

**Aboriginal & Torres Strait Islander Health
Medical Services and Beyond**

**Diabetes and Chronic Disease Prevention
Health Reform**

Key Considerations and Proposed Action

Western Australia

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'International figures demonstrate that optimally and consistently resourced primary health care systems can make a significant difference to the health status of populations within a decade.'

ACKNOWLEDGEMENT

The East Metropolitan Health Service - Diabetes Steering Committee identified Aboriginal health as a priority area for action in February 2003. A working party was formed consisting of:

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The working party recognised the need to develop a framework to guide service development and collaboration with synergistic groups impacting on health and well being of Aboriginal people. This document can be used in part or in full if it is seen as a suitable planning framework Aboriginal health service planning.

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PREAMBLE

In February 2003 the East Metropolitan Diabetes Steering Committee identified Aboriginal diabetes services as a priority area for action. Later that year a steering committee was formed with representation from all key stakeholder organisations and the Western Australian Diabetes Strategy Group. The first identified task of the working party was to review an existing submission put forward in May 2003 to the Office of Aboriginal Health (OAH). This submission focussed on re-establishing diabetes services at Derbarl Yerrigan Health Service, however, it was recognised that the submission needed to be broader than that. This has sent the working party down the road of developing this proposal. A review of the evidence of overseas successes, the various innovative experiences that have already begun in Australia and key informing National and State documents have formed the basis of this planning document.

What has been proposed is not new, it has drawn from landmark documents that have recently been released in a contemporary format. This planning document provides a framework for the proposed plan of action in the first section and background and discussion material in the second section.

It is a dynamic document that can be utilised as an overall-planning framework but also be modified to suit each region. The localised implementation plans need to be developed locally to reflect the context of the region. The objectives for this planning have been drawn from the National Strategic Framework and provide a blueprint for this process.

IN SUMMARY

Clearly, for a large proportion of Aboriginal and Torres Strait Islander people, **current approaches** to preventing chronic diseases including Type 2 diabetes and its complications **are inadequate**. Despite the high standard of health care available to Western Australians and the improvements in diagnosis and treatment of chronic disease generally, Aboriginal and Torres Strait Islander people are still dying at a median age of 51 years and this measure has not improved in the last 10 years.

Crucial to improving Aboriginal health is the availability of **comprehensive, effective and appropriate primary health care services**. These services should maximise community ownership and control, be adequately funded, have a skilled and appropriate workforce and be seen as a key element of the broader health system.

Success depends on **effective partnerships** between Aboriginal organisations, communities and individuals, government and non-government agencies, both **within and beyond health**. With this we will be better equipped to address the complex and inter-related factors that contribute to the causes and persistence of diabetes, its risk factors and complications. In the **immediate and short term** this requires:

- » Engagement and commitment of key stakeholders
- » Comprehensive mapping of present services and initiatives
- » Identification of enablers and barriers to accessing health services
- » Development of a localised implementation plan, short and long term
- » Commitment to proposed plan by key stakeholders
- » Securement of funds for the proposed plan, short and long term
- » Ongoing evaluation

In the **medium and long term** we need to ensure that important initiatives are being implemented and the required changes to service delivery have occurred. Continued community participation and increases in the number of

Aboriginal and Torres Islander health professionals are also key elements of any reform of diabetes services.

Aboriginal and Torres Strait Islanders **can achieve the major gains** experienced by Aboriginal populations elsewhere. It has been demonstrated that an optimally and consistently resourced primary health care system can make a significant difference to the health status of Aboriginal people **within a decade**. This requires leadership, a willingness to work together and a commitment to make a difference.



WHERE WE STAND IN THE WORLD

Australia is a first world nation. It stands at the forefront of medical research with major and exciting medial breakthroughs in a number of areas. It has successfully confronted difficult and complex issues such as AIDS and cancers in women.

Despite these significant improvements in some areas of health, the Aboriginal and Torres Strait Islander population are still dying at a median age of 51 years and there has been no improvement in this measure in the last 10 years. With an improvement of three years in the median age of death for the general population the gap between Aboriginal and non-Aboriginal Australians has now increased to 26 years (Ring, I. T. & Brown, N., 2002).

Furthermore, overall death rates for Aboriginal Australians are still three times as high as for the rest of the Australian population. Diabetes death rates are eight times as high, respiratory deaths almost four times as high and circulatory conditions almost three times as high (Australian Institute of Health and Welfare, 2002)

In contrast to this, the mortality level of the Aboriginal populations of Canada and US are only 20% higher than is the case for the rest of the population. As well the median age at death is much higher for the Aboriginal populations of Canada (65 years) and the United States (63 years). In New Zealand figures are similar at 59 years. The figures for these three countries have been progressively improving for at least the past 25 years (Ring, I. T. & Brown, N., 2002).

The history and circumstance of Aboriginal people in all four countries does have a great number of parallels, and the main conditions are the same sorts of conditions, which cause much of the mortality in Australia.

Differences lie, in part, in the delivery of primary health care services. It would seem that it is the detection and treatment of illness at an early stage, which has been responsible for the far greater headway that's been made in other places. This is to say that an Aboriginal person in Australia, compared to an

Aboriginal American, has more untreated diabetes, more untreated blood pressure and more untreated heart disease. Figures in Australia suggest that maybe 50% or higher of Aboriginal people over 30 either already have chronic disease or one of the precursors, or a significant part of these conditions undiagnosed and untreated.

A range of factors is considered to have contributed to improved health outcomes for Aboriginal populations in the USA, Canada and New Zealand. These include:

- improved environmental health
- the continuing provision of good quality primary health care services supported by adequate resources over a substantial period of time
- a public health care approach with a prominent role for health education and promotion
- the development of strong community involvement in health services and issues
- pro-active workforce strategies focused on training and recruiting Aboriginal people into the workforce and
- attention to developing the capacity of the health system to collaborate with agencies outside the health sector (NATSIHIC, 1989)

Aboriginal people in Australia access medical services at about 30% to 40% of the rate of the rest of the country, despite being three times as sick (Tatchell, M., 2003). Despite the number of Aboriginal Medical Services across the country and the general practitioners (GPs) available there are just not enough doctors and nurses and health workers to treat the very high levels, of a range of other illnesses, particularly chronic illness.

The key issues affecting Aboriginal health extend beyond the simple provision of medical services. They include educational achievement, transportation and cost of food in regional and remote areas, employment opportunities and social issues such as child abuse, family violence, drug abuse and crime.

For Aboriginal and Torres Strait Islander people it is 'not just the physical well-being of the individual, but also the social, emotional and cultural well being of the whole community that contributes to overall health (NATSIHIC, 1989).

In traditional Aboriginal culture there was no single word for health. Health was life. It was experienced in connection with the land, with people and with the spiritual meanings at the core of their culture. It is not possible therefore to separate health issues from life experience (O'Donoghue, L., 2000).

A number of projects are underway in Western Australia, in both the metropolitan as well as smaller rural and remote communities. Here there is a greater engagement of community members in determining their future health and greater involvement of health workers in the health care team. Already there are promising results (Canning Division of General Practice, 2003)& (Thompson, D. *et al.*, 2003).

Aboriginal Australians can achieve the major gains experienced by Aboriginal populations in other countries. This requires leadership, innovation, a willingness to work together and a commitment to make a difference.

THE PROPOSED PLAN OF ACTION

If we are to see the sorts of results in Australia that international figures have demonstrated are possible, then we need to take immediate action. The 2003 *National Strategic Framework for Aboriginal and Torres Strait Islander Health* sets out a framework for action by Governments. From this each jurisdiction develops its own Strategic Framework Implementation Plan and determines its own specific initiatives, priorities and timeframes. Diabetes services need to be an integral part of any implementation plan and will benefit from the proposed objectives of the national framework.

It is clear that to improve Aboriginal health, the following **key elements** are crucial:

1. Acknowledgment of Aboriginal ways of being and working
2. Community participation in the ownership and operation of health services
3. Shared responsibility for the provision of appropriate health services
4. Optimally and consistently resourced primary health care system
5. Integration of government, non-government and private organisations both within and outside health
6. Effective health promotion and education
7. Ongoing workforce support and development
8. Increased presence of Aboriginal people in the health system at all levels
9. Integration of State and Federal program and financial planning
10. Accountability for services provided and for effective use of funds
11. Effective and appropriately managed reporting and feedback mechanisms

In the immediate and short term a **plan of action is required to get us started**. Medium and longer-term implementation plans will need to be developed within the proposed national and state frameworks and in collaboration with all stakeholders. To achieve our aims requires long term commitment at all levels.

GETTING STARTED – IMMEDIATE AND SHORT TERM PLAN OF ACTION

Commitment to an agreed common vision must be obtained in the first instance. Then a shared responsibility for provision of accessible and appropriate services across all government and non-government sectors is needed. Ongoing review and evaluation of progress towards desired outcomes with the ability to make modifications in order to achieve these is essential.

OBJECTIVE	ACTIONS	RESPONSIBILITY	TIMEFRAME
Draft plan of action	<ol style="list-style-type: none"> 1. Complete 'Getting Started' document 2. Present to Western Australia Diabetes Strategy Group 3. Present to Office of Aboriginal Health 4. Review by East Metro Aboriginal Diabetes Working Party and their representative organisations 5. Collate Feedback and finalise draft plan of action 	East Metropolitan Aboriginal Working Party	<ol style="list-style-type: none"> 1. Early Feb 2004 2. Mid February 2004 3. Mid February 2004 4. Mid February 2004 5. March 2004
Engagement and commitment of key stakeholders including local communities.	<ol style="list-style-type: none"> 1. Identify key stakeholders 2. Communicate with each stakeholder 3. Bring stakeholders together to develop common vision 	East Metropolitan Aboriginal Working Party Office of Aboriginal Health	<ol style="list-style-type: none"> 1. March 2004 2. April 2004 3. April / May 2004
Comprehensive map of local diabetes services and initiatives for Aboriginal people	<ol style="list-style-type: none"> 1. Map present diabetes / Chronic disease services and initiatives, details of positions, funding, timeframes, individuals, organisations, outcomes and evaluations 	Key Stakeholders East Metropolitan Aboriginal Working Party	<ol style="list-style-type: none"> 1. March 2004
Localised Implementation Plan / Framework Agreement for reforming diabetes services and outcomes for Aboriginal people	<ol style="list-style-type: none"> 1. Planning day for all stakeholders 2. Develop a living document! 3. Signed off by all stakeholders 4. Establish implementation and review committee to drive forward 5. Draw up TOR & MOU 	Key Stakeholders Office of Aboriginal Health East Metropolitan Aboriginal Working Party	<ol style="list-style-type: none"> 1. May / June 2004 2. June 2004 3. June 2004 4. June 2004 5. July 2004
Funds for proposed plan, short and long term	<ol style="list-style-type: none"> 1. Establish who is responsible for what 2. Determine funds available 3. Establish gaps in funds 4. Obtain ongoing financial commitment 	Office of Aboriginal Health All stakeholders	July 2004 – July 2005
Effective systems for evaluation and feedback	<ol style="list-style-type: none"> 1. Establish measurable outcomes and timeframes 2. Determine evaluation methodology 	Implementation and review committee	<ol style="list-style-type: none"> 1. June 2004 2. June 2004

MAINTAINING MOMENTUM – PROPOSED OBJECTIVES & ACTION AREAS

The following objectives and key action areas outlined in the National Strategic Framework (2003) need to be adapted to reflect local needs, resources and context and then developed into the Local Strategic Framework Implementation Plan detailing specific initiatives, priorities, timeframes and responsibilities. Key stakeholders including the community will need to be engaged at all stages

OBJECTIVE	ACTIONS	RESPONSIBILITY	TIMEFRAME
Towards a More Effective and Responsive Health System			
Strong community controlled primary health care services that can draw on mainstream services where appropriate to ensure a full range of services for Aboriginal people	<ul style="list-style-type: none"> • Engage and support general practice. • Share responsibility for provision of accessible and appropriate services across all government and non-government sectors • Gain commitment and agreement from all sectors on progressing transformation of health services • Identify roles and responsibilities for all organisations. • Robust referral and commination systems between service providers to ensure seamless diabetes care • Establish outreach services to DYHS and support for service providers in rural and remote locations • Dedicate tertiary diabetes management and education and specialist resources for rural and remote Aboriginal communities and service providers. • Support community controlled health services to provide high quality accredited and sustainable primary health care services 	Divisions of GPs ACCHOs Health Services Population Health Units Consumers Local Government State Government Commonwealth Government Tertiary Hospitals Regional Hospitals NGOs. <i>(This needs to be developed in the local context as each region's context will be different)</i>	

Improved community decision making, influence and control over the management and delivery of diabetes services	<ul style="list-style-type: none"> • Maintain and expand community development initiatives. • Dramatically improve information flow to communities • Increased participation in planning and managing diabetes services by Aboriginal people • Focus on building, strengthening and maintaining social networks 		
Effective primary health care, including health promotion and education programs	<ul style="list-style-type: none"> • Develop in partnership with communities, specific awareness programs that aim to increase community understanding and knowledge of the mainstream health system. • Consult with local community on health education and promotion needs. • Engage Aboriginal people and support them to make informed decisions about their health. • Ensure a holistic approach to health is addressed incorporating social and emotional wellbeing and other determinants of health • Utilise promotion and prevention approaches that enhance social and cultural wellbeing • Employ health promotion strategies as opposed to clinical or drug interventions • Follow the principles of the Ottawa Charter 		
Increased coordination and collaboration with strong partnerships and linkages between Aboriginal controlled organisations and mainstream services	<ul style="list-style-type: none"> • Maintain and expand integrated primary health care services between local, State and Commonwealth service providers. • Engage new partners • Commit to joint government action to assist families and communities to address areas such as emotional and social wellbeing, substance abuse, violence 		
Mainstream services that are better equipped to deal with Aboriginal people	<ul style="list-style-type: none"> • Identify training needs. • Address reasons, which influences whether or not or why Aboriginal people do not access mainstream services. • Advocate for primary health services that are acceptable and accessible to Aboriginal people eg Street Doctor, community action groups 		
Increased participation in planning and managing of diabetes services by Aboriginal people	<ul style="list-style-type: none"> • Engage and involve the local community. • Acknowledge and utilise the expertise of Aboriginal people and their traditional ways of working and identify what needs to be transformed in our health system, • Build on community concern about diabetes 		

Optimal and consistent funding on the basis of need	<ul style="list-style-type: none"> • Gain commitment from managers and funding bodies. • Secure funding for current initiatives that are working. • Fund community development strategies that engage the community in the ownership of and the operation of health services • Commit resources and organisational support in the long term eg 7 years 		
A competent health workforce with appropriate clinical, management, community development and cultural skills to address the needs of Aboriginal people	<ul style="list-style-type: none"> • Maintain and expand workforce development initiatives. • Identify training needs. • Specialist training in diabetes with recognition of their qualifications • Ongoing training and upskilling of Aboriginal health Workers; • Medical registrar positions in large ACCHOs. • Appoint a dedicated diabetes team for Aboriginal Diabetes services located in a central tertiary centre and outreached to urban, rural and remote ACCHOs • Support and develop more robust linkages between industry and training institutes in order to recognise knowledge and skills of Aboriginal health workers • Appoint a coordinator to drive the diabetes service transformation 		
Appropriate training, supply, recruitment and retention strategies for the workforce	<ul style="list-style-type: none"> • Gain support to o develop a strong and long term career pathway for Aboriginal Health Workers.; • A clear role definition and recognition of Aboriginal health workers, especially in mainstream service provision; • Dedicated time to provide health education, promotion and advocacy; • Recognition of community development as a valid primary health service; • Theoretical understanding of community development principles to consolidate and validate their natural way of working with their community; • Supportive professional networks to support Aboriginal health care providers; • Pro-active measures and funds to increase the number of Aboriginal health workers employed until we reach the benchmark of 1:100 Aboriginal people; • Provide Scholarships and training incentives for Aboriginal people 		

<p>Increased presence of Aboriginal people in mainstream health services at all levels</p>	<ul style="list-style-type: none"> • More placements of Aboriginal students in mainstream services areas in order to breakdown historical barriers for Aboriginal people accessing mainstream services; • Increase the numbers of Aboriginal people in front line services in health, housing, and general welfare • Adopt a mechanism for governments to quantify and achieve health workforce reform and to support Aboriginal and Torres Strait Islander organisations and people in driving the reform process 		
<p>A health workforce that is appropriately skilled to manage emotional and social well-being</p>	<ul style="list-style-type: none"> • Cultural awareness training for all mainstream services providers; • Reorientation of existing health services to ensure they are culturally secure. This will require education, service review and adjustment of organisational practices. This step is vital in order to overcome the significant barrier to Aboriginal people's early presentation, self-management and treatment. 		
<p>Influencing the Health Impacts of the Non–Health Sector</p>			
<p>Improved capacity of individuals and communities to manage and prevent diabetes and its complications</p>	<ul style="list-style-type: none"> • Resolve issues of food insecurity • Promote a family focussed healthy eating program • Encourage councils, recreational organisations to support and become involves in sports and recreation for Aboriginal people • Provide practical solutions to barriers to health access and healthy lifestyle choices eg Transport, community places to meet • Develop education programs and support that is culturally appropriate and acknowledges traditional Aboriginal communities ways of working • Establish legal frameworks for preventing diabetes and other chronic diseases • Identify and act on community and social forces that impact on health outcomes eg education, money, nutrition, medical care, housing, jobs and environment. “ Give back hope for the future of Aboriginal people”. • Build on community concern about diabetes • Address food security and food supply issues 		

Effective partnerships with agencies outside health to address issues that impact on health such as employment, education, housing, recreation and transport	<ul style="list-style-type: none"> • Define new partners and possibilities. • Engage with all stakeholders and interested parties as the beginning of new partnerships and ways of working together. • Map assets and resources of current communities, organisations, governments and businesses. • Develop the capacity of the health system to collaborate and integrate service areas within and outside the health sector • Address barrier to health access eg transport, education, housing, food security • promote co- location of organisations that impact on health outcomes of Aboriginal people 		
Providing Infrastructure to Improve Health Status			
Improved quality of information and information management systems about diabetes in Aboriginal communities	<ul style="list-style-type: none"> • Strengthen Aboriginal data collection and research capacity • Ensure all data collection is undertaken in consultation with Aboriginal people and is appropriate 		
Improved collection and utilisation of information on successful models of diabetes care in Aboriginal communities	<ul style="list-style-type: none"> • Increase training and support of health care providers to understand the importance of collecting data about Aboriginal health status at all collection points 		
Greater range and quality of research about diabetes in Aboriginal people and interventions to improve outcomes	<ul style="list-style-type: none"> • Use information from research and data collection to inform planning of diabetes services 		
Accountability for diabetes services provided and for effective use of funds	<ul style="list-style-type: none"> • Identify all sources of funding and agree on a better methodology for determining the real level of need for services across the whole of the health system including mainstream • Make resources available sequentially in a deliberate way in line with building service capacity instituting employment and training programs 		
Integration of State and Federal program and financial planning	<ul style="list-style-type: none"> • Provide for a flexibility of resource allocation locally through allowing control of consolidated and sustained funding at the community level. 		

CONCLUDING WORDS

What we propose is not new. In 1989 a landmark document set the agenda for Aboriginal and Torres Strait Islander health. This document, the *National Aboriginal Health Strategy* (NAHS), was built on extensive community consultation and although never fully implemented, it remains the key document in Aboriginal and Torres Strait Islander health. The *National Strategic Framework 2003* is a complementary document that builds on the 1989 NAHS and addresses approaches to primary health care and population health within contemporary policy, environments and planning structures.

We propose a plan of action for the collaborative development of a *Local Framework Agreement Implementation Plan* for developing services in the context of chronic disease prevention, that will be effective and sustainable in the long term. If the health status of Aboriginal and Torres Strait Islander people is to improve we need to be committed to working together in ways that are acknowledging and supportive of Aboriginal people and their ways of being and working. In the present climate of financial restraint we need to pool both financial and other resources to gain maximum effect. This will require some rethinking and reorientation of services and the establishment of partnerships between Aboriginal and mainstream services both within and beyond health.

Success is possible. This has been demonstrated in developed countries around the world, all with histories and circumstances similar to ours. Work has begun here with initiatives already showing promising results that must be supported, reviewed, evaluated and learn from their results. We need to gain the confidence of Aboriginal communities who have for so long seen programs come and go with little or no improvement in their health.

Diabetes education and management services in this country are of a very high standard and we pride ourselves in being an innovative nation, leading the world in many areas of health. It is time then that we applied these same strategies to achieving better health for Aboriginal and Torres Strait Islander peoples.

Aboriginal & Torres Strait Islander Health

Background and Discussion Paper

BACKGROUND

To understand the health and social issues that affect Aboriginal people today it is important to understand the impact of colonisation on Aboriginal people. For Aboriginal people, colonisation resulted in profound and sustained social and economic disadvantage (Taskforce on Aboriginal Social Justice, 1994).

The official British settlement of Western Australia came in 1826 and in 1829 the whole area West of longitudinal 129 was claimed as a British colony. Prior to 1829 Aboriginal people had lived in Australia for more than 2000 generations. There were over 200 distinct languages spoken by diverse groups. Different forms of land use were practised, natural resources were managed, sacred sites were protected, and there were exchange and trade between groups. There were also kinship links, cultural laws and a strong spiritual base to their culture (Sutherland, J., 1994). People in the desert moved vast distances in search of food and had to be extremely fit. In wetter parts of the country with more plants, fish and game, like the Kimberley coast, people stayed in one place for long periods of time. Other groups moved with the seasons, following food sources in other areas.

Aboriginal people did not see themselves as owners of the land, they were users and occupiers of the land and environment which they all belonged to. All resources of the country were shared and everyone worked. Aboriginal peoples knew how to trap fish, remember when food was ripe and how to eat them, farm using fire, understand the weather and read the land. They were first class conservationists who kept Australia clean, fresh and productive for 40,000 years (Duncan, G., Undated).

However, the Europeans regarded Australia as “Terra Nullius”, which meant that the land belonged to no one and could be claimed. Aboriginal people were not seen to be “farming” the land, their use and respect of the land was not understood by the new arrivals. Fences were built and strange animals were introduced. Aboriginal people speared the sheep and cattle as they had been killing kangaroo and emus for thousands of years. The Europeans retaliated with

force. Aboriginal people were shot, whipped, poisoned, arrested, chained, transported, jailed, tortured and executed (Duncan, G., Undated).

The population of Aboriginal people rapidly declined during the years after colonisation. There were three main factors contributing to this decline. Firstly, there were the deaths and massacres from frontier fighting as Aboriginal people attempted to defend their traditional lands and resist being moved from them. Secondly, infectious diseases had a particularly devastating effect and were responsible for deaths of whole groups of Aboriginal people. The third factor was the physical and psychological effects of the displacement and incarceration of Aboriginal people moved from their traditional lands (The Western Australian Branch of The Australian Medical Association, 1998).

The rapid decline in the Aboriginal population led governments to believe that the Aboriginal population would die out. The 1905 Aboriginal Protection Act had a profound effect on Aboriginal people. The Act provided the “Chief Protector” with the power to control all property belonging to Aboriginal people; remove unemployed Aboriginal people to a reserve; declare specific areas out of bounds for Aboriginal people; regulate Aboriginal employment; be made legal guardian of all Aboriginal children under the age of 16 years. New laws on segregation and protection were passed which led to devastating effects on both individuals and families. Mass settlements were established for full blooded Aboriginal people. Different Aboriginal groups were often placed together at mission settlements. This included groups who were traditionally enemies. Assimilation policies resulted in thousands of Aboriginal children being separated from their families and placed in foster care in missions.

Although the 1905 Act no longer applies today the terrible damage done to generations of Aboriginal people still has its impact. The reserves where people were forced to live were unhealthy places with few resources. Instead of roaming free across their country they were reliant on rations allocated by the police. Rations were predominantly flour, sugar and tea. Instead of being lean, tough and free of disease they became overweight and ill. Diet related diseases including diabetes and heart disease are a major cause of illness and death in

Aboriginal people today. Aboriginal people who have been dispossessed of their lands and resources bear a disproportionate burden of health problems (Voyle, J. A. & Simmons, D., 1999).

Diseases of the circulatory system, injury and poisoning, cancer and diabetes were the leading causes of death among Aboriginal people for the period 1999-2001 (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2003). Diabetes develops at a much younger age and in the older Aboriginal population it has been observed to occur in 50 percent (Health Department of Western Australia, 1999). It is well established that much of the damage of diabetes can be prevented with early diagnosis and treatment, and good metabolic control (DCCT Research Group, 1993) (Turner, R. *et al.*, 1996).

Aboriginal people are particularly susceptible to Type 2 diabetes. A 'thrifty gene' theory has been proposed by De Courten *et al.* (1998), that links the development of diabetes, overweight and obesity to the westernisation of the Aboriginal people and culture. Prior to colonisation Aboriginal people lead a hunter gatherer lifestyle. This meant they would experience times in their everyday lives whereby they would be feasting or going through famine (De Courten, M. *et al.*, 1998). Aboriginal people were physically active, slim and their food intake consisted of foods that were low in fat, particularly in saturated fats, high in protein and nutrient dense. Over the years their activity levels and food intake and lifestyle have changed significantly. They now have a diet that is high in fat and alcohol, much higher in refined carbohydrate and less nutritious overall. This combined with a reduction in physical activity has led to increased levels of obesity and its complications. Along with cigarette smoking these are modifiable risk factors that play a crucial role in the development of many diseases, and can also be changed and can reduce the likelihood of developing diabetes mellitus (Australian Institute of Health and Welfare, 1998)]. There is increasing evidence that primary prevention of Type 2 diabetes is also possible (Pan, X. R. *et al.*, 1997) & (Tuomilehto, J. *et al.*, 2001). Preventative strategies focus on healthy lifestyle behaviours, namely achieving and maintaining a healthy weight, eating appropriately and exercising regularly.

As a result of lifestyle issues and related poorer health status, elective admissions to hospital in WA for Aboriginal people are four times the rate of the general population, while attendances at Emergency departments are an estimated six times greater (National Summary of the 2000 Jurisdictional Reports, *Draft*). In 2000- 2001 the most common reason for Aboriginal peoples being hospitalised was diabetes. Compared to the non-Aboriginal population, the rate of hospitalisation was 3.1 times higher in Aboriginal males and 4.3 times higher in Aboriginal females. Age standardised hospital admission rates for Aboriginal women diagnosed with diabetes condition during 1995 showed rates that were approximately 20 times that of non – Aboriginal women, with some up to 30 times that of non – Aboriginal women (Ridolfo, B. & Codde, J., 1998).

Aboriginal people have been found to have life expectancy of approximately 20 years lower than non-Aboriginal Australians (Australian Institute of Health and Welfare, 2002) The number of patients on dialysis in Western Australia has tripled in the past decade. Aboriginal people have the highest level of preventable risk for end stage renal disease (ESRD), and currently represent the vast majority of patients requiring dialysis in rural and remote Western Australia. As identified by the Health Reform Committee (2003), incidence of ESRD could and should be reduced by a State wide approach to improving preventative measures which include active management of diabetes and within a broad chronic disease/ self-management framework (Health Reform Committee, 2003b).

Despite their awareness that diabetes is a major issue in the Aboriginal community, risk factors for Type 2 diabetes remain common. Many Aboriginal people do not seek testing and so remain undiagnosed and untreated. Despite the availability of first class mainstream specialist services and treatment there is a disproportionately high mortality and loss of quality of life for Aboriginal people from diabetes and its associated complications. It appears to be a case of too little too late. The need for health reform to improve Aboriginal people's access to primary, secondary, tertiary health services, patient transport and accommodation are well described in the Western Australian Aboriginal Health

Strategy (2000). The strategy reported that Aboriginal people used mainstream health services approximately 80% less than the overall population. Most services to Aboriginal people are offered by government managed health care providers (80%). Most often these general health services do not address the cultural and lifestyle issues pertaining to Aboriginal communities.

According to Department of Health (2000) 66% of Aboriginal Western Australians live in rural and remote and isolated areas of the State. Aboriginal people do not have access to high quality and timely primary health care services. Consequently, early intervention of diabetes is low.

Most of the diseases responsible for the greater burden of ill health among Aboriginal people are preventable. However, the health system is primarily geared towards the treatment of illness rather than prevention of illness. The cost of intervening too late leads to a high rate of death, increased hospitalisation, early complications and increased community and personal costs. (Department of Health, 2000).

Health care providers, clients and governments appreciate the disadvantages Aboriginal people experience in accessing culturally appropriate health services. Since the unforeseen closure of a specific diabetes service for Aboriginal people at DYHS in 2001 there is no dedicated diabetes specific service for Aboriginal people in the metropolitan area and there are significant barriers for Aboriginal peoples access to mainstream services. This has created a situation of inequitable access to culturally secure and essential services for Aboriginal people with diabetes and other chronic diseases in the metropolitan area.

In addition too limited access to health services many Aboriginal people also experience profound socioeconomic disadvantage that impact on their health and wellbeing. Aboriginal people have substantially lower incomes, higher rates of unemployment, poorer educational outcomes and lower rates of home ownership than the rest of the population (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2003).

Our current health system appears to be out of touch with the ideals of Aboriginal communities causing a conflict that has led Aboriginal people to be more and more dependant on welfare, without control of their lives. The impact of complex issues has distorted creative ideas for change and development. The current approaches to the prevention of chronic disease and its complications are inadequate. Fresh and innovative approaches are needed in order to transform the future Aboriginal health (Gilchrist, D., 2002)

The need to provide culturally secure health services will require services to be delivered by people with a positive approach and understanding of Aboriginal culture and lifestyle. There is a need for a sound framework to balance the resourcing for community control, prevention, treatment and continuing care services. In addition, it has been recognised that State and Commonwealth Offices of Aboriginal Health need to develop processes for planning and service delivery that are seamless to service providers and the community. State and Commonwealth funds could be more effectively pooled and resources allocated to better reflect the Aboriginal populations and their needs, geographical and other costs factors (Health Reform Committee, 2003a).

PRESENT SERVICES

Current Services in EMHS and suggestions to add to service delivery.

At present the prevention, diagnosis and treatment of diabetes are carried out in a variety of settings. These include general practice, community health centres, hospitals, Aboriginal Community Controlled Health Organisations (ACCHOs), Divisions of General Practice, population health, community organisations and private practitioners.

Current primary and community services

The majority of Western Australian Aboriginal people seeking health care, generally access GPs at ACCHO service sites. In the East metropolitan area, primary health care services for Aboriginal clients are predominantly provided by Derbarl Yerrigan Health Service (DYHS). According to ABS census data (2001), there are 58,502 Aboriginal people in the State of which 20,997 live in the metropolitan area. In 1998 it was recorded that DYHS provided a holistic health service to 11,000 people in Western Australia per annum (Unsworth, M. & O'keefe, N., 1997). The reported number of registered clients accessing DYHS in 2003 has increased to 13,185. GPs are the main primary health care providers to the general population in the State. While Aboriginal people access GPs, their availability is almost limited to the metropolitan area.

These GPs are responsible for the diagnosis of diabetes, co-ordination of clinical care and referral to support staff within the community. Support staff in the community include a limited number of diabetes educators, dietitians, community nurses, podiatrists, and Aboriginal Health Workers. Support staff provide education on management of diabetes, monitor glucose levels, adjust therapy and coordinate referrals for podiatry and retinal screening. GPOs and support staff are able to facilitate early diagnosis of diabetes and cardiovascular disease through screening and raising community awareness of risk factors. However, most work in mainstream health services, which tend to be not culturally appropriate or easily accessible for Aboriginal people.

The discontinuation of the successful diabetes services provided by DYHS has been damaging and has caused an undercurrent of distrust among Aboriginal Health Workers and the Aboriginal community. It would appear that no matter how innovative or sensitive new programs or personnel are in the region there is no assurance of sustainability. Past experiences have left people with an underlying fear that a service or person “ will be moved on in a few months”. Continuity of services and staff with a high Aboriginal presence is imperative.

Secondary services

Secondary diabetes services exist in mainstream health services at Bentley Health Service (BHS) and at Swan & Kalamunda Health Service (SHS&KHS) in EMHS. Secondary services support primary health care through the provision of diabetes and nutrition education, diabetes management, podiatry and access to tertiary health care where required.

Secondary services are also required at DYHS in the form of a diabetes education team with recognised expertise in diabetes education. A dietitian/diabetes educator, nurse/diabetes educator, an appropriately trained Aboriginal health worker, and a podiatrist are the basic team requirements to implement this service at DYHS. Currently DYHS has a podiatry service three days per week at East Perth.

There is need to increase capacity at Bentley and Swan Health Service sites to provide culturally secure services for Aboriginal people. A higher presence of Aboriginal staff employed in health services and hospitals will improve access. Cultural awareness training will also assist staff at Bentley and Swan Health Services to increase their capacity to meet this need in mainstream health services.

Development of a system of referral between primary, secondary and tertiary service sites is necessary to improve inter-sectoral communication.

Tertiary services

In general, Aboriginal people do not access tertiary services to the same level as the rest of the population and therefore have poor prognosis for recovery from complications caused by diabetes.

RPH have the specialist skills and the service providers required for complicated care. The major responsibility of the RPH specialist diabetes services includes shared-care, case-conferencing, standards implementation, treatment protocols, training, consultancy and support across the state. In addition to tertiary responsibility to EMHS, Royal Perth Hospital provides tertiary diabetes services to most of the remote health services that have a high proportion of the Aboriginal population. Royal Perth Hospital is committed to improving culturally secure health services and increasing the number of Aboriginal staff employed. This is critical as the majority of people who come to Perth from rural and remote communities attend RPH for tertiary care.

A high proportion of Aboriginal people with diabetes and cardiovascular disease, present at Derbarl Yerrigan Health Service and other ACCHOs with established tertiary complications. They have complicated treatment regimes and do not have the support they need to be able to self-manage their health conditions effectively.

Shared-care, outreached from Royal Perth Hospital (RPH) is required to support primary health care providers to appropriately manage complex health care issues.

It is recommended that a dedicated diabetes team with a central role of supporting rural and remote health services and developing linkages and systems will improve the level of access Aboriginal people have to secondary and tertiary services. This same diabetes team could be outreached to DYHS to increase Aboriginal people in the metropolitan areas access to secondary and

tertiary medical intervention and improve integration between services provision for Aboriginal people. This must not reduce the local services, as the health system must be flexible to ensure that local solutions address local issues. However, the low uptake or provision of services at all levels to Aboriginal people is evident. A central team to support all of Western Australia to assist with development of systems connecting services will help to overcome the barriers to accessing services.

The Department of Health Reform (2003) identified a number of issues that will require central coordination. These include regular data collection; partnerships between community and mainstream sectors; expanded services in some areas; delineation of responsibilities and capacity between regional and metropolitan areas; clearer referral pathways and attention to access issues such as transport, social support and accommodation for Aboriginal people from the country.

East Metropolitan Population Health Unit

The role of East Metropolitan Population Health Unit (EMPHU) include health promotion, planning health services, program and resource development, coordination of workforce development, priority setting, consumer consultation and provision of support to the diabetes program across the East Metropolitan Health Service (EMHS).

Aboriginal health and diabetes are priority health issues for the EMPHU. The EMPHU have a dedicated program area specific for Aboriginal health. In addition to service provision, the EMPHU is a lead-organisation in health promotion and diabetes prevention, and targets members of the community with least access to health services. The EMPHU is also the sponsor organisation for the Regional Diabetes Coordinator for EMHS.

A coordinator to oversee the transformation of the health system to incorporate the new approach to health for Aboriginal people will be required in the long term. The Population Health Units in Western Australia have taken a key role in coordinating the Department of Health Integrated Diabetes Program. The

East Metropolitan Health Service executive has already proposed that an Aboriginal Health Access Coordinator should be appointed. Senior management of EMHS has supported this proposal. A proposed solution is that the Aboriginal Services Coordinator could be partially incorporated to the existing newly proposed Aboriginal Health Access Coordinator position.

CURRENT INITIATIVES

A number of initiatives have been implemented in order increase the capacity of existing health services to provide culturally appropriate services and to increase their capacity to provide a specific service for Aboriginal people with diabetes in this region which need to be endorsed and supported. These initiatives focus on community development, primary health care and work force development.

COMMUNITY DEVELOPMENT

It is a natural process for Aboriginal people to utilise community development strategies in their work. These skills and methods are valid strategies that have worked internationally to improve the health and health inequalities of Aboriginal populations in New Zealand, Canada and United States. Health workers need to be supported in recognising the effective way they work naturally with their communities through training that will link theory to practice. Community development strategies need to be a funded component of our health system. A number of new initiatives successfully utilise this approach.

The Community

There are a number of very motivated and mobilised Aboriginal people who have already done a great deal for their community to establish itself and obtain necessary resources. A number of Aboriginal organisations have already been formed. These include MAMBA in Queens Park and the Aboriginal Corporation in Midland, the Aboriginal Corporation in Great Southern Health Region. A greater recognition of Aboriginal people's request for resources is needed. In the metropolitan area Aboriginal people are "without wheels in an urban area designed for wheels". Community buses would help overcome isolation, transport children to school, sports venues and facilitate community identity and celebration.

An increase in Aboriginal presence in the front line services of health, housing, employment related and general welfare areas is needed in order to facilitate:

- dramatic improvement information flow into the community;
- an increase in the use of vital services in health;
- a role model for young Aboriginal people;
- a greater understanding of the poorly understood health and social problems that could be festering (eg domestic violence; child abuse, unemployed Aboriginal men, the state of Aboriginal men's health) and
- recognition by non Aboriginal people that Aboriginal people are best placed to determine their own desirable future in health.

Canning Division of General Practice Diabetes Project

Current initiatives at CDGP include discharge planning between Royal Perth Hospital and primary health care; linkages and collaboration between Aboriginal organisations and GP practices; development of diabetes programs for Aboriginal people utilising a community development model; ongoing consultation with the Aboriginal community and workforce development for mainstream service providers and Aboriginal health care providers.

CDGP has utilised a community development model to engage with the Aboriginal community in the South East Metropolitan area. Through a National Diabetes Incentive Program grant an Aboriginal health worker has utilised the Asset Based Community Development (ABCD) model to gain trust and participation of three Aboriginal groups with diabetes in the Bentley, Maddington and Armadale area. These three groups (n=50) have been meeting weekly for three to four months. The model focuses on strengths of the community as opposed to the traditional problem focused model utilised in health service planning. This is a bottom up approach that builds on existing community strengths with local solutions for local problems, and shared decision making with the agenda being set by the people. The outcome for increased self-efficacy and self-management skills for members of the group has been very impressive with

some members ceasing insulin therapy, losing weight and improving their diabetes control.

Each small group has identified issues related to diabetes and the information they need in order to understand and manage their diabetes. 50 Aboriginal people have attended at least one group meeting, with many attending 9-12 weekly meetings. One of the aspects of the program involves identifying peer supporters from amongst those attending the group educational sessions, and a number have volunteered to undertake training as peer leaders.

Partnerships are being built with a number of community based organisations and Aboriginal Health Workers working in the community providing considerable assistance in the establishment of the groups and they are keen to expand this work in their own organisations. This project has been funded for twelve months and concludes in July 2004. The support provided by Bentley Community Health staff has been pivotal to the success of the program and has provided the infrastructure for sustainability of the group.

In addition to the Diabetes Project, the CDGP have an Aboriginal primary health care team that have commenced a number of initiatives that will improve access to quality primary health care.

The Unity of the First People Diabetes Management and Care Program

The Unity of the First People (UFPA) work in partnership with local Aboriginal communities to recruit volunteers who are willing to give their time for various time periods are placed in remote communities to provide extra support to complement our existing health system. A diverse range of skills is offered including medical, allied health, nursing, music, cooking, sports and “anyone who has experienced the University of Life”. The communities work in partnership with UFPA who is responsible for recruiting volunteers. The Department of Health and Aged Care coordinates this program and provides administrative support and infrastructure. UFPA works with government organisations both Commonwealth and State to access non-recurrent funding. Although this program is available to

all communities, implementation is limited by funding availability (Unity of First People of Australia, nd).

The Neporendi Community Development Initiative

The Aboriginal communities in the Southern area of Adelaide, South Australia has achieved a number of encouraging and positive community initiatives. Two new Aboriginal organisations have been formed, the Neporendi Aboriginal Forum and the Neporendi Youth Association, with youth and community members running the management committees. These committees are responsible for a number of areas in community health including aged and frail, disabled, women and child clinics and liaison with Aboriginal Medical Service. A committee based at TAFE is responsible for the Neporindi Newsletter, student accommodation and student career development initiatives.

The Neporendi News is a community newspaper that is distributed to every Aboriginal family in the area. It has assisted to mobilise and inform the community along with word of mouth.

A committee responsible for the Neighbourhood House Multi-purpose Complex brings together the Aboriginal Land Trust, ATSIC, Children's Service office, Family and Community services, Office of Aboriginal Affairs, Noarlunga Council representative and also provides for CES, social security and other visiting services. A committee addressing Southern Heritage issues brings together the Kaurna Heritage Committee, Aboriginal heritage branch, Aboriginal Lands Trust and the Museum Family Genealogical Organisation. The committee for Aboriginal youth Issues employs a full time youth worker. It provides a number of programs including Mother/daughter program, Father / son excursions and camps, employment orientation, arts and crafts, sports and recreation, accommodation and so on. The committee on childcare issues have established an Aboriginal day care and a kindergarten (Brice, G., 1993).

Primary Health Care

International evidence suggests that the delivery of comprehensive primary health care for a substantial period of time is fundamental to improving

the health of Aboriginal people. Mainstream health providers need to work in partnership with Aboriginal organisations to develop culturally secure health services. Cultural security is a step towards strengthening community leadership and for positive attitudinal and behavioural change in mainstream and within the Aboriginal community (Department of Health, 2000).

Midland Integrated Primary Health Care

The Swan Kalamunda Health Service and the community Aboriginal health team, DYHS, and a number of GPs that are preferred by Aboriginal people in the district are working together to provide a specific service for Aboriginal people with diabetes. The Aboriginal health team has consulted with the local community to ensure the community priorities are going to be met.

Engaging General Practitioners (GPs)

Recent consultation with GPs in the Midland and Bentley areas have identified a number of GPs who wish to provide primary health services to Aboriginal people. Training of GPs and other non-Aboriginal health care providers in culturally appropriate approaches to Aboriginal health is mandatory. The Aboriginal Reference Group convened by CDGP has a GP representative. This forum is an example of how to engage GPs for the planning and implementation of primary health care for Aboriginal people.

Perth & Hills Division of General Practice engaging new partners.

The Adult Health Program Officer with the Perth & Hills Division of General Practice is responsible for improving the way to address Aboriginal health issues and has begun to engage with individuals and organisations that work to support Aboriginal people in a number of ways. These include:

- Centrelink in Cannington, which has a team of Aboriginal men and women working on housing issues across the metropolitan area.
- Department of Indigenous Affairs (DIA)
- Department for Community Development (DCD)

Street Doctor

Street Doctor is a mobile clinic that operates out of a bus in both the Perth & Hills Division of General Practice and Fremantle. The role of the Street Doctor is to increase access to quality primary health care services to people who have the least access to services. It reports that on average approximately 30% of their clients are Aboriginal and this is increasing. Many of these people do not attend other services.

The Street Doctor has established a regular clinic for Aboriginal women in the city with the assistance of an Aboriginal health worker employed by the EMPHU. Most of these Aboriginal clients have never accessed quality primary health care before. This gives Aboriginal women the opportunity of regular health checks and appropriate follow up.

This also provides an opportunity for General Practitioners to further develop their skills in working with Aboriginal people which they in turn can take back with them to their mainstream practices (Wayland-Peck, M., 2003). This initiative overcomes many of the barriers that Aboriginal people experience accessing preventative and primary health care.

The Coordinator of the Street Doctor provides continuity to the service and has built a strong rapport with local Aboriginal people. The nurses, allied health and AHWs have considerable experience in working with Aboriginal people. The service has addressed other barriers to accessing primary health care such as transport, cost and set appointment times. The service has local government and community business support to maintain and run the bus.

Great Southern Integrated Diabetes Care

The Great Southern Division of General Practice, the Aboriginal Corporation and the Great Southern Population Health Unit have worked in partnership to develop a referral pathway aimed at increasing Aboriginal people's access to primary health care. The services include diabetes education programs, podiatry services and self-management equipment and consumables from the National Diabetes Services Scheme. A specialist Aboriginal Health Worker is central to reducing access barriers to services in the referral process.

Workforce Development

Aboriginal Health Workers (AHW) familiar with their local communities should be employed in both mainstream and community controlled health services. Where there are insufficient numbers of available AHWs, accredited training should be provided and undertaken by selected local Aboriginal people. Where there is insufficient or inferior training available, greater support by government, financially and educationally, is necessary (Thompson, D. *et al.*, 2003).

Marr Mooditj Graduate Certificate in Healthy Lifestyle

Marr Mooditj Foundation provides an education and training in primary health care for Aboriginal people. Marr Mooditj has just taken its first intake of students to complete a Graduate Certificate in Healthy Lifestyle. The modules in this certificate include diabetes, cardiovascular, renal and health promotion. This course will help AHWs to specialise in clusters of conditions with similar risk factors and health outcomes in Aboriginal health. Robust linkages between industry and training institutes are imperative to ensure that Aboriginal health workers are being recognised for their knowledge and skills. Formal links have been formed between CDGP and Marr Mooditj to increase the number of clinical placements available to Aboriginal students in general practice.

Leadership in workforce development

The Child, Community and Primary Health Directorate of Department of Health provided 10 scholarships for allied health and nursing working in public health sector to complete the Graduate Certificate in Diabetes Education in 2003. Such initiatives need to be considered for Aboriginal health workers, as an increase in Aboriginal presence in the mainstream work place is needed.

PROPOSED ACTION AND RATIONALE

Support for transformation of health service delivery for Aboriginal people in Western Australia is required at all levels. There is a need for both health and non-health government sectors to work together as a single entity in the transformation of health service delivery. The objectives of the National Strategic Framework will need to be adapted to suit local and regional resources and environments and then developed into local agreement frameworks. This proposal seeks support for the transformation process to begin.

Towards a More Effective and Responsive Health System

The burden of providing such health services should not be the sole responsibility of ACCHOs. The responsibility needs to be shared with other key stakeholders, both State and Commonwealth health systems and health care providers.

The first step in the transformation of the current health system will require a summit (search conference) that brings all stakeholders together to commit to the process. Representation from both Commonwealth and State funded health services from metropolitan, rural and remote regions, non-government organisations, community controlled organisations and the community should come together to:

- identify current resources;
- define roles of various providers within the services;
- develop new partnerships and opportunities for collaboration;
- acknowledge and utilise the expertise of Aboriginal people and their ways of working and identify what needs to be transformed in our local health service,
- commit support, resources and services.

Commitment to sustain approaches that are already working needs to be gained. *The critical focus will have to be a greater understanding of cultural and*

historical reasons, which influence whether or not, or why Aboriginal people do not access mainstream services.

A major issue in Aboriginal health is that there are numerous organisations, individuals and funding bodies that support excellent initiatives aimed at addressing the inequalities and disadvantage experienced by Aboriginal people. Most of these initiatives struggle for sustainable funding because they do not fit in with mainstream funding systems. These initiatives need to be identified, built on and recognised as legitimate strategies that will make a difference to the health outcomes of Aboriginal people. There needs to be collaborative planning and resources allocation at all levels of health service planning and management.

There is a need to foster greater community participation and engagement in the ownership of and operation of health services.

The Ottawa Charter for Health Promotion (1986) states that, 'to reach a state of complete physical, mental and social well-being, an individual or group must be able to realise aspirations, to satisfy needs, and to change and cope with the environment'. This cannot occur for submerged groups in society who are subject to the policy and decision making power of a dominant group, until a more equitable power balance is achieved. Enabling or empowerment has been advocated as the key concept in the Ottawa Charter as it represents a challenge to power imbalances in social relationships that rob subordinate groups of the capacity to exercise control over their lives (Labonte', R., 1990).

While there is no single path to achieving empowerment, community development stands out as one approach which has much to commend it for advancing the health status of Aboriginal people (Feather & et al., 1993) & (Labonte', R., 1993). We must begin engaging with community members so that our health system planners hear the ideals and values of Aboriginal people. We must focus on what already works for Aboriginal people, with the assumption that they are the experts, and allow them to inform the developmental process of future resources and programs for their people.

Aboriginal people's ideals and values should be heard by our health system planners and inform the development process of future resources for Aboriginal people. 'When people can envisage and imagine a more desirable future, present barriers and past conditioning ceases to blind them (Gilchrist, D., 2002).'

General Practice and community controlled health services play a key role in providing access to quality primary health care services.

The mortality rate of Aboriginal people in United States of America, New Zealand and Canada are 15 and 14 years less than the Australian Aboriginal population. A range of factors is considered to have contributed to their improved health outcomes in the USA, and Canada. Differences lie in delivery of primary health care services. It is evident that the detection and treatment of illness at an early stage has been responsible. Compared to other Aboriginal populations the Australian Aboriginal has more untreated diabetes, hypertension and heart disease.

In the East metropolitan region alone there are 650 General Practitioners that are funded through Medicare to provide the high quality primary health care available to Western Australians however, Australian Aboriginal people use mainstream health services 80% less than the overall population. An increase in Aboriginal presence in mainstream primary health care services is one strategy that has been a main contributing factor to an increase in access to mainstream services by Aboriginal people in other countries.

A multi strategic approach is required. A number of initiatives have already been commenced by CDGP. These need to be maintained and generalised through out Western Australia. The critical focus will have to be a greater understanding of cultural and historical reasons, which influence whether or not, or why Aboriginal people do not access mainstream services.

The Western Australian Diabetes Strategic Plan (1999) highlights the need for cultural security when planning for diabetes services for Aboriginal

people. It states that the 'policy around cultural security in Aboriginal health involves cultural protection around health practices, ensuring that Aboriginal people have access to higher quality health care. The fundamental principle being to improve social conditions and the environment. This means working in partnership with all organisations that influence health and lifestyle. The elements essential for Aboriginal health care include

- Aboriginal self determination
- the need for health care to encompass the family and their community
- the respect for cultural differences and needs and
- the need for equity in access to services'

It is clear that attention needs to be devoted to interventions that are most cost effective in achieving health gains. In this context, placing priority on culturally secure health promotion directed at the key health lifestyle determinants will be fundamental both to arresting the epidemic of diabetes and chronic diseases and to ensuring that health as well as economic and social development strategies can make an impact.

A focus group conducted by CDGP with 15 Aboriginal health workers (2003) identified that most Aboriginal people did not recognise the need for ongoing care or understand the seriousness of or the outcomes of uncontrolled diabetes. The most effective messages that were delivered to clients by Aboriginal Health Workers was that they were available when clients needed to know this information.

The importance of increasing individual and community capacity to improve their own health status has been widely recognised (Department of Health, 2000). Giving people the required knowledge, skills and power to effect health change are an essential prerequisite to large-scale improvement in health outcomes. Strengthening community participation is vital for programs and services to be effective and efficient. Communication and cooperation between the range of agencies and organisations involved in health and health related services organisations are essential.

Aboriginal people need to be able to choose where they access primary health care services. Some Aboriginal people prefer to use mainstream health services for reason of confidentiality. Therefore mainstream and ACCHOs need to be integrated to ensure seamless and appropriate services are provided.

A range of strategies is required to ensure that there is sufficient workforce to meet the community needs. Workforce support and development in mainstream and community controlled health services is urgent.

The Aboriginal workforce is one of the principal and crucial elements in improving the health of Aboriginal people. Despite this recognised need, Aboriginal health workers are the least prepared educationally, the least supported professionally and the least rewarded financially. The Department of Health recommends one health worker per hundred people, this equates to 250 in Western Australia. However, there are only approximately 92 health workers in the Western Australian Government system and 105 health workers in Aboriginal Community Controlled Organisations (ACCHO). A minimum of 50 new positions for health workers needs to be created. (Department of Health, 2000).

Community development principles need to be incorporated into the delivery of health services. It is now clear that Aboriginal people naturally work together in a way that is engaging of the community members when they need to find solutions to problems. Aboriginal Health Workers need to be recognised for their community development skills and their work valued as best practice for delivery of health services to Aboriginal people. Aboriginal people should lead the way in achieving their own health gains. Mainstream health care providers should walk beside Aboriginal health care providers to learn how best to deliver services that is going to meet the need of Aboriginal Australians.

Pro-active strategies are required to further increase the number of Aboriginal Health Workers in the State. Health workers have been central in USA, Canada, New Zealand and Albany in Western Australia in increasing Aboriginal peoples access to quality primary health care services. Workforce planning should be a

key issue for the transformation of health services for Aboriginal people. What is needed is:

- support to develop a strong and long term career pathway for Aboriginal Health Workers;
- specialist training in diabetes with recognition of their qualifications ;
- clear role definition and recognition of Aboriginal health workers, especially in mainstream service provision;
- ongoing training and up-skilling of Aboriginal health workers;
- dedicated time to provide health education, promotion and advocacy;
- recognition of community development as a valid primary health service;
- theoretical understanding of community development principles to consolidate and validate their natural way of working with their community;
- more placements of Aboriginal students in mainstream services areas in order to breakdown historical barriers for Aboriginal people accessing mainstream services;
- cultural awareness training for all mainstream services providers;
- supportive professional networks to support Aboriginal health care providers;
- medical registrar positions in large community controlled health services;
- pro-active measures and funds to increase the number of Aboriginal health workers employed until we reach the benchmark of 1:100 Aboriginal people;
- reorientation of existing health services to ensure they are culturally secure. This will require education, service review and adjustment of organisational practices. This step is vital in order to overcome the significant barrier to Aboriginal people's early presentation, self-management and treatment.

In the EMHS there are currently 9.6 FTE including Nurses, Dietitians, Physiotherapists and Podiatrists dedicated to delivering diabetes services to the community in the EMHS that has a population of 500,000 people. The staff are

employed in a variety of settings and funded through State and Commonwealth systems. The resources are inadequate working in isolation. Linkages and intra-sectoral planning between community controlled health services, Division of General Practice, Population Health Units, Hospitals and other government agencies working with the Aboriginal Community is imperative. Bilateral Agreements and Primary Health Partnerships provide the infrastructure for better collaboration between our dual health funding system.

All health care providers funded by the health system, including State funded, Commonwealth funded, mainstream and community controlled health services need to be transparent and accountable to a single entity at State health management level eg State Health Management Team.

At present state health providers are responsible to a variety of disconnected funding bodies. Clearly transparent planning and service delivery processes that will ensure seamless service delivery to service providers and the community are required. This would integrate and improve the efficiency and effectiveness of planning, resource allocation, contracting and community development roles by removing duplications and inconsistencies between service providers and funding bodies both at State and Commonwealth level. Ideally funds and resources should be pooled to ensure resources are being allocated according to community needs and costs (Health Reform Committee, 2003b).

Performance indicators should reflect the transformation of the health system to inform the health system, the government and the community as to how the system is performing against the key areas for transformation and the outcomes that are being achieved.

INFLUENCING THE HEALTH IMPACT OF THE NON- HEALTH SECTOR

Attention is needed to develop the capacity of the health system to collaborate and integrate service areas within and outside the health sector

The key issues affecting Aboriginal health extend beyond the simple provision of medical services. They include educational achievement, transportation, and the cost of food in regional and remote areas, employment opportunities and social issues such as child abuse, family violence, drug abuse and crime.

It is important to recognise the need for all elements of comprehensive primary health care to be accessible to the Aboriginal population. This also includes community assistance, linkage and liaison on health related matters within the health and non health sectors.

Better integration by government and non-government agencies of the provision of basic infrastructure, social, economic and health strategies can improve performance in all areas (Health Reform Committee, 2003a). The population approach to the prevention and control of diabetes and chronic disease requires a multi-disciplinary approach that takes into account not only bio-physiological and lifestyle influences but also the politico-economic environments and social structure (Foliaki', S. & Pearce, N., 2003).

A model that has addressed the need for integrated planning and working together has occurred in Midland, Perth. Co-location of health, welfare and education support services has occurred around the primary school in Midland. This example is likely to significantly improve coordination of services and health outcomes in the area. The development of similar co-location of multi agency departments such as shopping centres, Centrelink and community owned places needs to be promoted.

PROVIDING INFRASTRUCTURE TO IMPROVE HEALTH STATUS

Australia has very disconnected processes for allocation of resources from Commonwealth, State and other funding organisations, particularly for Aboriginal services. Differentiation between community controlled and mainstream services is not factored into funding and planning processes, therefore community networks, linkages and communication is vital.

There needs to be greater collaboration between Commonwealth, State and local service providers. The Department of Health Reform, (2003), identified the Commonwealth Primary Health Care Access Program (PHCAP) as an initiative that utilises Medicare funds, however, the program requires local planning and governance arrangements to be in place for the expenditure of new funds. The transformed health system to address the Aboriginal Diabetes Program is an ideal new initiative to improve linkages between service providers for all primary health care issues. *That is primary health care that goes beyond medicine.*

Local planning and coordination will improve linkages and communication. The Statewide Integrated Diabetes Program has made considerable progress in facilitating the integration of diabetes services. Each region has a steering committee that facilitates intersectoral planning. The East Metropolitan Health Service Diabetes Program has identified Aboriginal services as a priority area for action and has been responsible for submitting this proposal for the transformation of Aboriginal diabetes service delivery.

Evidence of Linkages and collaboration between sectors and individuals working with the Aboriginal communities need to be recognised as key performance indicators to improving health outcomes.

The shortcomings of data and evidence in Aboriginal health and welfare are well documented. The variability of the quality across jurisdictions, problems with Aboriginal identification and inadequate recognition and reporting of evidenced based approaches that work. Therefore commitment is required to

develop a strategic approach to improving and sharing the evidence on interventions that work. This will also increase the local communities to utilise local data to enhance health outcomes.

Community development principles need to be incorporated into the delivery of health services. It is now clear that Aboriginal people naturally work together in a way that is engaging of the community members when they need to find solutions to problems. Aboriginal Health Workers need to be recognised for their community development skills and their work valued as best practice for delivery of health services to Aboriginal people. Aboriginal people should lead the way in achieving their own health gains. Mainstream health care providers should walk beside Aboriginal health care providers to learn how best to deliver services that is going to meet the need of Aboriginal Australians.

RECOMMENDATIONS FOR IMMEDIATE ACTION

1. Integrate this document into other frameworks for Aboriginal health reform in Western Australia.
2. Commission a summit to bring all parties together to commence collaborative planning and resource allocation at all levels of health service planning and management.
3. Introduce a Statewide approach to improving preventative measures which include active management of diabetes and within a broad chronic disease/ self-management framework (Health Reform Committee, 2003b).
4. Appoint a dedicated diabetes team with a central role of supporting rural and remote health services, develop linkages between service providers and providing outreach service to DYHS.
5. Endorse the central coordinating role of Office of Aboriginal Health in data collection, partnerships between community and mainstream services, expanded services in some areas, role delineation of responsibilities, addressing transport issues and accommodation.
6. Develop partnerships between mainstream health providers and Aboriginal organisations.
7. Develop robust linkages between industry and training institutes.
8. Undertake a comprehensive approach to increasing the presence of a skilled Aboriginal workforce in mainstream and ACCCHO services.
9. Employ at least 50 more Aboriginal health workers in mainstream and ACCHOS in order to maintain the recommended 1-100 ratio.
10. Utilise community development principles into delivering health services.
11. Implement culturally secure health promotion directed at determinants of health.
12. Engage the community at all decision-making levels.

13. Agree on performance indicators that provide evidence of linkages and collaboration between sectors and individuals working with the Aboriginal communities.

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