

## 7. Prevention is better than cure - Comprehensive Primary Health Care

**One of the keys to improving the health of Indigenous people in Australia is the provision of accessible, affordable, comprehensive primary health care services.**

The general population of Australia is one of the healthiest in the world, and most Australians have ready access to a world class health system. At the same time, Indigenous Australians have the poorest health and do not have the same access to appropriate health care as the general population<sup>1</sup>.

The Australian Medical Association reported in 2002 that greater progress in Indigenous health had been made in other developed countries<sup>2</sup> due to greater investment in primary health care, environmental improvements and social justice in those countries<sup>3</sup>.

### What is primary health care?

When you visit your local GP or go to the chemist, you are using a primary health care service. Primary health care should be available as close as possible to where people live and work.

For most people in Australia, primary health care services are convenient, easily accessed and affordable. The Medicare system first established in Australia in the 1970s<sup>4</sup>, was designed to be a universal scheme, providing access to health care for all Australians<sup>5</sup>. This scheme still underpins our health system and most of the cost of primary health is paid for by governments under the Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS).

This health system is not 'universal' for Indigenous Australians. Indigenous people have much less access to doctors and pharmacies because of the cost and because of the lack of provision of health services in outer urban areas, and rural and remote regions where most Indigenous people live.

Indigenous people tend instead to use Aboriginal community-controlled health services (ACCHSs) or hospitals. ACCHSs

often play a critical role in Indigenous health, but they are not always available.

Where they do exist, ACCHSs are generally over-stretched and under-resourced; many are unable to employ key health staff or provide a full range of services because they do not have enough funds.

***“An effective primary health care system must provide a range of services that match client needs, are available and accessible, and are delivered in such a way that the target group can make full use of them.”***

(Commonwealth Dept of Health and Aged Care, *Better Health Care*)

### What is comprehensive primary health care?

Comprehensive primary health care is a broad based approach to health care. It can include not only clinical care (doctors, nurses, health workers), but prevention programs, health promotion, rehabilitation, public health measures and advocacy on health related matters<sup>6</sup>.

Prevention programs can include immunisation, antenatal care, screening and early intervention, preventing complications of chronic diseases, and other measures.

International experience has shown that a comprehensive approach can help bring about real improvements in health in developing countries and in Indigenous populations. This approach is starting to be used in Australia<sup>7</sup>.

**The World Health Organization** defines primary health care as the principal vehicle for the delivery of health care at the most local level of a country's health system. It is essential health care made accessible at a cost the country and community can afford with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it. Beside an appropriate treatment of common diseases and injuries, provision of essential drugs, maternal and child health, and prevention and control of locally endemic diseases and immunization, it should also include at least education of the community on prevalent health problems and methods of preventing them, promotion of proper nutrition, safe water and sanitation.

[www.iime.org/glossary.htm](http://www.iime.org/glossary.htm)

### Primary health care is more cost-effective

About half of the total national expenditure on Indigenous health is spent on hospital care. This reflects not only their poorer health, but a significant lack of access to primary health care services.

Indigenous people in Australia are not receiving health care early enough to prevent serious ill health.

Indigenous people carry a heavy burden of illness that takes a huge toll on communities and families, physically, emotionally and financially.

The financial consequences of this burden of illness impact on all Australians because public health budgets must cover the high cost of hospital care for people who are ill from diseases that could have been prevented.

## Investing in primary care can save lives and costs

The rising epidemic of kidney disease is an example. Kidney disease following streptococcal skin infections is almost unheard of in the developed world but is a major problem in Indigenous communities<sup>8</sup>. In Australia, the rates of kidney disease requiring dialysis are *6.4 times higher* for Indigenous men and *14 times higher* for Indigenous women than for non-Indigenous men and women.

As well as the suffering of the individual, this is an unsustainable burden on the health system. Dialysis treatment in hospital costs approximately \$100,000 per person per year<sup>9</sup>. In the Northern Territory, end-stage renal disease is doubling every four years<sup>10</sup>. It is estimated that an additional \$50 million will be needed for the NT alone over the next five years just to cover the cost of dialysis<sup>11</sup>.

### Yet these levels of serious illness and their high cost can be prevented.

Research on the Tiwi Islands north of Darwin has shown that a simple screening, prevention and treatment program at community level reduced deaths due to heart disease, and limited progression to end stage kidney failure by over 50%<sup>12</sup>. Before the study, the Tiwi people (population 1800) had a renal failure rate *60 times* higher than the non-Aboriginal NT population.

The program was mainly conducted by local health workers and community project officers. It cost \$1,210 per person per year (for 258 people who took part) and is estimated to have saved up to \$11.4 million in dialysis costs<sup>13</sup>.

In the Torres Strait, 24% of people over the age of 15 have diabetes. A study in Indigenous communities has shown that the use of diabetes outreach services and systems which recalled patients for check ups resulted in significant reductions – up to 41% – in costly hospital admissions for diabetes-related conditions<sup>14</sup>.

Studies like these show that timely prevention is not only better for health, it is much less expensive.

### Cost-effective health care

The current health situation is unjust and unrealistic in terms of the long term future costs for all Australians. A major injection of funding is needed to turn the **health emergency** around.

**“...we know about the poor health of our people, and therefore it is important that we are the ones who make the decisions about our health problems. Communities that make the decisions about their health problems are the most successful in fixing those problems.”**

Donna Ah Chee, Branch Manager, Congress Alukura

### Investing ‘smarter’ – Coordinated Care Trials

Lives and long term costs can be saved by using resources *more effectively* and by empowering Indigenous people to take control.

An Indigenous ‘Coordinated Care Trial’ in the Katherine West region of the NT pooled Commonwealth and Territory funds for the region and gave control of the funds to a regional health board, elected from local communities. In a region 2.5 times the size of Tasmania, the Katherine West Health Board was able to employ doctors to work in communities (for the first time), hire community-based health administrators and more nurses, and provide better services. During the trial, the number of evacuations to hospital was reduced by 19% over a period of just six months<sup>17</sup>. A review of the trial concluded there was a shift from hospital-based services to primary care services which showed that access had improved and service provision was *more efficient*. Non-Aboriginal people in the region also gained a significant upgrade of health services<sup>18</sup>.

### The Primary Health Care Access Program (PHCAP)

In 1999, the Commonwealth initiated PHCAP, which aims to increase the availability of appropriate primary health care services to Indigenous people. The program provides a way for the Commonwealth, states and territories to work together in a coordinated way and provides increased funding to start meeting regional health needs.

PHCAP is a good start, but the additional funding will not meet the need. It is estimated that an additional \$300 million per year is needed to provide equitable primary health care, including public health and prevention programs<sup>15</sup>. PHCAP will only receive \$54.8 million in 2003-4 and \$57.2 million in 2004-5<sup>16</sup>.

### Appropriate and accessible care for all Australians

Many Indigenous communities have established their own health services to ensure they have access to health care. However, there are many more regions and communities which don’t have such services at all, or where these services can’t deliver comprehensive primary care. In these situations, good cooperation is needed between Indigenous and non-Indigenous services. Some mainstream services may need to change to ensure that Indigenous people can use them, and that our health system is truly ‘universal’.

### References

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3. AMA Report Card, *No More Excuses*, 2002
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5. Stephen Duckett, *The Age*, 5 Mar 2003, <http://www.theage.com.au/articles/2003/03/04/1046540186994.html>
6. See Aboriginal Medical Services Alliance Northern Territory (AMSANT) website for a description of comprehensive primary health care at <http://www.amsant.com.au/amsant/what-is-primary-health-care.html>
7. Information in this section is drawn from *Better Health Care* (see footnote 1)
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18. *Better Health Care*, p.83

