Engaging Urban Aboriginal Australians in Health Care-A Person-Centered Primary Health Care Response.

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In this presentation I will highlight the importance of a person-centered approach in engaging vulnerable urban Australian Aboriginal patients in primary health care. I will draw on my experience as a general practitioner working within a team in a Multidisciplinary Community Health Service which serves a relatively high proportion of urban Aboriginal Australians in its catchment area. Many of the challenges faced can be seen to relate to globalisation - the human story of migration over the millennia, and in the Australian context over the past 250 years- with its continuing impact on the local indigenous peoples.

I will begin by briefly describing my health care setting followed by an overview of the historical – cultural context of Australian Aboriginal peoples. I will highlight pertinent Australian health demographics and illustrate through a number of case examples how a person-centered approach in my practice of Primary medical care overcomes some of the challenges and supports the engagement with this group of patients.

This Service is situated in the northern suburbs of Melbourne in the state of Victoria and it serves the highest proportion of Aboriginal Australians in the state. Individual Aboriginal people have priority access to all mainstream medical and allied health services in our Centre. They also have access externally to non-mainstream and non-government services, through Aboriginal Community Controlled Health Care Organisations - the local one being the Victorian Aboriginal Health Service. And through the federal government “Close the Gap” program¹ whereby patients receive free medication, help with attending appointments and care-co-ordination services.

Identification of the aboriginality of patients is therefore essential and with cultural awareness training staff have gained confidence in asking people directly and in a straightforward manner their status. Urban aborigines often have mixed Aboriginal and European ancestry. Propensity to identify as an Aboriginal and/or Torres Strait Islander is determined by a range of factors, including: who provides the information (e.g. the person in question, a relative, a health professional, or an official), the perception of why the information is required, and how it will be used and cultural aspects and feelings associated with identifying as Aboriginal and Torres Strait Islander Australian.

The employment of specialist aboriginal liaison and health workers in my mainstream Community Health Service has been a significant factor in helping individuals in the Aboriginal community engage with and maintain continuity of care with our services. In particular targeted health promotion and educational activities by these staff have increased engagement and they have been instrumental in raising essential cultural awareness with the medical and allied health staff, valuing and supporting a person-centred health care approach. Moreover they also help in specific instances, such as for the Aboriginal person or their family in attending an appointment with a health care professional, thus overcoming barriers that can exist to accessing health care.

My Community Health Service receives state program funding for allied health services such as physiotherapy, occupational therapy, podiatry, counseling, maternal and child health, speech therapy and dentistry, while there is federal funding for medical services in a fee for service model. The mobile nature of the specific urban population and the multiplicity of family and community expectations poses many challenges for health care delivery.

I will now briefly set the historical and cultural context of the Australian Aboriginal people. British colonial settlement of Australia dating from the time of the Enlightenment had a profound effect on the indigenous population, with impacts continuing into the present. Extended family ties and loss of “country” (ancestral lands) significantly influences their health.
The Europeans who came met people who were hunters and gatherers who had a deeply spiritual, close relationship with the land, moving round their territory in extended family groups according to the rhythm of the seasons, with a strongly communal way of life within their distinct roles in the community. Everything was shared. There was communal land stewardship.

With European settlement, common infectious diseases in Europe had a devastating effect on aboriginal populations.

This geographic map of Australian Aboriginal tribal language groups gives a sense of the many different groups of Aboriginal peoples not commonly recognized today.

https://www.google.com.au/search?q=images+australian+tribal+language+map&es_sm=122&tbm=isch&tbo=u&source=univ&sa=X&ei=1jVPUtqKB-ywiQfsopoCQDw&ved=0CCwQsAQ&biw=1366&bih=600&dpr=1#facrc=_&imgdii=_&imgrefurl=sQGUF4lrUPz9gM%3A%3BNW0GeG1HwmOdMM%3Bhttp%253A%252F%252Fmappery.com%252Fmaps%252FAustralia-Aboriginal-Tribes-Map.jpg%3Bhttp%253A%252F%252Fmappery.com%252Fmap-of%252FAustralia-Aboriginal-Tribes-Map%3B2432%3B2217

Children who were of mixed race and light skinned were taken from their families and brought up in orphanages or with white families. These were the so called “stolen
generations” which continued up to the 1970s in my state of Victoria with Aboriginal people only given citizenship of Australia by referendum in 1967 and the federal government giving an official apology to those of the stolen generations in 2008.

An examination of the demographic patterns of health for Aboriginal and non-indigenous peoples the gaps are very obvious. Aboriginal Australians suffer a burden of disease that is two-and-a-half times greater than the burden of disease in the total Australian population. Two-thirds of the difference in the burden of disease was due to mortality and one-third was due to disability. Non-communicable diseases, which include chronic illnesses such as cardiovascular disease, diabetes, mental disorders and chronic respiratory diseases were responsible for 70% of the observed difference in the burden of disease between the Indigenous and non-Indigenous population. If Indigenous Australians experienced the same burden rates as the total Australian population due to the 11 selected risk factors examined, 29% of the total Indigenous Australian burden of disease could be avoided.²

This graph of the proportion of deaths by age group for Aboriginal and Torres Strait Islander and non-Indigenous people for the period 2006 – 2010 indicates the differences in mortality.

PROPORTION OF DEATHS BY AGE GROUP (a), Aboriginal and Torres Strait Islander and non-Indigenous people (b)—2006–2010

Overall, the death rate for Aboriginal and Torres Strait Islanders was almost double that of non-Indigenous Australians.³

(A variety of measures of mortality (including age-specific death rates, median age at death, and infant mortality rates) indicate that the mortality level of Aboriginal and Torres Strait Islander persons is substantially higher than that of the non-Indigenous population. The exact scale of difference is difficult to establish conclusively. This is due to quality issues with Aboriginal and Torres Strait Islander deaths data and the uncertainties inherent with estimating and projecting the size and structure of the Aboriginal and Torres Strait Islander population over time. Some of the issues affecting the reporting of Aboriginal and Torres Strait Islander mortality include misidentification of Aboriginal and Torres Strait Islander deaths, unexplained changes in the number of people recorded as being Aboriginal and Torres Strait Islander Australians in different data collections and over time, the incorrect use of a standard Indigenous status question, changes in administrative processes, and not stated Indigenous status.)

Over two-thirds (70.3%) of deaths of Aboriginal and Torres Strait Islander persons were accounted for by the following four underlying causes of death: Diseases of the circulatory system (I00-I99) (589 deaths or 24.7%); Neoplasms (C00-D48) (508 or 21.3%); External causes of mortality (V01-Y98) (371 or 15.5%); and Endocrine, nutritional and metabolic diseases (E00-E90) (211 or 8.8%).

**Closing the Gap**

In December 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Indigenous communities to achieve the target of closing the gap in Indigenous disadvantage. One of the priority area targets was to ‘close the gap in life expectancy within a generation.’ (ABS website)

My first experience in really becoming aware of the disparity in health status between aborigines and non-indigenous Australians and the importance of cultural awareness and sensitivity in treating aboriginal patients came after I had been working as a GP for a number of years and became involved in the health care of aboriginal elders in a nursing home. Listening empathically and learning about the patient’s history from their perspective with the ongoing impacts on their health on families and communities was vital. It was striking to me then, the complexity of the medical
presentations - each one had 3-4 chronic medical conditions - commonly heart disease, COPD, diabetes with or without liver disease and renal failure. With each one, I would visit regularly, allowing plenty of time to sit and “have a yarn” with them, finding out about their lives and family. It was also a balancing act with medications needing to be aware of their effects on multiple organ systems. Even though elderly and in a nursing home many were also quite mobile e.g. one elder went to visit family in a town 2 hours drive from Melbourne for a few weeks before returning. For those living in the community, moving from one relatives house to another depending on what was happening in the family is very common. For example a matriarch would try to help out various siblings, children, grandchildren, nieces or nephews they saw were struggling, staying for a week or so, sometimes longer before moving back to her home or she would visit relatives in the country, or head off for a funeral (which happens a lot), making continuity of care very difficult.

This cultural aspect of mobility was outside my previous experience. I worked very much in collaboration with the nursing home staff in responding to each patient’s needs and recall one patient, Uncle Peter (elders are addressed as Aunty or Uncle as a sign of respect) whom we managed to get to stop smoking using bupropion and valium with support from the nursing staff to manage his withdrawal.

Recently there was a tragedy involving one of our patients who was being treated for heroin addiction whose 13 year old son was killed with 3 others in a car crash. She was devastated by his death and became quite chaotic in her distress. One busy Friday afternoon, the aboriginal liaison officer emailed me mid-way through the clinic to ask whether I would be able to see the patient at home. I noticed the email in between seeing patients and had the thought not to reply since I wouldn’t be able to do anything till I had finished. I decided to reply, telling her that I couldn’t go to see her till later in that evening. The Aboriginal Liaison Officer was happy and contacted the patient. Our CEO then convened a group of health care providers including myself in our organization to meet to co-ordinate her care and provide support for the Aboriginal Liaison Officer. We learned that she also saw the GPs and other health care providers at the Victorian Aboriginal Health Service and there was a question whether she had had a psychiatric assessment since some of her symptoms appeared quite psychotic. I was able to speak directly to a GP at the Aboriginal Health Service.
within professional confidentiality in the client’s best interests. The GP commented at the end that it was important to open communication with our organization where we had shared patients. The information helped answer questions and helped guide us in the services we could provide for her. I saw her recently, she is much more at peace and happy to be living in a house close to the cemetery where her son is buried.

On that same Friday afternoon our Chief Executive Officer (CEO) asked me whether I could fit in an extra patient- the wife of an aboriginal elder who worked for our organization, a well-respected elder. He had been diagnosed with terminal cancer and was living his last moments. He was originally from south east Queensland and regarded as being a foreigner to the Victorian aborigines. His wife and children are from Victoria. I was able to see her. She was distressed with his symptoms and how to manage them which was compounded by a visit from his family who had traveled down to Melbourne and wanted to take him back to his “country”. His wife was torn with what to do. I listened carefully to her distress, helped explain the symptoms and how to use the medications and considered with her whether he was fit enough to travel. He in himself was happy not to return to his “country,” but was conflicted over how to manage the family pressures. After listening to the end I put forward some possibilities which gave her peace. I made myself available if she needed to come back to see me in the future.

The philosophy of the Aboriginal Health Service\(^4\) with which our service collaborates reinforces that not only physical, social, emotional and cultural aspects of health but spiritual aspects - cycle of life-death-life and the aboriginal relationship with land/country need to be attended to as they present with each individual patient. Awareness of these aspects of the person’s holistic view of health facilitates effective health care as the previous case anecdotes illustrate.

In conclusion, these case anecdotes also illustrate aspects of holistic person-centered health care outlined by Mezzich et al\(^5\), namely, the extension of the focus of medicine

\(^{4}\) Tony McCarthy, manager, formerly from Victorian Aboriginal Health Service (informal Communication),

from disease to patient to person and the prime importance of building a relationship to engage the person in a therapeutic alliance. With the aboriginal people who access health care through my service, the need to be open, flexible, and an empathic listener are apparent. It is especially important to approach each person with a deep cultural awareness of the history of colonization, the impact of the burden of grief from the high mortality rate and the breakup of families from forced adoption of children and the understanding that the aboriginal person brings their own view of health with a sense of everything being interrelated, extended family relationships and a different concept of time and mobility.  

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6 Professor Ian Anderson, Foundation Chair of Indigigenous Higher Education, Assistant Vice Chancellor (Indigenous Higher Education Policy), Director Murrup Barak Melbourne Institute for Indigenous Development, University of Melbourne (Informal Communication)