Improving Indigenous patients' access to mainstream health services: the Inala experience

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ABSTRACT

- In 1994, only 12 Indigenous people attended the mainstream general practice in Inala, south-western Brisbane, Queensland.
- An Indigenous community focus group and telephone interviews revealed deficits such as: few items (eg, artwork) that Indigenous people could identify with; lack of Indigenous staff; staff perceived as unfriendly; inflexibility regarding time; and intolerance of Indigenous children's behaviour.
- Access to the Inala Indigenous Health Service by Indigenous people improved when these issues were addressed, and has grown significantly every year from 1995 to 2008.
- Other important factors in improving access include: energetic Indigenous leadership; enabling bulk billing to increase funding; moving to a stand-alone clinic; and engaging with teaching, research and community programs.
- A Centre of Excellence in Indigenous Primary Health Care is envisaged as the next innovation required to improve access and quality of service, and to close the gap between Indigenous and non-Indigenous health outcomes.

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Forced relocation, urban migration, poor education, lack of employment, low income, inadequate housing, lack of environmental infrastructure and a paucity of appropriate health service provision are important social determinants of ill health for Aboriginal and Torres Strait Islander people.[1]

Historically, health services have been absent or inappropriate for this community. For example, accommodation in the public hospital system was segregated until the 1960s.[2] In the 2001–02 financial year, Medicare expenditure per person for Indigenous Australians was only 39% of that for other Australians.[3] Cultural and financial factors and distance have been important barriers limiting Indigenous Australians' access to mainstream services.[4] It has been argued that low levels of access by Indigenous people to primary health care settings and inadequate government funding contribute to their continuing poor health status.[5] Improved primary care access is vital for closing the gap for most health outcomes including chronic disease,[6] cancer mortality,[7] infant mortality,[8] asthma admissions[9] and immunisation coverage.[10]

Starting in Redfern, Sydney, New South Wales, in 1971, Aboriginal community-controlled health services (ACCHSs) began to be established to improve access. The principles underlying ACCHSs are essential to overcome barriers to effective health service delivery for Indigenous people.[11] The National Aboriginal Community Controlled Health Organisation, the peak body supporting ACCHSs, has listed the main principles guiding the sector, including concepts of health as holistic, the right to self-determination, recognition of the centrality of kinship, recognition of different communities and needs, high-quality health care services, and equitable funding.[12]

In 1994, Queensland Health identified culturally appropriate service provision as one of seven key areas needing to be addressed to improve the health of Indigenous Queenslanders.[13] A culturally appropriate service takes into account local language(s), beliefs, gender and kinship systems, thereby making service delivery settings more acceptable to the Indigenous community.

Despite the existence of primary care ACCHSs in many areas, mainstream services continue to be, numerically, the main source of health provision to Indigenous people. If Indigenous health is to improve, Indigenous people need to feel comfortable accessing mainstream health services.

The Inala context in 1994 to 1995

The suburb of Inala in south-western Brisbane is a low socioeconomic area, with significant cultural diversity; many residents live in public housing. According to the 1996 census, 8% of the total Inala population (1063/13 284) was Indigenous, significantly more than the national proportion of 2.1% in the same year.[14] The Inala Community Health Centre, a Queensland government-funded service established in 1977, aims to provide comprehensive primary health care, with very good access to allied health and specialist health teams operating under one roof.

In 1994, nursing staff members expressed concern that Indigenous people were grossly under-represented among the clinic's patients — they could only identify 12 Indigenous clients who regularly used the Inala Health Centre General Practice. This led to the establishment, in 1995, of the Inala Indigenous Health Service (IIHS), which operated out of three rooms as part of the Inala Health Centre General Practice and was staffed by one Aboriginal doctor (N E H) and, shortly thereafter, one Aboriginal nurse (N E W). In July 1995, one of us (N E H) conducted a focus group and telephone interviews to evaluate poor attendance with the aim of improving access (Box 1). We used these findings to guide a series of changes to the service.

Following further community participation and feedback, five key strategies were developed and implemented:

- ***Strategy 1.*** More Indigenous staff — employ an Indigenous person as health worker, receptionist or liaison officer for the centre.
- ***Strategy 2.*** Culturally appropriate waiting room
  - Purchase or acquire culturally appropriate health posters and artefacts for the centre to help make Aboriginal and Torres Strait Islander people "feel more at home".
  - Play Aboriginal radio station AAA Murri Country on occasions to help Indigenous people identify with the centre.
- ***Strategy 3.*** Cultural awareness — provide cultural awareness talks to all staff within the centre.
- ***Strategy 4.*** Inform the Indigenous community — disseminate information into the Indigenous community about services available at the centre.
- ***Strategy 5.*** Promote intersectoral collaboration

1 Access barriers and facilitators identified by the Inala community in 1995

Method: focus group and phone interviews with three questions

1. Why didn't Aboriginal and Torres Strait Islander people access the Inala Health Centre General Practice (IHCGP)?
2. If Aboriginal and Torres Strait Islander people did attend, then why did they attend?
3. What does the service need to do for local Aboriginal and Torres Strait Islander people to attend?

- The focus group was conducted at the Inala Community Health Centre. Eight community members, representing local Indigenous organisations, and one community Elder attended.
- Phone interviews were conducted with 10 current users of the service.

Results

Reasons for not attending IHCGP:

- No Indigenous person working within the centre
- Staff perceived as unfriendly and uncaring
- Staff talk down to you, "make you feel shamed"
- Staff body language, as interpreted by Indigenous people, suggested they were not wanted at the centre
- Treated poorly at reception, eg, "Why are you coming in at 4:30pm, we close at 5:00pm? Go home and come back tomorrow"
- Staff showed low tolerance to Indigenous child behaviour: "Keep them quiet"
- Long wait to see doctor
- There is "nothing" at the centre that Indigenous people can identify with.

Reasons for attending IHCGP:

- Convenience, live nearby
- Satisfied with doctors and staff
- Treated well by staff. ◆

- Liaise with ACCHSs in the Brisbane area.
- Liaise with the Inala Aboriginal and Torres Strait Islander Women's Health Support Group.
- Attend Aboriginal and Torres Strait Islander interagency network meetings.

Implementation phase (1995–2000)

Between 1995 and 2000, 899 new Indigenous patients attended IIHS. Of these, 68% were from Inala and 32% from surrounding suburbs. Numbers of new patient consultations remained relatively constant each year at 180, whereas second or subsequent patient consultations increased from 720 in 1995 to 2546 in 2000. On average, non-Indigenous Australians visit a GP five times a year, whereas Indigenous people average fewer than two consultations per year.[15] Between 1995 and 2000, Indigenous consultations at the IIHS averaged four per person per year.

A satisfaction questionnaire was formally conducted in 1998 by an Indigenous medical student, and the results from 35 patient interviews confirmed that the main reasons for a high level of satisfaction were the service's Indigenous focus and better communication with an Indigenous doctor. With this significant access increase, extra staff members were needed. New positions included a nutritionist (1996), a child health nurse (1997) and Aboriginal health worker (1998).

Rapid growth (2001–2005)

As use of the service increased, the IIHS and its Indigenous doctor (N E H) become very busy and overloaded. With the doctor frequently seeing over 30 patients a session, acute care had to be prioritised over vital chronic disease prevention and management. Funding and space limitations made expansion difficult, although the service was able to secure one session a week each from a female doctor and general practice training registrar.

Expansion (2006–2008)

In 2006, the IIHS was allowed to operate with an exemption from section 19(2) of the *Health Insurance Act 1973* (Cwlth), which enables Medicare rebates to be claimed for state-remunerated primary health care services in certain circumstances. Bulk-billing payments have enabled the service to employ extra staff members, including two doctors, two nurses and two administrative officers.

In 2007, in conjunction with the refurbishment of the Inala Health Centre General Practice, the IIHS moved to a stand-alone clinic with four consulting rooms, a large procedural area with two beds for minor operations and emergencies, and a large non-clinical area for community-based staff. With additional staffing and space, the service was able to make maximum use of the newly launched Indigenous health checks, which now span all age groups. In the 2007–08 financial year, the IIHS performed 555 of 4819 Adult Health Checks (item 710) in Queensland; 238/3341 Child Health Checks (item 708); and 83/1150 Older Person's Health Checks (item 704).[16]

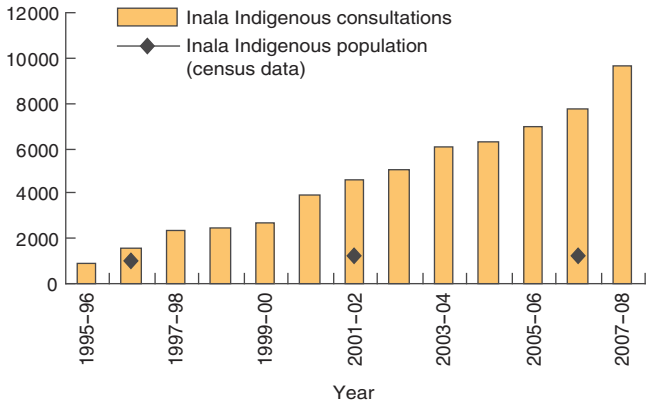
In the same timeframe, use of Indigenous health checks and chronic disease Medicare item numbers contributed significantly to the employment of another doctor and registered nurse in 2007. In the same year, we added specialist services, such as a paediatric registrar (one session/week) and retinal photography. Indigenous and other community health workers in the service provide outreach immunisations, child playgroups, NAIDOC Week coordination, facilitation of local rugby league teams, and sexual health, nutrition and chronic disease self-management programs. Research activity has expanded, with the service participating in a number of projects funded by National Health and Medical Research Council (NHMRC) grants, as well as conducting research internally, often in collaboration with the Queensland Aboriginal and Islander Health Council's Centre of Clinical Research Excellence and the Centre for Indigenous Health at the University of Queensland.

Increased attendance at the Inala Indigenous Health Service

Attendance data over the past 13 years are presented in Box 2. There were 3006 patients (96% Aboriginal, 3% Aboriginal and Torres Strait Islander and 1% Torres Strait Islander) registered in 2008 and about 900 medical consultations are completed monthly. The profile of patients is 61% female, 39% male; 38% are aged 14 years and younger, 56% are aged 15–54 years, and 6% aged 55 years and older.

By 2008, 22 full-time staff members were employed to cope with the increased demand on services. Other important factors relating to access are the low turnover rate of staff, which has provided continuity of care for patients, and the "one-stop shop" approach, with access to allied health services, mental health, alcohol and other drug services, and child health services.

2 Improved access to the Inala Indigenous Health Sevice, 1995–96 to 2007–08 financial years



The results of the census data for the Inala Indigenous population are also presented in Box 2, showing that this population was stable from 1995 to 2006. Clients accessing the service principally live in the local area, but significant numbers travel from surrounding suburbs. The improved access has led to many important community health gains.

Vision for the future

Within 1 year, the IIHS has outgrown its new clinic space. We envisage a Centre of Excellence in Indigenous Primary Health Care with the following objectives:

- Improve health outcomes for Aboriginal and Torres Strait Islander people through high-quality primary health care service delivery.
- Address current shortfalls in workforce development in Indigenous settings by
  - establishing strong links with universities to deliver high-quality teaching to medical, nursing and allied health students;
  - training advanced specialist trainees and GP registrars; and
  - providing an alternative teaching environment for doctors in prevocational years.
- Develop a research agenda that focuses on Indigenous chronic disease and child and maternal health.
- Provide expert outreach clinics to areas where Indigenous access to primary health care is problematic.

Progress towards closing the gap in life expectancy for Indigenous people is slow. New, innovative strategies are needed to improve health outcomes and increase life expectancy.

Vital to the success of this project were community consultation and participation of the local Inala Elders, employing Indigenous people and holding cultural awareness talks. Strong links with the Elders have been important in fostering trust in the community that has led to improved access, high participation rates of local Indigenous people in research, and more importantly, the development and implementation of community-based health activities, often conducted at the Elders' building. However, the impact on access of energetic Indigenous leadership within the service cannot be understated. Under Indigenous leadership, the IIHS has been able to work more effectively with Indigenous organisations, including the ACCHSs, in addressing health issues and improving health outcomes.

The Australian Government and universities must ensure that more Indigenous doctors and nurses graduate and encourage them (but not oblige them) to work in delivering culturally appropriate services to their communities. Breaking down the barriers to access for Aboriginal and Torres Strait Islander people will increase the numbers attending mainstream primary health care services and result in significant improvements in Indigenous morbidity and mortality.

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Competing interests

None identified.

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