

Strengthening primary health care to improve Indigenous health outcomes

We need to better implement what we know works for Indigenous populations

What can the health system do to improve Indigenous health outcomes in Australia? Two articles recently published in the Journal offer some insights into the evidence behind what works, how we know it works, why it works and implications for policy.^{1,2}

In Australia, hospitalisation rates are high and primary health care (PHC) services are relatively underused by Indigenous populations, and this trend worsens with increasing remoteness.³ There is strong evidence locally and internationally that strengthening PHC results in fewer hospitalisations and better health outcomes.^{4,5} How can we “strengthen PHC”?

We know that a number of strategies are effective. These include increasing access to encourage utilisation. For example, in remote areas of the Northern Territory, increasing PHC utilisation was associated with decreased hospitalisation, improved clinical outcomes and decreased mortality.⁴ Overcoming access problems, particularly in a culturally and historically complex environment, may not be simple and relates to workforce and governance issues as discussed below.⁶ Straightforward system changes, such as introducing recall systems as part of quality improvement with specialist outreach support, results in improved clinical outcomes.⁷ Cresp and colleagues in Western Australia recently reported on the Koorliny Moort program.² This program provides partnership with community-based primary care providers, nursing led care coordination, and outreach care closer to home. It was able to substantially reduce the number of children’s emergency department presentations (incidence rate ratio [IRR], 0.47), hospitalisations (IRR, 0.7), length of stay (IRR, 0.23) and the number of non-attended appointments (IRR 0.83).² The study showed that hospitals can play a significant role in supporting PHC through a combination of improved coordination (eg, help with follow-up and combining and coordinating appointments), a focus on communication (eg, locating medical records, ensuring discharge planning and dealing with social issues) and providing treatment as close to home as possible through outreach clinics or telehealth.

Both Segal and colleagues¹ and Cresp and colleagues² demonstrated the importance of collecting, analysing and using health information to inform service delivery, patient care and population health programs at local and regional levels.



For PHC strengthening measures to be successful, the service models need to be appropriate for their context, be it rural, remote or urban. This is exemplified by a 10-year follow-up of morbidity and mortality in a decentralised Indigenous community.⁸ Segal and colleagues’ economic evaluation of intensive management by Indigenous Health Workers of poorly controlled diabetes showed a relatively expensive model (\$6706 per annum per capita) with a modest non-significant differential effect on the level of HbA_{1C} (−0.43%, 85% CI, −1.06% to 0.19%). The authors described limitations of the study such as a short follow-up period, difficulties in recruitment, clinic pressures and the disruption of service restructuring. They also speculated about whether a broader model of care might be required, given the severity and complexity of disease and its underlying drivers.¹

“We need service models fit for context and adequately funded, with a strong focus on prevention”

Aboriginal Community Controlled Health Services have developed a model of comprehensive PHC that seeks to focus on prevention and health promotion, and to address the social determinants of health.⁹ There is evidence that such models positively influence access and other outcomes.^{9,10} This has undoubtedly been a positive response to health and social needs. However, the evidence base is not strong and there are inherent methodological difficulties (such as agreed measures and standards of effectiveness in the Aboriginal health context).¹¹ More studies on their impact would be useful.

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At the same time, mainstream general practice needs to ensure its acceptability for Indigenous patients through strategies such as engagement with the local Indigenous community.¹²

Funding needs to be adequate to the task. Most costs will relate to health professionals. Successful strengthening of PHC entails building regional training pipelines with universities, recruiting and preparing an appropriate workforce that includes Indigenous health professionals. Only 1% of nurses and 0.5% of doctors are Indigenous. This is well below population parity. Growing the Indigenous workforce across all health disciplines is imperative, especially to improve service acceptability for Indigenous patients.¹⁰ The Koorliny Moort program highlights the effectiveness of Indigenous staff's ability to engage Aboriginal families.²

Monitoring and evaluation are not possible without appropriate information technology infrastructure. Improving the e-health capacity in Australia remains a

priority, particularly for mobile populations for whom coordination and continuity of care are critical.

In conclusion, there are multiple proven strategies for strengthening PHC and improving health outcomes. We need service models fit for context and adequately funded, with a strong focus on prevention, and we need to continue to develop an appropriately trained workforce with strong Indigenous leadership. Better integrated care is achievable and Primary Health Networks must play an important role. We also need the wherewithal to rigorously evaluate performance and outcomes. Underlying these individual strategies is the imperative for a whole-of-system approach and policy consistency, as system stability can result in good health outcomes at an efficient price.¹³

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