

# Improving the health of rural and remote Aboriginal communities through state-wide education and employment initiatives

**Aeron Simpson**<sup>1</sup>

<sup>1</sup>Office of Aboriginal Health, WA Health

Comprising around 2.3% of the overall Australian population, and 3.5% of the West Australian population, Indigenous Australians are fighting battles that have persisted for around 200 years<sup>1</sup>. There is an overwhelming body of evidence testifying that Aboriginal Australians experience poorer health, education and employment outcomes than any other population group in Australia<sup>2,3,4,5,6,7,8</sup>. While determinants of these outcomes are as varied as Aboriginal communities themselves, there is little doubt as to their interrelated complexities.

Over the past decades, extensive work has been dedicated to improving Aboriginal standards of living. While these efforts have resulted in improvements to Aboriginal health on the whole, two centuries of dispossession and the lasting impact of colonisation have resulted in levels of ill health among Aboriginal people remaining unacceptably high<sup>9</sup>. Furthermore, this modest progress has occurred in tangent to significant gains in the health status of Indigenous people elsewhere in the world<sup>10</sup>.

Geography is a key determinant of health. While deaths due to heart disease, cancer, diabetes, respiratory diseases and injuries remain major issues for all Aboriginal people, Aboriginal people living in rural Western Australia generally experience higher rates of mortality and hospitalisation than those living in the metropolitan area<sup>11</sup>.

This outcome may be attributed to approximately 66% of Aboriginal Western Australians residing in rural, remote and isolated areas. Historically health services in these areas have been culturally inappropriate due to cultural and geographical inaccessibility, and cost factors.

The main health problems experienced by these Aboriginal populations are:

Infants	High rates of low birth weight, high rates of growth faltering (or failure-to-thrive), high rates of infections (particularly respiratory and gastrointestinal)
Young children (3-8 yrs)	Repeated and/or chronic infections (particularly of the skin, ears/nose/throat, eye, respiratory system, gastrointestinal and genitourinary), under nutrition, anaemia, intestinal parasites
Older children 9-14 (yrs)	Repeated infections, growth retardation, accidents, alcohol and drug abuse
Youth (15-20 yrs)	Communicable disease, incarceration, suicide, self harm, injury, poisonings, alcohol and drug abuse
Adults (21-40 yrs)	Respiratory diseases, digestive system disorders, obesity, hypertension, cardiovascular disease, diabetes (type 2), complications of pregnancy; chronic renal diseases and renal failure, alcohol-related disorders, psychosocial stress and mental disorders, accidents and violence
Elderly (>40 yrs)	Disabilities, immobility, chronic diseases requiring regular clinical care and supervision, provision of adequate and culturally appropriate services and facilities

(West Australian Department of Health)

Poor health status is reflected in the average life expectancy of Aboriginal people at birth (males 61 and females 67 years). This is approximately 14 years lower than for other Western Australians. Rural and remote factors impacting on these health outcomes include:

- fresh food costing between 150-180% of capital city prices in some remote communities (which has a weighted factor given many Indigenous Australian are on work for the Dole programs with limited disposable income)
- education, numeracy and literacy levels being significantly lower in many Aboriginal than non-Aboriginal communities
- basic health services being non-existing or not accessible to many Aboriginal people residing outside metropolitan and regional areas
- lower employment availability, skill mix may not be suitability for employment options, or distances to employment may be too great to justify.<sup>12</sup>

Furthermore, through discussion with Aboriginal communities in regional areas, it has become apparent that many people are reluctant to seek medical attention until their condition is serious. High Aboriginal morbidity and poor access to health services results in many Aboriginal people suffering acute stages of preventable chronic diseases that could have been better managed through early identification and treatment.

The current approach to improving the health of Aboriginal people relies to a large extent on general health services. However, the workforce in the public hospital and community health sector remains overwhelmingly non-Aboriginal even in regions where a significant proportion of the client base is Aboriginal.

In many circumstances, general health services are not adequately meeting the particular needs of Aboriginal people. It has been clearly demonstrated that health services for Aboriginal people are more effective if they are delivered by people with a positive approach and understanding of Aboriginal culture and lifestyles. Increasing the number of Aboriginal employees at all levels throughout the health system will contribute to culturally 'secure' health services. The establishment of Aboriginal Community Controlled Health Services (ACCHOs) promotes the responsibility and understanding that Aboriginal people need in order to be involved in health delivery.

Cultural security is the maintenance and protection of cultural identity. It is a policy and practice by which health providers and individuals recognise the diversity of Aboriginal culture in delivery of appropriate health services to Aboriginal people. Mainstream health providers are required to work in partnership with Aboriginal organisations to develop culturally secure health services. Cultural security is the next step in strengthening community leadership, for attitudinal and behavioural change in mainstream society and within the Aboriginal community. It will also set the benchmark for best practice models in service delivery for Aboriginal people.

As such, the way forward to a healthier future is ensuring Aboriginal ownership and participation. In March 2004 the report of the Health Reform Committee, *'A Healthy Future for Western Australians'* identified the benefit of an increase in the number of Aboriginal health professionals in improving health outcomes for Aboriginal and Torres Strait Islander people (ATSI)<sup>13</sup>.

While the Aboriginal health workforce is one of the principal and crucial elements in improving the health of Aboriginal people, it is often a workforce that is the least prepared educationally, the least supported professionally, and the least rewarded financially. The Aboriginal health workforce requires adequate and appropriate infrastructure to increase opportunities for Aboriginal people to participate in appropriate health training programs. Recognising the high use of health services by Aboriginal people, it is critical that efforts be made to ensure that the health workforce profile, in all professions and occupations, better matches that of the client group. Education and training pathways also need to allow for specialisations in all areas

of health and particularly in Aboriginal health work. There is currently a shortfall in both the number of Aboriginal Health Workers (AHWs) positions, the number of AHWs employed throughout Western Australia, and the pool of health qualified Aboriginal people<sup>14</sup>.

Aboriginal representation on government and non-government Health Boards throughout Western Australia is also low. Having Aboriginal representation has been shown to improve Board decision making and produce positive outcomes in the way local health services are delivered and received. Aboriginal representation, at least in proportion to service utilisation, is an urgent area for action.

Community participation is also vital to the effective and efficient delivery of programs and services. Given the range of agencies and organisations involved in health and health related service provision it is essential for all parties to communicate and co-operate, and jointly provide services in a holistic approach to Aboriginal health. Self-management has a greater implication for the economic control and responsibility of Aboriginal people to direct their own resources and affairs<sup>15</sup>.

To address these concerns in Aboriginal health, education and employment, the Office of Aboriginal Health (OAH) is working in consultation with the Western Australian Department of Education and Training (DET) to develop an innovative Vocational Education and Training in Schools (VETiS) program. This project is being driven by item 1.8 of the West Australian *Aboriginal and Torres Strait Islander Employment Framework*: Utilise existing training programs and support mechanisms to achieve Aboriginal employment targets.

The Program aims to deliver Certificate II in ATSI Primary Health Care to year 11 students, with the intent of graduating year 12 students in Certificate III ATSI Primary Health Care. The Program is being piloted at four sites across the Kimberley, Pilbara, Goldfields and Metropolitan region through a mix of Indigenous and mainstream registered training organisations.

The aim of the ATSI VETiS project is to improve employment outcomes for West Australian Aboriginal and Torres Strait Islander student schools leavers in health related services.

There are several objectives of the ATSI VETiS project. These are:

- To increase high- school student retention
- To increase the skill base of students, in particular those who do not necessarily respond to classroom based learning
- To increase the number of school leavers with formal qualifications (Certificate II in HLT21307 ATSI Primary Health Care)
- To improve the employment outcomes of school leavers in meaningful and community orientated roles
- To increase the number of ATSI individuals working in the health field
- To increase community and organisational support for students to participate in and complete the VETiS program
- Facilitate schools in their duty of care to provide suitable formal education for each attending student
- Increase Aboriginal community participation in population wide initiatives
- Build upon the nexus between RTOs, universities, local communities, and state government departments.

There are numerous benefits that this initiative may present to Aboriginal students and communities, as well as the education and health sectors.

Benefits to Aboriginal students participating in the VETiS program include:

- Provides nationally accredited qualification free of charge
- Provides career path opportunities
- Enhances opportunity to complete a recognised qualification
- Education and training is delivered in a culturally appropriate environment and in a manner suitable to their learning style

In addition, the benefits of the program to Aboriginal communities may include:

- Increasing accessibility and availability of services to Aboriginal people, particularly primary health services in rural, remote and isolated areas
- Improving access to health services government health sector which are culturally secure and address the needs of Aboriginal people
- Increasing culturally appropriate services and Aboriginal community controlled health services, some requiring capital works
- Developing community participation and control—Action areas:
  - Reinforce healthy Aboriginal lifestyles with whole-of-life involvement
  - Develop partnerships for protocols in health service delivery with Aboriginal people
  - Develop community action plans for health issues including continuing care
  - Train local Aboriginal people for Health Board and Hospital Board appointments
  - Strengthen regional focus in health activities.

Many of these benefits will indirectly come about by students acting as role models for healthy attitudinal and behavioural change. Most of the diseases responsible for the greater burden of ill health among Aboriginal people are preventable. Beneficial health outcomes from prevention programs often take many years and can be difficult to measure. Nevertheless, many positive examples exist of prevention programs dealing with nutrition, tobacco, alcohol and substance misuse, maternal and child health and mental health problems.

In terms of addressing issues relating to the suitability of existing health services, this initiative aims to:

- Promote existing services available to everyone but which Aboriginal people do not currently use
- Increase innovative health programs
- Increase visits from medical specialists especially to remote areas
- Improve systems such as leadership development; development of best practice guidelines for health interventions; improving use of new information technologies to disseminate best practice knowledge and enhance information sharing.

- Develop processes such as enhancing monitoring and evaluation systems; consistent collection of information and data; ensuring compatibility with other systems.
- Increase inter-sectoral collaboration such as establishment of sustainable consultative mechanisms, participatory structures, working groups, strategic alliances to enable effective partnerships with key sectors, organisations and communities.

In terms of addressing health sector employee shortages, this initiative aims to:

- Increase the Nursing workforce
- Increase the Aboriginal health workforce
- Increase health services especially mental, dental, aged care and prison health services

In terms of addressing educational disadvantage, this project aims to:

- Introduce a new model for delivery of enrolled nursing meeting Australian Quality Training Framework standards for continuous improvement
- Meet government policy objectives to build social inclusivity
- Provide existing Aboriginal health workforce opportunity to up-skill
- Allow for flexibility in regional health delivery
- Enable students to participate in the global economy and workforce

Notwithstanding the proposed benefits of this initiative, there are several barriers that had to be addressed before implementation. For example, while there is current support for delivery of the Program, there is a concern that some targeted year 11 students may not possess adequate English literacy skills to undertake the training. Additional in-school support has been arranged for these students.

In addition to this, at point of graduation, some students may be deemed too young to commence work in the health sector. To combat this, OAH and DET are developing a Cadetship program that will employ graduates for a one year period. This Cadetship will effectively orientate new workers into the health industry while providing opportunity for professional development and networking. As part of this Cadetship, OAH is also looking to develop and support Certificate IV traineeships through some Aboriginal Medical Services. Attainment of a Certificate IV will deem graduates eligible to work in government as well as non-government health services.

What is more, contracts and guaranteed availabilities for clinical placement for Certificate III and IV, and employment options had to be finalised prior to commencement of the training. A fatal error to any training program is providing training for students without ensuring there is employment guaranteed for them post-graduation. This is not purely a matter of knowing there is a workforce need. Funding and resources need to be allocated to the positions so that employment can go ahead indefinitely.

There are several key learning that can be taken from this initiative, including lessons regarding the value of connectedness between government and non-government agencies. The health sector has recognised that improving the health of Aboriginal people requires working with other sectors in a holistic approach to address the underlying determinants of ill health. To make a difference in improving health outcomes, a partnership approach is essential at all levels of the system.

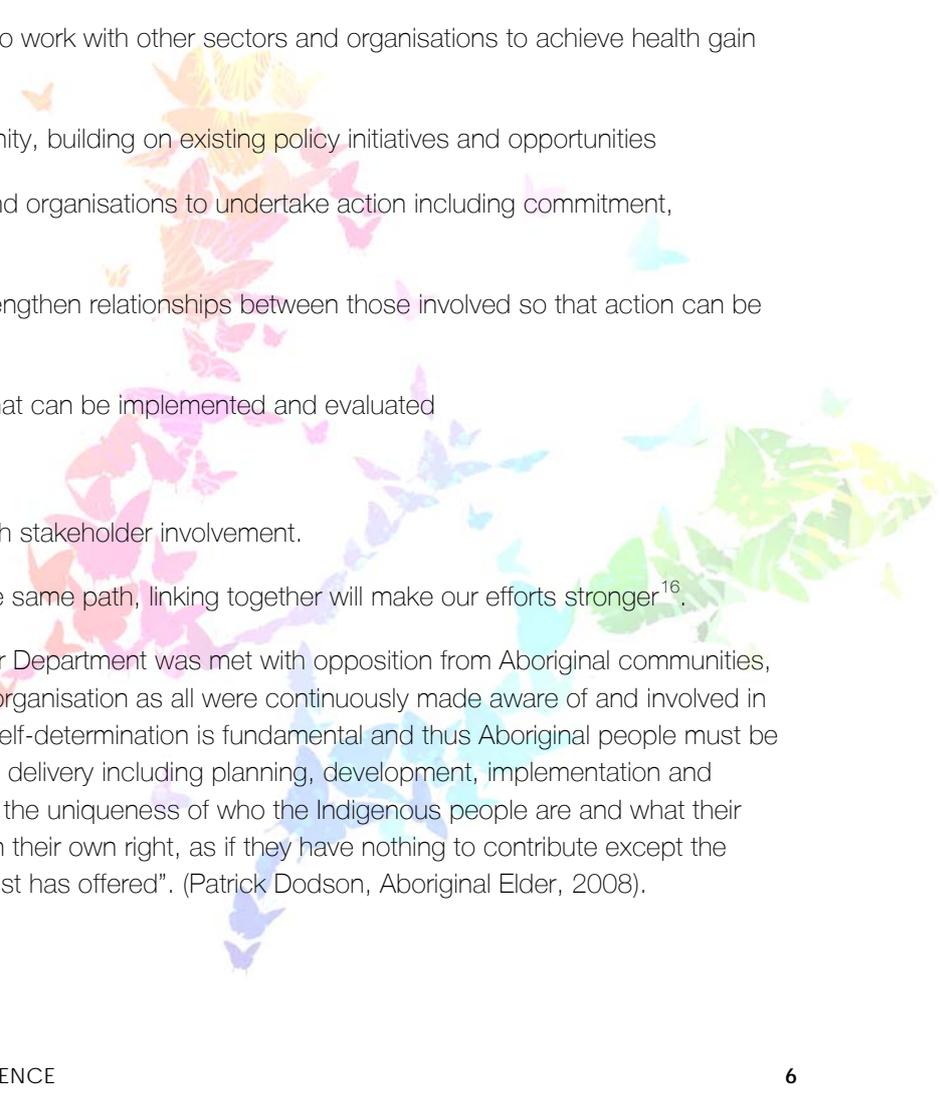


Intersectoral action can take many forms and use a wide range of strategies. The critical dimension of intersectoral action is that it is based on organisations recognising their interdependence in achieving a common end. Improving agency cooperation through mechanisms such as joint projects, and collaboration on service planning and delivery will assist in making a positive contribution to health outcomes.

Rationalisations for why the health and other sectors need to commit themselves to intersectoral action include:

- More effective use of resources for health
- Greater transparency in terms of funding allocation and usage
- Reduction in duplication of services and ensuring quality of care
- Ability to address issues that are beyond the direct control of the health care system
- Working together to find solutions to commonly agreed problems that are often complex in nature
- Addressing inequalities in health status
- Developing sustainable solutions.

Intersectoral action is complex and can at times be difficult. Steps can be taken to minimise risk and to increase the chances of success if the participants understand and create conditions for effective action. These conditions may include:

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- Necessity for the health sector to work with other sectors and organisations to achieve health gain rather than act independently
  - Support from the wider community, building on existing policy initiatives and opportunities
  - Capacity of the other sectors and organisations to undertake action including commitment, knowledge and resources
  - Willingness to establish and strengthen relationships between those involved so that action can be undertaken and sustained
  - Identified, well planned action that can be implemented and evaluated
  - Provision to sustain outcomes
  - External funding sources through stakeholder involvement.

After all, we are all working along the same path, linking together will make our efforts stronger<sup>16</sup>.

As developers of this project, neither Department was met with opposition from Aboriginal communities, health services, schools or training organisation as all were continuously made aware of and involved in the project development process. Self-determination is fundamental and thus Aboriginal people must be involved in all aspects of health care delivery including planning, development, implementation and evaluation. Failing to do this “denies the uniqueness of who the Indigenous people are and what their contribution to this country can be in their own right, as if they have nothing to contribute except the absorption of the culture that the west has offered”. (Patrick Dodson, Aboriginal Elder, 2008).

While this framework provides a basis for learning that can be utilised across Australia, it remains imperative for Project Managers to remember that while many Aboriginal communities share similar health, education and employment outcomes, solutions to these problems may not be as synonymous. It is the right of Aboriginal people to choose to be different and to choose different models of health care. Aboriginal people are not a culturally or socially homogenous group. Similarly, diverse geography, history, access and a range of other issues also influence their health needs. Health, education and employment programs must be tailored to fit the needs of each community or group (as identified by that group)<sup>17</sup>.

## Presenter

**Aeron Simpson** is a Project Officer with the Office of Aboriginal Health, WA Department of Health. She has a Bachelor (Hon) in Population Health and a Masters in Public Health Nutrition. Her professional experience extends across industry training, population health, and workforce education, training and retention. Miss Simpson spent a number of years working in refugee and migrant health service delivery in Victoria, before moving to Western Australia to specialise in state-wide Aboriginal health policy. Her passions in health centre on public health nutrition policy and interventions, and reducing the gap in Indigenous Australian life expectancy.

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