Background

The Eastern Goldfields Medical Division of General Practice Ltd. (EGMDGP) is one of the largest and most remote regions in Australia covering 815 464 sq kilometres and approximately 1/3rd of the land mass of Western Australia. It stretches from Southern Cross in the west across to the arid region of the South Australian border, the remote mining communities up to Wiluna, the Ngaanyatjarra Lands and the pristine coastline of Esperance.

The Rural and Remoteness Metropolitan Index (RRMI) for the region is 7 (remote) and the total population for is 54 855 persons (GEDC June 2003) with 32 042 residing in Kalgoorlie-Boulder and 13 271 residing in Esperance. The number of Aboriginal people in the region represents 10.5% of the total population (Regional Health Needs Analysis 2003), many of whom reside in isolated communities.

One of the key challenges for the delivery of health services for the region is ensuring that Indigenous people in the rural and remote regions of the Northern Goldfields, particularly those individuals with chronic diseases and disabilities, access and receive adequate services and support.

It is recognised across the state that the status of Indigenous health is a major challenge. For example Indigenous males are 25 times more likely to die from diabetes and related illnesses than non-Indigenous men and Indigenous women are 43 times more likely to die from the same conditions as non-Indigenous women (Australian Indigenous Health website 2006).

In addition to this, statistics from 2004 show that there is a stark contrast for the average life expectancy of Indigenous men and women compared to that of non-Indigenous men and woman as outlined in the table below.

<table>
<thead>
<tr>
<th>WA population</th>
<th>Average life expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous men</td>
<td>59.4</td>
</tr>
<tr>
<td>Indigenous women</td>
<td>64.8</td>
</tr>
<tr>
<td>Non-Indigenous men</td>
<td>76.6</td>
</tr>
<tr>
<td>Non-Indigenous women</td>
<td>82.0</td>
</tr>
</tbody>
</table>


The local challenge—Laverton community

In the Goldfields region it is acknowledged that issues relating to poor Indigenous Health are prevalent across the Northern Goldfields which includes Laverton and its surrounding communities.

Laverton is the gateway to the Outback Highway which links WA to Alice Springs and the Northern Territory. It is 956kms north east of Perth and 360kms north of Kalgoorlie and the health services in this region include a resident GP and a district hospital.

In early 2006 it was recognised by local service providers in the Goldfields region that Indigenous people in Laverton and surrounding communities were not being engaged in the management of their chronic illness at a level that would normally be considered appropriate. Despite the best efforts of the available health service providers including the GP, Community Health, Disability Services and the EGMDGP Allied Health Services. There was a need for stronger advocacy, liaison and encouragement to engage and provide services to the Aboriginal population.
It was assessed by key stakeholders including the EGMDGP that Laverton (compared to other remote communities in our region) is particularly vulnerable as along with the normal issues of remoteness and limited services, there has a number of tragedies which occurred in quick succession that have impacted specifically on this community. A number of these incidents were related to drugs and alcohol abuse.

One example that has significantly impacted on the community is the number of fatal motor vehicle accidents for the 6 month period prior to commencing the “Lurtjuringa Lan Project” in which 4 local Aboriginal people died. Alcohol/drugs were a significant causal factor in these accidents.

In addition to this, although there were health care services in place, the staff providing these services were all female. This included community health nurses, Aboriginal health Workers (AHW) and hospital staff. Whilst this is particularly beneficial to Aboriginal females, it created considerable challenges in engaging Aboriginal men.

Underlying the development of this Project it was seen as highly significant that men within these communities needed to be supported and encouraged to use the available services and for the services to ensure culturally appropriate care and information delivery.

The Project

To respond to the challenges outlined above, the EGMDGP, Disability Services and the WA Department of Health (through Population Health) recognised in mid 2006, that through our collaboration there was an opportunity to increase access to primary and secondary health care for Aboriginal people in the Laverton community.

The collaboration between the EGMDGP, Disability Services and Population Health would not only ensure adequate funds were available, but that a close working relationship would enable better access to a wider range of health services.

As a result of this understanding the 3 organisations embarked upon a Pilot Project called “Lurtjuringa Lan”. “Lurtjuringa Lan” is an Indigenous term meaning “joining together”. It reflects the desire of the health care service providers in this initiative to amalgamate with the local communities to provide a sustainable and equitable program which is of benefit to all community members.

The objectives of Lurtjuringa Lan are as follows:

- identify issues relating to service delivery and service gaps in Laverton and surrounding communities with the proposed outcome of improved co-ordination of service delivery and improved access to Indigenous community members
- to maximise and ensure a sustainable and effective health care service delivery in Laverton and the surrounding communities
- to provide support to health service providers to follow-up and engage Aboriginal patients who require ongoing health care.

Project implementation

The first key activity of the Pilot Project in order to achieve these objectives was to develop a Memorandum of Understanding (MOU) between the 3 key stakeholders including the EGMDGP, Disability Services and the Department of Health (Population Health). The MOU enables the service providers to come together to forge a bond which would aid in filling the health needs and gaps in the respective communities.
The MOU recognises the shared aims of each organisation to build the capacity within the community of the Northern Goldfields with respect to their health and general well-being, and supporting culturally and linguistically diverse (CALD) groups.

The MOU is not intended to be a legal document rather it is an administrative document that seeks to ensure mutually beneficial working arrangements and to clarify the relationship between the collaborating organisations.

The aim of the MOU is to work with, build the capacity and support people of the Laverton region so as to improve overall health outcomes for Aboriginal people and promote access and inclusion for people with disabilities.

There are 4 key objectives outlined in the MOU which are as follows:

- establish collaborative approach between three organisations to enable the fulltime employment of an Aboriginal Project Officer to meet the needs of each represented agency
- employ an appropriately trained Aboriginal Project Officer to increase the capacity of health services in the shire of Laverton
- encourage and support Aboriginal people to access available health and other community based services
- promote access and inclusion within the communities of the Northern Goldfields.

It was also agreed as part of the MOU that the identified Aboriginal Project Officer should be male as it was the male Indigenous population who was viewed as not accessing the available services. This does not preclude the Aboriginal Project Officer engaging with Aboriginal women to ensure that they have access to relevant health services.

In August 2006 an appropriately skilled Aboriginal Project Officer was appointed to the position. This position supports the role of primary health care setting using a multi-disciplinary approach.

Key activities of the role of the Aboriginal Project Officer include the following:

- identify Indigenous people in Laverton and surrounding communities that require health services from visiting allied health professionals
- promote and advertise the available visiting health care professionals, particularly allied health professionals including the podiatrist and physiotherapist
- engage and communicate with the EGMDGP, Disability Services, Population Health, allied health professionals and the local GP in order to provide an effective service to Indigenous people with chronic diseases
- identify those gaps in services that need to be filled to provide a comprehensive health service
- develop and maintain a process for tracking individuals requiring ongoing health care.

Achieved outcomes (so far) of the Lurrtjurringa Lan Project:

- In the short time the Project has been in operation it has been demonstrated that there has been a significant increase in the utilisation of visiting allied health services by local Aboriginal people. This increase in access has also been accompanied by a better co-ordination of services for individuals with disabilities, their families and carers.

The Project has settled well and some of the more practical outcomes have been:

- fortnightly visits to Mt Morgan Work Camp Prison which includes health checks for blood pressure, blood sugar levels, weight and education on diet and management of health issues
• fortnightly clinics are conducted in Laverton providing the same services above

• there has been a notable increase in the communication process between providers of health services to the community of Laverton and the advocacy, support and advice to Aboriginal people and service providers with regards to public health issues

• visits to Mt Margaret community fortnightly to follow-up on any medical needs and make sure no one needs to see the Laverton GP

• the Project Officer’s role includes:
  – advertise the dates and arrival of podiatrist and physiotherapist and other specialists
  – collect patients and take them to visiting specialists, physiotherapist and podiatrist
  – Chairman of Aboriginal Elders committee
  – works in Population Health Centre
  – liaises closely with the doctor and hospital
  – takes patients he is concerned about to doctor
  – encourages community members to have regular checks
  – has recently started collating data on the number of patients seen
  – identifies clients in the community needing specific services e.g. Disability Services, HACC etc
  – health promotion

• in the first 4 months the Project assisted in arranging Podiatry appointments for Aboriginal patients in Laverton area as follows
  – Laverton — 45
  – Mt Margaret — 96
  – Leonora — 25

• in the first 4 months the Project assisted in arranging Physiotherapy appointments for Aboriginal patients in Laverton area as follows
  – Laverton — 12
  – Leonora — 25.

It has been recognised that community participation is the cornerstone for the effective and successful running and administration of this program and that community members, health care consumers and health workers all influence the delivery and productivity of this program thus the necessity of stakeholders to collaborate well and listen to the information delivered.

This position has ensured that all health services offered to clients are supported by the health worker regardless of there origin or funding source. It has significant benefits to the community, the organisations and is reaching individuals that previously may not have been receiving proper health care.

**Key challenges**

Whilst this project is specifically directed towards the Indigenous community and provides a range of services that are specific to that community, it still utilises mainstream health services. It is important that as that as the Program develops, that Project continues to focus on developing main stream services in remote areas whilst at the same time ensuring equity of access.
In addition to this, an ongoing challenge with this Program is the limited availability of health care services within remote communities. It is therefore essential to adopt an innovative and flexible approach and delivery to ensure health service delivery is sustainable.

There is also the continuous need of ensuring positive and open communication remains between all parties involved in the MOU. It is a partnership that requires a strong commitment to ensure that the desired results are obtained and that territorial preciousness does not inhibit this.

There is an ongoing need to provide adequate training and support to the Project Officer which is challenging when the head offices for the key organisations involved are based in the regional centre of Kalgoorlie-Boulder.

Conclusion

Overall the Lurrtjurringa Lan Project has made an improvement in the Indigenous health of the community members, but more needs to be done and key challenges need to be addressed.

It is believed that Lurrintjurringa Lan has been an excellent example of the capacity for co-operation between different health care agencies to bring about improved health outcomes in the community of Laverton and the EGMDGP hopes to replicate the model across other communities in the region including Norseman, Ngaanyatjarra Lands and Leonora.

Based on our experiences to date with the Lurrtjurringa Lan Project the following observations can be made:

- changes need to be made to increase Indigenous health outcomes that involve strategies that involve Indigenous people’s input
- there is a need to increase access for Indigenous people to primary and secondary health care services particularly in remote areas that involve Aboriginal Health Workers. These workers need to be provided with adequate support and training to carry out this role often in isolated circumstances
- health organisations need to work together to achieve better outcomes and access for Indigenous people.

Acknowledgments

- Michael Smith, Aboriginal Project Officer, Lurrtjurringa Lan Project
- Charles Douglas and Naomi Sprigg dos Santo, Community Health
- Craig Parken and Peter McLean, WA Police Department

Presenter

Terry Keating is the CEO of the Eastern Goldfields Medical Division of General Practice. He took up the position in June 2005. Terry came to the Division from the Genetic Support Council WA (GSCWA) where he held the inaugural position of Executive Director. The GSCWA was established in June 2002 and is a not-for-profit peak body representing genetic support groups. There are some 50 genetic support groups in Western Australia and all are members of the GSCWA. Terry played a significant role in establishing the Australasian Genetic Alliance (AGA), which is a network of similar peak bodies across Australian states and territories and New Zealand. Launched in 2003, Terry was the AGA Chairperson until mid 2005. Terry is a social worker by profession and the majority of his career has been in the area of social welfare, working with families and troubled youth in the WA Departments of Community Development and Justice. In the late 80s and 90s his work focused on the area of juvenile justice. He was a Director in Justice and a member of the WA Senior Executive Service throughout the 90s until his resignation to pursue other interests after 35 years service.