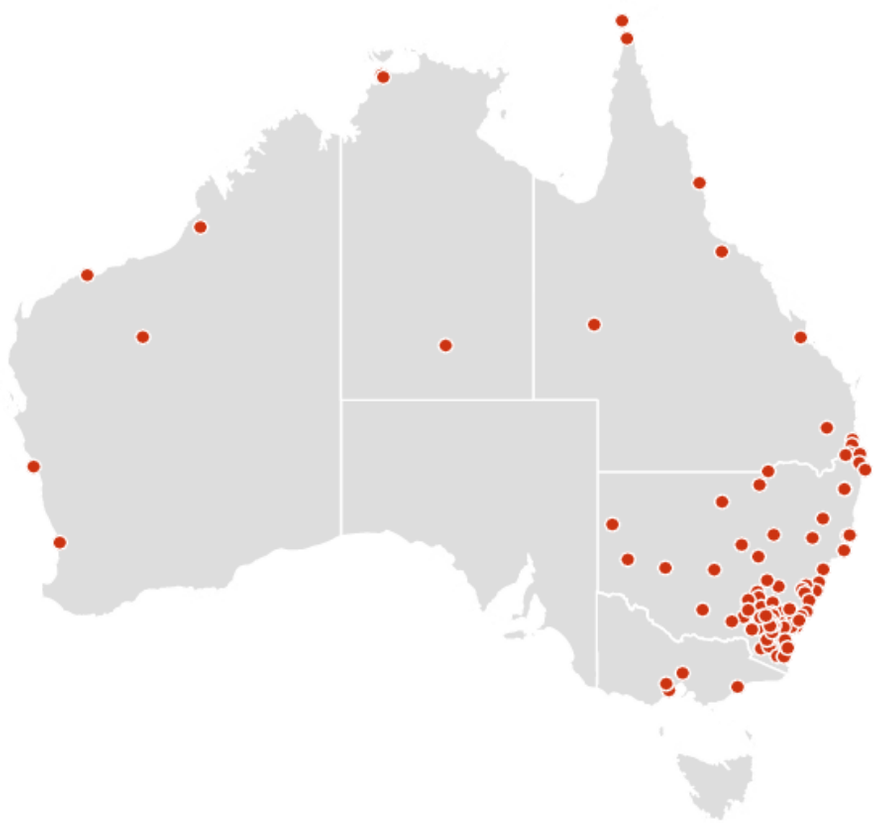
Although located in a capital city, Winnunga Nimmityjah Aboriginal Health and Community Services in Canberra functions as a regional health service. In the 2024 to 2025 financial year, 607 of 4,791 clients (13%) were from the Queanbeyan Region (Figure 11).[42] However, Winnunga clients do not just reside in the Australian Capital Territory and the Queanbeyan Region; instead coming from 226 suburbs in 119 postcodes in the 2023 to 2024 financial year (Figure 12).[43]

Figure 11. Distribution of clients attending Winnunga Nimmityjah Aboriginal Health & Community Services across Statistical Area Level 3 in the Australian Capital Territory and Quenbeyan region 2024-2025



Note: Darker shading shows areas with more clients. A yellow circle indicates the location of Winnunga Nimmityjah Aboriginal Health & Community Services.
Source: Winnunga Nimmityjah Aboriginal Health & Community Services Ltd, Annual Report 2024–25.

Figure 12. Postcodes of clients attending Winnunga Nimmityjah Aboriginal Health & Community Services in 2023-2024



Similarly, in 2023 to 2024, Danila Dilba Health Service in Darwin aimed to secure funding for a dedicated transient service to support their transient clients, who currently account for a significant proportion of clinic presentations.[44] In the 2022 to 2023 financial year, Danila Dilba Health Service saw approximately 3,000 transient clients from remote communities who presented multiple times.[44] They represented 26% (3,000 / 11,726)[44] of the total unique clients seen in the 2022 to 2023 financial year.

People have counted on urban AICCHS since we were counted

AICCHS were started in capital cities, initially the Redfern Aboriginal Medical Service in 1971, 18 services currently operate in capital cities in 2025. While more resources are required to deliver health interventions via AICCHS because they are more comprehensive than mainstream general practices, greater benefits also accrue because of improved health service access.[45] Resourcing capital city AICCHS adequately will thus benefit Aboriginal and Torres Strait Islander health in urban areas; we cannot "Close the Gap" in health inequity without this investment,[19] and there is no justifiable alternative investment that would enable the self-determination of Aboriginal and Torres Strait Islander people in capital cities.

Recommendations

1. We recommend that there is a greater focus on the health and wellbeing needs of First Nations peoples in the capital cities of Australia. This must not be to the exclusion or detriment of the health and well-being needs of First Nations peoples in other geographical areas of Australia.

2. Concerning Priority Reform 2 of building the community-controlled sector, there is a particular need to support services in capital cities to grow according to population growth, their number of transient clients, and the number of Aboriginal and Torres Strait Islander people living in capital cities who would like to go to an Aboriginal Medical Service / Community Controlled Health Service.

3. There is a need to embrace shared decision-making and work locally in partnerships to achieve efficiencies in healthcare, especially throughcare between primary and tertiary healthcare services, to achieve the best outcomes for Aboriginal and Torres Strait Islander patients and the healthcare system.

4. While data visibility and disaggregation are improving, there is a need to maintain this momentum to improve the timeliness of data disaggregated by capital cities.

5. There is a need to recognise the innovations in health care that capital city AICCHS have made, and for these innovations to be supported and scaled where there is sufficient evidence to do so.

6. There is a need to reverse the trend of more and more Aboriginal and Torres Strait Islander people needing access to AICCHS in capital cities in each national health survey. Strengthening the capacity of capital city AICCHS to meet demands for their services will ensure that Aboriginal and Torres Strait Islander people in capital cities continue to have access to quality care.

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