Community-governed health services in Cape York: does the evidence point to a model of service delivery?

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Abstract

Health service delivery model reforms are currently underway in Cape York in an effort to improve health outcomes for the Aboriginal and Torres Strait Islander communities. These reforms include the transition of the Apunipima Cape York Health Council from an advocacy agency to a community-controlled health service provider.

This paper investigates the literature on existing community governance models and community-controlled health service delivery models, to guide the choice of the most appropriate model for the Cape York health reforms.

The evidence collected suggests a new innovative health service delivery model is emerging that will not only improve Indigenous health status, but may also present a more appropriate model for the health care sector than the existing mainstream health service delivery model provided for other sections of the collective Australian population.

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What is known about the topic?

The literature on effective governance and management of Aboriginal community-controlled health organisations is limited particularly in relation to a systematic evaluation of the most appropriate governance models.

What does this paper add?

The topic of governance in relation to community health services for Indigenous peoples is a very topical issue, with health and welfare concerns for Indigenous peoples on the national agenda and ongoing questions about how best to respond. This paper makes a contribution to discussion of these issues and argues a position on community governance rather than imposed interventions as the most effective strategy for improving health in Indigenous communities. It also outlines an emerging model of health service delivery that may well also prove of benefit to mainstream Australians.

What are the implications for practitioners?

This paper describes the impending changes in systems for health care delivery on Cape York and the move to community control. This will impact on service providers already in the region should the community-controlled organisation want to make changes to the types, scope and practices of existing services. It may well inform the future service model for other remote locations across Australia.

PLANNING FOR SIGNIFICANT reform agendas in relation to both welfare and health services is currently underway in Cape York, Far North Queensland, in an effort to improve the wellbeing of the Aboriginal and Torres Strait Islander peoples living in the region. The health reform agenda is being led by the Apunipima Cape York Health Council (Apunipima), and a transition implementation plan is currently being developed to inform the organisational changes required for Apunipima to take on the role of community-controlled health service purchaser and provider for the region.

The population of this region according to the 2006 Census[1] was about 12 625, of which 53.6% identify as Aboriginal and/or Torres Strait Islander. The region includes two regional centres (Weipa and Cooktown, where most of the non-

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Indigenous population lives), nine discrete Indigenous communities and over 100 outstations.

To inform this transition process, Apunipima sought to explore the experience available through documentation of the existing governance models and service structures for health service delivery to Aboriginal and Torres Strait Islander communities. The aim is to identify their respective benefits and challenges and ensure the most appropriate model is implemented in the region to deliver the most effective services and achieve better health outcomes. Such a critical review is especially important given that there is much debate across the health sector as to which model is likely to be the most appropriate and effective given the urgency of improvement.

Healy and McKee[2] describe various health service models that have been designed to provide additional services for specific population groups and accommodate special needs that arise from, for example, cultural differences, gender, and remoteness, which cannot be addressed by mainstream services, as summarised in the Box. The authors have classified these services according to the access principle on which they have been designed, and whether they are separate or combined services. The combined services include the collective mainstream model that provides universal access for the entire population and the integrationist services that are provided to facilitate minority groups' access to these mainstream services, such as interpreter services. There are three models of separate services. Firstly, the participatory services involve consumers directly in the governance and management of the service. Secondly, alternative services that exist in addition to mainstream services enable consumers to choose to access one or both of the services. Lastly, parallel services are specifically designed for minority groups, and replace the mainstream services for that targeted minority group.

The proposed model for Cape York is a participatory service, but during its transition it embodies aspects of the parallel service model, as key stakeholders have committed to transfer the responsibility for management of, and funding for, primary health care services to Apunipima from existing mainstream service providers, including services provided by the state government health department, commencing in July 2008.[3]

Service delivery models and population group examples[2]

Service delivery models	Examples
Mainstream (collective)	Women's health care in Britain Rural people in Australia
Integrationist	Poor (disadvantaged) in Britain
Participatory	New Zealand Maori
Alternative	Women's health in Australia Aboriginal Australians
Parallel	Canadian Indians Aboriginal Australians Prison services

The aim of this paper is to document the examination of literature in this area as a basis for planning. It explores the evidence of available models and how these are governed and proposes an emergent option that builds on the strengths of existing models for implementation in the Cape York environment.

Methodology

The search strategy involved three components: a search of the scientific literature using PubMed; a search of the grey literature — policy, reports, program evaluation and similar documentation through the website of the Department of Health and Ageing, Office for Aboriginal and Torres Strait Islander Health, and linked government sites; and electronic libraries of the Centre for Aboriginal Economic Policy Research at the Australian National University, and the Cooperative Research Centre for Aboriginal Health.

The initial search of the PubMed computer database used the search terms: "community control", "evaluation", "models" and "governance". The decision to include "governance" in the search was based on the theory that the philosophy of community control is informed by the concept of self-determination and self-governance, a necessary precursor to improving the

disadvantage of Indigenous populations.[4] It was therefore presumed that learnings from self-governance models in other service sectors can also be applied to the health sector.

Indigenous management challenges are likewise under-researched, and in-depth exploration of management challenges would be very helpful, especially in early phases of health reform processes.[5] For the purposes of this study, it was felt that Indigenous management issues engaged a related but distinct set of issues from those informing governance models, and these have been explored in a separate analysis.[6]

The initial search was unfruitful, with identified papers relating primarily to specific evaluations of community-based health promotion or disease prevention/intervention delivery. These papers were not included because they did not inform this study.

The search of the Department of Health and Ageing, Office for Aboriginal and Torres Strait Islander Health website revealed a number of reports that evaluated various aspects of community-controlled health service delivery models including governance, in order to measure their appropriateness. Given the success of this strategy, searches for publications relating to Indigenous health or governance were also subsequently undertaken of other government departments' websites, including the Queensland Department of Communities and Queensland Health. The reference lists of these papers were also subsequently reviewed.

The electronic libraries of the Centre for Aboriginal Economic Policy Research at the Australian National University and the Cooperative Research Centre for Aboriginal Health provided several academic evaluations of community-controlled service delivery models and community self-governance models. As with previous documents, the reference lists of these papers were also reviewed.

Community governance — a framework or model

As identified by Dodson and Smith[7] there has been no holistic or systematic research undertaken in Australia of Indigenous governance, across communities and regions, to fully evaluate the appropriateness of the various models. However, as Rowse[8] points out, many leaders and academics, including the previous Australian Government, have been quick to condemn the shortcomings in the current parallel community-controlled models as a strategy for improving outcomes in Indigenous communities, clearly articulating their uncertainty about the viability of the Cape York health reform approach. This concern is generated because many Indigenous community organisations are perceived, rightly or wrongly, as being plagued with issues such as imposed structures and constitutions; under-resourcing; conflict over resources; lack of human, social and cultural capital; issues with staffing; unsustainable economies of scale; factionalism; gender-based disempowerment; levels of capacity; and erosion of cultural values and structures.[7-9]

Dodson and Smith[7] have adapted a matrix, developed by the Harvard Project, which applies the learnings from the American Indian community-development experiences, and demonstrates the links that can be made between the ingredients and core principles of governance and Australian Indigenous community-controlled models. They argue that those areas identified in the matrix, for which communities have low or moderate levels of control, are usually associated with external and short-term factors. These factors include political jurisdiction, market and development opportunities (which are often severely limited by large geographical distances), and access to capital and resources. These are often the areas that communities focus on in an attempt to create community development, when they may be better served by concentrating on the areas of governance that they have a high level of control over, and which will provide long-term sustainability, including their governance structures and capacity development strategies.

The authors go on to set out the guiding principles and key benchmarks of good governance, as determined by research in the United States and Canada, acknowledging that these need to be adapted to the local environment in

order to be appropriate. These principles include: stable representative structures; culturally appropriate institutional rules; sound corporate governance; separation of powers; strong stewardship; effective management systems; realistic and effective development strategies and activities; and a cultural mandate and legitimacy. Hence their supposition is that there is not a "one size fits all" model of governance, but rather a broader governance framework that should be implemented in order to govern appropriately.

In the Australian context, preliminary findings of the Indigenous Community Governance Project[10] also indicate that there is no single model suitable for all communities, and that cultural geographies, traditional relationships, history, laws and customs must be considered when designing the approaches, processes and structures of local governance. The authors agree that the governance principle of cultural mandate is critical, and the relevant local relationships and appropriate representation is stated as being of particular importance in relation to establishing cultural legitimacy, "which will not come about through externally imposed solutions,"[10] but from a "cultural match" with the local community. This discussion highlights the need to develop and maintain a flexible model that can adapt with changes in leadership and differences across settings and through time to ensure the "cultural match" is maintained and sustainable.

Challenges for effective community governance

It is noted that implementing self-governance at a local level creates challenges associated with economy of scale. Thus, small communities and organisations often struggle to develop and sustain tangible outcomes due to capacity and continuity issues,[10] as demonstrated by the local government reforms in the Northern Territory.[11] This situation is leading to the development of an increasing number of regional models of governance, similar to the model being developed for the health service in Cape York. Regional models enable pooling of resources and sharing of administrative burdens.[9] The other advantage of these models is that governments prefer to deal with wider regional groups.[11] However, regional models need to be planned thoroughly with a holistic long-term view to overcome the challenges of ensuring community participation and ownership that are required for effective and legitimate leadership.[9,10]

Another challenge for community organisations is generated by the complex government environment that enables or disables community governance, depending on the capacity of the organisations to divert the often limited resources away from service provision in an effort to meet their accountability requirements.[10] There is a lack of cooperation between the various government departments and agencies, and there is an urgent need to streamline community consultation processes, funding objectives, grant application and acquittal processes, and reporting accountabilities. In this respect, the capacity of government has to be addressed alongside that of community governance in order to overcome Indigenous disadvantage appropriately, and not overburden or stifle local innovation and responsiveness.[4,9]

In addition, the government sector creates a dichotomy for establishing measures of effectiveness to assess the performance of community governance. Governments typically measure effectiveness in relation to accountability frameworks, rather than according to community development, participation and ownership outcomes, which are the principles that inform the concept of community control. In Cape York this cross-cultural dilemma has resulted in organisations breaching audit requirements because their priorities have been focused on addressing community need rather than meeting the requirements of government.[9]

This dissonance is the focus of the work by Martin,[4] who argues that Indigenous organisations must operate in a complex "intercultural" domain, whereby they must strategically engage with mainstream society and even adopt practices from the dominant culture in order to achieve better governance and outcomes. Fitzgerald[9] also

identifies this tension in Cape York, between Aboriginal reserves and European pastoralists and mining conglomerates. The Aboriginal communities see maintenance of their separate cultural identity as a priority, but in order to achieve other priorities for economic development, they find they must make compromises and adopt mainstream, rather than culturally consistent, processes.

Implications for service models

It could therefore be construed that in order to achieve the fundamental goals of community control, an integrationist model, as described by Healy and McKee,[2] is a model that has supplementary strategies that encourage use of collective services by the minority group. In this model, cultural priorities are maintained and communities are encouraged to engage with the mainstream sector for economic benefit.

However, Martin[4] maintains that the key to community governance is that the community takes control over the terms of engagement with the mainstream domain, through appropriate mechanisms of governance, including practices from the dominant society, and that this essentially produces a system of valuing diversity that is critical for appropriate strategic engagement. Westbury and Sanders[11] suggest that one model of governance that achieves the intercultural engagement objective while valuing community diversity is a two-tiered model of governance with the community "elders" providing the strategic direction in relation to cultural issues and another group of community "representatives" making the decisions relating to service delivery. This model also maintains the separation of powers referred to by Dodson and Smith[7] as an appropriate governance framework.

This approach recognises that Indigenous people are not isolated from evolution and that cultural transformation applies to both Indigenous and non-Indigenous cultures.[4] It is therefore not an integrationist model, but a parallel form of governance with both Indigenous and non-Indigenous societies evolving concurrently over time and with change, and with the Indigenous communities adopting the mainstream processes to suit their needs as part of this evolution.

Community health service governance

In the study of *Achievements in Aboriginal and Torres Strait Islander health*,[12] the authors identify that, as with the examination of community governance models generally, there was no evidence to support a superlative model for Indigenous community participation in the health sector. Interaction with community, by means other than community-controlled and governed health services, such as specific community-influenced health promotion and education programs, has also been appropriate. They argue that in some cases, these individual and separate programs can be just as effective as a community-governed service model if there is community input into the program, irrespective of the governance of the provider of that service. They suggest that one of the reasons for this is the loss of efficiency and effectiveness when there is diffused responsibility and accountability for governance over a range of stakeholders, which is often the case where services are being provided regionally but require individual communities to own the proposed solutions that are delivered at the program level.

This suggestion is in line with the conclusion drawn by Dodson and Smith,[7] as discussed earlier, that communities should be focusing on improving governance structures and processes to implement community control appropriately. Evidence from the Katherine West Coordinated Care Trial, "where collaboration between agencies has resulted in a single point of accountability," suggests that service provision and health outcomes improve remarkably when there are defined community governance structures in place.[12] This also supports the supposition made by Martin[4] that community control is about influencing the mainstream domain through good governance.

In addition, Shannon et al[12] identified the need for health service delivery models to reflect the

diversity between communities and to adapt accountability and governance processes accordingly, rather than aiming for one regulatory model. The evaluation of the Coordinated Care trials also reiterated the need for maintaining a strong principle of Indigenous governance to meet diverse local community needs,[13] given that Indigenous Australians need different services to address their differing health needs and poorer health status, and they require self-determination to overcome this disadvantage.[13] This is especially the case where there is no consistent or comprehensive approach to engaging the Indigenous population in governance of collective mainstream services.

Interestingly, the Katherine West, Tiwi Islands and Wilcannia Coordinated Care trials were designed to deliver services to the whole population, including non-Indigenous residents of the region, similar to the proposal for Cape York. The trials provided an opportunity for health service delivery to be controlled by the Indigenous population to demonstrate that it "may be better placed to service non-Aboriginal health servicing needs than the usual government provider."[11] This was demonstrated through the ongoing services provided by the successful Katherine West Health Board for not only the Aboriginal communities but also for the white pastoralist population across the region. Its success has resulted in the possible evolution of a new collective community-governed model of health service delivery. This broader approach achieved an improvement in whole-of-community ownership for both the Aboriginal and non-Indigenous Australian populations and generated gains in capacity building and health responsibility across the trials.[14]

It also indicated that a model of small, autonomous, local community-controlled services as an alternative service delivery approach is no longer viable, and that a regional approach is more sustainable. The Katherine West, Tiwi Islands and Wilcannia Coordinated Care trial sites were all administered by a regional governance structure, with local clinical, organisation and community leadership.[14]

In addition, funds from government agencies in some sites were "pooled", to enable more flexible planning of service delivery to meet local needs, and develop a focus on shared outcomes. Where implemented unconditionally, this approach also appropriately reduced the resourcing and administration challenges associated with government accountability processes.[14]

The Apunipima model

Apunipima has developed Health Action Teams (HAT) in each Cape York community to play the main local governing role in the health service reform process. The membership of each HAT is being developed to reflect the social structure of the respective local communities, including the non-Indigenous population in townships, as is the case in the community of Coen. Each HAT meets on a monthly basis and will initially be responsible for the development and/or revision of a Community Health Action Plan, which identifies local health issues and service priorities, to be incorporated in the Apunipima service planning processes; and local orientation programs and recruitment procedures for health service staff appointments. The HAT will also play a key role in the monitoring and evaluation of services delivered at a community level in the longer term.

Two members of Apunipima from each community are elected from representatives of the local HAT to the Governing Committee, which provides the strategic direction for the organisation. Seven of these members are then elected to the Executive Board, and are directly involved in the governance of the organisation, alongside five external ex-officio expert advisor positions, which include two government representatives.

This model therefore enables cultural mandate and legitimacy of the organisation through strategies to enable a "cultural match" with the various communities, despite their diverse cultural and population needs, while maintaining a broad representative governance structure regionally that can utilise economies of scale in funding, staff and resource management.

This structure also allows for the separation of powers between the governance and management arms by virtue of the governance tiers and the mixed Executive Board. A focus has also been given to developing strong corporate governance processes, often with assistance from the external Board members, who inevitably provide capacity-building opportunities for the community board members through shadowing and mentoring.

This structure also enables strengthening of the relationship between the Aboriginal communities and their external stakeholders, building the knowledge and understanding of government and technical representatives in relation to the challenges associated with the dichotomy of the intercultural community governance environment. However, it also maintains the community self-governance of the service given the ex-officio representatives do not have decision-making power.

Discussion

There is considerable consensus and increasing evidence that indicates that Aboriginal community control of health services represents a positive direction for improved models of care and in "closing the gap" in health outcomes between Indigenous and non-Indigenous communities. However, finding the right model of governance that can support the implementation of better models of care is a crucial challenge for each Aboriginal community-controlled organisation. The serious lack of literature, which to date appears to include only a few reports, is a major stumbling block for new and existing services to learn from past and current experience as they develop or reform their structures. One recommendation from this study is to encourage all existing community-controlled services to document their experiences and make this publicly available so that innovative approaches, problem-solving mechanisms and lessons learned can be shared.

Despite the small body of literature identified, this review has been able to discuss a range of options for governance that have been implemented both in the general Indigenous community governance sector and the community-controlled health service delivery sector in the context of current health reform in Cape York. While the evidence gathered in this investigation indicates that the Katherine West model may be well suited to the Cape York environment, it may also suggest that the Cape York model of community-controlled health services has the potential to also provide an enhanced service for mainstream populations in these remote areas. On the basis of the evidence that is available, the Cape York Reform agenda is producing a new innovative emergent model for community control that builds on the strengths of the past and results in a new collective community-governed model for the future.

Given the dollars and effort that have been put into health reform and the extent to which success depends on good governance, there is an urgent need for more research input and documentation of existing governance experience in the context of Aboriginal community-controlled health services. This research should investigate and evaluate the underlying suppositions of models in practice to determine their validity and appropriateness, and to firmly establish the degree to which collective community-governed health service delivery models will achieve improved health outcomes. Clear demonstration of success, and cost-effectiveness, as well as greater guidance on how challenges can be effectively addressed, is needed to strengthen and provide sustainability to the community-control movement.

Conclusion

In conclusion, this paper has highlighted that the existing, although sparse, evidence from the literature suggests that collective community-governed health service delivery is the most appropriate model to guide efforts to overcome Indigenous health disadvantage, where it is not viable to sustain a parallel model of service delivery. Furthermore, given its grounding in fundamental principles of primary health care

and community development, this emergent model may also contain the essential components for addressing health issues across the broader Australian population more appropriately and effectively than the current collective mainstream model.

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Competing interests

The authors declare that they have no competing interests.

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