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# Indigenous health

## *A role for private general practice*

### Background

The Aboriginal and Torres Strait Islander life expectancy gap is associated with lower primary care usage by Indigenous Australians. Many Indigenous Australians regard private general practitioners as their usual source of healthcare. However, a range of barriers results in relatively low access to primary care, with subsequent inadequate prevention and management of chronic disease. Indigenous primary care requires development of a set of attributes by the GP. Clinician autonomy may need to be tempered to be responsive to the needs of local indigenous communities.

### Objective

A partnership between an urban indigenous community and a private general practice is described.

### Discussion

Over a period of 1 year, registered indigenous patients at the private general practice clinic increased from 10 to 147; monthly attendance increased from five to 40 ( $p < 0.001$ ). Local engagement between private practices and indigenous communities may be implemented widely to reduce the primary care gap.

**Keywords:** general practice; health services; indigenous; Aborigine; delivery of health care



Aboriginal and Torres Strait Islander people were estimated to have a life expectancy at birth of 72.9 years for females and 67.2 years for males in 2005–2007; 9.7 years less for females and 11.5 years less for males compared to non-Indigenous Australians.<sup>1</sup> This 'life expectancy gap' is attributed to increased disability and chronic disease, as well as young child mortality. Parallel observations include an excess of potentially preventable hospitalisations<sup>1</sup> and a younger population profile.<sup>2</sup>

Despite increased morbidity, Indigenous Australians access primary care less than non-Indigenous Australians, although access is recognised as a key determinant of indigenous health outcomes.<sup>1,3</sup> Government spending through Medicare rebates and the Pharmaceutical Benefits Scheme (PBS) allows the comparative measurement of access to primary care: the indigenous ratio is calculated as the per capita payment for indigenous patients expressed as a proportion of nonindigenous patients<sup>4</sup> (Table 1). It has been suggested that the indigenous ratio for total government health spending should be 2.2, given poorer health and more expensive remote service delivery.<sup>5</sup> In 2006–2007 the indigenous ratio for Medicare payments to general practice was 0.8. By contrast, nonadmitted hospital patient services had a ratio of 1.54, contributing to an overall ratio for government primary care expenditure of 1.29. The PBS indigenous ratio was 0.6. When Section 100 (for remote indigenous communities) and other special pharmaceutical payments are excluded, this falls to 0.45. While indigenous status is likely to be underestimated in these datasets, the impact of under-reporting on gap measures is unpredictable.<sup>1,4</sup>

Another way to measure the indigenous primary care gap is to count general practice consultations. In 2008–2009, the Bettering the Evaluation and Care of Health (BEACH) program found 0.8% of consultations were with indigenous patients.<sup>6</sup> This proportion is less than a third of the indigenous population rate of 2.5% in 2006, but is likely to be an underestimate due to low indigenous identification.<sup>7</sup>

Aboriginal Community Controlled Health Services (ACCHS) are the preferred model for delivering indigenous primary care by the indigenous community<sup>5</sup> and government.<sup>8</sup> Analysis of the 2004–2005 National Aboriginal and Torres Strait Islander Health Survey indicated that 60% of Indigenous Australians identified a general practitioner outside of ACCHS as their usual source of healthcare.<sup>9</sup> A further 7%



**Table 1. Ratio of per capita health spending for Indigenous compared to non-Indigenous Australians according to government and private spending<sup>4,5</sup>**

Area of expenditure	Ratio
Total government health (also includes research, administration)	1.25
Public secondary and tertiary health	1.37
Public primary health	1.29
Nonadmitted hospital services	1.54
Public nonhospital medical services	0.65
General practitioner (Medicare)	0.80
Pharmaceutical Benefits Scheme	0.60
Mainstream Pharmaceutical Benefits Scheme	0.45
Recommended total government health spending	2.20
Total private health	0.26
Private nonhospital medical services	0.42
Private medications	0.23

went to hospital but only 3% did not access the health system. For the 53% of the indigenous population residing in major cities and inner regional areas, the use of non-ACCHS GPs rose to 80%. Aboriginal Community Controlled Health Services dispute this data, claiming 50% of the indigenous population access their services for usual care.<sup>10</sup> Non-ACCHS GPs also include dedicated government run indigenous clinics.<sup>11,12</sup>

Indigenous people access primary care less because they face greater barriers. For remote communities geography is an issue. Cultural insensitivity, racism<sup>1</sup> and cost<sup>4</sup> may be relevant to private general practice regardless of location.

## How is general practice for indigenous patients different?

A general practice orientated toward indigenous consultations relies on a partnership with the community and tends to be more multidisciplinary in approach, often including indigenous health workers.<sup>13</sup> Consultations tend to be with younger patients and contain relatively more complex care needs.

The ability to identify indigenous patients and communicate comfortably with them is important, as is current knowledge of indigenous health prevention and management, and working with local indigenous organisations.<sup>14</sup> Strategies to help GPs include cultural awareness training, networks of GPs with an interest in indigenous health, publications describing key issues, and registrar training in indigenous health.<sup>15</sup>

Re-orientating to engage the indigenous community requires responsiveness to consumer needs, and this needs to be balanced against practice autonomy. Although innovation is beneficial to general practice, it is uncommon for GPs to seek consumer guidance.<sup>16</sup> Instead, GPs generally choose a practice that suits their own mix of clinical,

business and personal needs. Indeed, clinical and financial autonomy contribute to job satisfaction.<sup>17</sup>

## Private practice closing the health gap The Majellan model

A collaborative model of private general practice at the Majellan Medical Centre (MMC) in Scarborough, Queensland, has achieved significantly improved indigenous access (*Figure 1*). The MMC is a practitioner owned private billing group practice. Since April 2009, MMC has developed an 'indigenous friendly' practice in partnership with Moreton Bay Regional Elders Council (Elders), Queensland Health, Moreton Bay General Practice Network (MBGPN) and Redcliffe Community Association.

The concept to form links between the indigenous communities of Redcliffe Peninsula and Deception Bay and a local private practice was advanced by the Elders during discussions with Queensland Health in response to low Medicare funding access and advanced illness presentations at hospital. Redcliffe is 30 kilometres from the nearest indigenous specific primary care service. Lack of both bulk billing and understanding of indigenous issues by GPs were identified as local barriers to primary care. The MBGPN was then approached for advice, and recommended contact with MMC because of previous clinician experience in indigenous health: one of the authors (RPJ) had worked with an Elder from Moreton Bay at an ACCHS during an advanced rural skills post in Aboriginal health.

Negotiation between the Elders and MMC resulted in three key strategies to improve indigenous access:

- bulk billing for all indigenous patients (by agreeable doctors)
- one session each week ('the clinic') specifically for indigenous patients (usually with RPJ), and
- a bus to the clinic (bus provided by Redcliffe Community Association, petrol subsidised by MBGPN, volunteer driver from the community).

While the bus has not run consistently, the other two strategies have been implemented.

The MMC patient registration form was modified in consultation with the Elders to align indigenous identification with Australian Bureau of Statistics guidelines. The MMC staff were briefed before the commencement of the clinic and plans have been made to provide staff with cultural safety training. Importantly, the indigenous friendly clinic has increased indigenous access through the coordination of existing services, without the need to develop any new entity or employ new staff.

As part of Queensland Health's commitment to the partnership, the district indigenous health worker attends the clinic, referring patients to MMC, facilitating patient recalls, and ensuring cultural safety for patients. A monthly stakeholder meeting has provided ongoing community ownership of the collaboration.

There was a dramatic increase in the indigenous clientele of MMC during the 12 months to March 2010, compared to the baseline



6 months to March 2009: registered indigenous patients rose from 10 to 147 and average monthly indigenous consultations increased from five to 40 ( $p < 0.001$ ) (Figure 2). Sixty-one percent of indigenous consultations were on the clinic day and 70% with one of the authors (RPJ). Hence, while the majority of indigenous patients saw one doctor during the clinic, strategies have increased indigenous access to all doctors in the practice, at all session times.

Between December 2009 and March 2010, the hourly billing rate for the afternoon indigenous clinic was 76% of the rate for the morning general session of the same doctor on the same day.

### Discussion

The success of the indigenous friendly general practice at MMC is largely due to its initiation and ongoing endorsement by the local indigenous community, and the supportive engagement of Queensland Health. Although ACCHS and indigenous specific government services have established strategies to engage the indigenous community, ensure cultural safety and reduce barriers to access, to date, there has been no documentation in the scientific literature of similar collaborations in private practice.

The creative redeployment of existing resources averted the need to secure funding to establish a new service, and contributed to short set up times: the clinic was established within 1 month of commencing negotiations, as there was no need to spend time recruiting staff or developing physical infrastructure.

While the increase in access has been positive, the transaction

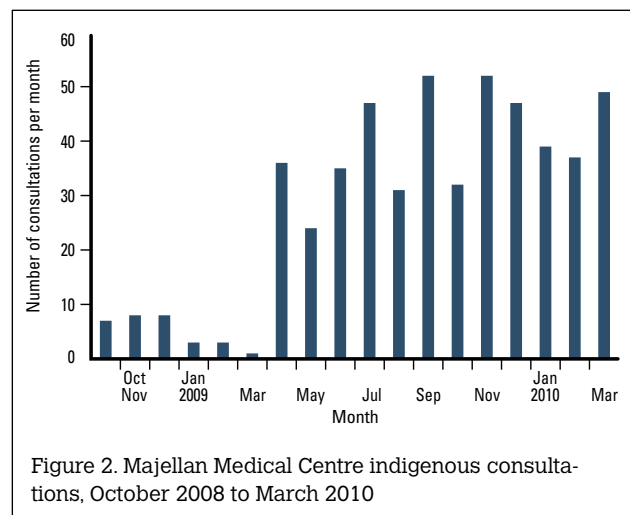


Figure 2. Majellan Medical Centre indigenous consultations, October 2008 to March 2010

costs are significant. In addition to clinic sessions, unpaid clinician time is required to maintain community consultation. Patient attendance at the clinic is unpredictable, the community driver intended to support the practice has been unavailable for the past 6 months and the clinic generates less income than other sessions due to lower patient numbers. Hence, although substantial practice nurse assistance is required, less money is generated for nurse wages. Review appointments for chronic illness occur less than desired from a medical perspective and responses to recall are patchy. The Majellan model is also dependent on each partner continuing to contribute to the partnership. Two Queensland Health health workers have retired from the district since the clinic started, without replacement. There are also current plans to establish a community controlled health service in the region, which may divert resources.

The clinical practice itself, and the relationships that the partnership has established, are rewarding. Indigenous Well Person Health Checks<sup>18</sup> are already funded by Medicare above the normal consultation rate to encourage holistic care. Introduction of the Indigenous Practice Incentive Program<sup>19</sup> should substantially correct the current reduced income of the Majellan model.

Drawing on the Majellan model, Queensland Health has assisted indigenous communities in four other areas of northern Brisbane to engage other GPs to discuss similar collaborations. The MBGPN is planning to present the model to other interested GPs. The Majellan model has potential for dissemination. As it developed in a 'grass-roots' fashion it is not prescriptive as to the shape of local collaborations but expects adaptation to local need.

### Recommendations

General practitioners who wish to learn more about indigenous health issues should consult the *National guide to a preventive health assessment in Aboriginal and Torres Strait Islander peoples*<sup>20</sup> and *Aboriginal Primary Health Care*.<sup>5</sup>

General practice registrars who wish to develop indigenous health skills are advised to seek work with an ACCHS. Advanced rural skills

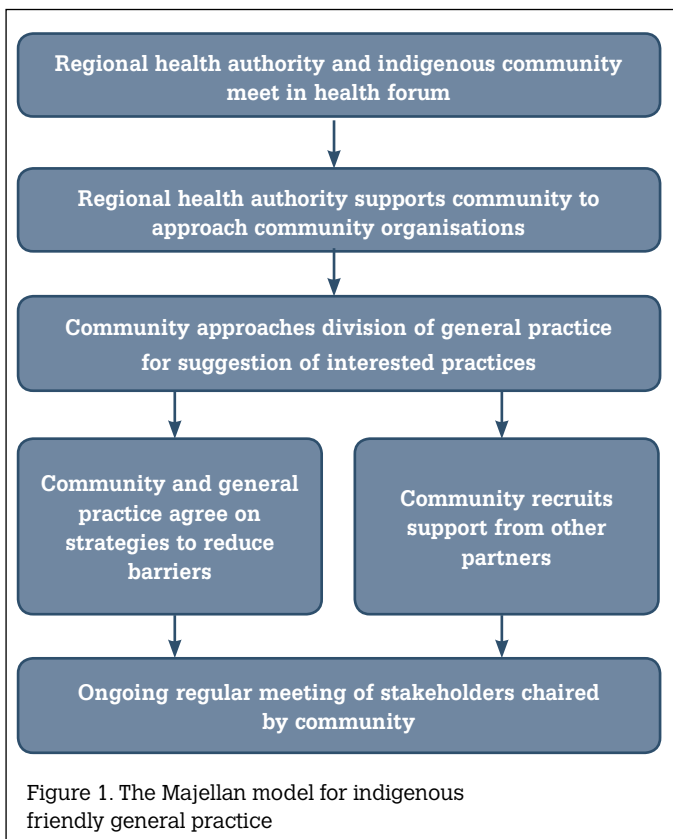


Figure 1. The Majellan model for indigenous friendly general practice



training posts within the Fellowship in Advanced Rural General Practice<sup>21</sup> are designed for this purpose.

General practice networks should become familiar with their local indigenous leadership structure and any regional health forum. They are well placed as an initial intermediary between interested general practices and indigenous communities.

Private general practices can form effective partnerships with local indigenous communities to reduce barriers to indigenous primary care. This requires some re-orientation of general practice with direction from, and accountability to, the indigenous community. The actual change in clinical practice and practice management is not large, but the improvement of local indigenous primary care access can be.

## Summary of important points

- Aboriginal people and Torres Strait Islanders currently have a life expectancy that is 9.7 years less than the non-Indigenous Australian life expectancy for women and 11.5 years for men.
- On a per capita basis, government subsidies for primary care through general practice consultations and prescription medications are less for Indigenous Australians than non-Indigenous Australians.
- A substantial portion of Indigenous Australians identify private general practice as their main source of primary care.
- Private GPs can improve access for indigenous patients through partnership with their local indigenous community.
- Better general practice access is likely to reduce the indigenous health gap.

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