## B2 | REVITALIZING COMMUNITY CONTROL IN PRIMARY HEALTHCARE

Community-controlled primary healthcare (PHC) services are governed by a board of management consisting of community members, allowing high-level community inputs into service planning, delivery and evaluation. The history of community control in PHC predates the World Health Organization's Alma-Ata Declaration on Primary Health Care (WHO 1978). The Alma-Ata Declaration laid out the key aspects of PHC, which were being implemented in many nations, to provide a vision for achieving health for all by the year 2000: namely, the provision of comprehensive PHC to promote health and prevent disease, as well as the provision of curative and rehabilitative services that address existing ill health.

The Alma-Ata Declaration "requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care". The Alma-Ata Declaration also argued for a new world economic order to counter the massive growth in the power and influence of the transnational corporations, which were weakening the power of citizens to take action in support of their health. The subsequent WHO Ottawa Charter for Health Promotion (WHO, 1986) heavily emphasized the need for enabling community power and control in order to promote health. The People's Charter for Health[1] (2000) was grounded in the need for citizens' involvement in all aspect of healthcare, stressing that "Strong people's organizations and movements are fundamental to more democratic, transparent and accountable decision-making processes."

Health systems and services have implemented community participation in ways that are often not as democratic as envisaged in the People's Charter for Health (Rifkin, 2009, pp. 31–36; Rifkin, Lewando-Hundt and Draper, 2000). The continuum and typologies of community participation in health services show how community inputs can range from tokenistic efforts and consultations to seek community views to structural participation, as in the case of community-controlled services, where the community has real power to control the scope of participation, and affect service decisions and planning (Arnstein, 1969, pp. 216–23; Baum, 2015; Oakley, 1989). Across the continuum, the terms used to describe the different levels of community participation differ. This acknowledges that different community participation efforts vary in the extent to which they truly realize the democratic control of health services.

While efforts at the consultative end of the spectrum are largely concerned with ensuring the acceptability of health services, community control has the more ambitious goal of providing space for community power to control healthcare, to increase the community's control over its own health and to improve the responsiveness of the health service to the local community (Freemanet al., 2016a, pp. E1–E21). Internationally, this goal continues to be blocked by, and is always hard won against, the opposing force of entrenched corporate and private sector interests in the health field (Mackintosh et al., 2016, pp. 596–605; Mooney, 2012). In the face of the current trend towards privatization of healthcare services, revisiting and revitalizing the community control of health services is more relevant than ever.

The Alma Ata Declaration was informed by many case studies of grassroots healthcare programmes in China, Cuba, India, Indonesia and elsewhere, which stressed participation, local flexibility and responsiveness, the use of community health workers and less professional dominance (Cueto, 2004, pp. 1864–74; Rifkin, 2003, pp. 168–80). In Australia, one of the pre-Alma-Ata pioneers of comprehensive PHC and community control has been the Aboriginal Community Controlled Health Organizations (ACCHOs).[2] Briefly, ACCHOs were first established in the 1970s as a response to the Aboriginal and Torres Strait Islander peoples' poor access to health services and the discriminatory practices in mainstream healthcare (Torzillo, et al., 1992). Currently in 2017, there are about 150 Aboriginal community-controlled organizations in Australia, serving between a third to a half of the total Aboriginal and Torres Strait Islander population (Dwyer, et al., 2011, pp. 34–46). The principle at the heart of the ACCHOs is that Aboriginal and Torres Strait Islander communities should be in control of their own health and healthcare (Bartlett and Boffa, 2001, pp. 74–82). Aboriginal community-controlled health services "are initiated, planned and governed by boards elected from the local Aboriginal community" (National Aboriginal Community Controlled Health Organisation, 2011, p.1), though some organizations started as government services with the control then transferring to the community (South Australian Department of Health, 2010).

Alongside ACCHOs, multidisciplinary community health services with community boards emerged in Australia in the early 1970s under the federal community health programme (Australia. Hospitals and Health Services Commission. Interim Committee, 1973). Community health services developed in Canada (Abelson and Lomas, 1990, p. 575), the USA (Ulmer, et al., 2000) and elsewhere, working in a manner consistent with the Alma-Ata vision of comprehensive PHC. The present chapter considers the evidence for the benefits of community control, with specific reference to ACCHOs and community health centres.

### Evidence for the benefits of community control in ACCHOs

The great extent of health inequities and the barriers to health service access faced by Aboriginal and Torres Strait Islander peoples in Australia have been well documented (Australian Institute of Health and Welfare, 2011; Australian Institute of Health and Welfare, 2015). The lack of equity has occurred in the context of ongoing colonization due to which mainstream health services are often not culturally safe, reproduce unfair power relationships, are not in accord with Aboriginal and Torres Strait Islander perspectives on health and well-being, and fail to address the inequities of such social determinants of the peoples' health as income, access to transport, and racism and discrimination (Freeman, et al., 2014, pp. 355–61). Indigenous peoples in Canada, New Zealand and Australia have all emphasized the centrality of self-determination to health and well-being, and the need for indigenous community-governed health services (Lavoie and Dwyer, 2016, pp. 453–58).

In Australia, the ACCHOs were a result of grass roots Aboriginal and Torres Strait Islander-led activism, identifying community-controlled health services as the solution to the problem. Given this, it is unfortunate that the innovative approaches and unique contribution to indigenous health of Aboriginal community-controlled health organizations are too often neglected in PHC studies. It is typical for research studies to rely on quantitative comparisons between mainstream PHC and ACCHOs, despite the very different models of care and the populations served (Dwyer, et al., 2015). The results of such studies are mixed, but often indicate that ACCHOs achieve clinical curative or chronic condition management outcomes similar to mainstream PHC (general


**Image B2.1** Public demonstration in Alice Springs, leading to the establishment of Congress, 1973. (Central Australian Aboriginal Congress)


**Image B2.2** ACCHOs were a result of grass roots Aboriginal-led activism. (Central Australian Aboriginal Congress)

practice) despite having a more complex and disadvantaged caseload (Aboriginal Health & Medical Research Council, 2015; Dwyer et al., 2015; Mackay, Boxall and Partel, 2014). This is in itself a very strong finding, but does not still take into account the more comprehensive suite of activities the ACCHOs engage in, such as community development, advocacy and health promotion.

A study of a community-controlled health service, the Central Australian Aboriginal Congress Aboriginal Corporation, in the Northern Territory, found that in addition to primary medical care, the Congress exhibited strengths in comprehensive PHC over and above those in the other PHC models in the research study, including the following (Freeman et al., 2016b, pp. 93–108):

- more comprehensive multidisciplinary services, with a wide range of allied health disciplines, along with visiting specialists to provide services out of the Congress clinics
- a wide range of strategies to engage with and seek inputs from the community, including the community board: the only example of structural participation in the research, which allowed the community to set the scope and nature of their participation
- considerable efforts to ensure accessibility of services, through the provision of a mix of appointments and drop-ins, transport service, outreach services and home visits, employment of local Aboriginal staff and respect for local cultural protocols

- greater orientation towards health promotion and addressing the social determinants of health, while meeting the strong demand for curative services, including collaborative advocacy on alcohol supply reduction measures, early childhood services and community health education.

The Central Australian Aboriginal Congress Aboriginal Corporation drew its name from Mahatma Gandhi's Congress Party, and to this day has a quote on him its website that is often attributed to him (CAAC 2017):

> "Our clients are the most important visitors on our premises.
> They are not dependant on us.
> We are dependent on them.
> They are not an interruption on work.
> They are the purpose of it.
> They are not an outsider to our business.
> They are part of it.
> We are not doing them a favour by serving them.
> They are doing us a favour by giving us the opportunity to do it."
> Gandhi [*sic*]

A number of health services in Australia have been transferred from state government management to community control, providing an opportunity to examine what benefits community control may bring. In the Northern Territory, where some key research has been done, once health services were transferred to Aboriginal community control, a range of benefits were observed: there was an increased focus on health promotion, greater employment of local people, a greater focus on culturally safe care and improved community participation (Dwyer et al., 2015). Adequate resourcing of community-controlled health services is also critical: the Central Australian Aboriginal Congress benefited from an AUD 30 million per annum budget, and when the health services in the Northern Territory transitioned to community control, this came with an increase in budget. However, the findings still highlight how community control appears to allow a more comprehensive PHC vision to bloom, in line with the Alma-Ata Declaration.

These findings reflect other international experiences of indigenous community-controlled health services. In Canada, indigenous community-controlled health services have been largely services transferred from federal government management (Lavoie and Dwyer 2016, pp. 453–58). In one study (Lavoie et al., 2010, pp. 717–24), it was found that the First Nation community health services, which transitioned from government control to community control, achieved a 30 per cent reduction in hospital utilization rates for ambulatory care sensitive conditions (those conditions for which PHC is most well placed to prevent hospitalization). The benefits were greater the longer the services had been under community control, and the authors concluded the positive

health benefits were due to self-determination. In the USA, some organizations have been transferred to community ownership from the Indian Health Service. There is not enough research on the benefits or performance of these organizations, though there is some evidence that community-controlled services focus more on prevention and local needs than do federal services (Rainie et al., 2015, pp. 1–24).

In Australia, the Redfern Statement, signed by over 50 Aboriginal and Torres Strait Islander and non-indigenous organizations, called for a change in policy and government relationships on Aboriginal and Torres Strait Islander health to transform inequitable power relationships and support self-determination (National Congress of Australia's First Peoples et al., 2016). The achievements of Aboriginal community-controlled health services in Australia and internationally provide evidence for the importance of self-determination and increased power and control as determinants of indigenous health.

### Evidence for the benefits of community control in community health centres

Another leading model of community-controlled PHC is community health centres, found in many countries, including Australia, Canada and the USA. In Australia, these centres have their roots in the Federal Community Health Program (National Hospital and Health Services Commission Interim Committee 1973), although this programme only lasted three years and left the different states and territories to run community health centres in their own way. Two states, South Australia and Victoria, have particularly strong histories of vibrant community health sectors based on a comprehensive PHC approach (Legge et al., 1996, pp. 22–26). Legge et al., (ibid.) emphasize the importance of community participation, particularly the power of community control, in achieving good comprehensive PHC practice. Critically, a comprehensive PHC approach allows the melding of professional approaches to health that focus on diseases and risk factors with community approaches that are more likely to focus on living conditions and community capacity to work to improve health. This potential is supported by a 1992–1993 survey of South Australian boards of community health centres, which found that two of the three functions board members were most involved in were "deciding philosophy and policies" and "deciding which issues the health service should address" (Laris, 1995).

Since the period that Laris (ibid.) and Legge et al. (1996) have studied, there has been in South Australia and other states and territories a state policy move away from comprehensive PHC (though less so in Victoria). Community boards in South Australian services were abolished in 2004, with power shifting to the central health department by 2006. A series of neoliberal restructures and changes to South Australian PHC have been documented, and indicates the threat that neoliberalism, with its narrow focus on outputs and control of staff through managerialism, poses globally to community control of health services and to comprehensive PHC generally (Baum et al., 2016, pp. 43–52).

Community health centres also have a strong history in Canada, where the implementation of this model has varied from province to province. Some have community governance structures, while others do not. A survey conducted by the Canadian Association of Community Health Centres (2013) of over 200 centres across Canada found that those with community governance were more likely to undertake work that addressed social determinants of health and health equity: for example, programmes and advocacy about food security, racism, housing and homelessness, poverty and income security, and refugee health services. Again, this demonstrates a link between community control of health services and the ability to enact the comprehensive Alma-Ata vision of PHC. In the USA, community health centres service 22 million people, primarily those with low income, who are uninsured or have low English proficiency (Li et al., 2016, pp. 356–70). These, too, are community- governed, and have a focus on prevention and the social determinants of health, including access to healthy food, employment, housing and education (National Association of Community Health Centres, 2012).

## Conclusion

Community control has the potential to democratize health services. Implementing the approach throughout health systems would help realize the original Alma-Ata dream of health or all: through community perspectives that complement and strengthen professional views of health; through community management to take responsibility for the health of the local community in such a way as to foster action on the social determinants of health; by responding to local needs, supporting accessibility and building community capacity for health.

Community control offers more relevant, effective and efficient healthcare than corporatized, for-profit care. Involving citizens in the management of health services is likely to make them strong advocates for non-commercialized healthcare and provide a counter voice to the powerful corporate voices baying for more chances for profit. For indigenous peoples, it also provides greater self-determination and control over health and healthcare, and more culturally respectful services that take into account holistic, indigenous conceptions of health and healing.

Community control will contribute to decolonization, which is essential to restoring indigenous people's health and well-being. Of course it is also a central mechanism in the achievement of comprehensive PHC as envisioned in the World Health Organization's Alma-Ata Declaration – a vision that was immediately challenged by a more selective, technical view of PHC and which continues to be challenged in an era of neoliberalism, austerity and the privileging of biomedical and commercialized models of health. The value of community control in combating these threats to comprehensive PHC and health for all is as relevant, and as urgent, as ever.

## Notes

1 The People's Charter for Health is a statement of the shared vision, goals, principles and calls for action that unite all the members of the PHM coalition... [A] widely endorsed consensus document on health since the Alma-Ata Declaration,... [it] was formulated and endorsed by the participants of the First People's Health Assembly held at Dhaka, Bangladesh in December 2000. http://www.phmovement.org/en/resources/charters/peopleshealth

2 The ACCHOs were the subject of a chapter in *Global Health Watch 4*. See *Global Health Watch 4*, http://www.ghwatch.org/sites/www.ghwatch.org/files/E9.pdf

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