Introduction

The gap in health and life expectancy between Aboriginal and Torres Strait Islander Australians and other Australians continues to be significant. There are some indications of change, but these are limited and the changes are gradual. If the gap in health and life expectancy is to be closed by 2030, further sustained efforts are needed to hasten the pace of change.

This will mean tackling the factors that contribute to the poor health of Aboriginal peoples and Torres Strait Islanders, such as low income, limited education, low levels of employment, and poor housing and living conditions. It will also mean an increased focus on the type and quality of health care that is available. The gap in life expectancy will not be closed until Aboriginal peoples and Torres Strait Islanders have the access they need to high quality primary health care. The AMA believes that this lack of access has been partly due to a lack of clarity within successive governments as to what high quality and accessible primary health care for Aboriginal peoples and Torres Strait Islanders should look like.

Australia’s primary health care system is currently undergoing reform. The AMA believes that these reforms should strive for, and be judged by how well they support, best practice in primary health care for Aboriginal peoples and Torres Strait Islanders. The AMA makes recommendations in this Report Card about the characteristics that Australia’s primary health care system needs to ensure this best practice.

In developing its specific recommendations, the AMA has investigated the latest data and evidence about the barriers that stop Aboriginal peoples and Torres Strait Islanders accessing primary health care services. Importantly, the Report Card identifies factors that encourage appropriate access and contribute to high quality health and clinical outcomes - in short, the key characteristics of best practice in primary care for Aboriginal peoples and Torres Strait Islanders.

There are significant service limitations and capacity gaps in primary health care delivery for Aboriginal peoples and Torres Strait Islanders, including in urban and non-remote areas where three-quarters of Aboriginal peoples and Torres Strait Islanders live. Aboriginal peoples and Torres Strait Islanders visit mainstream private general practices and local community health centres, as well as primary care services designed for Aboriginal peoples and Torres Strait Islanders. The challenge for the health reform process is to focus on what can be achieved through collaboration and integration between these services, to ensure continuity of high quality care through coordination, sharing of cultural understanding, resources, expertise, geographical availability, and opportunities to provide care.

Best practice in primary care for Aboriginal peoples and Torres Strait Islanders is about implementing models of collaborative service delivery that sustain continuity of care and are suited to the particular needs of particular regions and locations in Australia.

The AMA believes that best-practice primary health care has to be informed by the perspectives of the Aboriginal peoples and Torres Strait Islanders who are the potential recipients of that health care, and of those who successfully deliver it. This Report Card reflects perspectives from the coal-face in its case studies on models of best practice in different service contexts, including models witnessed by the AMA on site visits to primary care services in remote and urban areas.

Progress to close the gap must escalate significantly. So far, the reforming of Australia’s primary health system has paid scant attention to the health of Aboriginal peoples and Torres Strait Islanders. Planning or implementation has not been conducted in genuine partnership with Aboriginal peoples and Torres Strait Islanders. This perpetuates an unacceptable approach to policy.

Article 23 of the United Nations Declaration on the Rights of Indigenous Peoples states “indigenous peoples have the right to be actively involved in developing and determining health . . . programmes affecting them . . .” The AMA believes that full and genuine recognition of this right is long overdue in Australia, and that now is the time to change this.
Best Practice Primary Health Care for Aboriginal Peoples and Torres Strait Islanders.

PART 1 – PRIMARY HEALTHCARE AND THE HEALTH OF ABORIGINAL PEOPLES AND TORRES STRAIT ISLANDERS

There were an estimated 562,681 Aboriginal and Torres Strait Islander Australians in 2010, of whom 23.4 per cent lived in remote and very remote locations, while the majority lived in urban areas [ABS 2009a]. The Aboriginal and Torres Strait Islander population is expected to have the highest growth in major cities and inner regional areas, particularly among the 0-4 year olds, and those 55 years and over [Biddle and Taylor, 2009].

Health and life expectancy

Aboriginal peoples and Torres Strait Islanders experience significantly shorter life expectancy than other Australians [AIHW 2010]. An Aboriginal or Torres Strait Islander boy born between 2005 and 2007 can expect to live 11.5 years less than any other Australian boy (67.2 and 78.7 years respectively), and an Aboriginal or Torres Strait Islander girl born in that period could expect to live 9.7 years less than any other Australian girl (72.9 and 82.6 years, respectively) [ABS 2010b]. In 2004-2008 an Aboriginal Australian or Torres Strait Islander was 2.6 times more likely to die at any age than any other Australian [Thomson, et. al., 2010].

These higher death rates and shortened life expectancies reflect the significantly poorer health status of Aboriginal peoples and Torres Strait Islanders. For example:

- In 2008, Aboriginal peoples and Torres Strait Islanders were 2.7 times more likely to die as a result of diabetes and 3.6 times more likely to die from liver diseases [ABS 2010a];
- In 2007-08, Aboriginal peoples and Torres Strait Islanders were hospitalized for major preventable chronic conditions at 3.9 times the rate of other Australians [SCRGSP 2010];
- In 2008, 31 per cent of Aboriginal peoples and Torres Strait Islanders over 15 years reported high to very high levels of psychological distress [ABS 2010b], and
- In 2007-08, 7 per cent of hospitalisations of Aboriginal peoples and Torres Strait Islanders were due to mental disorders [AIHW 2010].

If the gap in health and life expectancy is to be closed by 2030, further sustained efforts to redress health inequalities are needed. These efforts must be commensurate with the burden of poor health among Aboriginal peoples and Torres Strait Islanders, including the fact that 60 per cent of the difference in death and disability between Aboriginal peoples and Torres Strait Islanders and the total Australian population is attributable to the poor health of Aboriginal peoples and Torres Strait Islanders living in non-remote areas of Australia [Eades, et. al., 2010; Vos et. al., 2007]. Forty per cent of the difference in death and disability is attributable to the poor health of the 23.4 per cent of the Aboriginal and Torres Strait Islanders living in remote and very remote areas.

Access to appropriate primary health care

In 2004-05, Aboriginal peoples and Torres Strait Islanders reported recently visiting a GP or specialist (either in a private practice or an Aboriginal and Torres Strait Islander primary health care service') at a similar rate to other Australians [AHMAC 2008]. Aboriginal peoples and Torres Strait Islanders are also over-represented in their presentations to hospital emergency departments, often to seek primary care. In 2008-09, 4.5 per cent
of presentations were for Aboriginal peoples and Torres Strait Islanders, who made up an estimated 2.4 per cent of the population [AIHW 2010b].

Despite the appearance of equitable or high access, Aboriginal peoples and Torres Strait Islanders do not access primary healthcare at a level appropriate to their need. While they may visit doctors, children under 15 years of age have comparatively low rates of access to primary care, particularly those aged under five years [Deeble 2009]. Utilisation of Medicare benefits and subsidised medicines through the PBS is also markedly lower for Aboriginal peoples and Torres Strait Islanders, with total expenditure in 2006-07 being 35 per cent less and 56 per cent less per capita respectively than for other Australians [AIHW 2009]. The use of MBS Aboriginal and Torres Strait Islander Health Assessment items is also low, despite the opportunities for health improvements that they offer [DiGiacomo et. al. 2010]. It has been estimated that less than 12 per cent of eligible Aboriginal people and Torres Strait Islanders received these assessments in 2009-10 [Russell 2010]. There are also low rates of access to specialist follow-up medical care when it is needed [Deeble 2009].

Appropriate access to primary health care can narrow the life expectancy gap, and may also offset some of the harmful health effects of socio-economic disadvantage and inequality [Dwyer, Silburn and Wilson 2004; Griew 2008]. A significant effort must be made to improve the access of Aboriginal peoples and Torres Strait Islanders to an appropriate range and quality of primary health care. This means addressing the barriers experienced in accessing that care, and building on the factors that promote access.

Making long-term improvements in access to high quality primary care requires Aboriginal peoples and Torres Strait Islanders to be engaged as genuine partners with governments and others in the development and implementation of strategies, policies and programs.

**Barriers experienced in accessing primary health care**

Access needs to be understood in terms broader than mere physical or geographical access, to also include economic, social and cultural dimensions, all of which are relevant to the opportunities and decisions of Aboriginal peoples and Torres Strait Islanders to utilise primary care services.

**Availability of services**

Geographical distance is a major access barrier for Aboriginal peoples and Torres Strait Islanders living in remote and very remote areas [SCRGSP 2010]. In 2008, 71 per cent of Aboriginal and Torres Strait Islander adults living in remote areas had no public transport, and 46 per cent reported problems accessing health services because of transport and distance [ABS 2010b]. Even in non-remote locations, where primary health care services are more geographically available, 55 per cent of Aboriginal peoples and Torres Strait Islanders reported in 2008 that appointments were not available when needed, and waiting times were too long [ABS 2010b].

Poor linkages, communication and coordination between primary health care services can also restrict their availability [Scrimgeour and Scrimgeour 2008]. This presents particular difficulties for Aboriginal peoples and Torres Strait Islanders who often have complex health conditions requiring a range of services.

**Affordability of services**

Affordability is a major factor determining Aboriginal peoples’ and Torres Strait Islanders’ access to primary health care services, particularly in urban settings [Scrimgeour and Scrimgeour 2008]. In 2008, 37.5 per cent of Aboriginal peoples and Torres Strait Islanders living in non-remote locations, and 16.5 per cent in remote locations, reported that they had problems accessing health services because of their cost [ABS 2010b]. Given the lower average income of Aboriginal and Torres Strait Islander families, there is higher sensitivity to the costs of medical services and medications, including MBS and PBS co-payments [Scrimgeour and Scrimgeour 2008].
Acceptability of services
 Whether or not a health care provider recognises, respects or incorporates Aboriginal or Torres Strait Islander cultural values in the design and delivery of its services is a factor that affects whether Aboriginal peoples and Torres Strait Islanders access that provider [Houston 2004; Lumby and Farrelly 2009]. When cultural values are ignored or offended in the provision of healthcare, this is a significant disincentive to access [AHMAC 2004]. Cultural values and perspectives can be excluded in many ways, from the attitudes of individuals to the characteristics and design of health services. In 2008, 4.7 per cent of Aboriginal peoples and Torres Strait Islanders living in remote locations, and 5.5 per cent living in non-remote locations, reported problems in accessing services because they were not culturally appropriate [ABS 2010b].

Even when primary care services are available, affordable and culturally accessible, not all Aboriginal peoples and Torres Strait Islanders will be fully aware of when to access those services. This is also a barrier to access.

PART 2 – REMOVING THE BARRIERS AND PROMOTING SUCCESS

Best practice in promoting access to primary health care for Aboriginal peoples and Torres Strait Islanders

Services that are reachable and available
 Increasing the number and distribution of high quality primary health care services clearly makes more services geographically available. Improving the availability of affordable transport and accommodation near existing services also contributes. In some remote Australian locations, where great physical distances are involved and Aboriginal or Torres Strait Islander communities are small, some health services have developed regionalised models of delivery that involve a larger service in a regional centre supporting smaller services in surrounding communities.

Outreach and community visiting can increase the availability of services, and can promote trust and ongoing relationships with Aboriginal and Torres Strait Islander communities. The outreach role often undertaken by Aboriginal Health Workers is invaluable in these respects, in urban as well as remote contexts. Aboriginal Health Workers are also significant in facilitating the journeys of Aboriginal peoples and Torres Strait Islanders between the range of health services they need.

It is also important to have linkages and coordination between the services and expertise that Aboriginal peoples and Torres Strait Islanders need in their region or locality. Some services have adopted particular approaches to address this. For example, the service model developed by the Queensland Aboriginal and Islander Health Council, integrates Aboriginal and Torres Strait Islander-specific and mainstream services. The need for coordination, integration and continuity of care for Aboriginal peoples and Torres Strait Islanders exists across Australia’s health system, which suggests that a system-wide response is needed.

Services that are culturally acceptable
 Aboriginal or Torres Strait Islander cultural values and perspectives can be reflected in health services at different levels. Often, staff can have knowledge about Aboriginal or Torres Strait Islander culture (cultural awareness). But the real difference is made when cultural values and perspectives are incorporated into the organisational arrangements and clinical approaches adopted by primary care services to make them non-discriminatory, more culturally respectful, and ‘culturally secure’ (cultural security).

Actions that contribute to cultural security can include having Aboriginal or Torres Strait Islander doctors, nurses or health care workers on staff, respecting gender-based cultural values and practices in clinical approaches (ie., men’s business and women’s business), having access to interpreter services, and recognising cultural conceptions of health and wellness in clinical practice.
Many services have successfully adopted measures to improve and promote cultural security. The Darebin Community Health Service experienced an 85 per cent increase in its Aboriginal and Torres Strait Islander clients after it employed an Aboriginal access worker, established links with local Aboriginal organizations, and built relationships with local Aboriginal people [Firebrace, et. al. 2001]. The Flinders Medical Centre established an Aboriginal health team and strengthened its relationships with local Aboriginal people and organizations. It experienced a tenfold increase within five years in its Aboriginal and Torres Strait Islander patient population, from 178 to 1752 [Dwyer, Silburn and Wilson, 2004]. The Inala Indigenous Health Service in Brisbane is an outstanding example of how a mainstream primary health care service has actively transformed itself [Hayman 2010].

Aboriginal culture is also represented in its strongest form (cultural appropriateness) through Aboriginal communities governing and owning health services [AHMAC 2004]. The care provided by Aboriginal community-controlled health services will be culturally appropriate because it is care provided by Aboriginal people for Aboriginal people.

Health-aware communities

Primary care services will be better accessed in Aboriginal and Torres Strait Islander communities that understand when it is appropriate to seek health care or advice. Health-related community capacity-building, such as that provided by many Aboriginal community-controlled health services and by NGOs such as Save the Children, is valuable in encouraging health-seeking behaviour. Outreach, liaison and ongoing relationships between primary care services and Aboriginal and Torres Strait Islander communities (often through the work of Aboriginal Health Workers) play a great role in this.

Best practice in promoting high quality outcomes in primary health care for Aboriginal peoples and Torres Strait Islanders

Primary health care services also need to produce high quality clinical and health outcomes for Aboriginal peoples and Torres Strait Islanders. The evidence suggests that certain characteristics of services and the health system are very conducive to producing these quality health outcomes.

Culturally secure services

Cultural security is important not only for improved access, but also for the relationships of trust and intimacy that are central to good clinical care, particularly for Aboriginal peoples and Torres Strait Islanders who can be subject to multiple and complex conditions [Nguyen 2008]. Aboriginal or Torres Strait Islander men, for example, might not disclose certain concerns or conditions to female doctors or health staff, with the result that their concerns might not be addressed [Wenitong 2002]. Cultural security in clinical practice can be strengthened in a number of ways, including by recognising holistic Aboriginal or Torres Strait Islander conceptions of personal health, which encompass social, emotional and spiritual wellbeing, and an awareness of the historical and cultural factors that affect the health of Aboriginal peoples and Torres Strait Islanders [Zubrick, et al 2005].

Decision-making relationships

Involving Aboriginal peoples and Torres Strait Islanders in decisions about their health care will, as with all Australians, improve health outcomes. This should involve ongoing liaison and the involvement of communities in a range of service decisions through to full community ownership and control of primary care services. Strong relationships between primary care services and Aboriginal and Torres Strait Islander communities can provide feedback on the cultural security of services and the care they provide. Involvement in decision-making can also improve the identification of the health problems that are being experienced by local communities. It will also bring health benefits due to strengthening the identity and self-determination of Aboriginal peoples and Torres Strait Islanders [Chandler and Lalonde 2008]. There is also evidence that Aboriginal community controlled health services can produce clinically better outcomes for Aboriginal and Torres Strait Islander patients than mainstream primary care services for certain conditions. Recent evidence
suggests that some interventions to prevent cardiovascular disease are delivered more cost-effectively through Aboriginal community-controlled health services compared to mainstream GP services [Vos, et. al., 2010]. Aboriginal community-controlled health services also support health-related community development through programs in parenting, mental health, substance misuse, home visiting and health promotion.

Quality clinical care, comprehensive primary care and a core set of services
Primary care that is comprehensive and addresses the whole of the person and the social and environmental factors that influence health will be more successful for all Australians, including Aboriginal peoples and Torres Strait Islanders. Aboriginal community-controlled health services and some other Aboriginal and Torres Strait Islander primary health care services provide comprehensive primary care in a multidisciplinary environment. Comprehensive care includes not only general medical services, but child and maternal services, dental services, pharmaceutical services, social and emotional wellbeing, mental health and drug and alcohol services, health promotion and a range of other care. Aboriginal community-controlled services are also active in health awareness raising in communities, tackling determinants of health at the community level, and advocating for community members on matters that affect their health, including employment, housing and the living environment. For example, the Central Australian Aboriginal Congress collaborated with other organizations to purchase a licensed grocery store and established an Aboriginal business that did not sell alcohol [OATSIH 2001].

The health of Aboriginal peoples and Torres Strait Islanders would be significantly improved if a core set of primary care services were provided across the broad phases of life including early years, adolescence, adult and family years, and older age. Core services for the early years might include, for example, antenatal care, immunisation and growth and developmental assessments. Core services for adolescence might include family planning education, STI/BBV screening and education, resilience building and self-esteem education. Core services for the adult age could include annual adult health checks, chronic disease management, healthy lifestyle programs, medications regime, and eye checks [AMSANT 2007].

Monitoring of outcomes and appropriate follow-up
Having quality-assurance processes for patient outcomes is an essential part of good clinical care. This is particularly important for Aboriginal and Torres Strait Islander patients with multiple and complex conditions and low rates of access to health care. The Aboriginal community-controlled sector has been at the vanguard of clinical governance in Australia. It is important that data collection is used to improve clinical outcomes and not just to meet reporting requirements [Phillips, et. al., 2010].

Continuity of care and integrated services
Providing comprehensive primary health care and a core set of services is not always possible within a single service setting. Primary health care that is comprehensive and spans a lifetime will call upon a range of services, including allied health services and other social support networks. The capacity of comprehensive primary care to reduce the health gap faced by the Aboriginal and Torres Strait Islander population depends crucially on these necessary services being available, culturally accessible and coordinated. Continuity of care across the service system for Aboriginal peoples and Torres Strait Islanders remains a major challenge for Australia.

Enablers of best practice - appropriate resources, processes and support:
All of these elements of best practice need to be adequately resourced and supported with:

- appropriate infrastructure;
- professional clinical and health expertise;
- sufficient staff, including Aboriginal and Torres Strait Islander staff;
- training support in cultural competence if needed;
• workable funding arrangements for staff stability and adequate remuneration;
• good management capacity and governance, and
• data systems and e-health arrangements.

Of particular importance are established procedures to accurately obtain Aboriginal or Torres Strait Islander identity.

**PART 3: PROMOTING BEST PRACTICE**

In Australia’s diverse health system, there are different capacities among different types of primary care service and sectors, changing levels of demand for services in different regions of Australia, and variable availability of services. These differences need to be recognised when determining how best practice can be most effectively supported.

**Taking stock of best practice in Australia’s diverse service system**

**Capacities for best practice in Aboriginal and Torres Strait Islander primary care services**

Aboriginal community-controlled health services reflect the key elements of best practice very well and, with appropriate resourcing, could reflect best practice to an even greater degree. State, Territory and local community-funded Aboriginal health and medical services that are not Aboriginal community-controlled may also reflect many elements of best practice.

There are currently 152 Aboriginal community controlled primary health care services in Australia, and a limited number of other Aboriginal and Torres Strait Islander primary health care services. Of the 211 Aboriginal and Torres Strait Islander primary health care services receiving Australian Government funding in 2008-09, 130 employed 330 full-time equivalent doctors across Australia (an average of 2.5 doctors per service) [AIHW 2010]. A total of 745 full-time equivalent Aboriginal Health Workers were employed in 79 per cent of Aboriginal and Torres Strait Islander services. 87 per cent of these services employed one or more nurses, 58 per cent employed social and emotional wellbeing staff (counsellors, psychologists and social workers), and 15 per cent employed a dentist (not necessarily full-time).

Limited resourcing and support impede the capacity for best practice in Aboriginal and Torres Strait Islander primary health care services. Attracting and maintaining medical staff and maintaining infrastructure and equipment are difficult, particularly in remote locations where the costs of running health services are an estimated 3.5 times higher than in urban locations [Econotech 2004]. Properly supported training opportunities, incentives, and accreditation pathways for Aboriginal Health Workers and other support staff also remain a challenge. Having to rely on multiple funding sources also creates a significant administrative burden for Aboriginal community controlled services [Dwyer et. al 2009].

**Capacities for best practice in private GP services**

Privately owned general practices and mainstream community health centres are numerous across Australia, generally well-resourced, with a range of professional expertise, and are often well connected to acute care and other referral options. These are significant contributors to best practice. But such services often fall short of delivering best practice to Aboriginal peoples and Torres Strait Islanders. For example, there will often be limited cultural competence among staff and a low degree of cultural security reflected in services; the clinical focus is often on specific health conditions rather than on comprehensive care; the processes in medical practices for Aboriginal and Torres Strait islander identification are often poor, resulting in low utilisation of important Aboriginal and Torres Strait Islander-specific MBS child and adult health checks; there is very limited engagement or consultation with Aboriginal and Torres Strait Islander communities by such services,
and little outreach or community visitation; there is also a very limited employment of Aboriginal and Torres Strait Islander staff in these services.

This situation might be expected given that many general practices and community health centres are located in areas that do not have a local Aboriginal and Torres Strait Islander population. However, many of these primary care services are in locations with a significant Aboriginal and Torres Strait Islander population.

Unmet need and service availability

54.5 per cent of Aboriginal and Torres Strait Islander people accessed Australian Government-funded Aboriginal and Torres Strait Islander primary health care services in 2008-09 [AIHW 2010d; ABS 2009a]. However, these services are not strongly represented in urban areas, where the existing health need is high and expected population growth among Aboriginal people and Torres Strait Islanders is high. Most Australian Government-funded Aboriginal and Torres Strait Islander primary health care services are located in outer-regional, remote and very remote locations. In 2008-09, 19.5 per cent were located in inner regional areas, and 12.7 per cent in major cities [AIHW 2010d]. An estimated 32.4 per cent of Aboriginal peoples and Torres Strait Islanders lived in major cities in 2008 [ABS 2009a], which means there were 6,719 Aboriginal people and Torres Strait Islanders to every Aboriginal and Torres Strait Islander primary health care service in major cities. Data from the Australian Institute of Health and Welfare indicate that, in 2008-09, there was a full-time equivalent of 59.7 doctors employed by Australian Government funded Aboriginal and Torres Strait Islander primary health care services in major cities [AIHW 2010e]. Other sources indicate that more than 544 general practitioners work in Aboriginal community-controlled health services in non-remote locations [QUMAX NCN, 2010].

Aboriginal and Torres Strait Islander patients are under-represented in attendances at private general practice, with an estimated 1.6 per cent of encounters with GPs involving these patients [Fahridin & Britt 2009]. However, a significant number of GPs in private practice do see Aboriginal and Torres Strait Islander patients. Between 1998 and 2003, an estimated 26 per cent of GPs in private practice saw Aboriginal and Torres Strait Islander patients [Britt et. al. 2003]. Nearly two-thirds of these GPs practised in cities and metropolitan areas, and 35 per cent of the Aboriginal people and Torres Strait Islanders who saw GPs in this period were also from cities and metropolitan areas, compared to 21 per cent from remote areas [Britt et. al. 2003]. The opportunities offered by private general practice in the context of this unmet need should not be overlooked. However, it needs to be recognized that Aboriginal people and Torres Strait Islanders will usually be a minority among the potential patient populations of private general practices and community health centers.

The challenge for the health system

Australia’s primary health care system is currently undergoing reform, including the establishment of regional organisations intended to facilitate the identification of local health needs and the efficient delivery of primary care services at a local level. This regionalised approach also aims to promote better linkages between primary care and hospital services. The success of these reforms must be judged in terms of how well they improve the health outcomes of Aboriginal peoples and Torres Strait Islanders. This will, in turn, depend on how well the reforms support best practice in primary care for Aboriginal peoples and Torres Strait Islanders.

Supporting collaborative models of service delivery

Given the existing pattern of service limitations and capacity gaps, there should be a stronger focus on what can be achieved through collaboration between services and service sectors. Aboriginal people and Torres Strait Islanders visit private general practices and community health centres as well as Aboriginal and Torres Strait Islander primary health care services. It is important to ensure continuity of high quality care across these different providers through coordination, and the sharing of resources, expertise, cultural understanding, geographical availability, and opportunities to provide care. Best practice should be thought of in terms of
models of collaborative service delivery that sustain continuity of care, and suit the particular needs of different regions and locations in Australia.

For example, smaller, geographically dispersed Aboriginal and Torres Strait Islander primary care services and/or other primary care services might form a network based around a larger, better-resourced Aboriginal health service in a regional centre. In metropolitan and city areas with Aboriginal and Torres Strait islander populations, local private general practices and community health centres might develop collaborative service arrangements with Aboriginal community controlled or other Aboriginal and Torres Strait islander services in the area. Other permutations will provide workable responses to particular local and regional needs.

For collaboration to succeed, primary care services should be resourced to develop best practice to a level appropriate to need. For private general practices and community health centres, best practice in Aboriginal and Torres Strait Islander health should be resourced at a level that recognises that Aboriginal people and Torres Strait Islanders are usually a minority among patients. For Aboriginal and Torres Strait Islander primary care services, which have a high proportion of Aboriginal people and Torres Strait Islanders among their patients, a very high level of best practice is achievable.

Complementary services and clinical resources offered in the mainstream sector will be valuable for Aboriginal and Torres Strait Islander primary care services. The leadership of the Aboriginal community-controlled sector in sharing cultural advice, understanding of Aboriginal health, and strong relationships with local Aboriginal communities, is invaluable for private general practices and community health centres with Aboriginal and Torres Strait Islander patients.

The term “Aboriginal and Torres Strait Islander primary health care services” is used here to refer to Aboriginal community-controlled primary health care services that receive funding from OATSIH, and services for Aboriginal peoples and Torres Strait Islanders run by State and Territory governments and Divisions of General Practice, which receive funding from OATSIH. [AIHW 2010d]

RECOMMENDATIONS: HARNESING OPPORTUNITIES TO PROMOTE BEST PRACTICE

Australia’s primary health care system is currently undergoing reform. It is crucial that the significant improvement of Aboriginal and Torres Strait Islander health should be a central goal in those reforms. This will require the Commonwealth to adequately fund, and appropriately support, the development of best practice primary health care for Aboriginal peoples and Torres Strait Islanders. The following are fundamental preconditions for this:

1. Aboriginal peoples and Torres Strait Islanders must be supported to play a leading role in the planning of their primary health care.

2. Any future arrangement to transfer some or all of primary health care funding to the Commonwealth must ensure that this does not disadvantage Aboriginal community-controlled health services and other Aboriginal medical services at the local level that are currently in receipt of State or Territory funding.

3. Governments must ensure that:
   - there is ongoing monitoring to determine what additional services and capacity are required, and where, to close the gap in health inequity;
access to hospitals and continuity between primary care and acute care for Aboriginal peoples and Torres Strait Islanders is promoted;

- the Lead Clinician Groups being established as part of the COAG health system reform process include medical practitioners involved in the care of Aboriginal peoples and Torres Strait Islanders;

- there is systematic, rather than piecemeal and ad hoc, access to specialist services for Aboriginal peoples and Torres Strait Islanders, and

- the quality and continuity of health care for Aboriginal peoples and Torres Strait Islanders is underpinned by high quality e-health systems within regions.

To close the gap, it is important to support integrated and collaborative models of primary health care for Aboriginal peoples and Torres Strait Islanders, which are suited to particular regional needs and reflect best practice.

4. Priority should be given to funding and supporting Aboriginal community-controlled primary care services, so these services can maximise their high potential for best practice.

A Capacity-building Plan for Aboriginal community-controlled services should be implemented to encompass governance, capital works and recurrent support. This plan should include the following:

- services being funded through a single core of pooled funds for a minimum of five years at a time, and at least three times the per capita MBS utilisation by non-Indigenous Australians (with a rural and remote loading of up to an additional three times);

- implementation of capital works programs to assist Aboriginal communities wishing to develop a new community-controlled health service;

- Aboriginal community-controlled health services being supported for accreditation, including governance, capital works, and service delivery;

- Aboriginal community-controlled health services being supported to provide home visiting services and to have facilities for provision of visiting allied health and specialist services;

- resources for NACCHO affiliates and Torres Strait Islander community-controlled health services to support every Aboriginal and Torres Strait Islander community that wishes to develop its own Aboriginal and Torres Strait Islander primary health service into a legally incorporated community-controlled service;

- where local Aboriginal communities agree, a process of transition to Aboriginal community control should be supported for State and Territory funded Aboriginal health services. This transition should proceed according to frameworks such as the Northern Territory Health Forum ‘Pathways to Community Control’, the Queensland Aboriginal and Islander Health Council Strategic Plan 2010 - 2013, or the Torres Strait Transition to Community Control, and
development of a workforce for Aboriginal community-controlled health services, including general and specialist medical practitioners through to practice managers and support staff.

Private general practices and community health centres have a crucial role to play in order to close the gap. Some of them will potentially have a significant number of Aboriginal people and Torres Strait Islanders among their patient population. Others will have few, if any. Investment in best practice primary care for Aboriginal peoples and Torres Strait Islanders in these services should reflect these differences.

5. Private general practices and community health centres providing significant services to Aboriginal people should be linked where possible with Aboriginal community-controlled services. The resulting set of services should be resourced and supported to develop best practice primary care for Aboriginal people and Torres Strait Islanders to an extent that is appropriate to the size of its potential Aboriginal and Torres Strait Islander patient population.

The AMA recognises the significant funding that COAG has committed to the Commonwealth’s Indigenous Chronic Diseases package, and its measures and incentives to support general practices in providing high quality and accessible care for Aboriginal peoples and Torres Strait Islanders.

6. The following are among a range of further measures that could be supported in private general practices or community health centres to empower them to better provide accessible and high quality primary care for Aboriginal peoples and Torres Strait Islanders:

- support for services to meet accreditation standards that require Aboriginal and Torres Strait Islander identity to be routinely recorded in active patient records;
- incentives to allow routine bulk-billing of patients identified as Aboriginal or Torres Strait Islander;
- further incentives to utilise Aboriginal and Torres Strait Islander-specific MBS items and GP mediated health interventions such as immunisation;
- in practices with a potential Aboriginal and Torres Strait Islander patient population, the completion of a cultural safety training program that has met the RACGP and/or ACRRM educational standards. It is important that the training is provided through practical and flexible learning options;
- the development and implementation of Aboriginal and Torres Strait Islander-endorsed curricula for Registrars training towards Fellowship of the RACGP and ACRRM that ensures core competencies in matters relating to the health of Aboriginal peoples and Torres Strait Islanders, and
- measures and incentives to train and employ more Aboriginal health workers in practices in locations that have a significant Aboriginal and Torres Strait Islander population.
The AMA believes that Aboriginal Health Workers play a very significant role in providing and facilitating access to primary care services.

7. The role of Aboriginal Health Workers should be strengthened and supported through:
   - implementation of the negotiated national award for pay;
   - development of stronger career pathways between schooling and the training sector;
   - a commitment that at least some of the training for Aboriginal Health Workers takes place at the local community level to encourage local recruitment and sustained workforce;
   - ensuring that Aboriginal Health Workers have the necessary support to prevent them being disadvantaged and discouraged by the obligations and responsibilities imposed on them from July 2012 as registered practitioners under the Health Practitioner Regulation National Law Act 2009;
   - amendments to the Medicare Benefits Schedule Aboriginal Health Worker rebates to ensure there is parity in eligibility to claim across all States and Territories;
   - the introduction of an incentives scheme for Aboriginal Health Workers (particularly in remote areas); and
   - development of a training pathway for progression to graduate primary healthcare staff level.

Greater efforts should be made to train a health and medical workforce and increase the research and knowledge base for Aboriginal and Torres Strait Islander health.

8. A national network of Teaching Health Centres of Excellence in Aboriginal and Torres Strait Islander health should be established across Australia to act as training and research hubs for health and medical professionals seeking high quality practical experience in Aboriginal and Torres Strait Islander health in primary and tertiary care settings. These Centres should be linked into existing undergraduate and graduate training processes, and also include a focus on cultural safety training.
Models of Best Practice: Examples from the Field

The AMA believes that best practice in primary health care for Aboriginal and Torres Strait Islander peoples must be informed by the perspectives of the people who receive that health care, and the perspectives of those who successfully deliver the care. The AMA conducted site visits to primary care services in remote and urban locations to gain these perspectives. The following examples reflect some of the key characteristics of best practice in primary health care delivery to Aboriginal and Torres Strait Islander peoples in different service contexts.

The Queensland Aboriginal and Islander Health Council and the Institute for Urban Indigenous Health
(a model of collaboration for an expanding urban Aboriginal and Torres Strait Islander population)

The Queensland Aboriginal and Islander Health Council (QAIHC) is the peak body representing Aboriginal community-controlled health services in Queensland. QAIHC facilitates the provision of comprehensive primary care as well as specialist care, community programs, and programs in environmental health. In response to the rapidly expanding urban Aboriginal and Torres Strait Islander population in South East Queensland and the drastic under-servicing of that population, QAIHC undertook strategic planning to regionalise the delivery of primary care services for local Aboriginal and Torres Strait Islander people and integrate that service delivery with mainstream providers and private general practices.

As part of its response to the under-servicing of local Aboriginal and Torres Strait Islander communities, QAIHC has supported four community-controlled health services in South East Queensland to form the Institute for Urban Indigenous Health (IUIH). The IUIH integrates health planning and servicing for Aboriginal and Torres Strait Islander communities in this region, and strengthens service relationships between local Aboriginal and Torres Strait Islander health services, Divisions of General Practice, private practitioners, allied health providers and hospitals. The IUIH has developed and implements an eight-step service model for chronic disease. It starts with a comprehensive health assessment that captures a patient’s total health status, rather than starting with a single disease diagnosis, which can often miss other relevant health conditions and risk factors.

The Majellan Medical Centre, Queensland
(a model of relationship building and small practical changes in private general practice)

The Majellan Medical Centre (MMC) is a practitioner-owned private billing group practice in the Moreton Bay area. The area has an Aboriginal and Torres Strait Islander population but no Aboriginal and Torres Strait Islander-specific primary health care services. Local Elders approached Queensland Health about the poor availability of services for the local Aboriginal and Torres Strait Islander community, and MMC was in turn contacted. In negotiations between MMC and the Moreton Bay Regional Elders Council, a number of practical strategies were developed to improve Aboriginal and Torres Strait Islander peoples’ access. These were bulk billing of all Aboriginal and Torres Strait Islander patients (by doctors who agreed); one session time each week specifically for Aboriginal and Torres Strait Islander patients (the Indigenous “clinic”), and a volunteer bus service to the clinic. The MMC patient registration form was modified to appropriately capture Aboriginal and Torres Strait Islander status, and MMC staff were fully briefed on the clinic. Queensland Health and others partnered in this initiative, and the district Aboriginal and Torres Strait Islander health worker attended clinic sessions to facilitate patient referrals and recalls, and to ensure cultural safety for patients. MMC holds monthly meetings with the Elders and other stakeholders to maintain community ownership. In the first 12 months operation of the MMC clinic, there was a dramatic increase in registered Aboriginal and Torres Strait Islander clientele, from 10 to 147, and average monthly consultations increased from five to 40.

Katherine West Health Board
(a hub and spoke model of remote health service delivery)

The Katherine West Health Board (KWHB) is an Aboriginal community-controlled health organization that provides clinical, emergency and preventative services to people within a 162,000 sq/km region in the north western part of the Northern Territory. KWHB is governed by an 18 member Board of Aboriginal
representatives from the communities in the region. These Board members provide advice about the health concerns and priorities faced by their communities. As well as having a health centre in the larger regional centre of Katherine, KWHB owns and operates health centres in seven communities in the region, which are staffed by GPs, nurses, qualified and trainee Aboriginal Health Workers, administrative staff, and visiting specialists. KWHB has a mobile health team that travels to remote outstations and cattle properties in the region. A key aim of the KWHB is to develop strategic alliances and friendships between Aboriginal and mainstream or Government entities and agencies responsible for health-related services in the region.

KWHB provides comprehensive primary care to its clients through a range of programs including, among others, child health, healthier young families, sexual health, social and emotional wellbeing, chronic conditions, environmental health and hygiene, and nutrition and physical activity. KWHB reinforces strong collaboration and communication between its regional health centres, and between the health programs and streams in KWHB. The AMSNet satellite shared IT network system facilitates this communication across the region. Storage of, and ready access to, patient records across the regional health centres, including mobile access, is provided through the Communicare IT platform. Advice on the cultural appropriateness of materials and programs used by KWHB in the region is provided by the Ngumpin Reference Group of Board members and past and current Aboriginal Health Workers from local communities in the region. KWHB produces health outcomes in the region that are better than average on nearly all of the key health performance indicators used in the Northern Territory.

Inala Indigenous Health Service
(a model of mainstream success in Aboriginal and Torres Strait Islander health)

The Inala Community Health Centre is a Queensland Government-funded mainstream health service established in 1977. In 1995, in response to a very low representation of local Aboriginal and Torres Strait Islander people among patients (approximately 12), the Inala Indigenous Health Service was established within the broader Health Centre. Local Indigenous people were consulted and strategies were implemented to increase the degree to which local Indigenous people accessed the Indigenous Health Service. Initial strategies included employing more Aboriginal and Torres Strait Islander staff, having a more culturally appropriate waiting room, providing cultural awareness training to staff, stronger communication with the Aboriginal and Torres Strait Islander community, promoting intersectoral collaboration and liaison with Aboriginal community-controlled services in the area, and attending interagency network meetings.

Between 1995 and 2000, 899 new Indigenous patients had attended Inala Indigenous Health Service. In 2006 the Service was allowed to Medicare bulk-bill. This enabled additional health and medical staff to be employed, and the full potential of the MBS Aboriginal and Torres Strait Islander health check items and chronic disease items was utilized. By 2008, the Inala Indigenous Health Service was able to provide specialist services, and employed Aboriginal and Torres Strait Islander health and community workers who provide outreach immunizations, child playgroups, and nutrition and chronic disease self-management programs. The Service had also taken on a significant teaching and research role in Aboriginal and Torres Strait Islander health. By 2008, the Service had 22 full-time staff members, and had access to allied health services, drug and alcohol services, mental health services, and child and health services. There are currently 5,000 Aboriginal and Torres Strait Islander patients registered with the Service who complete 1,500 doctor consultations per month - a very substantial increase on patient numbers and consultations since the Service began 13 years earlier. In 2010, the Service received a substantial grant from the Queensland Government to expand to become the South East Queensland Centre of Excellence in Indigenous Primary Care. The Centre of Excellence will be completed in June 2012.

The Centre for Aboriginal Primary Health Care Training, Education and Research (CAPTER)
at the Kimberley Aboriginal Medical Services Council
(a model of regional support in teaching and research in Aboriginal primary care)

The Kimberley Aboriginal Medical Services Council (KAMSC) is a regional collective of five independently incorporated Aboriginal community-controlled health services in the remote Kimberley area of northern Western Australia. The Centre for Aboriginal Primary Health Care Training, Education and Research (CAPTER) provides a range of education and training programs, including, Aboriginal Health Worker training,
education and training for GP Registrars which involves clinical practice in Kimberley towns and remote communities, involvement in population health programs and local health promotion, and health research; and long- and short-term medical undergraduate placements. CAPTER is expanding its research profile, and has conducted a range of projects on Aboriginal primary health care, including the social and emotional wellbeing of Aboriginal youth. CAPTER promotes increased levels of GP services in the region, good working relationships between doctors and Aboriginal Health Workers, and encourages sustained interest among doctors in working in Aboriginal health. CAPTER is the only program of its kind based in an Aboriginal community-controlled health organisation in Australia.
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