The manager

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As Indigenous CEOs, we train non-Indigenous doctors in cultural safety, and rely on them to integrate Aboriginal health workers into the multidisciplinary team

ABORIGINAL COMMUNITY CONTROLLED health services (ACCHSs) are generally managed through an elected board of directors and an appointed chief executive officer (or equivalent).

In taking on such roles, managers face competing professional, community and political demands and requirements. The CEO is a member of the Aboriginal or Torres Strait Islander community in which he or she lives, and is also managing a major health service for their community. The demands placed on individuals in these circumstances, as well as the expectations to achieve outcomes often beyond their immediate control, are significant. The CEO is constantly balancing individual clients' needs with community expectations for an accessible high quality health service.

The reasons for choosing to work in this area are varied and are driven by personal, organisational and community goals. This is consistent with the findings of a report based on interviews with 41 Aboriginal and Torres Strait Islander health managers.[1] The report revealed that the distinctive features of the managers include:

- a very strong personal motivation to assist the Aboriginal and Torres Strait Islander community;
- a willingness to take on a leadership role and initiate change within the community;
- a direct sense of responsibility and accountability to the community; and

Nurse consultant at a "grass camp"

- a desire to work outside the bureaucratic processes that often create barriers to success.

Meeting the community's needs

Although ACCHSs were set up primarily to deliver comprehensive primary health care services, the responsibility of many of them now extends to child protection services, drug and alcohol programs, aged care, and housing and infrastructure and schools-based programs. This has significant management implications in terms of the multiple funding sources, the need to administer a wide range of programs, the increased staff size and skill mix, the physical infrastructure required, and the complex reporting requirements.

The accessibility of health services for Aboriginal and Torres Strait Islander peoples is affected by a number of factors, including the distance to and availability of health professionals. The employment of Aboriginal and Torres Strait Islander staff has long been recognised as an important factor in accessibility of services. Unpublished data from the Department of Health and Ageing and the National Aboriginal Community Controlled Health Organisation suggest that in 2000–01, 67% of full-time equivalent positions in federally funded Aboriginal primary health care services were held by Aboriginals and Torres Strait Islanders. However, examination of the workforce composition shows that most Indigenous staff (97%) were employed as health workers or field workers, while non-Indigenous staff were more likely to be employed in professional positions. Most doctors (98%), nurses (87%), allied health professionals (89%) and dentists (88%) were non-Indigenous.[2] Therefore, in the Aboriginal medical services, there may be three strata of employees. Tsey has described the pyramid structure of most of the services, with a small group of Aboriginal managers at the top of the pyramid, a middle stratum occupied by predominantly non-Aboriginal professional staff, and a bottom stratum of predominantly Aboriginal workers who occupy semi- or non-professional roles.[3] Thus, the CEO is faced on the one hand with the need to train their non-Indigenous staff in cultural safety, and on the other hand must rely very heavily on them for service provision and integration of Aboriginal health workers into the multidisciplinary team. Similarly, the CEO might be obliged to act as a manager for an Indigenous relative or close community member.

Prioritising needs and resources

The explosion of activity in relation to new policy initiatives and program development in Aboriginal and Torres Strait Islander health has resulted in increased opportunities to access funding, but it has also created many vertical programs within the services. As a result, a large amount of new money has been allocated on a short-term basis or for pilot programs, making it difficult to sustain any gains made. The management challenges associated with such growth include future planning (when there is a high dependence on "soft" money), the accountability requirements of multiple funding sources, and the inefficiency of having to maintain systems to achieve this. Other challenges relate to managing staff in a climate of uncertain job security, and the workforce implications of funding new positions with ill-defined skills levels, training needs and career pathways. Finally, to access the additional funds, staff resources are needed for writing funding submissions and fulfilling the requirements of the granting bodies, a task that usually has to compete with clinical priorities.

An area in which services often struggle is obtaining access to specialist and allied health services. To address this, we are trying to improve linkages with mainstream service providers and foster relationships that allow for some flexibility in how and where services are delivered. For example, considerable barriers to accessing maternal and child health services were overcome in Townsville by arranging for a child health nurse to work four mornings per week at Townsville Aboriginal and Islander Health Services.

The importance of Indigenous community control

The ACCHS model essentially requires that ownership and management of the health agency are vested in the local Indigenous community, generally through a local Indigenous board of management. This arrangement allows the local community to decide on its priorities, policies, management structure, staff and service profile, within government funding guidelines.

The model has features in common with the community controlled primary health care services that have contributed to health gains in other indigenous peoples. International comparative analyses[4,5] demonstrate the success of community controlled models of health care, when governments have been engaged in the development of effective and efficient systems. For example, through the 1976 Indian Health Care Improvement Act in the United States, appropriated resources were used to expand health services, build and renovate medical facilities, provide safe drinking water and sanitary disposal facilities, and establish programs to increase the number of Native American health professionals.[4]

The future of Aboriginal community controlled health services

The first of a series of reports on expenditure on Indigenous health identified the specific areas in which spending inequities have occurred.[6] As a result, major reforms and changes have been implemented. However, achieving a balance between time allocation for strategic initiatives and meeting acute clinical care needs remains a major challenge within many services.

While Aboriginal medical services only represent one sector of the health system with responsibilities in Indigenous health, they tend to attract the most attention when the government is seeking to explain the relative lack of progress in health outcomes. We need to recognise that while ACCHSs are an essential component of the health system, they do not have exclusive responsibility for Indigenous health. It is time for the entire system to embrace and respond to its responsibilities for the health of Indigenous Australians. The ACCHSs are well placed to support such an integrated approach.

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