

5. Conclusion

This report has taken a new approach to answering the question of how primary health care can contribute to ‘closing the gap’ in life expectancy between Indigenous and non-Indigenous Australia.

Rather than argue predominantly from case studies (which can draw the criticism of leading to ‘policy by anecdote’), or alternatively from the resource deficit between mainstream and Indigenous Australia, we have attempted to take a more rigorous approach. This has involved a new examination of the foundation evidence about the effectiveness of primary health care on population health.

What, then, are the lessons to draw for policy makers and governments in Australia which have the aim of closing the health gap between Indigenous and non-Indigenous Australians within a generation?

We identify several key policy questions – and how the evidence in this report relates to them.

Do health care services matter?

The arguments of Thomas McKeown in the 1970s and the evidence from the social determinants of health have added greatly to our understanding of how critically important economic, social and political factors are in determining the health of populations. Increased understanding, however, of the causal pathways involved in the complex conditions affecting adult populations, including Indigenous people, and advances in medical care, have combined to weaken the more polemic manifestations of the “social determinants” position.

Nonetheless, this position has led to a persistent popular and political argument that health services are fundamentally irrelevant to ‘closing the health gap’¹³⁴ and that economic and social approaches should be the focus instead.

The evidence does not support such a position.

Instead, the international evidence is clear about the positive effect of primary health care on the health of populations, and specifically on the health of Indigenous peoples. While unemployment, lack of education, poor housing, low income and social exclusion are all clearly associated with poorer health, the evidence shows that primary health care can ‘offset’ these effects to some extent, particularly through its

¹³⁴ See, for a recent example, Pearson, C. (2008). Nanny's unhealthy regard. [The Australian](#), 29 March 2008.

beneficial effects on the health of mothers and children and in the management of established adult disease, principally chronic disease.

The policy approach that makes most sense under such circumstances is not one that focuses *either* on the social determinants of health *or* on health services, but one that does *both*. Such an approach is advocated by numerous population health experts, most recently in Australia in the extensive examination of the burden of disease carried by Aboriginal and Torres Strait Islander people, which states that:

*... these requirements [to address the social and economic disadvantages that contribute to the poor health status of Indigenous Australians] should not lead to inaction by health policy makers arguing that the social and economic problems should be tackled first. It is within the reach of appropriately resourced health services to reduce a sizeable proportion of the Indigenous health gap.*¹³⁵

The evidence from this review strongly supports that conclusion.

Why have overseas gains not been reflected in Australia?

The evidence shows that Indigenous populations overseas have made gains in health that are attributable to primary health care. Their gains are, however, beyond that seen by Aboriginal and Torres Strait Islander communities as a whole.

We suggest that this is predominantly the result of under-investment in primary health care for Indigenous communities in Australia, compared to the large disadvantage they suffer. This is distinct from the large disadvantage that Aboriginal and Torres Strait Islander people suffer in many of the key social determinants of health such as education, housing, employment and income.

What gains have been made here in recent years have been the result of at best modest increases in primary health care funding against a backdrop where the social determinants of health have also not improved significantly.

Given the documented ability of primary health care to offset the effects of disadvantage, it is clear from this evidence that Aboriginal and Torres Strait Islander people are yet to fully benefit from what primary health care can deliver.

What needs to be done?

Given that primary health care services – along with action on education, employment, poverty, housing, etc – are an important part of improving the health of

¹³⁵ Vos T, Barker B, Stanley L, Lopez AD (2007). The burden of disease and injury in Aboriginal and Torres Strait Islander peoples. Brisbane: School of Population Health, The University of Queensland.

Aboriginal and Torres Strait Islander communities, we identify two key policy aims for the Australian Government.

Guaranteeing universal access to primary health care

The comparison in this report of the development of primary health care for Indigenous people and the reduction of avoidable mortality, between Australia and other developed nations, suggests that Australia has underinvested in primary health care. A national commitment by all Governments together to significantly increased investment in primary health care for Aboriginal and Torres Strait Islander people is supported by the evidence.

At the local level, many Indigenous primary health care services are able to document better health outcomes for the communities they serve. However, it is unfortunately, not the case that all Aboriginal and Torres Strait Islander communities have access to such primary health care services. To the extent that such access is only partial, the ability to close the health gap will be, at best, partial.

Increases in Indigenous primary health care funding over the last decade have overwhelmingly been provided by the Australian Government, through increased grant funding from the Office for Aboriginal and Torres Strait Islander Health (OATSIH) and also improved access to the MBS and PBS for Indigenous communities. These increases have, however, been offset by rising health care costs and an increasing Indigenous population.

Nevertheless, many communities have benefited only partially from the increases in primary health care funding provided by the Australian Government. A joint national commitment by all Governments would result either in increased State and Territory investment in primary health care services (including through community-controlled services in their jurisdictions, through funds-pooling models or funding of services such as mental health or substance misuse services for which those jurisdictions generally have responsibility) or in increased Australian Government investment. There are also significant gaps within the areas served by Australian Government funded services. No Australian government is exempt from this call.

We note also the demand made in some previous programs for formal mechanisms of community-control to be established before primary health care services could be established.¹³⁶ As we have seen, maximum community participation in the running of primary health care is central to their success. However, some communities do not have the ability or desire to take responsibility for running a health service – at least in the short term – and it is problematic to require communities which are amongst the poorest and most disadvantaged in the country to demonstrate sufficient cohesiveness to set up and run their own incorporated organisation before they

¹³⁶ For example, in some areas with the roll-out of the Primary Health Care Access Program.

receive an adequately resourced primary health care service. Already-established community-controlled services and their representative bodies may play a significant role in overcoming this barrier.

A fundamental policy aim must therefore be that all Aboriginal and Torres Strait Islander communities, whatever the governance structure they may choose, must be guaranteed access to the core functions of primary health care, under models that maximise the participation of the local community. This is equally true for urban, rural and remote areas, each of which pose their own challenges requiring imaginative and flexible solutions in the form of service provided.

The importance of evidence

Ensuring that all Aboriginal and Torres Strait Islander communities have access to primary health care will clearly cost money. However, achieving the greatest gain for any given investment in primary health care is also dependent on implementation of evidence-based best practice.

Services which have an evidence-base are more likely to achieve outcomes in health for the communities they serve. This evidence – in the shape of treatment protocols and a recognition of certain key interventions as an investment in long-term population health – have been increasingly well documented over the period since the transfer of Aboriginal and Torres Strait Islander health to the Commonwealth Health Department. In particular, maternal and child health and the early detection and management of chronic disease are critically important.

Applying this evidence effectively requires a recognition and respect for the diversity of health, cultural and social conditions at a local level, and in practice, attention to the conditions and capacity, needs and priorities of the local Indigenous community.

We would argue that it is no accident that many 'best-practice' models are those which emphasise genuine community engagement. It seems that whatever the benefits are in terms of local empowerment and employment (both important from a point-of-view that recognises the importance of the social determinants of health), community controlled health services provide fertile ground for 'the evidence' and the views, practices, priorities and needs of the local Indigenous world views to meet and inform each other.

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Appendix 1

Organisations and experts consulted

- Aboriginal Medical Services Alliance Northern Territory (AMSANT), Darwin
- Professor Ian Anderson, School of Population Health, University of Melbourne
- Professor Ross Bailie, Menzies School of Health Research, Darwin
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- Ms Heather Sculthorpe, Tasmanian Aboriginal Centre
- Mr Gavin Stewart, Coordinator AMHAT Project, Aboriginal Health & Medical Research Council of NSW
- Associate Professor Paul Torzillo, Central Clinical School, University of Sydney

Appendix 2

Interview outline for modified Delphi method panellists

We want to ask you about an Indigenous community (or communities) that you have worked with or of which you are aware where health (or some aspect of health) improved for the people there.

1. What about the health status of the people in that community improved?
2. What aspects of health improved? (e.g. infant and child health, nutrition, maternal health, adult health, health of old people)
3. How was this change measured? (e.g. service statistics, research / evaluation / observation)
4. Can you attribute at least part of this improvement to primary health care?
5. If PHC had an effect, what specifically about PHC was important?
 - Better access to services (including links to hospital / specialist services)
 - Specific programs (e.g. immunisations, child and maternal health, chronic disease management, social and emotional well-being, drug and alcohol interventions etc)
 - Organisation of the service (e.g. community involvement, evidence-based programs, workforce, resourcing)
6. If PHC did not have a direct effect, what caused the change in health status? For example, better housing, transport, education, local economy etc
7. Did the primary health care service have an indirect effect on the existence or shape on the factors that did contribute to better health? (e.g. through advocacy for better housing, environmental health etc)
8. Are there any published studies documenting the changes above? If so, where could we find them?
9. Are there other places where this has been written up – presentations, unpublished reports, conference papers? If so, are we able to access a copy?



10. Are you aware of other communities where primary health care may have had a positive effect on health? If so, where are they and who would be able to give us more information on these examples?

Thinking more generally about the effects of primary health care on the health of Aboriginal and Torres Strait Islander communities...

11. Who else do you suggest we speak to in order to understand these effects?
12. Nominate a second person who has a different perspective on these issues to yourself.