

Improving Indigenous access to a mainstream general practice

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POPULATION PROFILE AND DISTRIBUTION

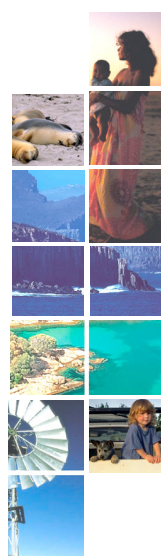
According to the 2001 Australian population census; 435,381 individuals identified as Indigenous Australians, representing 2.2 per cent of Australia's total population. The Indigenous population has doubled since the 1986 census. This increase cannot be explained by natural increases (births and deaths) alone. The increase comes from three areas. The first is enumeration, improved counting of Aboriginal people, especially in remote communities. Secondly, more Aboriginal people are identifying as being Indigenous, particularly those from the "Stolen Generation". And thirdly, the children from the union of Indigenous and non-Indigenous parents are more likely to identify as Indigenous than non-Indigenous, a term some researchers call ambilineal descent.

The Australian Bureau of Statistics experimental estimates of the Indigenous population as at the 30 June 2001 was 435,381, which represents 2.2% of the total Australian population of 18.31 million. New South Wales had the largest number of Indigenous people with 123,405 or 28.5% of the Australian Indigenous population, followed by Queensland with 121,601, Western Australian 62,577, Northern Territory 57,236, Victoria 24,974, South Australia 24,770, Tasmania 16,917 and Australian Capital Territory 3,058. The Northern Territory had the largest proportion of Indigenous people with 28.5% and Victoria the lowest at 0.8%, most states report an Indigenous population of between 1 and 3 per cent.

Indigenous population profile

Table 1 ABS experimental estimates June 2001

State	Indigenous population	Proportion of Indigenous population %	Proportion of total State/Territory population %
NSW	123 405	28.4	1.8
Qld	121 601	27.7	3.1
WA	62 577	14.4	3.2
NT	57 236	13.2	28.5
Vic	24 974	5.8	0.5
SA	24 770	5.7	1.5
Tas	16 917	3.9	3.2
ACT	3 058	0.8	1.0
Total	435 381	100.0	2.2



The distribution of the Indigenous population within a state can vary greatly from state to state. For example, in the Northern Territory two thirds of the Indigenous population live in rural and remote while the remaining one third live in urban areas. In contrast, in Queensland the reverse is true with one third living in rural and remote areas and two thirds in provincial and urban regions. The population profile and distribution impact greatly on access to services. Overall two thirds of the Indigenous population would live in urban areas. In rural remote Indigenous communities isolation is a very important barrier to accessing quality services.

INDIGENOUS ACCESS INTO MAINSTREAM GENERAL PRACTICE

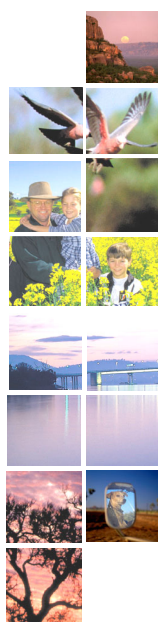
Social inequality has contributed to the poor health status of Indigenous Australians. Forced relocation, urban migration, poor education, lack of employment, low income, inadequate housing, lack of environmental infrastructure and a lack of appropriate health service provision are all important social determinants of ill health for Aboriginal and Torres Strait Islander peoples. There has been a long history of inadequate health service provision for Aboriginal people. Services have either been absent or culturally inappropriate. It has been noted that the resulting low levels of access by Aboriginal people to primary health care settings have contributed to their continuing poor health status.

Successive Federal and State Governments have made Indigenous Health a priority issue. For example, Queensland Health has responded to major inequalities in health status between Aboriginal and Torres Strait Islander people and non-Indigenous people in Queensland by developing an Aboriginal and Torres Strait Islander Health Policy in 1994. As part of the community consultation process by Queensland Health, a workshop involving Indigenous community members across Queensland was conducted to develop the policy document. The key directions of this policy focus on the following areas:

- community control of primary health care services
- participation
- needs based criteria for service provision and resource allocation
- workforce planning and development
- information, monitoring and evaluation
- across government approach to the provision of key social and infrastructure services to the Aboriginal and Torres Strait Islander population
- culturally appropriate service provision.

Services to be culturally appropriate means that local language, beliefs, gender and kinship systems are taken into account, thus making service delivery settings much more acceptable to the Aboriginal and Torres Strait Islander community.

Staff from hospital outpatients and community programs in Brisbane South noted that Aboriginal and Torres Strait Islander peoples were not accessing district services. These low utilisation rates indicated that a major problem existed with Indigenous



people accessing mainstream health care services. At the Inala Community Health Centre which is located within the QEII Hospital Health Service District, nursing staff had expressed concern in 1994 that they could only identify 12 Indigenous clients who regularly used the general practice clinic at the Inala Health Centre. This suggests that approximately 1 per cent of the local Inala Aboriginal and Torres Strait Islander population is utilising the services offered by the Inala Health Centre General Practice (IHCGP)

Inala is classified as an urban area with a total population of 13,284 as reported by the 1996 Census of Population and Housing. The Indigenous population of Inala is approximately 8% of the total population and is noticeably high considering that Indigenous Australians only make up 2.2% of Australia's total population.

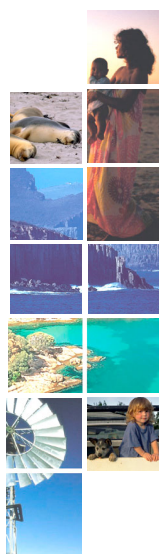
The staff of the Inala Community Health Centre work together with the community to improve health and quality of life. The Centre has specialised health teams, which aim to provide high quality care. The following health teams operate from the Centre:

- Indigenous Health
- Adult Health
- Child, Youth and Family Health
- Aged Health
- Oral Health
- Alcohol and Drug Services
- Adult Mental Health and
- Allied Health Service.

Barriers to access identified by local Indigenous people for not attending Inala Health Centre General Practice included:

- no Aboriginal person working within the centre
- Aboriginal people perceived staff to be unfriendly and uncaring
- staff talk down to you "make you feel shamed"
- staff body language was interpreted by Aboriginal people that they were not welcome at the centre
- treated poorly by reception staff
- long wait to see doctor
- there was nothing at the centre that Aboriginal people identified with.

Patients who did attend clinic were interviewed and the reasons they attended were convenience as they lived nearby, satisfied with doctors and staff. These patients reported no racism and were older and possibly more tolerant to adverse comments.



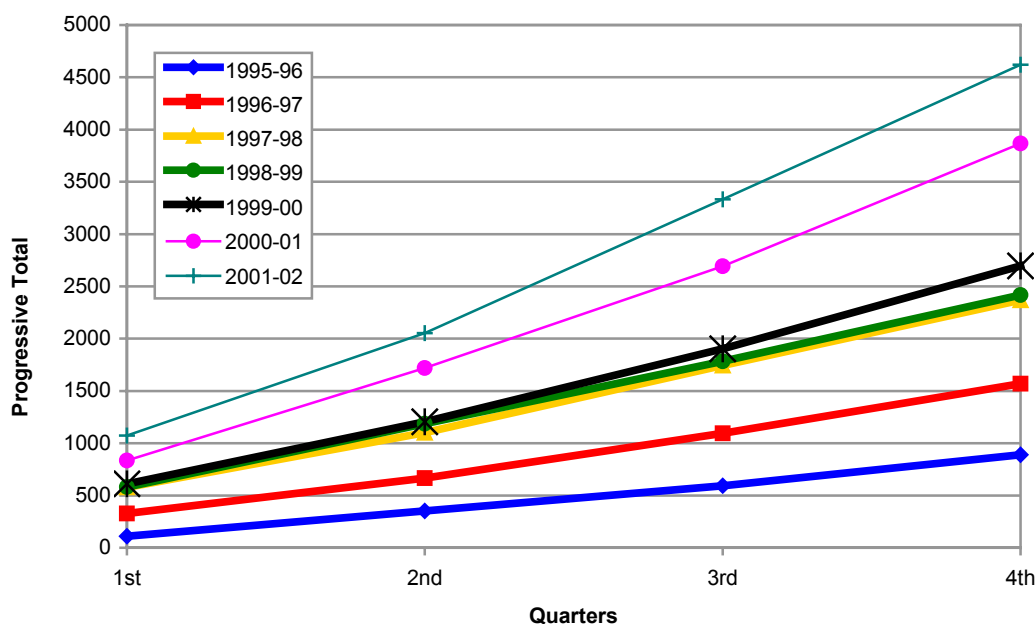
An intervention was developed with community participation and was implemented in July 1995. The intervention covered five important strategies aimed at increasing Aboriginal and Torres Strait Islander access to Inala Health Centre General Practice and are as follows:

- to employ an Aboriginal or Torres Strait Islander person in the Centre. This person could be a nurse, health worker, a receptionist or a liaison person for the Centre
- to purchase culturally appropriate health posters and artefacts for the Centre to help make Aboriginal people feel more at home
- to provide cultural awareness talks to all staff within the Centre
- to disseminate information into the Aboriginal and Torres Strait Islander community about what services are available at the Centre
- to promote intersectoral collaboration.

All strategies were implemented within the first year of intervention.

The results indicate that improving Indigenous access to the Inala Health Centre General Practice has been extremely successful. In 1995 there were approximately 900 consultations, in 1996-97 1600 consultations were completed, for the next two years consultations improved to about 2,500 per year and for the year 1999-2000 the total number of consultations was 2,695, in 2001-02 consultations increased to 4,621.

Figure 1 Indigenous access to IHCGP



New patient registrations in total were approximately 1200 over the five-year period. This is an excellent achievement remembering that only 12 Indigenous patients attended the clinic prior to intervention.

Table 2 shows the comparison between Indigenous access and total IHCGP access, as measured by the number of doctor consultations. IHCGP access (non-Indigenous) has remained relatively constant over the seven-year period. Whereas Indigenous access has increased significantly over this period, from 890 consultations to 4621 or 420%. The proportion of Indigenous consultations of the total IHCGP access has increased from 5.7% in 1995-96 to 23.1% in 2001-02.

Table 2 Indigenous access versus total IHCGP access

Year	Indigenous access	IHCGP access	Total IHCGP access	Per cent Indigenous of total
1995-96	890	14 591	15 481	5.7
1996-97	1 569	15 421	16 990	9.2
1997-98	2 396	14 487	16 883	14.2
1998-99	2 419	15 011	17 430	13.9
1999-00	2 695	16 221	18 916	14.2
2000-01	3 867	14 447	18 314	21.1
2001-02	4 621	16 718	20 002	23.1

These results suggest that Indigenous people will access mainstream health services if community participation and cultural differences are taken into account when developing intervention access programs. The strategies from this intervention, modified if necessary by community consultation, could be generalised to other mainstream health services across Australia. I believe significant community gains can result from improving Indigenous access to mainstream primary health care services, particularly in cardiovascular health. In this intervention the major areas of community gain were in diabetes, improved access to specialist services and childhood and adult immunisation.

