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Closing the indigenous health gap

■ On 24 March 2008, Prime Minister Kevin Rudd, the leader of the Federal Opposition, and health sector leaders signed a pledge to close the indigenous health gap by 2030 and the equity gap in health service provision by 2018. This is a big challenge – Indigenous Australians have a life expectancy 17 years less than non-Indigenous Australians and a burden of disease 2.5 times higher.^{1,2}

However, we do have evidence of some success. For example, between 1967 and 2004 indigenous life expectancy in the Northern Territory (NT) improved for men from 52 to 60 years, and for women, from 54 to 68 years.³ A study of infant mortality trends in Western Australia showed improvement from 25.0/1000 for 1980–1984 to 16.1/100 for 1998–2001.⁴

While there have been some positive trends in absolute outcomes, in some instances relative disparities have widened. For the period 1977–2001 in the NT, infectious disease mortality declined while chronic diseases such as noninsulin dependent diabetes and cardiovascular disease were still trending up, albeit at a reduced rate of acceleration.⁵

Regional studies provide some insight into the multifaceted reasons behind these transitions. A cohort study in the Urapuntja (NT) community for the period 1995–2005 demonstrated adult all cause mortality rates that were 40% lower relative to NT indigenous rates. According to Australian Bureau of Statistics data, this community is comparable with respect to housing outcomes, low average incomes and low rates of paid employment. It is possible that the better outcomes reflected local factors in the social organisation of the community – such as its decentralisation or capacity for local decision making – and the provision of an organised outreach focused primary health care service.⁶

In this agenda for change the provision of quality, effective primary health care is critically important. This is needed both to respond to the health needs of Indigenous Australians and to tackle the broader population level inequalities.

The role of Aboriginal community controlled health services (ACCHS) in the provision of primary health care to Indigenous Australians is well recognised. Mainstream general practice is also a significant provider of primary care for Indigenous Australians. Modelling based on 2001–2002 BEACH data estimated 600 000

consultations per year in non-ACCHS general practice with indigenous patients (out of a total 1 million consults).⁷ Notwithstanding some of the concerns with this data – it points to the significant role of mainstream general practice in improved care outcomes for Indigenous Australians.

Over the past decade, national policy has focused on improving health care for Indigenous Australians through financing and workforce reform. These strategies remain important. For the period 2004–2005 it was estimated that for every dollar spent on the health of non-Indigenous Australians, \$1.17 was spent on the health of Indigenous Australians – a significant global under-spend relative to need. At the same time, the Medical Benefits Scheme paid benefits at 45% of the nonindigenous average and the Pharmaceutical Benefits Scheme at 51% of the nonindigenous average.⁸ Health workforce strategies have focused both on supply and addressing the lower participation of Indigenous Australians in all aspects of the health workforce. In 2006, Indigenous Australians constituted 0.2% of the medical workforce and 0.5% of registered nurses.²

Quality of care has become a significant new focus in indigenous health strategy, with a number of different initiatives nationally to progress the development of this agenda.⁹ There is a need to ensure greater integration across these different models as well as a rationalisation of both continuous quality improvement and performance reporting processes. To date, most of the quality of care agenda has focused on indigenous specific services – but there is a need to broaden this to include mainstream general practice.

Improved identification of indigenous patients in mainstream general practice is an important step in achieving better care processes such as: improved uptake of relevant Medicare items, the development of care plans that draw on the right mix of mainstream and indigenous specific services, and improved referral between services; and would facilitate improvements in health data quality. A peak body reference group was set up by the National Indigenous Health Equality Council in June 2008 to facilitate the development of strategies that address this problem.

There is no doubt that closing the indigenous health gap will require a multi-layered and multi-faceted strategy. This is an agenda in which general practice can, and should play, its part.

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