

# Health services for Aboriginal and Torres Strait Islander people: handle with care



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This special Indigenous health issue of the *MJA* features stories of successful health care services and programs for Aboriginal and Torres Strait Islander people. As we seek to build on the wealth of experience outlined, it is worth considering what these contributions have to tell us about the characteristics and value of effective Indigenous health services.

It is more than 40 years since the founders of the first Aboriginal health service recognised a need for “decent, accessible health services for the swelling and largely medically uninsured Aboriginal population of Redfern [New South Wales]” (<http://www.naccho.org.au/about-us/naccho-history#communitycontrol>). There are now about 150 Aboriginal community controlled health services (ACCHSs) in Australia: services that arise in, and are controlled by, individual local communities, and deliver holistic, comprehensive and culturally appropriate health care. Panaretto and colleagues (*page 649*) describe how these services have led the way in high-quality primary care, as well as enriching both the community and the health workforce.

With the ACCHS model setting the standard, the values of responding to community need, Indigenous leadership, cultural safety, meticulous data gathering to guide improvement, social advocacy and streamlining access have gradually been adopted in other health care settings. The progress of the Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care (a Queensland Health-owned service also known as Inala Indigenous Health Service), is an example (*page 623*). Among the hallmarks of the service’s vitality are its ever-increasing patient numbers, research output, building of community capacity, expansion into specialist and outreach services and multidisciplinary educational role.

The East Arnhem Scabies Control Program, described by Lokuge and colleagues (*page 644*), is a dramatic example of innovation inspired by local need. This part of Australia has the highest rates of crusted scabies in the world, and the program involved collaboration between two external organisations, an ACCHS and the Northern Territory Department of Health. Importantly, it was able to be integrated into existing health services and largely delivered by local health workers, using active case finding, ongoing cycles of treatment and regular long-term follow-up.

Mainstream health services are now beginning to take the lead from Indigenous-specific ones. For example, the repeated observation that Indigenous men and women with acute coronary syndromes are missing out on interventions and are at risk of poor outcomes inspired a working group from the National Heart Foundation of Australia to develop a framework to ensure that every Indigenous patient has access to appropriate care (*page 639*). The framework includes clinical pathways led

by Indigenous cardiac coordinators, and it is already producing results.

There is growing evidence for the value of sound and accessible primary care for Indigenous Australians. A letter by Coffey and colleagues (*page 632*) highlights the significant progress towards closing the mortality gap between Indigenous and non-Indigenous Australians in the NT since 2000, temporally associated with investment in primary health care. A research report from Thomas and colleagues shows that patients with diabetes living in remote communities were more likely to avoid hospital admission if they accessed regular care at one of the remote clinics, saving both lives and money (*page 658*).

While the diversity of health services and the evidence of effectiveness is indeed something to celebrate, it is a fragile success. In their editorial, Murphy and Reath (*page 615*) highlight the need for sustained, long-term financial investment in primary health care services for Indigenous Australians and the uncertainty arising from changes to health care funding and Indigenous programs announced in the recent federal Budget (<http://nacchocommunique.com/category/close-the-gap-program>). The detail of how funding will be reallocated with the “rationalisation” of Indigenous programs has not yet fully emerged. Analysis indicates the cuts over 5 years include \$165.8 million to Indigenous health programs, which will be added to the Medical Research Future Fund. New spending on Indigenous programs includes \$44 million in 2017–18 for health as part of the Department of the Prime Minister and Cabinet Budget (Adjunct Associate Professor Lesley Russell, Menzies Centre for Health Policy, University of Sydney, NSW, personal communication).

Changes to primary care funding are of particular concern. Knowing, as they do, the importance of removing barriers to access, there is increasing public discussion that ACCHSs and large Aboriginal medical services will not pass on the proposed \$7 copayment to patients (<http://theage.com.au/act-news/health-service-facing-budget-blackhole-by-not-charging-copayment-20140527-zrpb7.html>). This will result in a decrease in funding to services that provide vital programs and deliver high-quality outcomes. The government has stated that everyone should share the deficit burden, yet the copayment has only been targeted at general practitioners and not specialist consultations. Is this fair and equitable?

It seems ironic that this threat to access and resourcing has arisen just as it is emerging that our investment in primary care for Indigenous Australians has been well made. In an Australia where many Aboriginal and Torres Strait Islander people still face significant socioeconomic and health disadvantage, the need for “decent, accessible health services” is greater than ever. □