

## **Mrs Glenda HUMES**

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### **We Are The Ones We Are Waiting For....A response to ‘Close the Gap’**

Much of the literature on Indigenous health outcomes and life expectancy all come to the same conclusion that life expectancy in Alaska, Australia, Canada and New Zealand is low, with Australian Indigenous people having the lowest life expectancy of all population groups as compared to non Indigenous populations<sup>1</sup>. Over many years, service providers in Aboriginal health within Western Australia have observed the practices of other countries and gained a perception that there may be a difference in the range and quality of health services provided to Aboriginal people in these countries. It is recognised that changes in other countries is the result of many years of commitment through funding and planning/policy frameworks.

In 1998, Gavin Mooney et. al. wrote ‘The health of Australia's Indigenous people is much worse than that of other Australians, and worse than that of people in many Third World countries. The life expectancy of Aboriginal and Torres Strait Islander people is about 17 years less than that for other Australians, and their average mortality rate is three times higher. Those living in remote areas have 10-20 times higher death rates from specific diseases, such as diabetes, cervical cancer, and infectious, parasitic and respiratory diseases’<sup>2</sup>. With the release of the NACCHO/OXFAM report in April 2007, it appears that only minor in-roads have been made in relation to the life expectancy of Indigenous Australians. Whilst making this point, it is important to acknowledge the best practice programs that are being implemented across Australia which are documented in the report that are making a difference.

Ring and O'Brien (2007) wrote ‘Australia should aim to become the country with the lowest mortality rate in the world. This could realistically be achieved through benchmarking performance nationally and internationally, applying current knowledge and available interventions, matching policies with funding, and implementing systemic national program and activities to promote health and prevent “illth”<sup>3</sup>.

In all countries that were visited, emphasis was placed on a total infrastructure that supported all determinants of health (such as education, housing, welfare, sanitation), based on Indigenous funded and controlled organisations that would continue to build capacity into rural and remote communities.

Oxfam Australia is committed to Indigenous health as it recognises that poverty exists with Australia's Indigenous population (approximately 500,000 people). They are the most disadvantaged group in the country in terms of income, unemployment, imprisonment, child protection, health and wellbeing indicators, life expectancy and education. With the release of the

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<sup>1</sup> <http://www.nzma.org.nz/journal/117-1207/1215/>

<sup>2</sup> Mooney, Gavin et.al. *MJA* 1998; 169: 508-509 How much should we be spending on health services for Aboriginal and Torres Strait Islander people?

<sup>3</sup> Ring, I.T and O'Brien, J.F *MJA* 2007; 187 (8): 447-451. Our hearts and minds – what would it take for Australia to become the healthiest country in the world?

independent report *Close the Gap, 2007*<sup>4</sup> commissioned by OXFAM Australia and the National Aboriginal Community Controlled Health Organisation (NACCHO), created a momentum within several key Aboriginal Health Services in Western Australia to make a difference to health outcomes in this State.

The report highlighted that Aboriginal and Torres Strait Islanders have a life expectancy 17 years less than other Australians. This situation needs to be changed. Many successful community run health programs are making a difference, for example, Aboriginal and Torres Strait Islander controlled health services have some of the highest vaccination rates in the country. Despite these efforts (provided by dedicated and committed service providers), the life expectancy of our people is still poor when compared to other countries. Questions arose within a small group of Western Australian Aboriginal Medical Services - what did these countries do (at a funding, planning, policy and implementation level) to achieve what we have not been able to do, despite best efforts in our services?

A proposal was submitted to OXFAM, Australia in early 2007 to fund a health study tour of New Zealand, Canada and Alaska by representatives from rural and remote Aboriginal health services in Western Australia. This proposal was accepted and jointly funded with the Aboriginal Health Council of Western Australia (AHCWA), Derby Aboriginal Health Service (DAHS) and South West Aboriginal Medical Service (SWAMS). The countries visited were chosen for their advances in Indigenous health in terms of health outcomes for their respective Indigenous groups to answer the fundamental question – what do they do better?

The purpose of the study tour was to explore the strategies utilised by these countries in reducing the differences in life expectancy between the Aboriginal and non-Aboriginal people in their respective countries. The group identified regions similar to their own regional demographics, so that some comparisons could be observed. The group interviewed academics, policy makers, service delivery people and consumers of services to ascertain what they attributed to the reduction of the years of life expectancy that has not been seen in Australia. They also visited facilities and observed programs being implemented in local environments.

This project was based on an action based methodology with service providers taking control of ‘closing the gap’ in this State, however, it is envisaged that the information will have national implications for all Aboriginal Medical Services (AMS’s). Over the years, there has been ongoing relationship between the three agencies (AHCWA, DAHS and SWAMS) who recognise the complexities and who are committed to making changes to the provision of health services to their communities across urban, rural and remote settings in Western Australia. The support of OXFAM Australia was imperative in gaining inroads into areas highlighted in the ‘*Close the Gap*’ document.

The project had a three-pronged approach that encompassed:

- A detailed planned itinerary for the study tour that included timeframes, key stakeholders, locations to visit in Canada and New Zealand. Later Alaska was added as part of the tour due to the isolated nature of their tribal groups and the proximity to Canada.
- A study tour of New Zealand, Canada and Alaska, to identify aspects of policy, funding and service delivery that could be transitioned into the Australian context from the aspect of people providing a service delivery; and
- A report from the study tour that outlines the current barriers and solutions at a service delivery level for Western Australia AMS’s to implement that will make a difference to improving Aboriginal Health outcomes in WA.

Representatives from AHCWA, DAHS and SWAMS (all from Western Australia) formed the group that went to New Zealand, Canada and Alaska. The group were joined by two representatives from OXFAM, Australia (both from Victoria) in Canada and Alaska only.

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<sup>4</sup> Close the Gap Report, Oxfam Australia, April 2007

## **Scope of the Project**

This project was based on an action based methodology with service providers taking control of 'closing the gap' in the State of Western Australia, however, it was envisaged that the information will have national implications for many service providers of Aboriginal health across Australia.

AHCWA, DAHS and SWAMS represent a strong connection that recognize the complexities of providing services across urban, rural, remote settings, together with the overarching policy group that provides support to the AMS's in Western Australia.

It was proposed that the study tour engaged all areas that impacted on health outcomes as research shows that health is affected by many other factors. It was envisaged that many questions would be answered by the study tour which included the following:

- *What is the level of funding commitment (per capita of Indigenous person/s) of various groups towards Indigenous health programs (government and non-government)?*
- *What commitment has been shown and what strategies have been implemented to embrace cultural security in these countries?*
- *Where has the funding been targeted and what gains have been made?*
- *What integrated health programs and strategies to access mainstream health programs have been successful?*
- *What programs (across government) have been integrated into health programs to meet the needs of the social determinants of health (for example housing, income support)?*
- *What community engagement strategies are utilised across different groups/communities – what has worked and what has not?*
- *What specific evidenced based health programs were implemented over the last 10yrs/5yrs which have improved health outcomes?*
- *What are the various prevention and promotion programs implemented across populations/communities, specifically those related to primary health care.*
- *What early intervention programs have been successful and what are the identified factors that have contributed to their success?*
- *What specific child and maternal health programs have been implemented?*
- *Which programs and specific strategies were targeted at chronic disease to improve health outcomes and over what period of time?*

## **Outcomes of the Study Tour**

The group identified five areas sustained effort that would (given long term investment) that would make a difference to Aboriginal communities:

- Focused funding
- Holistic and traditional healing approaches
- Chronic disease self management
- Emphasis on building culture
- Workforce development

### **Focused funding:**

From a specific health program perspective – the main focus across all three countries (but in Canada particularly) was the emphasis and funding that went into child and maternal health.

Programs such as *Headstart* (also known as *Firststart*) need to be funded and implemented in every Aboriginal Medical and/or Health Service across Australia.

Oral health programs were also a major investment in all three countries. The link between oral health and physical health has been well documented and the investment needs to be consistent and long term. This is an important area to target within the health promotion, prevention and early intervention in day care centers, pre schools and school age children. Various outreach programs have proved to be successful, for example the oral health vans in New Zealand and the use of telemedicine in Alaska, especially the trained Indigenous dental therapists.

### **Holistic and traditional healing approaches:**

Across all three countries (Alaska, Canada, New Zealand) the Indigenous populations all have federal recognition for their respective ‘stolen generations’ and a systematic and holistic view of health services. Health programs are funded equitably across regions, however, the specific implementation differed between countries and regions dependent on the needs of the community.

Traditional healing centers have a strong presence in all three countries – an example of this is the South Central Foundation (Alaska Native Medical Centre) who provides:

- Healing hands
- Prayer
- Cleansing
- Song and dance
- Culturally sensitive, supportive counseling
- Talking circles
- Alaska native traditional healing garden

Traditional healing clinics/centers are accepted and recognised as an integrated practice alongside western medical practices.

### **Chronic Illness Self Management**

All three countries but specifically New Zealand and Canada promote self management for chronic disease conditions. This is promoted through the provision of information, guidance, care coordination and self-management methods that assist patients to monitor and manage their own health.

### **Emphasis on Building Culture:**

A strong cultural influence was observed in all three countries, bearing in mind that minimal time was spent in urban areas, in which the perspective could have been different as compared to observations made in rural and remote regions by the group. As stated previously, culture and tradition permeate throughout communities and is the foundation for all health care.

All Indigenous services are provided by Indigenous controlled organisations. This was considered an important element by local health authorities in planning, developing and implementing health care services to Indigenous populations. Elders in communities in all three countries provide strength and bonding for the communities.

### **Workforce Development:**

In all three countries visited, there was a strong emphasis and commitment to workforce development at all levels. Funding is provided for paid work and teaching/learning scholarships to create Indigenous health professionals that return to work in local communities.

## **Summary**

The group returned from the study tour committed to provide a framework to address the future health needs of Indigenous people within Western Australia. The tour met all expectations of the group in terms of information exchange and learning from rural and remote areas on strategies to meet health needs of their respective Indigenous populations. The connections and networking during the tour was a major outcome where there is an ongoing commitment from all parties to continue communicating and sharing strategies into the future.

In addition, the study tour participants returned to Western Australia with the knowledge and commitment to make changes to their services which would be small steps towards a growing momentum towards increasing the life expectancy of their people. The document '*We are the Ones We are Waiting For*' was written as a summary of the study tour. The report summarises:

*Australia can aspire to have the lowest Indigenous mortality rate in the world. It will need to have a large targeted investment into Indigenous health and the ability to unite all groups that have a commitment to change the status of the Indigenous people of Australia. This will require a multi dimensional - cross government approach to a framework that addresses all social determinants of health for this group. A framework that is flexible, targeted and long term for addressing child welfare, education, employment, health, housing, income support, mental health and social welfare areas, will meet the needs of Indigenous people in a holistic planned approach.*

The information taken from all three countries was analysed and transferred to the West Australian context and will also have ramifications nationally. Ten recommendations were made addressing many areas for Australia to consider and implement into the future. It is time for us all to act, as we are the ones we are waiting for.

## **References**

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