

AUSTRALIAN MEDICAL ASSOCIATION REPORT CARD SERIES 2007

Aboriginal and Torres Strait Islander Health

INSTITUTIONALISED INEQUITY NOT JUST A MATTER OF MONEY

EQUAL HEALTH ACCESS A PRIORITY FOR ABORIGINAL AND TORRES STRAIT ISLANDER AUSTRALIANS

The AMA Aboriginal and Torres Strait Islander Health Report Card Series has carried a consistent theme throughout its existence – the tragic state of health and the lack of health services endured by Aboriginal peoples and Torres Strait Islanders.

We have called it a national tragedy and a national shame, and I think we are being kind in that assessment.

It is the 21st century and we are still seeing health conditions and health outcomes from a bygone era.

The gap in life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians is a constant reminder of our failings as a community. It is a gap that reflects a lack of government commitment – over decades – to fix the problem.

But we continue in our efforts to educate and inform and hopefully reform.

Each year our *Report Card* paints a picture of appalling statistics and sad realities on things like life expectancy, low birth weight, Aboriginal and Torres Strait Islander peoples' imprisonment, and the shortage of Aboriginal and Torres Strait Islander health workers.

This is balanced with stories of successful programs and services that provide optimism for the future of Aboriginal and Torres Strait Islander health.

The bottom line, of course, remains criminal underfunding of Aboriginal and Torres Strait Islander health, but this year we bring you a sorry tale of failure by the health system that is meant to be the provider of care for all people, including Aboriginal and Torres Strait Islander peoples.

Our story this year is all about access barriers.

There is a great divide between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians in actually getting into the health system to take advantage of the care and treatment that is supposed to be there equally for all of us. Some of these barriers are financial, some are geographic, and others are personal and cultural.

Whatever they are, we have to get rid of them. It is folly for us to fight for more funding and services and programs and hope, if the people we are desperate to help cannot get to see their doctors and carers – for whatever reason.

We, the people who work in the health system, have to continue to lead the charge to right this most grievous wrong.

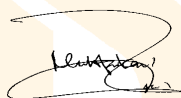
It is not an impossible task, but it is a vitally important task. We must never shirk it.

We have to study the successful programs in this *Report Card* and learn from them. We must also fund and support these programs to allow them to continue their important work.

This year is a symbolic year for Aboriginal and Torres Strait Islander health reform.

It is a Federal Election year, but it is also the 40th anniversary of the 1967 referendum, which removed from our Constitution significant discrimination against Aboriginal and Torres Strait Islander Australians.

It is time now to remove discrimination from our health system.



Dr Mukesh Haikerwal

President, Australian Medical Association
May 2007



AMA

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH OUTCOMES

THE SITUATION

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH OUTCOMES

Life Expectancy at Birth in Australia (years)

Population Category	Male	Female
All Australians (1999–2001) ¹	77.0	82.4
Aboriginal and Torres Strait Islander peoples (1996–2001) ²	59.4	64.8
All Australians (1920–1922) ³	59	65
Most Disadvantaged (2000–2001) ⁴	76.2	82.1
Least Disadvantaged (2000–2001) ³	79.8	84.5
Living in remote area ⁵	73.1	79.7
Living in highly accessible area (1998–2000) ⁵	77.3	82.7

The gaps are stark. The poor state of Aboriginal and Torres Strait Islander peoples' health is clearly not just a problem of disadvantage or rurality. For the rest of the Australian population these two factors have very little impact on life expectancy.

The life expectancy shortfall for the 20 per cent of the non-Indigenous Australian population classed as most 'disadvantaged' – compared to the rest of the population – is about 10 months for men and four months for women. Turning to the shortfall for those living in the most remote areas, the statistics rise to 3.9 years for men and 2.7 years for women (much of this differential is due to the high proportions of those living in remote areas being Aboriginal and Torres Strait Islander peoples). Compare that to the 17.6 year life expectancy shortfall for Indigenous men and women. Indigenous children born in 1996–2000 can only expect to live as long as non-Indigenous Australians who were born in the 1920s.

There have been some welcome gains in child health, communicable diseases, and some chronic diseases, but these gains have not been sufficient to narrow the health gap between the Aboriginal and non-Aboriginal populations. So, while life expectancy is improving a little, the gap is barely narrowing, and the difference is still significant. The population is in a grim situation, and has a right to expect exceptional measures.

Why the differences?

The explanations for the observed differences in life expectancy are complex. Some causes are not the responsibility of the health system, such as the social determinants of health: income and social status; social support networks; education and literacy; employment and working conditions; social environments; physical environments; and housing.

The AMA *Position Statement on Aboriginal and Torres Strait Islander Health* states:

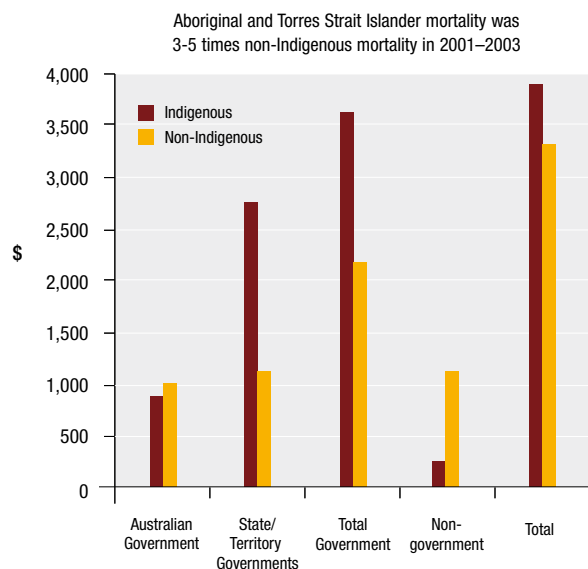
That Aboriginal peoples and Torres Strait Islanders will not achieve equal health outcomes until their economic, educational and social disadvantages have been eliminated. Nevertheless, while social disadvantage continues, Aboriginal people and Torres Strait Islanders should not be doubly disadvantaged by the neglect of potential medical solutions arising from health sector inequities.

As a natural progression this *Report Card* focuses on those determinants that are within the sphere of the Department of Health and Ageing and its equivalents at the State and Territory level: health promotion/education; some primary prevention, secondary and tertiary prevention; primary, secondary and tertiary health services.

HEALTH SPENDING

Annual expenditure per person on health by source and Indigenous status 2001–02

Source: AIHW 2005⁶



Although there has been an increase in Australian Government funding for Aboriginal and Torres Strait Islander health, particularly on Aboriginal and Torres Strait Islander specific programs, since 2001–02, it is clear that the pattern of spending on Aboriginal and Torres Strait Islander health service provision is different from that for the Australian population as a whole. Clearly, State and Territory Governments are disproportionately picking up the additional cost, providing 2.4 times the spending for non-Indigenous Australians. Much of this is generated unintentionally by the higher level of hospital use by Aboriginal and Torres Strait Islander peoples. However, State and Territory Governments spend on Aboriginal and Torres Strait Islander community and public health over four times what they spend on non-Indigenous community and public health.

Overall, per capita government spending on Aboriginal and Torres Strait Islander peoples is 1.7 (or 1.2 if you include non-government spending) times that for the rest of the population. That would be fine if Aboriginal and Torres Strait Islander peoples had only 70 per cent (20 per cent) more health problems than the total population, but in fact mortality levels in 2001–03 were between 300 and 500 per cent higher in the States and Territories where this data was available.^{1, 6}

The AMA calls for the Australian Government to pledge \$460 million a year, that's \$1.8 billion over four years, to Aboriginal and Torres Strait Islander primary health care.

In 2005–06, Australian Government actual health expenditure was \$37.1 billion.⁷ The AMA is only calling for an annual increase of 1.2 per cent. To put this into context the Australian Government's advertising bill for 2005–06 was \$208.5 million, and in 2003–04 Australians spent over \$10 billion on alcohol and tobacco.^{8, 9}

PREVENTION

Primordial Prevention – Prevention of risk factors themselves, beginning with change in social and environmental conditions in which these factors are observed to develop, and continuing for high-risk children, adolescents and young adults

Primary Prevention – Interventions prior to the exhibition of symptoms of a condition, eg. legislating against food advertising during children's programs, immunisation, developing urban environments that promote exercise, fostering self-esteem and pride in family and community

Secondary Prevention – Interventions that identify or treat people who are asymptomatic but who already have risk factors or pre-clinical disease, eg. raised blood pressure, pre-diabetes, smoking, obesity, sedentary lifestyle

Tertiary Prevention – Interventions when there is established disease and the aim is to maximise function and minimise complications, eg. cardiac rehabilitation, and efforts aimed at reducing circulatory complications from diabetes

Much prevention lies outside the health system in the education, housing, and economic sectors. However, some primary prevention, and secondary and tertiary prevention, occurs within primary care, so underspending to this area would reduce the prevention activities.

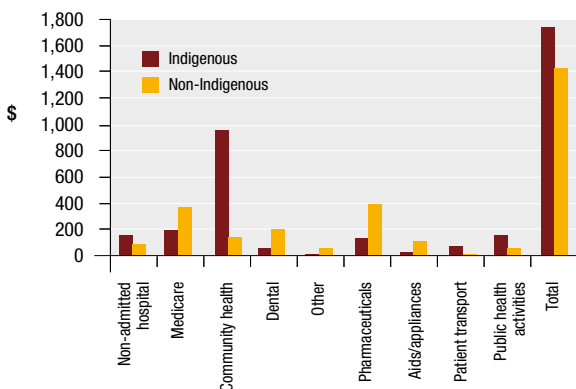
Secondary prevention requires diagnosis of the problem, and then interventions to reduce its impact. This could be by providing quit smoking initiatives, high blood pressure treatment, or efforts to reduce obesity (and diabetes). Some of this occurs in primary care but also through referral for tests and/or to specialists when necessary. *Bettering the Evaluation And Care of Health (BEACH)* study data shows that Aboriginal and Torres Strait Islander patients who visit General Practitioners (GPs) appear to receive about the same level of tests and prescriptions as non-Indigenous patients.¹⁰ However, due to higher levels of illness, there should be higher levels of treatment including greater numbers of prescriptions and tests for Aboriginal and Torres Strait Islander patients.

The main shortfall, resulting in low levels of secondary prevention, is access to GPs or other primary care services (Aboriginal health services), Pharmaceutical Benefits Scheme (PBS), and other Medicare Benefits Schedule (MBS) funded services.

PRIMARY CARE

Primary health care funding per capita - all sources 2001–02

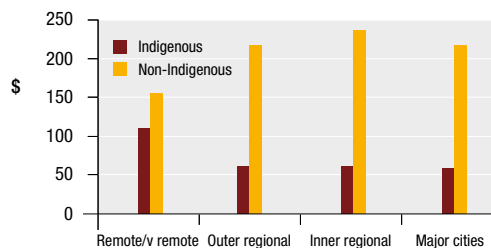
Source: AIHW 2005⁶



PHARMACEUTICAL BENEFITS SCHEME

PBS spending per capita by Indigenous and residence status 2001–02

Source: AIHW 2005⁶



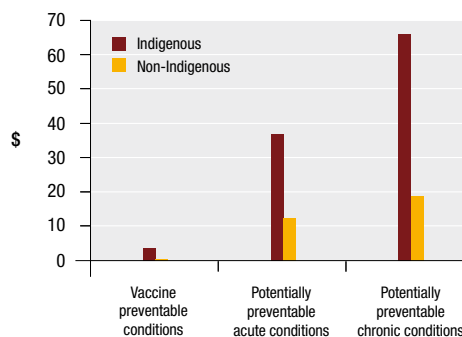
Effectiveness of current primary care services

The recent *Productivity Commission Report on Government Services* uses hospitalisations for certain diseases as a measure of the effectiveness of primary care services. Vaccine preventable hospitalisations and hospitalisations for potentially preventable acute and chronic conditions indicate the effectiveness of primary and community health care.

The primary care system is clearly failing Aboriginal and Torres Strait Islander peoples compared to the rest of the population.

Standardised hospital separations per 1000 people 2004–05

Source: Productivity Commission 2007¹¹

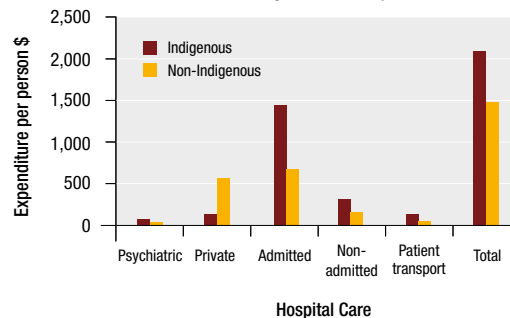


SECONDARY CARE

Secondary/tertiary care expenditure per capita - all sources 2001–02

Source: AIHW 2005⁶

Aboriginal and Torres Strait Islander mortality was 3-5 times non-Indigenous mortality in 2001-2003



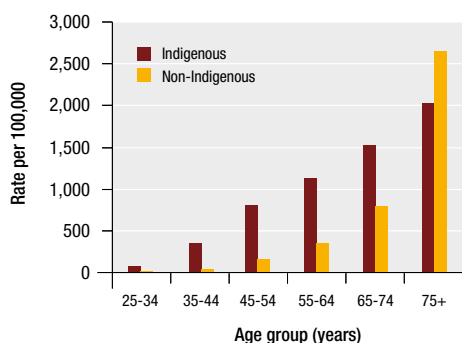
Coronary Heart Disease*

What is happening in coronary heart disease (CHD) is overwhelming:

- Aboriginal and Torres Strait Islander peoples are three times more likely to have a major coronary event than other Australians
- The rate is higher in all age groups except the over-75s
- If Aboriginal and Torres Strait Islander peoples had the same health profile as non-Indigenous Australians, 1338 of them would not have had a heart attack in 2002–03. Compare this to the 2005 Australia-wide road toll of 1636¹²
- Aboriginal and Torres Strait Islander peoples are 1.5 times more likely to die after a major coronary event than other Australians
- If fatality rates were equal across the population, 242 fewer Aboriginal and Torres Strait Islander people would have died in 2002–03
- If the incidence and case fatality rates were equal across the population there would have been 594 fewer Aboriginal and Torres Strait Islander deaths in 2002–03
- Indigenous patients are less likely to have angiography to assess the problem or to undergo coronary revascularisation.^{13,14}

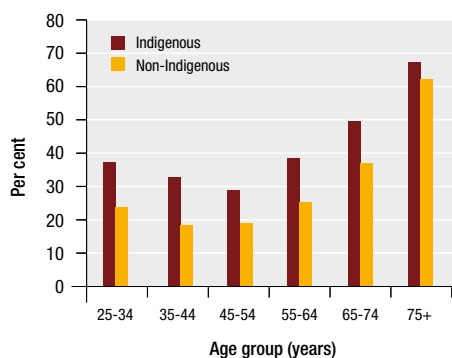
Incidence of major coronary events in QLD, WA, SA and NT, 2002–03

Source: AIHW 2006¹³



Case fatality rates for major coronary events in QLD, WA, SA and NT, 2002–03

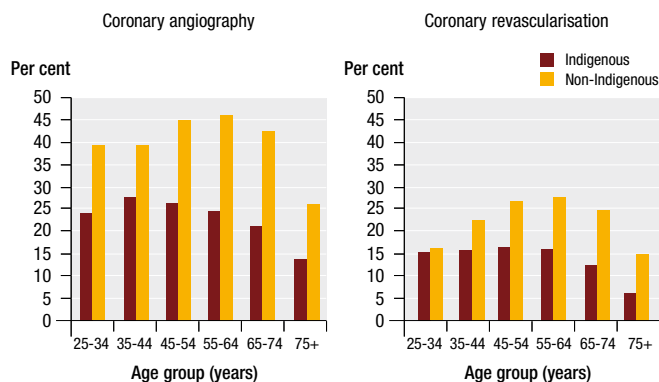
Source: AIHW 2006¹³



* The data for this section are from Qld, WA, SA and NT which represents 60% of the Indigenous population. The numbers have been extrapolated to represent the whole population assuming the patterns are the same in ACT, Tas, NSW and Vic.

Proportion of CHD hospitalisations with a coronary procedure (during one episode of care) in QLD, WA, SA and NT, 2002–03

Source: AIHW 2006¹³



Renal transplantation for end stage renal disease

A study to assess Aboriginal and Torres Strait Islander peoples' access to renal transplantation, compared with non-Indigenous Australians, found barriers to acceptance onto waiting lists and progressing to transplantation. The NHMRC-funded *Improving Patient Access to Kidney Transplantation (IMPAKT)* study is currently undertaking research to identify the causes. The results will soon be available and will help to focus strategies to improve transplantation equity.^{15,16}

A study of Aboriginal and Torres Strait Islander recipients of cadaveric kidney transplants in the Northern Territory found they had worse outcomes than non-Indigenous recipients, mainly due to increased mortality and morbidity from infective causes.¹⁷ Might this be why they do not get put on the list or move up the list? Is this an acceptable reason?

In-hospital diagnostic and therapeutic procedures

A study of 1997–98 public hospital patients found that patients who identified as Aboriginal and/or Torres Strait Islander were significantly less likely to have a principal procedure recorded – even after adjusting for patient, episode and hospital characteristics – than other patients. This difference was apparent for most diseases and conditions. In private hospitals, there were no significant differences, but Aboriginal and Torres Strait Islander patient numbers were relatively small.

The disparity in procedure rates, after adjusting for relevant factors, indicates there could be systematic differences in the treatment of Aboriginal and Torres Strait Islander and non-Indigenous patients at Australian public hospitals.¹⁸

Summary

There is evidence that Aboriginal and Torres Strait Islander peoples are disadvantaged throughout the health system. There is inadequate funding in primary care, mainly due to significant under-utilisation of MBS and PBS, which leads to low levels of prevention, primary care treatment services, under-use of MBS-funded specialists, and under-servicing in the hospital system compared to equally ill non-Indigenous patients. The result is avoidable, premature mortality – even without addressing the underlying social and economic issues.

CAUSES

WHAT ARE THE BARRIERS?

The causes of the observed differences are multiple, as are the solutions. In the United States, concerns about the quality of health care provided to racial and ethnic minorities, compared with white Americans, prompted Congress to request an investigation by the US Institute of Medicine (IOM). Their landmark 2003 report, *Unequal treatment: confronting racial and ethnic disparities in health care*, found convincing evidence that racial and ethnic disparities existed across a wide range of conditions and health services, and were associated with poorer health outcomes.¹⁹ The study focused on health care disparities where differences in the quality and quantity of health care were not due to clinical needs, appropriateness of interventions, patient preferences and physical access related factors.

It is generally accepted that health care disparities are associated with socio-economic differences.²⁰ However, the US IOM report highlights that, in the majority of studies, racial and ethnic disparities remain, even after adjustment for socio-economic differences and physical access related issues. The data on life expectancy in this *Report Card* confirms the same is true for Aboriginal and Torres Strait Islander peoples.

Individual access barriers can be divided into financial and non-financial barriers. Non-financial barriers can be further divided into those due to the lack of availability of providers and services, personal issues and lack of social support, knowledge, and awareness of how services work and how services can and should be accessed.

Principal Financial Barriers

- Overall cost of services – MBS and PBS safety nets are often not accessible because family structures are not recognised by the system
- Travel and accommodation costs and
- MBS and PBS co-payments.

Principal Non-Financial Barriers

- **Availability of providers and services – including system design barriers**
 - lack of services (including equipment) within a reasonable distance
 - shortage of health workers
 - the necessity of Medicare Card and/or Concession Cards. Homelessness and overcrowded living conditions make storage and access to Cards difficult and
 - lack of transport.
- **Personal**
 - fear of services and what use of services may mean, eg. 'you go to the hospital to die'
 - lack of cultural awareness of health service staff
 - lack of sensitivity to cultural issues such as mixed sex environments, gender of health staff
 - language barriers
 - lack of effective communication
 - provider attitudes.
- **Lack of social support, knowledge, and awareness of how services work and how services can and should be accessed.**

INSTITUTIONAL RACISM

The US IOM study and the growing body of Australian evidence suggest that there is something more going on than these recognised barriers. This can be put under a definition of 'institutional racism'. Institutional racism '*refers to the ways in which racist beliefs or values have been built into the operations of social institutions in such a way as to discriminate against, control and oppress various minority groups.*'²¹ It has been claimed that institutional racism is embedded in Australian institutions, and in the health system in particular.^{22,23} Institutional racism is often covert, and is frequently unrecognised by the agents involved in it.

Forms of Institutional Racism occurring at the individual, and patient-provider levels

- The conflict between efficiency and equity. While trying to maximise efficient use of scarce resources, doctors prioritise interventions for those who are at lower risk of post-intervention complications, or those more likely to 'benefit'. This inadvertently reduces an Aboriginal and/or Torres Strait Islander patients' access to beneficial interventions as they often have multiple risk factors²⁴
- Published clinical guidelines may inadvertently bias services away from Aboriginal and Torres Strait Islander patients as they may receive less benefit from an intervention for example if those with diabetes or obesity are excluded from a treatment
- Stereotyping, bias, and uncertainty about the severity of the disease, and the capacity and willingness of Aboriginal and Torres Strait Islander patients to undergo a particular treatment successfully, may influence the offering of that treatment
- In the US, it was found that doctors who treat black American patients have less power, fewer resources, and possibly less training than doctors who treat white Americans.¹⁹ In Australia, approximately 30 per cent of doctors working for community controlled health services are International Medical Graduates (IMGs). A significant number of these IMGs do not speak English as a first language, and there is a likelihood that IMGs, especially recent recruits, will be less able to negotiate the system for their patients
- There is little evidence that an Aboriginal and/or Torres Strait Islander person's health care preferences are very different from a non-Indigenous person when based on a full and accurate understanding of the treatment options. Mistrust and lack of good communication may lead to refusal of treatment. Such refusals are often accepted as 'culturally based', rather than investigated to allow systems to be developed to overcome the mistrust or lack of communication
- Mainstream health services' expectations that they should provide the same service for all their patients neglect the differing needs of minority populations
- Experiences with direct discrimination such as being placed lower down a waiting list because they are Aboriginal and/or Torres Strait Islander people.

SOLUTIONS

THE AMA DEMANDS TARGETED ACTIONS TO REDUCE THE INEQUITY

There must be a commitment to reduce financial and cultural barriers for the individual and institutionalised inequity in diagnostic and treatment services. Hospital and clinic administrators including GPs must assess their present level of service to Aboriginal and Torres Strait Islander clients, compared to their non-Indigenous clients, and ensure that any differences are understood and addressed. These health service providers may need to provide additional training to their staff, and support services to their clients.

The AMA believes all Australian governments must commit:

1. To achieve the same life expectancy for Aboriginal and Torres Strait Islander peoples as for other Australians within a generation, and to close the life expectancy gap to 10 years or less by 2015
2. To ensure all Aboriginal and Torres Strait Islander peoples have geographical, financial, and cultural access to comprehensive primary health care services by 2012
3. To Aboriginal community control as the preferred option for providing appropriate and accessible comprehensive primary health care for Aboriginal and Torres Strait Islander peoples
4. To all health services provided specifically for Aboriginal and Torres Strait Islander peoples to be designed, developed, and controlled by the communities they serve, in collaboration with mainstream services
5. To services provided specifically for Aboriginal and Torres Strait Islander peoples to be increasingly provided by those from Aboriginal and Torres Strait Islander backgrounds
6. To improve access for Aboriginal and Torres Strait Islander people to all Medicare rebated services and the PBS for example by reducing to zero the PBS and MBS safety nets for Aboriginal and Torres Strait Islander peoples
7. To fund health services to achieve outcomes agreed by the community, rather than some benchmarked 'fair' level. Only when parity in life expectancy has been achieved would any such sense of 'fair' be appropriate
8. To make it part of the accreditation process that all government funded and private health services provide culturally appropriate services to Aboriginal and Torres Strait Islander peoples
9. To make it part of the accreditation process that all government and private health service providers have:
 - A policy on recruitment and retention of Aboriginal and Torres Strait Islander staff
 - A Charter detailing the level of service an Aboriginal and Torres Strait Islander patient will receive, including arrangements to ensure cultural issues are recognised and addressed within each service
 - A system to provide interpretation and cultural support where necessary for patients
 - A cultural awareness and safety-training program to ensure all staff understand and implement the Charter commitments.

The AMA calls for:

1. An additional \$460 million a year in targeted resources, particularly for community controlled primary care
2. Commitment to a target of 2.4 per cent of all health professionals being from Aboriginal and Torres Strait Islander backgrounds by 2012
3. Mainstream services to focus current resources to improve health outcomes for Aboriginal and Torres Strait Islander peoples.

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