

Better health care for Aboriginal and Torres Strait Islander Australians in rural and remote areas

Mary McDonald, Program Planning and Development Branch, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing

INTRODUCTION

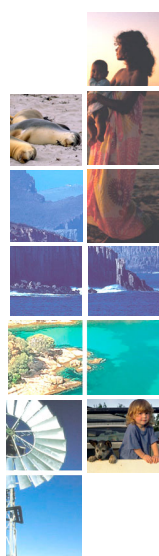
Global health statistics released by the World Health Organisation in June 2000 show that the Australian population in general is one of the healthiest of any developed country and has ready access to a world-class health care system. The Aboriginal and Torres Strait Islander population, is, however, the least healthy of any identifiable group within Australia, and international comparisons suggest that they have poorer health outcomes than Indigenous populations in comparable developed countries¹. In addition, there is ample evidence that Aboriginal and Torres Strait Islander people do not have the same level of access to appropriate health care as the general population in Australia.²

Primary health care has a central role in addressing the health needs of Aboriginal and Torres Strait Islander people. There are many challenges in improving access to appropriate care, but promising results are being achieved through innovative and focused approaches within a comprehensive primary health care framework.

These new approaches are bringing increased services to Indigenous communities particularly in rural and remote areas. Additionally the expansion of a comprehensive primary health care system in areas that previously had none, has also been of benefit to non-Indigenous people in these regions. For example in Katherine West which is one of the most remote areas in Australia, non-Indigenous residents are benefiting from a significant upgrade of health services to pastoral properties as a result of initiatives developed from the Aboriginal and Torres Strait Islander Co-ordinated Care Trials.

THE CONTEXT—ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Aboriginal and Torres Strait Islander people have an adult life expectancy around 20 years less than non-Indigenous Australians. They experience two to four times higher mortality rates, the differences being greatest in the productive middle decades. Another way of looking at this information is that for Aboriginal and Torres Strait Islander Australians (1997–99³) 76% of men and 65% of women die before the age of 65 years. These figures are reversed for non-Indigenous Australians, where the majority of deaths occur after the age of 65 years (73% of male deaths and 84% of female deaths).⁴ Accompanying this high mortality is a great deal of illness and disability in the middle years of life.



Australian health system

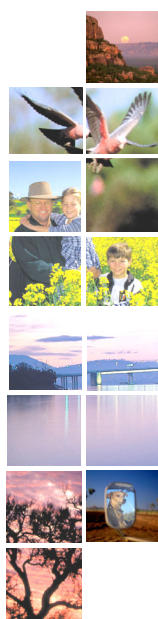
The Australian health system works well for the majority of the population, but it has not worked so well for Indigenous Australians, particularly those in remote areas. Health expenditure data provides some insights into the interaction of Aboriginal and Torres Strait Islander people with the health system compared with the rest of the Australian population.

On a per person basis, Aboriginal and Torres Strait Islander Australians are much greater users of public hospital and community health services than non-Indigenous Australians are. However, they use private medical, dental and other health professional services at a much lower rate (than non-Indigenous Australians). The Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) are the Commonwealth's main primary health care financing mechanisms. However, access levels for Aboriginal and Torres Strait Islander people in 1998–99 were estimated to be around only 39% of that of the general population, despite their poorer health status⁵. There is some evidence that access to Medicare may be increasing over the last few years, but it is still very low, particularly given the high level of need in this population group.

BARRIERS TO EQUITABLE ACCESS

Several barriers restrict access to needed health care for Aboriginal and Torres Strait Islander people. These barriers run across the mainstream health system, are inter-related and compounding. They include:

- limited or no provision and therefore access, to services in rural, remote and outer urban communities
- lack of a consumer focus in service organisation: poor links between different parts of the health system are commonplace and present difficulties for patients with complex health problems requiring multi-disciplinary and/or multiple specialist care; for example, for diabetes and for cancer care. Navigating one's way around the system is usually a challenge and this is particularly so for Indigenous people
- limited number and uneven distribution of health professionals with appropriate skills to address Indigenous health issues. Mainstream health staff are not always well equipped to work effectively in a cross-cultural context, nor to deal with the complex multiple morbidities and specific illnesses that are common in Aboriginal/Torres Strait Islander settings
- limited development of a population health focus in primary health care: This is particularly important for Aboriginal and Torres Strait Islander populations who have a high burden of undetected chronic disease such as diabetes and cardiovascular disease
- poverty among Aboriginal and Torres Strait Islander people leads to difficulty affording co-payments or in paying for private health services
- cultural and social factors, eg differing priorities between health care providers and their clients, discrimination, poor communication. Many Aboriginal and



Torres Strait Islander people can recount unhappy experiences with the mainstream health system.

REMOTENESS: A SIGNIFICANT BARRIER TO ACCESS

One in five Indigenous people live in “very remote” areas, compared to less than one in one hundred in the total Australian population.⁶ As a result, Indigenous people use transport services more often than non-Indigenous people, accounting for nearly half the cost of the Royal Flying Doctor Service and a large proportion of services from State Patient Assisted Transport Schemes (PATS).

There are particular problems in rural and remote communities in accessing health services that result from physical distance.⁷

The Aboriginal and Torres Strait Islander Survey (ATSIS), conducted by the Institute of Health and Welfare in 1994 found that over half of all Indigenous people living in rural areas had to travel more than 50 kilometres to a hospital.⁸ These difficulties are compounded by difficulties with transport, many people do not own their own vehicles, and communications ie access to telephones services etc, can also be problematic.

While patterns of disease may differ according to location, the health status of Indigenous populations in all geographic areas is consistently poorer than that of the general community.

INCREASED RURAL AND REMOTE HEALTH FUNDING

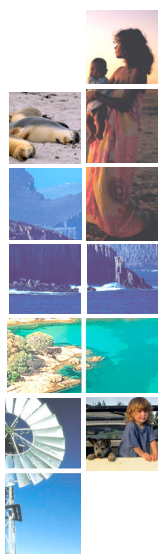
The Commonwealth Government recognises the significant barrier to the access of health services that remoteness poses to many Aboriginal and Torres Strait Islander communities. This is reflected in expenditures on Indigenous-specific health programs, which are highest on a per capita basis in rural and remote areas of Australia⁹. At this time approximately 2/3rds of Indigenous specific health funds go to programs servicing these regions¹⁰. This trend is opposite to that for mainstream Medicare and PBS programs (which have lower expenditure levels in remote areas).

Additionally by 2005–06 Commonwealth spending on Indigenous-specific health programs will have increased 94 per cent in real terms since 1996 to an estimated \$275 million in 2005–06¹¹. Importantly a significant proportion of these additional funds will be allocated to the enhancement of a comprehensive primary health care system.

COMPREHENSIVE PRIMARY HEALTH CARE

The comprehensive approach to primary health care delivery is based on the definition given in the World Health Organisation Alma Ata Declaration¹²:

...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's overall health system, of which it is the central



function and main focus, and the overall social and economic development of the community with the national health system bringing care as close as possible to where people live and work, and it constitutes the first elements of a continuing health care process.

In Australia, comprehensive primary health care has been developed by the Aboriginal community-controlled sector since 1971, when the first Aboriginal Medical Service was established by the local community of Redfern, an inner city suburb of Sydney.

In the broader Australian context, comprehensive primary health care relies on a partnership between Indigenous communities and health service providers. It requires community involvement and capacity building strategies, links with institutional structures beyond the health sector (eg environment, education, housing and food industries) and the involvement and co-operation of both mainstream and Indigenous-specific health services.

The clinical service components of this approach can be described as including:

- clinical care covering the treatment of acute illness, emergency care and the management of chronic conditions
- population health programs such as immunisation, antenatal care, adult health screening and specific health promotion programs related to issues such as nutrition, physical activity and substance use
- facilitation of access to secondary and tertiary health services
- client/community assistance and advocacy on health related matters and within the health and non-health sectors.

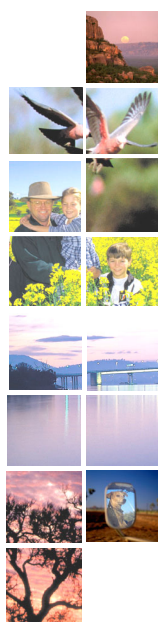
Health education/promotion permeates all these activities

Delivering the broad range of services that make up comprehensive primary health care is complex. Although it is possible for a single stand alone health organisation to provide all the elements of comprehensive primary health care to a population, more usually a variety of organisations and individual health professionals are involved.

Local solutions need to be adjusted to the needs of the population and the mix of providers available. Comprehensive primary health care approaches enable communities, with assistance, to tailor solutions to local circumstances. Where this happens there is the capacity to have positive impacts on the health of Aboriginal and Torres Strait Islander people as the following case studies show.

STUDIES IN SUCCESSFUL DELIVERY OF PRIMARY HEALTH CARE

Australia is in the early stages of development of a more comprehensive primary health care system in rural and remote Indigenous and non-Indigenous communities. There is innovative work occurring that will have a lasting impact, involving individual Indigenous communities and groups of communities, often in partnership with Commonwealth, State and Territory governments and health service providers. A recent publication shows how the expansion of a comprehensive primary health



care system is addressing the barriers to access of health services, faced by Indigenous Australians.

In 2001 the Office for Aboriginal and Torres Strait Islander Health published *Better Health Care: Studies in the Successful Delivery of Primary Health Care for Aboriginal and Torres Strait Islander Australians*. The publication details 26 case studies, which outline actions taken in these areas to improve primary health care delivery and the effectiveness of these changes. Some case studies that appear in this publication are described below.

APUNIPIMA CAPE YORK HEALTH COUNCIL, QUEENSLAND

Well Persons Health Check Program¹³

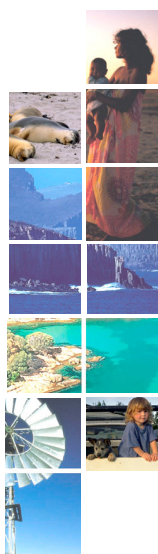
Apunipima Cape York Health Council was established in September 1994 following a four day summit involving representatives from each of the 16 communities and associated outstations of Cape York, Northern Queensland. Communities represented by the Health Council include Aurukun, Napranum, Marpuna, Lockhart River, Coen, Hopevale, Cooktown, Laura, Mossman Gorge and Wujal Wujal.

The area is a rural, remote location in the far north of Queensland with the main road routes being Cooktown to Cairns, Cooktown to Cape York and Cooktown to Weipa. There is no rail service in the region. Cairns to Brisbane is the nearest major rail route.

The core business of Apunipima Cape York Health Council is to co-ordinate health activities in three of these Districts, facilitate a change in service delivery and develop innovative solutions in partnership with communities to improve access to services for Indigenous people.

The Apunipima⁹⁹ Cape York Health Council conducted a Well Person's Health Check Program in conjunction with Queensland Health. Between March 1998 and December 2000 the program:

- was implemented in 26 communities with over 3,000 Indigenous people (>=13 years) participating
- achieved participation rates of between 19 and 92 per cent, with a mean of 47.5 per cent
- was run in collaboration with Queensland Health, who provide technical expertise and resources for community consultation, screening implementation, pathology, tests, data management, follow-up treatment and reporting
- detected high levels of a range of previously undetected health problems (including diabetes, sexually transmitted infections and cardiovascular risk factors) in most communities)
- included early clinical follow-up where this was needed (eg follow-up for sexually transmitted infections and new cases of diabetes were undertaken within one to three weeks of screening)



- has become a valuable tool for working through Aboriginal Community Councils to address influences on health such as nutrition, water and sanitation.

THE CO-ORDINATED CARE TRIALS AND THE EMPHASIS ON CAPACITY BUILDING

Many of these themes are echoed in the Aboriginal Co-ordinated Care Trials (CCTs). The trials followed from an agreement by the Council of Australian Governments in April 1995 to test new ways of delivering health and community services. The reforms proposed in the Trials aimed to introduce greater flexibility across programs and jurisdictions, in order to meet consumer needs more effectively, and to improve care management for people with complex and/or chronic needs.

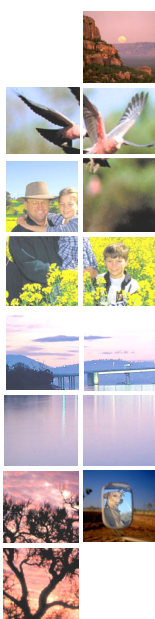
The Aboriginal Co-ordinated Care Trials National Evaluation report was released in 2001. Findings from the evaluation suggest the Trials successfully increased access to health services, including primary, specialist and auxiliary care, and to hospital services, through additional resources and through the financial flexibility made possible in the Trials. Service appropriateness was facilitated through a significant investment in the development and implementation of care co-ordination infrastructure and processes. The evaluation showed that funds pooling provided a useful mechanism for encouraging integration, flexibility and transparency in funding and service delivery between the Commonwealth and States/Territory. It also concluded that good clinical, public health, administrative and financial practice can be realised if the reform agenda is driven through community organisations that are adequately resourced and supported. Building capacity at a community level to plan, manage and deliver health services was a crucial component of the success of the Trials.

Organisational, individual and community capacity, the three elements of “capacity building”, all influence the rate at which services can be expanded and the nature of services that can be provided. Community leaders can drive organisational development. Once established, those organisations can engage the community in health planning and in management of the service, and can engage individuals in individual care planning and population health programs to foster greater responsibility in managing their own health. Local action to address difficult issues such as substance use or nutrition requires strong community leadership as well as mechanisms to engage communities in the development of local solutions.

The Katherine West Health Board case study below is an example of the effectiveness and importance of capacity building.

CASE STUDY: KATHERINE WEST HEALTH BOARD, NORTHERN TERRITORY

The Katherine West region is vast and sparsely populated, and covers one of the most remote areas in Australia. The population is approximately 3000, largely located in Aboriginal communities, outstations and cattle stations. Service delivery to the region before the Trial started was poor, with no resident GPs and little community involvement or action on health issues.



The Katherine West Health Board (KWHB) was established specifically for the co-ordinated care trial in 1997, in order for the area to assume responsibility for purchasing, and later also for directly delivering health services for the Trial population. However, the development of the KWHB enabled the community to influence decisions regarding the provision of health services, consistent with principles of community control.

Given the minimal pre-existing infrastructure, the Katherine West Trial placed significant effort on developing organisational, technical and community capacity, as pre-conditions to implementing health system reforms. Much of the Trial's organisational development related to administrative, financial and purchasing functions such as establishing fund-holding mechanisms, training and education of Board members, and negotiation of service agreements with Territory Health Service. Initially, Territory Health Services retained responsibility for operating the health centres located in communities. However, by the end of the trial period, responsibility for four of the eight health centres and full responsibility for allocation/expenditure for those health centres effectively passed to the KWHB.

The establishment of the Board has provided an on-going mechanism for communities to provide input into and to influence decisions about the nature of local health services, for example through health committees established in individual communities. As a result, the KWHB has become an important "asset" for local communities and the broader region, with organisational, financial and health issues and system expertise, which can be drawn on when the need arises.

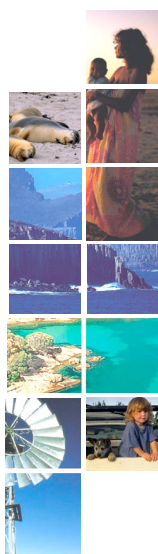
An important aspect of the Katherine West Trial has been the high level of collaboration between KWHB and others, including local government councils, various Aboriginal Land Trusts, and the Northern Territory Cattlemen's Association.

This has resulted in the non-Aboriginal residents of the area benefiting from a significant upgrade of health services to pastoral properties, an example of which is the mobile primary care unit that visits cattle stations and Aboriginal outstations. These achievements would not have been possible without the active involvement of KWHB members in their respective communities.

THE PRIMARY HEALTH CARE ACCESS PROGRAM

Building on the experience gained through the Aboriginal Co-ordinated Care Trials, the Primary Health Care Access Program (PHCAP) was announced in the 1999-2000 Budget. PHCAP was introduced to assist in improving comprehensive primary health care provision at the local level in areas where needs have been identified through Regional Planning¹⁴. The 2001-02 Budget announced additional funding from 2003-04, taking the total recurrent base for the program to \$54.8 million per annum.

The interlinked objectives of PHCAP are to increase the availability of appropriate primary health care services, to reform the local health system to better meet the needs of Aboriginal and Torres Strait Islander people and to empower communities and individuals to take greater responsibility for their health. Implementation of PHCAP involves the adaptation of agreed common reform principles to the needs in the local context. It builds on the CCT evaluations, and the information that is emerging from case studies on successful approaches.



Additional funds available under PHCAP make it possible to negotiate appropriate arrangements with State and Territory governments. These arrangements will result in transparency of funding, net increases in resources and a more integrated local health system. The emphasis on local health service system development will lead to more appropriate and accessible services and programs. Local planning and flexible implementation arrangements, including the scope for transfer of funding control to local organisations, will strengthen the responsiveness to local needs and enhance the capacity to engage communities and individuals in action to improve health.

IMPLEMENTATION OF PRIMARY HEALTH CARE ACCESS PROGRAM: FEBRUARY 2003

Round 1 PHCAP

South Australia

The first Local Area Strategic Plan has been completed and approved. This approval included funding to Nunkuwarrin Yunti South Australia Inc, to support expansion of primary health care services as outlined in the plan. This includes increased access to GP services, nursing and Aboriginal health worker services, child and youth services, men's health and nutrition and diabetes programs. The second of the five round 1 SA plans is now being finalised and the remaining three plans are expected to be completed by the end of March 2003.

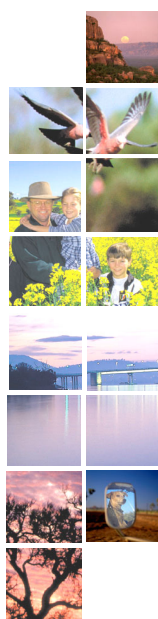
The local community has already started to see changes on the ground in these regions, with action to improve local health systems undertaken as an integral part of the planning process. Where possible, changes within the existing mainstream and Indigenous-specific services were made to meet needs identified through the planning process. This has resulted in more mainstream resources being directed to improve services, with the SA government making a substantial additional contribution throughout this process. Full implementation across most of the SA regions is expected this year.

Northern Territory

In the NT, priority sites have been chosen, joint funding arrangements between NT and the Commonwealth developed and an agreement specifying these signed. A community information and negotiation process has been undertaken, zone steering committees established and health planners in each zone selected. The zone health planners have now commenced work in the zones and it is anticipated that planning will be completed by May 2003. \$5.4 million for staff housing has already being provided in the NT PHCAP zones as a pre-requisite for the employment of additional health care professionals.

Queensland

In Queensland, priority sites have been chosen and the Commonwealth and Queensland Governments have agreed to principles of joint arrangements for PHCAP implementation. MoU negotiations are currently being finalised.



PHCAP Round 2

PHCAP Round 2 covering the remaining States, the ACT and the Top End of the Northern Territory was funded under the 2001/2002 Budget. However funding does not begin until 2003/2004, allowing time for completion of Regional Planning, multi-lateral negotiations on health system reform between the partners in each jurisdiction, and site selection.

In all States and Territories, Regional Planning is now complete with the exception of Tasmania (where it is well progressed). Multi-lateral negotiations on joint arrangements with the partners are well under way in most jurisdictions, with joint arrangements agreed in NT (Top End), WA and Victoria. Site selection is expected to take place early in 2003, with implementation in the first few sites* expected during 2003/2004.

SUCCESS FACTORS

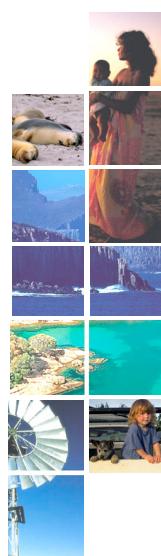
The case studies presented in the *Better Health Care* publication combined with other research within Australia and overseas^{15 16 17 18}, indicate that certain factors are crucial for successful delivery of effective comprehensive primary health care services. These factors underpin the Departments strategic direction in relation to Aboriginal and Torres Strait Islander health. These factors are:

- appropriate services and programs that are available and accessible
- a competent workforce including health professionals and health service managers
- capacity to engage individual and communities in action to enhance their own health
- capacity of the community to contribute to local service co-ordination and integration
- planning and evaluation
- sustainable services and programs.

CONCLUSION

Aboriginal and Torres Strait Islander people have poor health status and low levels of access to primary health care. A number of inter-related and compounding barriers impede access by Indigenous people to health services. Case studies such as those highlighted in *Better Health Care* and the experience of the Co-ordinated Care Trials show that positive changes can be achieved through communities and health providers working together to develop local service solutions that overcome the barriers to access. Many of these case studies and the CCTs illustrate a comprehensive approach to primary health care.

* We expect Top End (NT) and Victoria to be the first areas ready to implement, followed by WA. There have been significant problems in NSW in reaching agreement with NSW health on joint funding and implementation arrangements. These agreements are close to being formalised.



This information is assisting the implementation of the Primary Health Care Access Program – a program that aims to improve the availability and appropriateness of primary health care services for Aboriginal and Torres Strait Islander people. Particular attention is being given to strengthening local health systems that maximise the capacity of communities and individuals to take action on health.

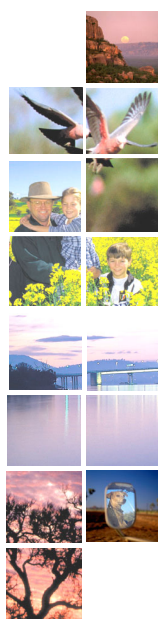
A recent report by the World Health Organisation noted that:

A good health system, above all, contributes to good health. But it is not always satisfactory to protect or improve the average health of the population, if at the same time inequality worsens or remains high because the gain accrues disproportionately to those already enjoying better health.

The health system also has the responsibility to reduce inequalities by preferentially improving the health of the worse-off, wherever these inequalities are caused by conditions amenable to intervention.¹⁹

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