

# Contemporary management issues for Aboriginal Community Controlled Health Services

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## Abstract

*Aboriginal Community Controlled Health Services face particular management issues as they adjust to the dominant Western paradigm of managerialism and the market model of health service provision. Their cultural orientation leads to distinctive organisational features which both advantage and disadvantages them in this environment. The holistic model of health used and community control enable the delivery of integrated, culturally appropriate health care.*

*However, effective community control is difficult to achieve. Services may benefit from partnerships with collaborators such as hospitals, regional health services and university departments of rural health if the partnerships are based on mutual respect and ensure that community control is retained.*

## Aboriginal Community Controlled Health Services in the current environment

Management literature consistently refers to the state of change and turmoil occurring in organisations as they are affected by globalisation of markets, deregulation of the economy, and social and technological changes (Dunphy & Stace 1990, Southon 1996). With regard to health service organisations, Braithwaite (1993a p417) refers to an 'Australian health service management revolution' as a process of reform and restructuring unfolds to find more effective ways of using limited resources to provide an increased range of services. This requires health service managers to adjust to different organisational structures, different funding arrangements, and to embrace the quality movement.

The moves toward a market model of provision involving contractualism, privatisation and competition demand health services adapt and adapt quickly (Baum 1996, Currie 1996, Keating & Calder 1997). Perhaps the most obvious way this has occurred is to promote a management culture using processes such as strategic planning and a results orientation to bring about organisational change.

What are the current management issues for the Aboriginal Community Controlled Health Services in this environment? These services operate from a cultural perspective that leads to a holistic model of health and they are community controlled. Does this orientation impact on their adjustment to the current environment? In answering these questions it is necessary to understand the environment in which all health services are operating.

## The market economy and managerialism

Kettner and Martin 1986, (p 36) describe the market model of provision as:

*“... a set of policies and practices (on the part of the public contracting agency) that encourages competition among potential contractors; and, where like contractors are competing to provide a like service, price is the determining factor. The market model places a high value on cost efficiency. An agency following the market model would emphasise the development of criteria for measuring efficiency and effectiveness and negotiate with a high degree of specificity on issues of performance expectations, program design, budget and cost.”*

Some of the consequences of the application of this model have received attention in the health management literature. Firstly there is a move away from public health service provision as Government moves from a provider to a purchaser or funder of health services. Health organisations move from an orientation as a public service to a consumer-orientated organisation with output governed by contractual arrangements (Baum; 1996, Currie; 1996, Southon 1996).

Secondly the strong focus on management has led to a managerialist approach. Managerialism, when put into practice, confirms the central nature of the management process and builds a management culture (Rees 1995). Managers are moving health organisations from professionally (producer) defined services to a patient (consumer) defined workplace, adopting business values and management culture, allocating scarce resources amongst competing priorities while maximising efficiency and productivity (Baum; 1996, Currie; 1996, Southon 1996).

Thirdly there is a focus on health outcomes in Australian health care. This focus is designed to strengthen and reorient the organisational system with activity being closely related to achieving outcomes (Rissel 1996).

## Aboriginal Community Controlled Health Services

Aboriginal Community Controlled Health Services are managing the delivery of health services to a group of people who are among the most disadvantaged in Australia (Bell, Couzos, Daniels, Hunter, Mayers & Murray 2000). In providing health care they are a practical expression of self determination and autonomy, which is necessary if the structural causes of poor health status among Aboriginal and Torres Strait Islander people are to be addressed (Bartlett & Legge 1994, Bartlett 1995). The services function at the interface of Indigenous and non-Indigenous cultures, and the delivery of services requires the application of a high level of skills to balance competing demands and integrate deep cultural knowledge into a Western management framework (Hill, Wakerman et al. 2001).

Aboriginal Community Controlled Health Services were established as an alternative to mainstream health services which were, for various reasons, not accessible or not appropriate for Aboriginal and Torres Strait Islander people (Franklin & White 1991, Scrimgeour 1997). As policy moved towards self-determination and self-management, community controlled health services provided an opportunity for Aboriginal people to have some control over how health services were delivered (Hill Wakerman et al. 2001). The first 10 services commenced with minimal Government funding relying heavily on donations (Bell, Couzos et al 2000). However there is now an expanding network of over 120 services in every State and Territory, with the umbrella organisation the National Aboriginal Community Controlled Health Organisation (NACCHO) providing a national voice and mandate to speak on health issues for Aboriginal communities throughout Australia. There are regional bodies affiliated with NACCHO at the State and Territory level (Hunter 1999).

Aboriginal Community Controlled Health Services are primary health care services that are initiated, planned and managed by local Aboriginal communities, and which aim to deliver high quality, holistic and culturally appropriate health care. Hunter (1999) says that “... community control is the local community having control of issues that directly affect their community. Aboriginal people must determine and control the pace, shape and manner of change and decision-making at local, regional state and national levels”.

The organisational model is adapted to the local situation but generally consists of an active board elected by members of the local communities or region. The board usually employs the Chief Executive Officer and management is accountable to the board and through the board to the community (Trogenza & Abbott 1995).

The organisation may provide a base for the development of other community-controlled organisations related to health such as youth services, women's services and accommodation services.

## Distinctive organisational characteristics

It is acknowledged that each of the health services is an independent, local organisation relating to that community's needs. However there are some common organisational characteristics.

- Their fundamental cultural orientation places them in an interfacing position between the predominantly Western management culture with its understandings of leadership, power, ways of communicating, planning and organising and the Aboriginal domain where community health and wellbeing issues predominate.

Tensions and conflicts occur when requirements of the management culture are seen to get in the way of meeting the health needs of the community (Office of Aboriginal and Torres Strait Islander Health 1999). Managers must undertake a balancing act to integrate the two approaches (Matthews, Wakerman & Hill 1999, Wakerman, Matthews et al 2000, Hill, Wakerman et al 2001). Many of the distinctive features of the organisations occur because of their cultural embeddedness.

- A holistic understanding of health usually results in integrated services addressing many of the health and social issues facing the community.

'Aboriginal health' not only means the physical well-being of an individual. It also refers to the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their community. It is a whole of life view and includes the cyclical concept of life-death-life (Aboriginal Health & Medical Research Council 1999 p8). The services provide a wide range of primary health care that pre-dates and best exemplifies the application of the Alma-Ata Declaration of 1978 (Hunter 1999). However the extent to primary health care service can be provided depends on organisational resources (Bell, Couzos et al. 2000).

- Aboriginal Community Controlled Health Services are highly participative.

They are characterised by and have been built through community control and participation, particularly in their establishment (Scrimgeour, 1997; Wakerman, Matthews et al. 2000). This process allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the community. It enables the locus of control of the organisation to rest with the community (Riley & Weston 1997). Participation occurs through board membership, through the process of defining needs and priorities and by providing feedback about service delivery. It is often a complex process with sectional interests sometimes being apparent.

As the health service usually occupies an important place in the community, there is a knowledge base and infrastructure to support social and political leadership and advocacy at a community, state and sometimes a national level (Bartlett 1995). For example, board members or staff may be called upon to give advice or information on Government policy initiatives related to Aboriginal health and wellbeing in a range of forums.

- The organisations are community-controlled, they are important sources of infrastructure and they have a cultural orientation. There may therefore be a blurring of the organisational and the social/family domain (Wakerman Matthews et al 2000).

At times, family responsibilities may be carried out in the organisational domain and organisational activities carried out in the family domain. Community obligations and responsibilities may conflict with as well as complement the functions that the organisation performs in delivering services.

Family/community responsibilities may involve the use of organisational resources in non- health related activities. On the other hand, staff may be able to ensure a high level of participation in health activities because of their family connections. Aboriginal and Torres Strait Islander health managers use high level management skills to separate these domains, and balance competing demands (Scrimgeour; 1997 Matthews Wakerman; et al 1999, Hill, Wakerman et al 2001).

- Aboriginal Community Controlled Health Services may be described as alternative organisations in that they provide integrated health and social services within a cultural framework that is different to mainstream health organisations (Rothschild-Witt 1976).

Alternative organisations, according to Rothschild-Witt (1976) originate with a strong social movement orientation in opposition to mainstream service provision and the values and ideology surrounding this provision. The organisational structures, processes and ideologies that characterise alternative service organisations are similar to collectivist organisations and are dissimilar to rational-bureaucratic organisations. These organisations are parallel rather than oppositional to mainstream health organisations. However, they continue to expand and develop with different cultural values to mainstream health services (Bartlett 1999).

## Adjusting to the current environment

The distinctive features of the Aboriginal Community Controlled Health Services both advantage and disadvantages them in adjusting to the market economy and managerialism. They are advantaged because they use a model of primary health care that integrates services. They are disadvantaged because the processes and structures that are valued in the managerialist approach are generally not those valued as a means of improving Aboriginal and Torres Strait Islander health (Sullivan 1996).

The following discussion highlights some of the factors about Aboriginal Community Controlled Health Services relevant to their adjustment to the current environment.

- Maintaining a broad focus

One theme of health care reform is a renewed focus on health rather than health care (Hunter & Berman 1997). Some health organisations may need to make changes to achieve this. However, Aboriginal Community Controlled Health Services already operate on a model of primary health care that is consistent with that promoted by the Ottawa Charter (World Health Organisation 1991).

The services provide clinical services to individuals but they also address many factors that affect health and some of the underlying causes of poor health (Scrimgeour 1997, Simpson & Hunt 1997, Pika Wiya Health Service 1999). However the very nature of many of the Government health funding streams is making it increasingly difficult for the services to address the underlying determinants of health. Comprehensive primary health care funding is not available as a single source of funding to address a range of issues in an integrated manner. Therefore funding for each aspect of health care must be accessed separately.

Often new programs providing holistic services, must seek private funding. A prenatal and perinatal service to young mothers, fathers and their children in Townsville, that included a child care and transport component, was funded by a private trust (Atkinson 2001).

- Developing the role of community controlled boards

Highly skilled management processes are required in health to set organisational goals and make difficult decisions about the efficient and effective use of scarce resources (Braithwaite 1993b; Southon 1996; Lloyd and Boyce 1998). Board members elected by the community generally possess deep cultural knowledge, and this has been highly valued and incorporated into the organisation of the health service provision (Scrimgeour 1997a; Wakerman Matthews et al 2000).

Because health service management is complex, specialised management knowledge is required and not all board members may possess, or wish to possess this type of knowledge (Kimberley Aboriginal Medical Services Council 2000). This highly complex issue has required ongoing commitment from funding and professional management bodies to support the services as they negotiate appropriate roles for board members (Office of Aboriginal and Torres Strait Islander Health 1999).

In addition to the highly specialised knowledge required, the range of tasks performed by board members is extensive. While mainstream health service boards can focus on governance issues, board membership of an Aboriginal Community Controlled Health Service may involve broader responsibilities. Board members may be asked to represent community views in consultations on a broad range of topics. Established health services are

often asked to assist in developing a new community organisation. These roles are time consuming and while the participation on boards of management may bring community cohesion and development, it is a demanding task (Kimberley Aboriginal Medical Services Council 2000).

- Maintaining participation

Participation occurs not only in management. Community members may provide their views about health needs and priorities and monitor service delivery according to their understanding of the health issues in the community (Riley & Weston 1997). This has been the process on which the primary health care model has been built.

However, there is not an exact fit between community need and service provision. Funding issues prevail and the needs identification process may prioritise some sectional interests over others (Wakeman, Matthews et al. 2000). In addition the capacity for community members to continue to participate in the entire range of activities may be affected by the requirements of the new management environment.

There has been an assumption in some literature that participation automatically occurs in these organisations, that it is representative and that community control brings this about (Bell, Couzos et al. 2000). However effective community participation in all health organisations takes a great deal of time, resources, appropriate knowledge and commitment from all those involved. Overall there must be a genuine reason for participation. When timeframes are short, issues are complex and there are many 'givens', participation in decision making may not occur (Labonte 1992, Baum 1996). The organisations may find it increasingly difficult to maintain their participative style of management and service delivery in the face of these pressures.

- Developing a results orientation

The move to define carefully products, consumers, units of service and outcomes requires a focus on the results of health service activities undertaken. Therefore a system is required that quantifies specific tangible health outputs for individual clients/patients as well as benefits to the community more broadly.

The challenge is for Aboriginal Community Controlled Health Services to develop performance indicators that are valid and reliable and do not constrain health service delivery to patients/clients (Anderson Brady 1999). In addition it is important to develop performance indicators to measure health benefits that may accrue to the community as a whole. Careful measurement of these health benefits will give credibility to the model of primary health care used by the services (Muetzelfeldt 1999).

- Committed management

As a 'social movement organisation', the Aboriginal Community Controlled Health Services are oriented to goals of social and personal change to improve the health status of Aboriginal and Torres Strait Islander people. Many Aboriginal and Torres Strait Islander health service managers enter management with a high level of personal motivation to assist their community in achieving "positive social, economic, political and health outcomes" (Wakeman, Matthews et al 2000 p.11). This commitment to change and the strong personal motivation of management may advantage these organisations in the current environment.

This theme is argued in relation to Canadian Indigenous Health Services. It has been stated that these organisations may cope better with the 'New Management Ideology' than non-Indigenous organisations. They may draw on traditional cultural values of tolerance, adaptiveness, collectivism and an egalitarian approach to improve organisational effectiveness (Redpath & Neilsen 1997).

- Management as leadership

The concept of leadership has currency in defining the management task in that it is an overarching competency relevant to most aspects of the management function (Hartley 1996). The importance of managers' and Board members' leadership in health activities may be acknowledged, supported and developed in Aboriginal Community Controlled Health Services.

Managers and board members of these organisations are usually in touch with trends and developments in health in the wider environment. They frequently take a leadership role in interpreting opportunities to their community (Wakeman, Matthews et al 2000). In many ways Aboriginal Community Controlled Health Services may be more leader-than manager-orientated.

## Aboriginal Community Controlled Health Services and partnerships

An overarching issue for the Aboriginal Community Controlled Health Services is the development and maintenance of equitable partnerships in health provision. Health provision is now so complex that workable alliances and partnerships between health and other services are critical (Hunter 1999, Sumner-Dodd 2001). However partnerships will inevitably be built on different understandings of Aboriginal culture and health and therefore the Aboriginal Community Controlled Health Services are not always equal partners. Non-indigenous culture will predominate and the partnerships must be developed within the Western management paradigm.

The establishment of partnerships with these services therefore requires an open negotiation of these different orientations and the inevitable competing priorities. In forming partnerships, the challenge is for the Aboriginal Community Controlled Health Service to maintain ownership of service delivery while benefiting from the contribution of the partners (Sumner-Dodd 2001).

Currently Aboriginal Community Controlled Health Services are negotiating a variety of partnering models with University Departments of Rural Health (UDRH), Divisions of General Practice, hospitals, general practitioners and other health organisations (Pika Wiya 1999; Bell Couzos 2000; Sumner-Dodd 2001). One UDRH and an Aboriginal Community Controlled Health Service have negotiated a memorandum of understanding based on the contributions each will make.

One aspect of the partnership is the employment of a training co-ordinator by the UDRH, based at the health service, which assists with the training needs of staff as well as co-ordinating placements of medical and other health profession students. The health service also uses the UDRH to recruit medical practitioners.

The UDRH, by working closely with the service, has the capacity fully to understand the requirements of the organisation and recruit a medical practitioner who has not only relevant clinical skills but is capable of relating well to Aboriginal people and working to a community controlled board. The medical practitioner is then employed by the Aboriginal community controlled health service and is responsible for working in that service under its guidelines although the UDRH may assist with professional development and industrial relations issues. The organisation then provides the UDRH with an excellent location for placements of medical and other health science students.

## Conclusions

Aboriginal Community Controlled Health Services are well placed to provide effective primary health care. They remain a source of community focus and energy and enable community members to act together to progress issues related to self-determination, health, and economic and social wellbeing. They have acknowledged interdependence between health sectors, have developed collaborative responses to health issues and shared resources.

However, in the current environment of health service reform, their position at the interface of Western management and Aboriginal culture produces challenges for their management. In an environment that calls for significant population health outcomes, the services have traditionally used a holistic model of primary health care. Their participative style and their broad view of health, enable them to provide integrated and holistic primary health services at the grass roots level, complementing mainstream health services. However participation may be difficult to maintain in the environment of increasing complexity of health service management and delivery. Funding sources to support integrated primary health care are not easy to locate.

How the management challenges the services face are overcome probably depends in part on the skill which they and their collaborators bring to their partnerships that are established to advance Aboriginal and Torres Strait Islander health.

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