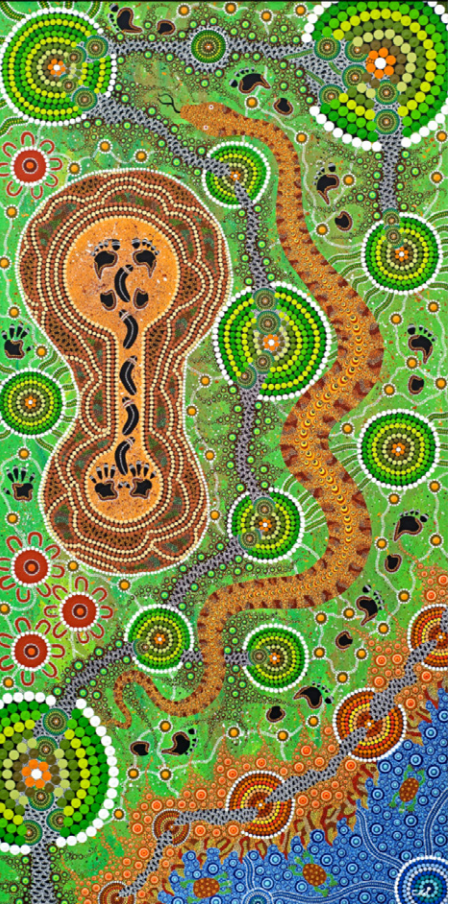


Aboriginal Artwork by Uncle Colin Jones

Carbal Institute of Aboriginal and Torres Strait Islander Health Research

The Key Elements Underpinning the Development of Indigenous Health Provision within Australia

The writer provides an overview of both evidence and research-based findings whereby the key elements', which should underpin the development and operations of indigenous medical seravices providers, are identified and elaborated upon. The connectivity between indigenous and mainstream medical services providers is also briefly examined concluding with Queensland's health services' stated commitment to both developing and implementing these pre-identified key elements

In 2003, following extensive stakeholder consultation by the National Aboriginal and Torres Strait Islander Health Survey, key areas were identified as comprising the eight domains underpinning the areas of medical issues as both perceived and experienced by indigenous patients. They are as follows:

Domains	
1	Psychological Distress
2	Impact Of Psychological Distress
3	Life Stressors
4	Discrimination
5	Anger
6	Removal From Natural Family
7	Cultural Identification
8	Positive Wellbeing

Source: ABS›s 05-2004 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS).

The results of the survey, constructed on the basis of the aforementioned domains, not surprisingly, revealed that the 'socio-demographic profile of the Indigenous population was significantly different from that of the non-Indigenous population, with a younger age distribution, lower educational attainment, and greater levels of disadvantage across a range of indicators (see Table 1). There were also marked differences within the Indigenous population according to remoteness of residence[1] Further research in the same year emphasised 'that Indigenous peoples have worse health than non-Indigenous, are over-represented amongst the poor and disadvantaged, have lower life expectancies, and success in improving disparities is limited.[2] An actual statistic was quoted in the British Medical Journal back in 2003 which revealed that 'the gap in life expectancy between indigenous and non-indigenous populations is estimated to be 21-19 years in Australia, 8 years in New Zealand, 7-5 years in Canada, and 5-4 years in the United States[3]. Thus, the evidence in support of providing indigenous medical services, it could be readily suggested, is irrefutable.

1. Socio-demographic factors and psychological distress in Indigenous and non-Indigenous Australian adults aged 64-18 years: analysis of national survey data Joan Cunningham & Yin C Paradies
BMC Public Health volume 12, Article number: 95 (2012)

2. Reducing the health disparities of Indigenous Australians: time to change focus Angela Durey & Sandra C Thompson
BMC Health Services Research volume 12, Article number: 151 (2012)

3. The health status of indigenous peoples and others
BMJ 2003; (Published 21 August 2003)

In terms of the cross-cultural aspect of this specialised indigenous medical services delivery researchers at the Centro de Investigación de Enfermedades Tropicales identified three steps as follows:

1. Trust building and partnership based on mutual respect and
2. principles of Cultural Safety Listen and To Adjust
3. Codesign, Evaluation and Discussion [1]

Table 1 Socio-Demographic Characteristics of Indigenous and Non-Indigenous Australians Aged 64-18 Years, 2004-05

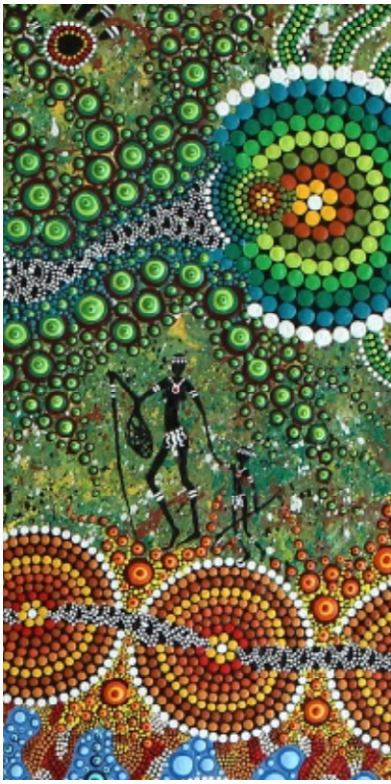
	Indigenous			Non-Indigenous
	Remote	Non-Remote	Total	
	%(%95CI)+	%(%95CI)+	%(%95CI)+	%(%95CI)+
Age(years)				
18-24	20.8(23.6-18.0)	23.9 (22.3-25.5)	23.1(21.7-24.4)	15.1 (14.8-15.4)
25-34	29.2 (27.1-31.4)	28.0 (27.0-29.0)	28.4(27.7-29.0)	22.4(22.3-22.6)
35-44	27.0(24.6-29.4)	22.8 (21.7-24.0)	24.0(23.5-24.5)	23.5(23.4-23.7)
45-54	15.6 (13.9-17.3)	16.3 (15.5-17.1)	16.1 (15.7-16.4)	22.0(21.8-22.1)
55-64	7.4(6.1-8.6)	8.9 (7.0-10.9)	8.5 (7.1-9.9)	17.0 (16.9-17.1)
Sex				
Male	46.7(44.1-49.2)	46.8(45.3-48.3)	46.8 (45.6-47.9)	49.8 (49.6-50.1)
Female	53.3(50.8-55.9)	53.2 (51.7-54.7)	53.2 (52.1-54.4)	50.2 (49.9-50.4)
Matrial status				
Married	48.6(44.1-53.1)	27.1(24.4-29.8)	33.1(30.8-35.4)	58.7 (57.6-59.8)
Not married	51.4 (46.9-55.9)	72.9 (70.2-75.6)	66.9(64.6-69.2)	41.3 (40.2-42.4)
Main language spoken at home				
English	52.0(46.8-57.1)	99.1 (98.7-99.6)	86.0(84.5-87.5)	90.8 (89.9-91.7)
Not English	48.0 (42.9-53.2)	0.9 (0.4-1.3)	14.0 (12.5-15.5)	9.2 (8.3-10.1)
Highest year of school completed				
Year 12	14.9 (11.8-17.9)	26.8 (23.9-29.8)	23.5 (21.2-25.8)	52.5 (51.2-53.8)
Year 11	14.8 (12.4-17.2)	12.4 (10.7-14.0)	13.0 (11.7-14.4)	10.9 (10.3-11.6)
Year 10	31.2 (28.2-34.2)	31.2 (28.9-33.6)	31.2 (29.4-33.1)	24.7 (23.7-25.7)
Year 9	13.1 (10.9-15.3)	14.2 (12.5-15.9)	13.9 (12.5-15.3)	6.3 (5.8-6.7)
Year 8	26.0(22.8-29.3)	15.4 (13.6-17.1)	18.3 (16.7-20.0)	5.6 (5.1-6.1)
Highest non- school qualification				
Past-graduate degree	0.7(0.3-1.1)	2.3(1.2-3.4)	1.9 (1.0-2.7)	6.2 (5.8-6.7)
Bachelor's degree	1.4(0.8-2.0)	3.5(2.6-4.4)	2.9 (2.3-3.6)	14.5 (13.8-15.3)
Diploma	2.4 (1.5-3.2)	5.6(4.2-7.0)	4.7 (3.7-5.7)	9.7(9.1-10.3)

1. Mexico's Guerrero State, researchers at the Centro de Investigación de Enfermedades Tropicales

Certificate	19.3 (16.4-22.1)	26.0 (23.6-28.4)	24.2 (22.2-26.1)	26.0(25.0-27.1)
No qualification	76.3(73.2-79.4)	62.6 (59.7-65.4)	66.4 (64.1-68.6)	43.5(42.5-44.5)
Employment status				
Employed	55.3 (51.5-59.1)	54.4 (51.3-57.5)	54.7 (52.2-57.1)	76.1 (75.3-76.8)
Unemployed	7.1 (5.5-8.6)	8.4 (7.0-9.9)	8.1 (6.9-9.2)	3.0 (2.7-3.4)
Not in the labour force	37.7 (34.1-41.2)	37.1 (34.3-40.0)	37.3 (35.0-39.6)	20.9 (20.1-21.7)
Housing tenure				
Owner/purchaser	6.8 (4.1-9.5)	31.6 (28.1-35.1)	24.7 (22.1-27.3)	n/a**
Renter/other tenure	93.2 (90.5-95.9)	68.4 (64.9-71.9)	75.3 (72.7-77.9)	n/a**
Reported food insecurity				
Yes	36.5 (33.0-40.1)	20.1 (17.7-22.4)	24.6 (22.7-26.6)	5.6 (5.1-6.0)
No	63.5 (59.9-67.0)	79.9 (77.6-82.3)	75.4 (73.4-77.3)	94.4 (94.0- 94.9)
Reported food insecurity				
1 (lowest)	37.1 (32.8-41.5)	32.4 (29.6-35.1)	33.7 (31.4-36.1)	11.3 (10.7- 11.9)
2	25.9 (22.4-29.4)	20.0 (17.6-22.4)	21.6 (19.7-23.6)	13.1 (12.5- 13.8)
3	8.7 (6.7-10.8)	16.4 (13.9-18.9)	14.3 (12.4-16.1)	16.9 (16.1- 17.6)
4	5.5 (2.7-8.3)	11.0 (8.8-13.1)	9.4 (7.7-11.2)	19.5 (18.7- 20.2)
5 (highest)	3.2 (1.6-4.8)	6.0 (4.4-7.6)	5.2 (4.0-6.4)	21.7 (20.7- 22.7)
Not known or not stated	19.4 (14.9-23.9)	14.1 (11.9-16.3)	15.6 (13.6-17.6)	17.5 (16.6- 18.4)
Seifa quintiles				
1 (most disadvantaged)	72.5 (62.6-82.4)	41.8 (35.1-48.4)	49.3 (43.7-55.0)	17.1 (15.7- 18.5)
2	11.5 (5.3-17.8)	21.8 (16.9-26.6)	19.3 (15.2-23.3)	19.0 (17.4- 20.7)
3	11.3 (3.7-18.9)	20.8 (15.8-25.8)	18.5 (14.3-22.7)	20.3 (18.4- 22.2)
4	4.6 (0.0-9.5)	10.4 (7.5-13.4)	9.0 (6.4-11.6)	21.3 (19.5- 23.0)
5 (least disadvantaged)	0.1(0.0-0.3)	5.2 (2.9-7.5)	3.9 (2.2-5.7)	22.3 (20.0- 24.7)
Area of residence				
Non remate	____	100.0	72.2 (70.6-73.7)	100.0
remate	100.0	____	27.8 (26.3-29.4)	____***

Source: Weighted data from the National Aborginals and Torres Islander Health Survey 05-2004 confidentialised unit record file (CURF). Based on data from 5,417 Indigenous participants (2,197 remote 3,220 non-remote) and 15,432 non-Indigenous participants.

It is immediately apparent that these steps are fundamental (among others) to the consideration of culture when implementing an indigenous health provider service. In an article in 'Globalisation and Health' (2018) researchers' had found that 'The evolution of Indigenous primary health care services arose from mainstream health services being unable to adequately meet the needs of Indigenous communities and Indigenous peoples often being excluded and marginalised from mainstream health services.[1] Furthermore, they concluded that 'the solution has been to establish Indigenous specific primary health care services, for and managed by Indigenous peoples.[2] The significance of socio-economic factors is reinforced in a paper prepared by the Australian National University (ANU) - Research School of Social Sciences (RSSS); Centre for Economic Policy Research (CEPR); IZA Institute of Labour Economics, when they state ' between one third and one half of the health gap can be explained by differences in socio-economic status.[3]



1: Characteristics of Indigenous primary health care service delivery models: a systematic scoping review Globalization and Health volume 14, Article number: 12 (2018)
2: Ibid
3: The Health Status of Indigenous and Non-Indigenous Australians34 Pages Posted: 21 Mar 2005 Alison L. Booth Australian National University (ANU) - Research School of Social Sciences (RSSS); Centre for Economic Policy Research (CEPR); IZA Institute of Labour Economics Nick Carroll Australian National University; Government of Western Australia - Labour Market Strategies Group

Even before such papers were researched and presented , back in 1994, the Medical Journal of Australia, reported on a case study undertaken in Inala, South-Western Brisbane, Queensland, where only 12 Indigenous people attended the mainstream general practice in Inala[1]. They further concluded that '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.[2]

Location of Indigenous Health Providers at Both Indigenous & Mainstream Facilities

WESTERN AUSTRALIA	20
NORTHERN TERRITORY	19
QUEENSLAND	28
NEW SOUTH WALES	38
VICTORIA	23
AUSTRALIAN CAPITAL TERRITORY	1
SOUTH AUSTRALIA	12
TASMANIA	1

While the establishment and operations of indigenous medical services providers' have progressed steadily it needs to be emphasised that the structures and facilities are meaningless in terms of effective delivery of specialised medical services in the absence of appropriately trained medical personnel. In a BMC on-line article published in 2019 the capacity of the Indigenous primary healthcare (PHC) sector to continue playing a crucial role in meeting the health needs of Aboriginal and Torres Strait Islander Australians is in large part reliant on the skills, motivation and experience of its workforce.[1] The article concludes that certain key strategies must be implemented in order for the success of indigenous medical providers in addressing both socio-economic issues as well as indigenous-specific medical conditions.

THESE STRATEGIES ARE AS FOLLOWS:

1 Strengthening Workforce Stability

- Creating good work conditions
- Identifying and filling workforce gaps

2 Having Strong Leadership

- Providing clarity and direction
- Lightening and being heard
- Communicating the big picture
- Being supportive, encouraging innovation

3 growing Capacity

- Grwing up our own
- Developing staff capacity

4 Working Well Together

- Communicating and sharing information
- Getting along together

Source: BMC Health Services Research Paper 'Working well: strategies to strengthen the workforce of the Indigenous primary health care sector Crystal Jongen, Janya McCalman, Sandy Campbell and Ruth Fagan 2019

1: Improving Indigenous patients' access to mainstream health services: the Inala experience Noel E Hayman, Nola E White and Geoffrey K Spurling MJA 2009 :190 604-606
2: Ibid
3: BMC Health Services Research is an open access healthcare journal, which covers research on the subject of health services. It was established in 2001 and is published by BioMed Central.

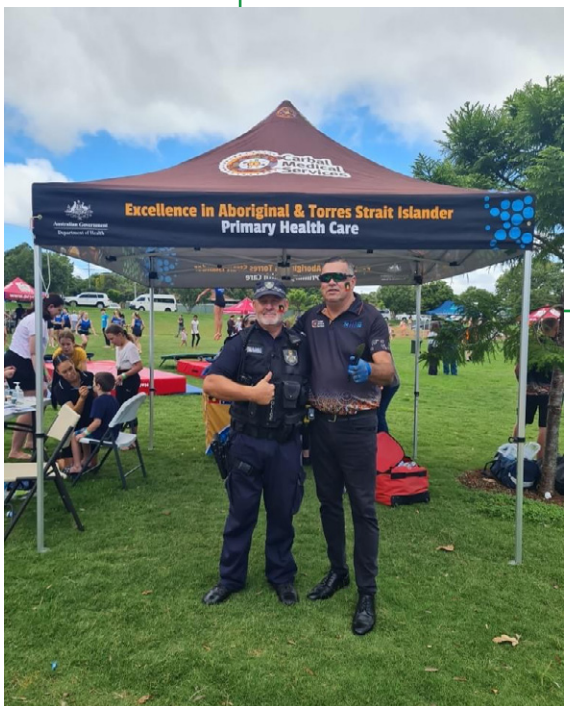
In terms of strengthening 'workforce stability ', apart from 'suggested improved continuing professional development, planning and opportunities and appropriate leadership for nurses[1] the BMC analysis concluded that to achieve workforce stability, 'staff [need] to understand and agree with the values and philosophies of community control …. and to have the right skills and experience.[2] It was also emphasised that stability in the workforce was supported through the work conditions provided to staff. These should include generous flexibility in roles and responsibilities, study support and training opportunities, leave conditions, and work schedules to account for changes in personal circumstances. These work conditions obviously reflect both the community and cultural values common to indigenous people.

WORK STABILITY

STRONG LEADERSHIP

When examining the strategy of 'strong leadership' the BMC research team pointed out that, 'although strong leadership was demonstrated at senior levels, the leadership was further enhanced 'through clarity and direction.[3] Leaders were aware of the special needs and challenges of the workforce and actively encouraged an 'open door' policy linked to a jointly developed system for resolving staff conflicts before they began to have an adverse effect on the established workplace culture. Leaders were also expected to provide a degree of education and training, if not directly by themselves, then with external resources. In the first instance leaders were expected to interpret and assist with an understanding of the policies and direction as set by the board. However, understanding is somewhat different from having the knowledge and skills to operationalise such polices and directives. An external 'change agent' and/or 'trainer' were identified to enable this vital learning.

The selection of such external personnel not only had to be carefully undertaken but there should be a leadership-led induction program to both reinforce the key cultural characteristics of the organisation as well as further refining the expected deliverables from the planned activities.



1: Ibid page 4
2: Ibid page 4
3: Ibid page 5

GROWING CAPABILITY

The third 'strategy' concerning 'growing capability' focuses not only on capability but also capacity. Regarding capability, many respondents were almost unanimous in seeking upper management endorsement for further training at the certificate level (Levels I-IV). Also, a 'strong desire was expressed by participants for further strategies to support strengthened local leadership, in particular, to increase the number of local Indigenous people in senior management positions[1]. Furthermore, it was also recommended that there should be an 'awards' system in place, obviously to motivate both achieving and exceeding stated Key Performance Indicators (KPIs'). Succession planning was also raised as a necessary methodology to ensure that 'young ones that are energetic…. want to be in that leadership positions, and they should be identified[2] There was also an acknowledged symbiosis between non-indigenous health workers and their indigenous counterparts encapsulated in the recommendation that specified the 'establishment [of] mentoring/role shadowing systems and building these into contracts and key performance indicators (KPI's)[3]

WORKING ALL TOGETHER

Now let's now turn to a brief examination of 'working well together' -the last category of the four strategies. It should come as no surprise that the respondents' confirmed that a strong and stable workforce requires strategies that support a positive work culture where staff members work well together, and feel good in the workforce.' with added observation that there should be 'clear communication and information sharing systems and processes[4] This strategy also emphasises the aforementioned necessity for 'Indigenous and non-Indigenous, [to] share knowledge, skills and experience.[5]

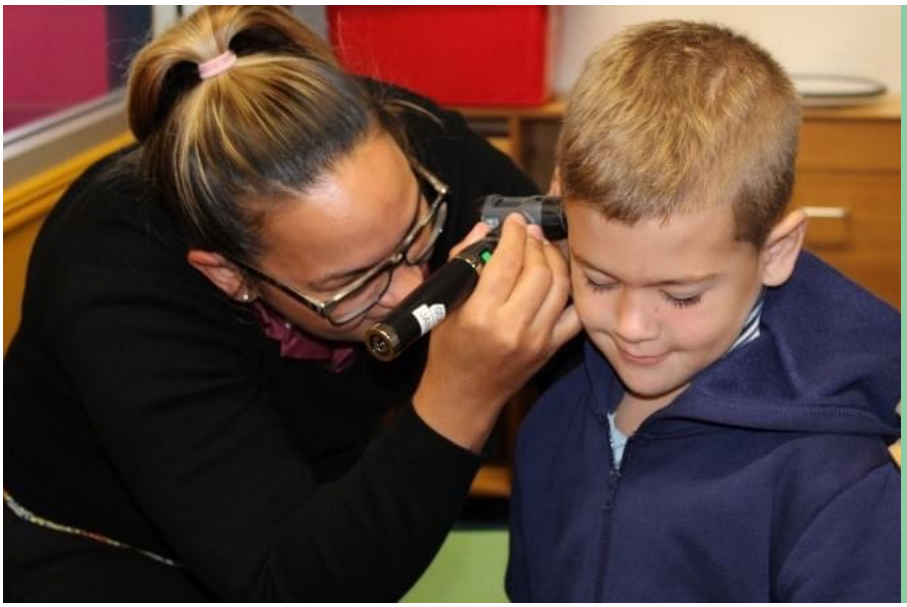
In the 'Australian Health Review' an article entitled Closing the (service) gap: exploring partnerships between Aboriginal and mainstream health services, submitted by Kate P. Taylor A B C and Sandra C. Thompson, while acknowledging that 'effective partnerships between Aboriginal and mainstream health services are critical to improve Aboriginal health outcomes, many factors can cause these partnerships to be tenuous and unproductive[6] Consequently, the foundations for both developing and maintaining these partnerships start with jointly acknowledging and discussing the ' legacy of Australia's colonial history' leading to ' [then] workshopping tensions early, building trust and leadership.[7]

1: Ibid page 6
2: Ibid page 6
3: Ibid page 7
4: Ibid page 7
5: Ibid page 7
6: Closing the (service) gap: exploring partnerships between Aboriginal and mainstream health services
Kate P. Taylor A B C and Sandra C. Thompson A Page 1
7: Ibid Page 1

In concluding this brief examination of partnerships between non-indigenous and indigenous health workers the previously cited paper by Taylor and Thompson remind us that ' failed partnerships risk inflaming sensitive relationships between Aboriginal and non-Aboriginal service providers ' which leads to the warning that 'it is critical that the factors supporting Aboriginal-mainstream collaboration are understood.[1]

SO WHERE TO FROM HERE?

We have demonstrated that the fundamental elements' underpinning indigenous health provision have been identified (based on substantial community evidence) and that, again based on research, the key strategies to redress various key issues and concerns' have also been examined. The State of Queensland, specifically the 'Children's Health Queensland Hospital and health Services' having published the 'Aboriginal and Torres Strait Islander Health and Wellbeing Services Plan 2023–2018' are clearly committed to:' promoting wellbeing and health equity, improving service design and integration, evolving service models, delivering services closer to home and pursuing innovation.[2] Similarly, other States have similar plans in place, all evidence-based, and so, the future appears to be optimistic in not only 'closing the gap 'between the mainstream and indigenous health services outcomes but also in an eventual mutual collaboration between the two systems. As one anonymous observer quipped, 'perhaps the indigenous services providers will teach the mainstream provider's something about the significance of both empathy and sensitivity.



1: Op.Cit. Page 2
2:Children's Health Queensland Hospital and health Services' have published the 'Aboriginal and Torres Strait Islander Health and Wellbeing Services Plan 2023–2018' Page 3

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- Closing The (Service) Gap: Exploring Partnerships Between Aboriginal And Mainstream Health Services
- Kate P. Taylor A B C and Sandra C. Thompson A Page 1
- 'Children's Health Queensland Hospital and Health Services' Have Published The 'Aboriginal And Torres Strait Islander Health And Wellbeing Services Plan 2023–2018' Page 3