

# Inequities in Aboriginal health

## Access to the Asthma 3+ Visit Plan

**BACKGROUND** The prevalence of asthma is higher in Aboriginal and Torres Strait Islander adults than in non-Indigenous Australian adults in all age groups, and hospitalisation rates for acute asthma episodes are much higher, indicating suboptimal prevention. A 2001–2002 Australian Federal Budget initiative, the Asthma 3+ Plan, encouraged doctors to talk to their patients about asthma management over at least three visits and provide an asthma action plan.

**OBJECTIVE** This article reports on the findings of a study examining the uptake of the Asthma 3+ Visit Plan initiative among Aboriginal community controlled health services.

**DISCUSSION** Significant barriers prevent ACCHSs accessing the Asthma 3+ Visit Plan limiting Aboriginal people's capacity to benefit. In addition, Aboriginal and Torres Strait Islander patient access to both spacer devices and asthma medication is often poor. A targeted asthma information strategy is needed, and spacer devices must be made accessible to the Aboriginal and Torres Strait Islander population. Chronic disease management Medicare items offer a preferable and alternative funding mechanism for asthma care, if supplemented by pharmaceutical access reforms.

The prevalence of asthma, the rate of hospitalisation, and the number of hospital patient days for asthma is higher in Aboriginal and Torres Strait Islander adults than in non-Indigenous Australian adults in all age groups.<sup>1</sup> Risk factors for asthma, which include smoking, infections, dietary causes and possibly low birth weight,<sup>2</sup> are also more common. Indigenous Australians over 18 years of age are twice as likely to be current smokers than non-Indigenous Australians (51% vs. 24% respectively).<sup>1</sup> The high rate of exposure to passive smoke in studies involving Aboriginal children (68.5% of children)<sup>2</sup> and smoking during pregnancy,<sup>3</sup> contrasts with smoking prevalence among parents of infants in the general population (28.9%).<sup>4</sup>

Asthma is a manageable chronic condition, but there is evidence effective treatment is underutilised.<sup>3</sup> Suboptimal asthma therapy for Indigenous Australians has been reported from North Queensland<sup>4</sup> and much higher hospitalisation rates for acute asthma episodes are indicative of suboptimal prevention.<sup>1</sup> Whether gaps in uptake of preventers and other medication is due to poor management by general practitioners, a lack of patient knowledge or other factors, is still unclear.<sup>5</sup>

The 2001–2002 Federal Budget initiative (\$48.4 million over 4 years) for the Asthma 3+ Plan encouraged doctors to talk to their patients about asthma management over at least three visits, incorporating diagnosis, assessment and review, with the provision of an asthma action plan.<sup>6</sup> The components of the package included financial incentives for GPs (through the Practice Incentive Program [PIP]), divisional infrastructure support, and a national awareness campaign targeting both GPs and the community. The PIP provides a service incentive payment (SIP) which is triggered by a Medicare Benefits Schedule (MBS) claim (eg. item 2546) upon completion of three



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GP visits for those with moderate to severe asthma over 4 weeks to 4 months.

However in 2001, the National Aboriginal Community Controlled Health Organisation (NACCHO) reported that Aboriginal community controlled health services (ACCHSs) faced barriers accessing this initiative.<sup>7,8</sup> With over 130 ACCHSs across Australia, these services are major providers of primary health care to the Aboriginal and Torres Strait Islander population.<sup>9</sup>

In 2004, a national evaluation of the Asthma 3+ Visit Plan was undertaken by the Universities of Adelaide and New South Wales.<sup>10</sup> NACCHO was subcontracted in order to examine barriers existing for ACCHSs.

## Methodology

As primary health care services, all ACCHSs could apply for the Asthma 3+ Plan initiative. A total of 52 ACCHSs were identified from the NACCHO membership database as meeting the eligibility criteria for participation in a questionnaire<sup>10</sup> (at least one full time equivalent GP employed by the service). Two services advised that due to staffing shortages, a full time equivalent GP could no longer be employed. The survey tool was pilot tested before dissemination in two ACCHSs (urban, and rural). Follow up interviews were conducted to support certain services and enhance the response rate.

Three focus groups were held (urban, rural and remote ACCHS location), with the assistance of a community member taking up to 2 hours each. Participants were a cross section of the Aboriginal population with asthma or asthma carers. Compensation was provided in the form of a meal.

Quantitative survey data was entered into an access database and analysed using the SAS package 38. Pilot survey data was included as part of the overall survey data. A sensitivity analysis was performed including and excluding the two pilot surveys which validated their inclusion.

Ethical clearance was obtained from the Aboriginal Health Research Ethics Committee of the Aboriginal Health Council of South Australia, and University of Adelaide Human Research Ethics Committee, and approved by the NACCHO Board of Directors.

## Results

Thirty surveys were returned (30/50, 60% response rate) with 27 Aboriginal focus group participants. The geographical distribution of ACCHS respondents appeared representative of all ACCHSs (*Table 1*).

## Uptake of Asthma 3+ Visit Plans

From respondent services, 60% (18/30) were accredited with the PIP, while the remaining 40% were either not accredited (8/30), were preparing to become accredited (2/30), or were not sure about their status (2/30). The Asthma 3+ Plan had been completed in the preceding 12 months by only five (25%) of the 20 accredited or near accredited ACCHSs, with between one and 5 patients. Of these services, only one had received a SIP payment. The remainder had either never completed the plan in that time (10/20) or were not sure (5/20). A written asthma action plan in the individual management of asthma with Aboriginal patients was utilised by 60% (17/28) of services.

Most ACCHSs (74%, 22/30) faced barriers to taking up the plan. Survey respondents felt that the Asthma 3+ Visit Plan was not a useful program for Aboriginal or Torres Strait Islander patients with asthma (46%, 14/30), while 33% (10/30) were unsure. Reasons given included:

- program inflexibility, complex implementation in a remote environment and 'red tape'
- patients not returning for the third visit, and
- lack of staff training and insufficient resources to understand and implement the program.

Most focus group participants were not well informed about the plan. Those that were, found it very difficult to attend for three visits, noting that they valued the Aboriginal health worker (AHW) support for follow up visits.

## Barriers and enablers

### Access to information and education

Few services (5/30) had the staff and resources to conduct asthma awareness activities for their patients, but 75% (21/30) were able to provide support in the form of educational material. Of the five services that did have the capacity to develop asthma education/awareness programs, three were self funded. General practitioners and AHWs were the primary source of asthma education within ACCHSs. Few services reported using asthma educators in the provision of education to Aboriginal patients.

Assistance provided by the local division of general practice with the implementation of the plan was received by 59% (10/17) of ACCHSs that were either PIP accredited or near accreditation. Around 60% (12/20) of services could not recall receiving invitations to attend National Asthma Council workshops on the initiative.

Focus group participants reported that asthma

health promotion programs to develop awareness and health literacy in the community were needed, with a focus on schools and young people.

### Access to medication and spacer devices

Eighty percent of services (24/28) indicated that patient access to spacer devices was a problem. Patient access to asthma medication was reported as a problem by 48% of services (13/27). The majority of those reporting no medication access problems (8/14) were Section 100 providers to Aboriginal patients.

Most focus group participants reported difficulties accessing medication and spacer devices, especially families with more than one asthmatic person. Many ACCHSs reported providing free spacer devices, or introduced systems where patients could pay at a later time. One remote area service referred to the use of 390 mL plastic 'Coke' bottles adapted to function as spacer devices given that patients could not afford to buy conventional spacers (*Figure 1*).

### Access to equipment

Nearly all services (26/29) had access to spirometry equipment to effectively monitor and assess patients with asthma. Many of the focus group participants were still reliant on home nebulisers for the treatment of acute asthma exacerbations.

## Discussion

Significant barriers exist for ACCHSs to access the Asthma 3+ Plan funding initiative that limits Aboriginal people's capacity to benefit. Around a third of services were immediately 'locked out' of the program on the basis of PIP ineligibility. Moreover, 50% of eligible services reported not using this initiative, and a further 25% were unsure. This situation is likely to be representative of all ACCHSs given the large sample of ACCHSs surveyed and their geographical parity.

The Asthma 3+ Visit Plan requirement for three visits to the GP in the space of 4 months has been identified as problematic for all Australians,<sup>10,11</sup> but is more onerous for Aboriginal Australians. The provision of preventive health care to Aboriginal peoples is more complex due to their mobility and geographic isolation, their subsequent need to access multiple service providers, poorer Medicare and the Pharmaceutical Benefits Scheme (PBS) access overall, poorer access to GPs who bulk bill, as well as educational and socioeconomic factors that lead to reduced adherence to medications.<sup>12,13</sup>

Aboriginal patients attending a private GP may also

**Table 1. Survey sample of ACCHSs according to ARIA\* category**

Geographical location	2000–2001 SAR data n (%)	Survey sample n (%)
Highly accessible	34 (27.4)	12 (40.0)
Accessible	28 (22.5)	6 (20.0)
Moderately accessible	11 (8.9)	3 (10.0)
Remote	12 (9.7)	1 (3.3)
Very remote	39 (31.5)	8 (26.7)
Total	124	30

\* Accessibility and Remoteness Indicator for Australia (ARIA) at postal area level, as at 20 January 2000  
SAR = service activity reporting data  
 $p > 0.05$  for all, indicating representativeness

Source: NACCHO and Commonwealth Department of Health and Ageing (2003). Service activity reporting 2000-01: A national profile of commonwealth funded Aboriginal primary health care services



**Figure 1. Plastic home made spacer device with instructions for use**

face barriers accessing this government initiative. Health Insurance Commission data shows a lower rate of asthma SIPs generated from general practice divisional regions with a high Aboriginal and Torres Strait Islander population. Moreover, 50% (80/161) of GPs with asthmatic Aboriginal or Torres Strait Islander patients reported not using the Asthma 3+ Visit Plan with them in 2003.<sup>10</sup>

Educational strategies developed to support the implementation of this program were not accessible to a substantial number of ACCHSs including those from divisions of general practice. Divisions are provided with a financial loading (\$2.55 per head) for the Aboriginal population in their area in the delivery of programs. In a recent survey, the majority of divisions did not provide the local ACCHSs with assistance in the implementation of the Asthma 3+ Plan (33/54).<sup>10</sup>

Aboriginal people's difficulty in accessing asthma medication and spacer devices is not unexpected. Homemade spacer devices using empty 'Coke' bottles are modelled from those reportedly used in South African communities. Plastic drink bottles are comparable to conventional spacers in the delivery and control of

asthma provided the bottles are appropriately sealed.<sup>14</sup> While driven by an unmet need, third world solutions to problems that can readily be met from improvements in Australian pharmaceutical access policy, should not be necessary. These improvements are required on ethical and equity grounds.

Section 100 of the National Health Act (1953) has helped enhance the supply of medications from the PBS directly to Aboriginal and Torres Strait Islander patients in remote area Aboriginal health services.<sup>15,16</sup> Extension of this initiative to rural and urban Aboriginal health services is clearly warranted. Spacer delivery devices for asthma inhalers should be subsidised for this population and supply schemes preferably include those operating under the PBS.

An Aboriginal and Torres Strait Islander asthma communication strategy has not yet been developed and is urgently needed, especially given the high rates of smoking. The provision of training to AHWs and more Aboriginal asthma educators requires resources and has broader workforce implications.

## Conclusion

As structured, the Asthma 3+ Visit Plan initiative provides very limited health opportunities to the Aboriginal and Torres Strait Islander population. The alternative and preferable funding mechanisms to the asthma SIP are the recently launched chronic disease management Medicare items<sup>17</sup> as they simplify claiming and do not require PIP accreditation. The development of a GP management plan (item 721) for asthma can also involve AHWs, including those AHWs contributing to team care arrangements (item 727) who are registered with the HIC as allied health professionals. Together with pharmaceutical access reforms and the inclusion of spacer devices in the PBS, a national Aboriginal and Torres Strait Islander asthma awareness strategy should reduce the inequitable health system response to this disadvantaged population.

Conflict of interest: none declared.

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