

# POSITION STATEMENT

**Service delivery in  
Queensland's remote and  
discrete Aboriginal and Torres  
Strait Islander Communities –  
Productivity Commission**

Queensland Aboriginal and  
Islander Health Council

(November 2017)



## **SUBMISSION**

**Name of person submitting this response:** Mr Neil Willmett – Chief Executive Officer

**On behalf of:** Queensland Aboriginal and Islander Health Council (QAIHC) and Member  
Aboriginal and Islander Community Controlled Health Services (AICCHS)

**Address:** Level 2, 55 Russell Street, South Brisbane QLD 4101

**Email Address:** [neil.willmett@qaihc.com.au](mailto:neil.willmett@qaihc.com.au)

**Phone:** 07 3328 8500

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### **About Queensland Aboriginal and Islander Health Council (QAIHC)**

QAIHC was established in 1990 by dedicated and committed Aboriginal and Torres Strait Islander leaders within the community controlled health sector.

Originally established as QAIHF (Queensland Aboriginal and Islander Health Forum), the organisation provided a voice for the community controlled health sector in Queensland. This organisation was self-funded until 1996, when the Commonwealth Department of Health commenced funding support. QAIHC has experienced considerable growth in membership and the scope of services provided to those members since its establishment.

In 2004, the organisation was reconstituted under the Australian Investment and Securities Commission (ASIC) and assumed its current form as QAIHC.

Today, QAIHC represents 27 community-controlled health services and 13 associate members who share a passion and commitment to addressing the unique health care needs of their communities through specialised, comprehensive and culturally-appropriate primary health care.

QAIHC is the peak body representing the Aboriginal and Torres Strait Islander Community Controlled Health Sector in Queensland at both a state and national level. Its membership comprises of Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) located throughout Queensland. Nationally, QAIHC represents the Community Controlled Health Sector through its affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation (NACCHO) and is regarded as an expert in its field.

Queensland Aboriginal and Islander Health Council (QAIHC) as the Peak Aboriginal and Islander Health Organisation of Queensland wish to express the collective views on behalf of our state-wide members, regarding the current approach to service delivery in remote and discrete Aboriginal and Torres Strait Islander communities.

The purpose of this submission paper is to demonstrate how services can be reorientated to meet the needs of people living in remote or discrete Aboriginal and Torres Strait Islander

communities through government investment and implementation of 'best practice models.'

QAIHC would like to thank the Queensland Productivity Commission for the opportunity to comment on the 2017 Draft Report on 'Service delivery in remote and discrete Aboriginal and Torres Strait Islander communities' (referred to hereafter as The Report).

Comments are made with regard to the Health and Wellbeing chapter of The Report:

1. It is QAIHC's view that the report should make a strong recommendation for service delivery in communities to support patient-centred care.

The Report does not mention patient-centred care. Good medical practice is patient or person-centred (PCC).<sup>1</sup> PCC means that a health care professional can deliver care that is *"respectful of and responsive to individual patient preferences, needs and values, and ensures that patients values guide all clinical decisions."*<sup>2</sup> This is the most widely cited and global definition adopted by the US Institute of Medicine in 2001. This simple definition represents several concepts that are explained below, and in the widely cited conceptual framework developed by Mead and Bower in 2000.<sup>3</sup>

PCC describes a partnership between patients and their healthcare providers. Such a partnership can occur at the level of the individual (between patient and healthcare provider), and at health service and health system levels (often referred to as community or consumer engagement).<sup>4</sup>

Healthcare providers who are orientated to PCC are more likely to satisfy their patients, and improve the quality of life. Clinicians with person-centred skills can enhance their patient's capacity for chronic disease self-management.<sup>5</sup> What follows are concomitant reductions in mortality,<sup>6</sup> improved shared decision-making to reduce antibiotic overprescribing,<sup>7</sup> and reductions in hospitalisation.<sup>8</sup>

Delivering person-centred care requires a culture change in the way the health profession provides healthcare. Key enablers to delivering patient-centred care are:

- a strategic vision within the institution,
- the active engagement of patients and families throughout the institution, and
- the active measurement and reporting of patient experiences.<sup>9</sup>

Aboriginal and Torres Strait Islander Community Control Health Services (ATSICCHS) are exemplar deliverers of patient-centred, primary health care (PHC) by virtue of their community-controlled health service model.<sup>10</sup> It is unclear to what extent existing healthcare services to remote communities are patient-centred. However, there is evidence that mainstream healthcare services deliver inferior levels of engagement with Aboriginal peoples.

The following is an extract from (Couzos & Delaney Thiele, 2016):

## Box 1

Even when Aboriginal peoples access care, they receive inferior care. Access to treatment for coronary heart disease (which is the most common cause of death) is 40% less for Aboriginal peoples. This disparity is partly explained by inferior care being offered to Aboriginal patients than other Australians.<sup>11</sup>

When 2,682 Aboriginal patients were given a say about their experiences in NSW hospitals during 2014, their experiences were inferior to non-Aboriginal patients.<sup>12</sup> Similarly, when approximately 3,000 Aboriginal and Torres Strait Islander patients were asked to report on their experiences within general practices (surveyed as an accreditation requirement), their experiences were also considerably inferior to other patients.<sup>13</sup>

Aboriginal peoples have fewer opportunities to voice their concerns, and are often disempowered in their interactions with the health care system limiting their ability to engage as partners in decision-making about their care. Lower educational levels, and the disproportionate impact of social determinants on health compound Aboriginal people's inability to participate in, and consequently take responsibility for, health care decisions.

There is evidence that treatments offered to Aboriginal peoples are influenced by stereotypes about them. A refusal of treatment by an Aboriginal patient may be viewed as 'culturally based' rather than a result of fear, misunderstanding or other preferences never elicited. The high rate of hospital discharge against medical advice (8 times higher in Aboriginal peoples than non-Indigenous Australians) is one example of this phenomenon. Discharge against medical advice is an indirect indicator of the cultural responsiveness of hospitals.<sup>14</sup> Private general practices continue to have problems identifying Aboriginal peoples and Torres Strait Islanders in their patient population.<sup>15</sup> As a result, they are unable to respond adequately to their needs. For example, poor uptake of health checks (item 715) persists despite the Indigenous Health Incentive payment. Continuing barriers include Indigenous status under-identification and lack of awareness of health checks as good practice.<sup>16</sup>

Chapter 2 of the recent Commonwealth Productivity Commission's report 'Shifting the Dial'<sup>17</sup> has proposed that the focus should shift to patient centred care. The key recommendation from the report is: *"All Australian governments should re-configure the health care system around the principles of patient-centred care, with this implemented within a five-year timeframe."*

Although in The Report, draft recommendation 15 states there should be: "better integration of services through increased collaboration with non-government health service providers (particularly (ATSICCHS)) and improved transition care arrangements", there needs to be better effectiveness and efficiency of Queensland Government investments in health care for these communities. This means directing it **toward delivery of PHC, as**

**opposed to merely 'acute care' in remote locations** as is currently the case with Queensland Health.

2. QAIHC supports points made with regard to chronic disease and mental disorders. However, there are considerable issues with other diseases as well which could be referred to in the report. Examples of other health gaps:

- Acute rheumatic fever/rheumatic heart disease is entirely preventable. It starts as a Group A Streptococcal infection of the throat (and perhaps skin) which is most likely an outcome of overcrowding and poorly functioning health hardware in the often government supplied housing. Lack of access to appropriate PHC limits access to early preventable treatment and facilitates the development of acute rheumatic fever. Continuing lack of access to appropriate PHC further exacerbates this issue culminating in rheumatic heart disease, an extremely expensive and complex disease that contributes to the life expectancy gap in Aboriginal and Torres Strait Islander communities.
- Persistent and recurring ear infections may lead to hearing loss if not appropriately followed up in PHC. They can result in learning difficulties/involvement with the criminal justice system/incarceration. The Report refers to Deadly Ears which is a commendable state-wide Queensland Health program but it runs the risk of becoming a siloed approach instead of being an integrated PHC initiative.

There are a myriad of other examples and we will detail issues related to sexual health below.

3. QAIHC recommends the report describe the model of care of ATSI CCHS PHC should be culturally appropriate, community controlled (see Box 2) and patient centred; 10 patients are then willing to engage in health care decisions that result in better patient outcomes. Most of the Queensland health government services in remote North Queensland are acute care models rather than comprehensive PHC.

## Box 2

### **Model of Care in Aboriginal and Islander Community Controlled Health Organisations in Queensland** (S Couzos & V Slinko, Queensland Aboriginal & Islander Community Controlled Health Organisation; document provided)

The model of care that underlies interactions between ATSI CCHS and their clients differs considerably to mainstream general practice activity and acute primary care or hospital care models. Health has a more holistic meaning to Aboriginal and Torres Strait Islander peoples and the culturally appropriate care which is the basis of the model leads to more effective health outcomes. It is a bottom up approach where the local community leads and facilitates the local decision making, corporate governance and clinical service delivery. The model has more emphasis on improving access to PHC (often in novel settings), on preventive health and chronic disease care and reliance on Aboriginal and Torres Strait Islander Health Workers/Practitioners and other allied health staff working as part of a multi-disciplinary team. It not only focuses on the biomedical aspects of disease but also on the biopsychosocial needs of the patient, as part of a family and community, which is at the centre of the care model. More prominence is placed on streamlining the patient journey and allowing people to participate in decision making about their health. To address the social determinants of illness, advocacy is required, by facilitating and coordinating access to a range of in-house, plus government and non-government supports in ways that are person-centred. Service delivery is structured consistent with the chronic care model and health systems assessment help services to optimise this model when undertaking continuous quality improvement activity. Continuous quality improvement initiatives are fundamental to the services to ensure the needs of the community are met with health system processes (such as consumer feedback, reminders and recalls etc.) incorporated in the Plan, Do, Study, Act cycles. This model provides comprehensive, person-centred and culturally appropriate care for Aboriginal and Torres Strait Islander peoples.

4. QAIHC recommend that there needs to be substantial effort put into transitioning many of the services in northern Queensland that are currently run by HHS/Queensland Health to ATSI CCHS. It is recognised that this will be a long process (longer than the electoral cycle) that will need considerable investment.

When PHC delivery is poor and fragmented, this does not occur. The recent Multijurisdictional Syphilis Outbreak (MJSO; see Box 3) is an example of the result of models of care that are not aligned with patient-centred PHC:

### Box 3

#### **Multi-jurisdictional Syphilis Outbreak**

There is an ongoing outbreak of infectious syphilis affecting young Aboriginal and Torres Strait Islander people, predominately aged between 15 and 29 years, living in northern Australia (Department of Health, 2017). The outbreak began in north western Queensland in January 2011 in a region and in a large community that lacked access to ATSI CCHS. Despite this outbreak being apparent to the Hospital and Health Service (local hospital network) by the Queensland Health Syphilis Register and Tropical Public Health Units in Cairns and Townsville, it was virtually ignored by the HHS that was responsible for PHC in the area. The acute care services were not modelled to provide appropriate levels of community engagement and community empowerment, and to offer holistic well persons health checks to encourage early testing for sexually transmitted infections (STI; particularly in antenatal care), treatment and contact tracing. The epidemic then extended to the Northern Territory in July 2013, and then onto the Kimberley region of Western Australia in June 2014 and to date there have been at least five cases of congenital syphilis. It was made an outbreak of national significance before it was made an outbreak of state significance and is now consuming considerable health resources. Cases of Human Immunodeficiency Virus (HIV) have been linked to the epidemic. This signals a significant failure in the Queensland Health PHC system. Instead, there is more focus on victim blaming, and calls for more 'public health unit funding' when this is not what is required.

The reform required is a shift to more patient-centred care and ATSI CCHS exemplify this. A recent review of factors associated with higher rates of STI testing<sup>18</sup> were health centre factors including provision of an adult health check (odds ratio (OR) 3.40; 95% Confidence Interval (CI) 3.07-3.77) and having conducted 1–2 cycles of CQI (OR 1.34; 95% CI 1.16-1.55). These two factors are everyday business for ATSI CCHS in Queensland. The review also suggested that government operated health services had lower levels of STI testing than the ATSI CCHS sector, (22% lower), but this was not statistically significant.

ATSI CCHS characteristics that are likely to contribute to success in STI control include:<sup>19</sup>

- a high level of accessibility to Aboriginal people
- continuity of well-trained STI program coordinators
- use of regional protocols
- free treatments and condoms
- routine opportunistic screening
- high Pap smear screening rates
- syndromic treatment
- long-term follow-up of known repeat STI clients and
- dedicated Aboriginal Health Workers (AHWs), especially males.

Acute care services delivered by Queensland Health continue to limit the degree of STI screening offered to individuals as they attend the clinic for other reasons i.e. opportunistically. They do not have systematic active recall (either inviting individuals to attend the clinic or delivering field-based care) or provide mass screening of populations (intensive screening effort directed to groups over a defined period). In addition, active recall strategies and efficient opportunistic care in PHC require information management systems to systematically offer testing to the entire target population, track care, and prompt overdue or upcoming care. These are core services that should be locally available in rural and remote Australia.<sup>20</sup> Many acute care services still do not have electronic medical records to facilitate recall and reminders.

The 3<sup>rd</sup> National Sexual Health Strategy <sup>21</sup> has also recommended **improved models of care** for priority populations in PHC settings:

“A common feature of the priority populations in this Strategy is their difficulty in accessing health services. Services are encouraged to consider how approachable they are for clients, and to ensure they provide a suitable and appropriate service for priority populations.

Models of care need to consider all these factors, and look at innovative ways to improve clinical management, treatment, care and support. These models should deliver best practice care and support and appropriate and timely referral between specialist and PHC services. Services may require reorientation to address the needs of priority populations, in particular young people. Differing roles for different healthcare professionals, particularly nurses and Aboriginal health workers, should be explored as part of these models.

Tools and activities to improve treatment and management need to be piloted, and those determined to be effective should be promoted and adapted as required. These must be targeted towards priority populations. There have been important advances in the use of continuous quality improvement programs in PHC that deserve consideration, including new media and web-based decision-support tools for general practitioners...”

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