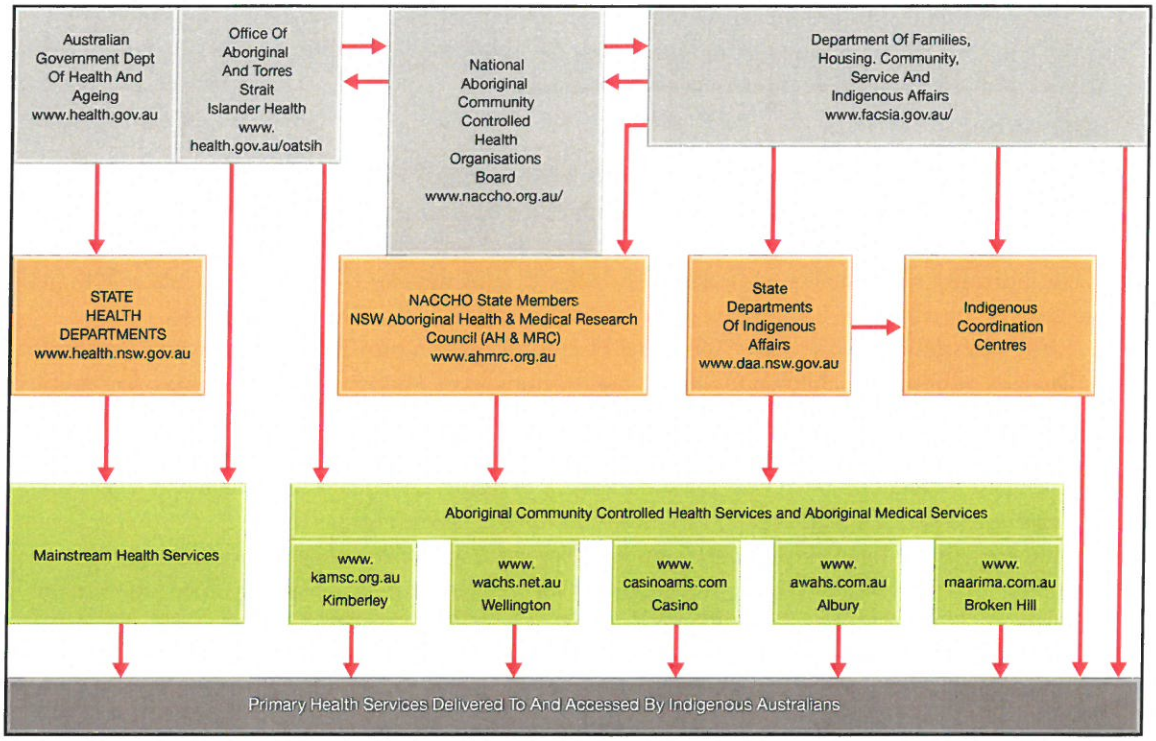
FIGURE 2.8
ATSI health system



Community

Indigenous Australians do not access primary healthcare services to the extent they should, as a consequence of lack of availability of services, transport and distance to services, cost and language or cultural barriers.

OATSIH, NACCHO and the AH&MRC all aim to improve the access of Indigenous people to primary healthcare services. These agencies base their strategies on the principle of working in partnership with the Aboriginal and Torres Strait Islander community controlled health sector. Improved access and stronger delivery of comprehensive primary healthcare at the community level are the most sustainable ways of making a significant long-term difference to Indigenous health status.

Aboriginal Community Controlled Health Services (ACCHSs) and Aboriginal Medical Services (AMSs) are primary healthcare services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate healthcare to the community that controls it.

Aboriginal communities run hundreds of such local health services. Some are large, providing a wide range of services through numerous medically trained staff. Others are small, relying solely on Aboriginal health workers and nurses to deliver primary care, education and preventative services. All of these services are independent, but together they form a health network that shares the philosophies of self-determination and a holistic view of health.

The nature of the services provided varies from one community to another, though generally they include clinical care, health education, promotion, screening, immunisation and counselling, as well as specific programs such as men's and women's health, aged care, transport to medical appointments, hearing health, sexual health, substance use and mental health.

> *'Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.' (NAHS, 1989).*

The responsibility for producing Aboriginal health solutions lies with the local Indigenous people working in their own communities and using their own philosophies, to promote healthy behaviours and deliver culturally appropriate primary healthcare services.

Individuals

An individual's capacity to reduce their risky health behaviours and to increase their protective health behaviours or promote good health in others is influenced by a variety of factors; these include age, family history, community support, education, role modelling, access to health services and socioeconomic status. While individual responsibility for health might differ in some ways for mothers, fathers, the elderly, health professionals or educators, it is education and access that appear to have the greatest impact.

There is a strong focus in many Aboriginal Health Services on providing education and support for Indigenous mothers and children, on increasing the number of Aboriginal health workers, community support workers and medically trained staff and on increasing community capacity by empowering individuals. Health services focus on improving the knowledge and skills of community members. Women and mothers are often targeted as custodians of health knowledge and practice. A recent initiative to target men's health has also been introduced and funded by OATSIH.

The Healthy for Life (H4L) Program provides support for local health services and programs, including improved health training and education for Indigenous people. Among its initiatives is the *National ATSI Child and Maternal Health Exemplar Site Initiative*, which identified and documented three outstanding child and maternal health services. The resultant website has been used to educate and promote best practice in this area of health.

➲ www.health.gov.au/internet/h4l/publishing.nsf/Content/respack-exemplarsite

– socioeconomically disadvantaged people

Socioeconomic status (SES) describes the 'position' or 'power' of a person or group in the community. In Australia, Socioeconomic Indexes for Areas (SEIFA), which measure the average SES of people living in a local area, such as within a postcode region, are used to produce an Index of Relative Socioeconomic Disadvantage (**IRSD**).

Socioeconomic disadvantage is the existence of:

- limited material resources (including income)
- reduced access to educational opportunities

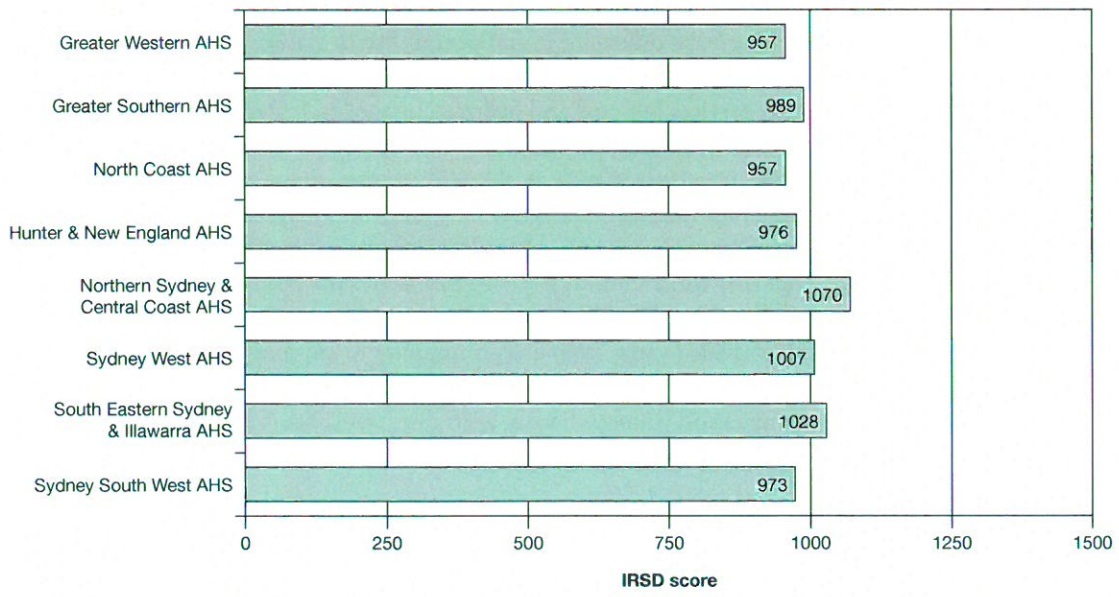
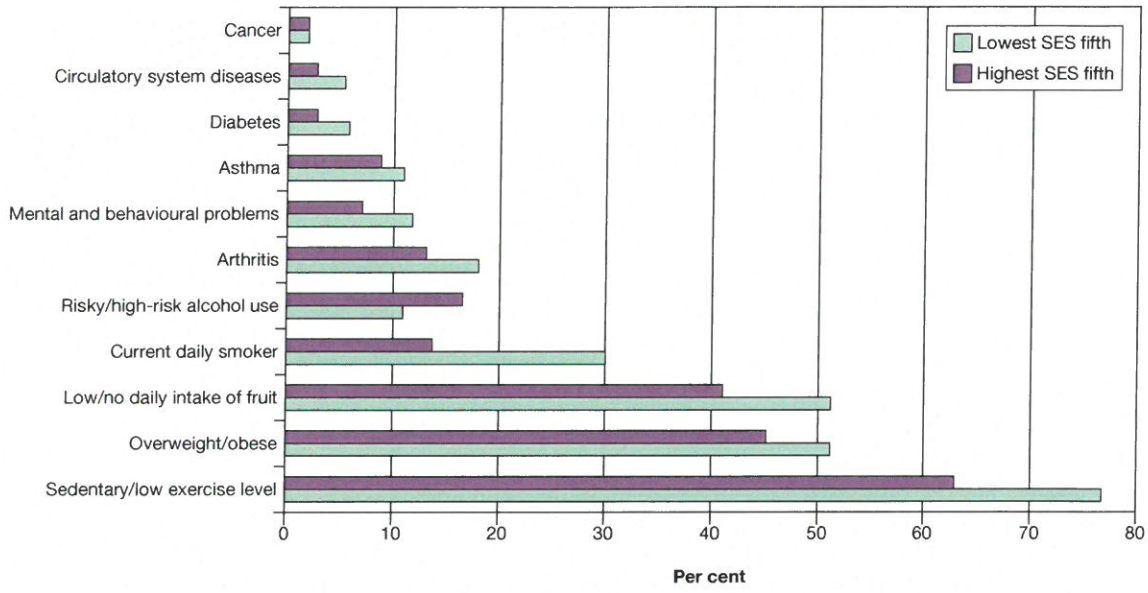


FIGURE 2.9 **Index of relative socioeconomic disadvantage scores by health area, NSW 2006**

SOURCE: ABS SOCIOECONOMIC INDICES FOR AREAS

FIGURE 2.10
Low socioeconomic risk factors and conditions



SOURCE: ABS 2006. NATIONAL HEALTH SURVEY: SUMMARY OF RESULTS 2004–05, AUSTRALIA. CAT NO 4364.0

- less safe working conditions
- lower employment status
- worse living conditions during childhood
- less access to services
- greater likelihood of racism or discrimination.

– the nature and extent of the health inequities

Many studies have identified a strong relationship between low socioeconomic status and lower health status.

Health status is better or worse according to where a group or individual is positioned on this social ladder. For instance, those with the most resources and access are healthier than those in the middle, who in turn are healthier than those with the least resources and access.

People from areas of lower socioeconomic status:

- are more likely to suffer cardiovascular disease, diabetes, asthma, mental illnesses and arthritis
- lose more years of life due to diabetes, cardiovascular disease, road traffic accidents and lung cancer
- experience lower life expectancy as a result of these and other causes.

– the sociocultural, socioeconomic and environmental determinants

Studies have highlighted a strong relationship between low socioeconomic status and low health status which, for an individual, may persist from birth through to adulthood and into old age (and possibly to the next generation). If this is the case, it presents difficult challenges for governments and health service providers who aim to improve the health status of the socioeconomically disadvantaged.

Inadequate income, single parent family structure, poverty or family breakdown can all contribute to low SES, and by their nature they increase the likelihood of a person to have reduced access, limited resources, restricted educational opportunity and control over their life.

People from areas of lower socioeconomic status are more likely to:

- be daily smokers
- eat less than the recommended servings of fruit and vegetables

- be overweight or obese
- be sedentary or physically inactive
- report higher levels of psychological stress
- visit a doctor or emergency clinic
- depend on government assistance
- avoid the use of preventative health services.

The relationship between socioeconomic disadvantage, health determinants and health status is very complex. Just as low SES appears to lead to poor health, so poor health can lead to low SES. This can result in a cycle of problems. For example, illness or disability might cause unemployment or reduced capacity to work or study. This would lead to reduced income, which might limit capacity to pay for medical services like dental checkups, or health insurance. In turn, this would contribute to a lower level of health, which might restrict employment opportunities, and so the cycle continues.

Lower levels of education result in poorer health knowledge, which might affect health behaviours. However, studies indicate that the most critical influence of lower education levels on health is a sense of 'lack of control' over life and the future.

– the roles of individuals, communities and governments in addressing the health inequities

ACTIVITIES 4 AND 5

Socioeconomically disadvantaged Australians experience universally poorer health status than other Australians. They also report greater use of doctor and casualty outpatient services, but are less likely to use preventive services.

Government

Federal and state governments recognise the costs of poor health among people with low SES and are committed to continually make improvements in funding and broad policy to reduce health inequities. At the national level, Medicare and the Pharmaceutical Benefits Scheme (PBS) are programs designed to address the needs of the socioeconomically disadvantaged, by providing lower cost health services and medications for those who can least afford them.

The key priorities in the State Health Plan are for other government and non-government services and the private sector to work together and bridge the health gap between the people with the best health and those with poorer health in New South Wales.

State government responsibilities relate to service provision and prevention. Exposure to risk factors is higher among low SES people and the NSW Government has strategies in place to address this. Some of these strategies relate to:

- child health and wellbeing
- immunisation
- mental health
- obesity
- sexual health
- oral health
- chronic disease
- urban planning
- tobacco
- drugs and alcohol.

The State Health Plan reflects the NSW Government's priorities for the development of the public health system towards 2010 and beyond. A full copy is available on the Department of Health's website:

➲ www.health.nsw.gov.au/pubs/2007/state_health_plan.html

Communities and individuals

The success of these strategies is dependent on services and information being successfully delivered into the most disadvantaged communities. Reduced exposure to risk factors and better delivery of primary care services is critical in order to reduce the inequitable burden of disease these communities suffer.

The prevention of disease and the management of illness within communities rather than

hospitals will become increasingly important and relevant to changing needs. This will require the development of an increasingly community-based health workforce. As socioeconomic disadvantage is caused by many different factors, any agencies that can provide community healthcare, childhood services, parenting and maternity services, community language services, housing assistance, employment training, home care, meals, migrant services, education and other services that address the actual causes of low SES will improve the health outcomes of low SES people.

– people in rural and remote areas

People who live in regional areas represent 29% of the Australian population and those who live in remote areas represent 3%. In general, they experience higher levels of mortality, disease and health risk factors than Australians living in major cities.

– the nature and extent of the health inequities

Compared to their city dwelling counterparts, people living in rural and remote areas:

- experience similar levels of diabetes, cerebrovascular disease (stroke), coronary heart disease, depression and anxiety
- experience slightly higher levels of cancer in rural areas but lower levels of cancer in remote areas
- are more likely to suffer acute or chronic injury
- experience lower life expectancy, increasing with remoteness
- were less likely to report very good or excellent health
- were more likely to show high to very high levels of psychological distress amongst males.

– the sociocultural, socioeconomic and environmental determinants

Information about people in rural and remote areas can parallel closely with information about Indigenous Australians and about low socioeconomic status. People living in rural and remote areas have fewer educational and employment opportunities, lower income and less access to goods and services; they may even have less access to basic necessities like fresh fruit and vegetables.

The long distances between population centres, sparse population distribution and difficulty providing health services, staff and goods all contribute to lower health status in rural and remote areas.

People living in rural and remote areas were more likely to:

- drink alcohol in risky quantities that would be harmful in the short term
- be overweight or obese
- consume less low-fat or skim milk or to eat under the recommended two serves of fruit per day
- consume four or more serves of vegetables per day
- experience lower birthweights, particularly among teenage mothers.

– the roles of individuals, communities and governments in addressing the health inequities

ACTIVITY 6

Government

The Rural Health Priority Taskforce provides advice to the NSW Government about improving health services to people in rural areas of the state. Among the main responsibilities identified in the State Health Plan are the need to:

- attract and retain more health professionals in rural and remote communities
- provide sustainable quality health services
- make health services more accessible for people in rural and remote areas via initiatives such as Telehealth, a visual telecommunications system for clinicians and patients

- implement innovative models of service, staffing, networking, rural and remote health professional support, professional development and family support.

The NSW Government runs programs such as the Medical Specialist Outreach Assistance Program, offers a range of scholarships and grants to support rural health professionals and in cooperation with the Australian Government, runs the Multi Purpose Service (MPS) Program, as one model of service delivery to address the difficulties of providing health, aged and community services in rural and remote communities.

Communities

Rural communities struggle to sustain adequate health and medical services for their residents. They work in partnership with governments and other agencies to adapt to changing demands and circumstances that require flexibility and constant adaptation. These communities find it difficult to run services based on the same models established for services in the larger centres and cities.

Since November 2008, there were 49 multipurpose services running in New South Wales rural communities. These programs set aside the normal program guidelines and constraints so that smaller communities can integrate services, better match services to community needs, achieve gains in productivity, reduce administration overheads and share resources. The MPS model is aimed at:

- establishing viable acute health, aged care and community services
- improving access to appropriate services
- increasing coordination, flexibility and innovative service delivery.

▲ FIGURE 2.11
Rural communities experience difficulty accessing health services

In order to run health services, it is essential that rural communities are able to attract and retain properly trained staff. The Australian Rural Health Education Network (ARHEN) is another agency that plays an important role in sustaining health and medical services in the bush. This is a network of University Rural Health Departments committed to increasing retention of health professionals in rural areas. Their initiatives include training and educational opportunities for medical and health professionals that are linked to rural placements for graduates. They also carry out research into the satisfaction rates of rural doctors and health workers.

– overseas-born people

The Australian population comprises 24% of people born overseas. Because of their own natural selection or government selection policies, they are most often people who can afford to emigrate and who have lower levels of illness and disease. Nevertheless, within the entire population of people born overseas, there is great diversity of group characteristics and of health status.

– the nature and extent of the health inequities

The 'healthy migrant effect' is reflected in the very low death rates for people born in Hong Kong and Vietnam. Most residents born overseas, especially in South-East Asia, enjoy lower rates of death than other Australians. However, there is a tendency for this effect to reduce as length of residence increases and exposure to typically Australian lifestyle and risk factors becomes more prevalent.

People born overseas:

- suffer higher levels of psychological distress if they have come from war zones, don't speak English or have trouble in the resettling process

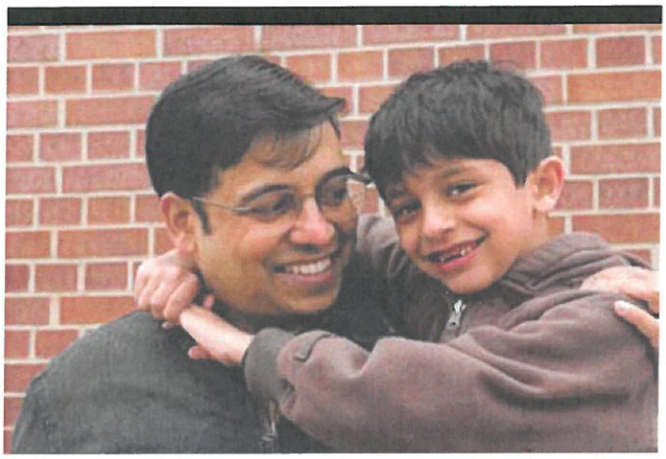


FIGURE 2.12 ▲
Your country of birth can determine your health

- have hospitalisation rates almost 20% lower than other Australians
- are hospitalised for the following diseases, according to country of birth, at greater levels than others:
  - tuberculosis—India, Vietnam, Philippines, China
  - lung cancer—United Kingdom and Ireland
  - diabetes—Greece, India, Italy, Vietnam
  - heart attack—India
  - heart failure—Italy, Greece, Poland
  - dialysis—Greece, Italy, Vietnam, Philippines, Croatia, India
  - breast cancer—women from England and Northern Ireland
- generally experience death rates lower than for Australian-born people, but with some exceptions, including:
  - lung cancer among people born in the Netherlands and the United Kingdom and Ireland
  - diabetes among people born in Croatia, Greece, India, Italy, Lebanon and Poland
  - coronary heart disease among people born in Croatia and Poland
  - influenza and pneumonia among people born in the United Kingdom and Ireland.

– the sociocultural, socioeconomic and environmental determinants

Migrants are often less exposed to harmful risk factors for cardiovascular and other diseases, such as overweight or obesity, physical inactivity and high risk alcohol consumption in their countries of origin. Nevertheless, the 2004–2005 National Health Survey reported that there were higher levels of exposure to some risk factors for some groups. These included:

- current daily smoking—Oceania (includes New Zealand, Papua New Guinea, Solomon Islands, Kiribati, Fiji, Antarctica)
- sedentary or low exercise levels—Southern and Eastern Europe, North Africa and the Middle East, South-East Asia
- consuming less than the recommended five serves of vegetables per day—every other country-of-birth group

TABLE 2.2 ▼
Health risk factors by country of birth, people aged 18 years and over, 2004–2005 (per cent)

COUNTRY OF BIRTH	CURRENT DAILY SMOKER	RISKY/ HIGH-RISK ALCOHOL	SEDENTARY/ LOW EXERCISE LEVEL	OVERWEIGHT/ OBESE BMI	1 OR FEWER SERVES OF FRUIT	4 OR FEWER SERVES OF VEGETABLES
Australia	22.3	15.3	69.2	50.1	47.8	84.4
Other Oceania	26.1	12.5	66.8	58.3	44.4	89.2
United Kingdom	18.6	15.5	68.6	51.1	45.6	86.7
Other North-West Europe	18.0	11.8	67.3	50.9	42.0	87.0
Southern & Eastern Europe	18.4	6.0	81.8	59.5	29.4	88.8
North Africa & the Middle East	22.8	2.2	79.5	47.5	40.1	92.2
South-East Asia	15.6	4.4	76.7	29.4	43.5	92.6
All other countries	14.8	4.7	74.4	34.2	44.5	89.6

SOURCE: ABS 2006. NATIONAL HEALTH SURVEY: SUMMARY OF RESULTS 2004–05, AUSTRALIA. CAT NO 4364.0

- varying body weights and heights showing they are more likely to be overweight or obese than people born in Australia—Oceania and Southern and Eastern Europe.

– the roles of individuals, communities and governments in addressing the health inequities

ACTIVITY 7

Government

Many Australians born overseas experience cultural and language barriers that should be addressed so that they can achieve positive health outcomes.

The main approach by governments to the health of people born overseas is to provide translation and language services to improve communication of health issues and access to health services among culturally and linguistically diverse (CALD) communities. This is a more cost effective approach than duplicating services to specifically address the needs of overseas born people.

The NSW Multicultural Health Communication Service (MHCS) works with health services to provide non-English speakers with access to important health information. These services are strongly promoted to clinical staff and include phone and on-site translation, information and advice, as well as printed materials. They are available to any community members or health professionals who need them.

The NSW Government identifies the delivery of health services to CALD communities and refugees as one of its objectives. Support is also given to health services to extend their coverage in line with the settlement patterns of new arrivals and refugees.

Communities

Community participation in health service planning has been able to maximise the quality of health services because communities themselves are best equipped to identify and address the health needs of their members. Historically though, there has been limited capacity for CALD communities to provide input and feedback. Capacity to improve health outcomes improves as communities are given greater opportunity to contribute to health service planning and development.

The critical role of communities is to provide support for their members by advocating, promoting and engaging in the use and delivery of culturally appropriate health services. The training and education of CALD community members to join and support the healthcare profession is the most enabling of all strategies.

The capacity of CALD communities to provide and support healthcare services is governed by the age of the community. The longer a community has been established, the greater capacity to provide appropriate and effective healthcare services.

Many government and non-government services work in partnership with CALD communities to provide a range of healthcare services.

Activities

Activity 1 (Page 25)

Read Tara Raven's article, 'Intervention "has done lasting harm" ' on page 26. With reference to the listed determinants of Indigenous health, write a one page challenge or justification of the intervention.

Activity 2 (Page 28)

Use the diagram of the Indigenous healthcare system (Fig. 2.8 on page 30) to **construct** a table which **contrasts** the strengths and weaknesses in the current structure.