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Improving the accessibility of health services in urban and regional settings for Indigenous people

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Vicki-Ann Ware

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Summary

What we know

- Accessible health services are those that are physically available, affordable (economic accessibility), appropriate and acceptable. Health services can be inaccessible if providers do not acknowledge and respect cultural factors, physical barriers and economic barriers, or if the community is not aware of available services.
- There are many strategies for successfully improving Indigenous access to urban and regional health services. Individual service providers need to consult with their local community to identify the specific issues relating to their context and selectively adapt the strategies outlined in this report.

What works

Few evaluations have been set up to specifically assess accessibility. Even so, a rich body of research and documented practice experience suggests that health services can effectively promote the four main facets of accessibility.



- Addressing physical and economic barriers through strategies such as:
 - providing services locally
 - providing transport to health services
 - having flexibility in setting appointments
 - using home visitation as part of a multi-faceted engagement strategy
 - increasing services that do not require co-payment
 - improving access to private health insurance and private health services.
- Addressing cultural competence, acceptability and appropriateness through strategies such as:
 - developing services around the holistic model of health and wellbeing
 - building therapeutic and clinical relationships based on trust and mutual respect
 - employing Indigenous health professionals and health workers to promote culturally safe service delivery
 - where feasible, providing a choice between Indigenous-specific and non-Indigenous-specific health professionals and services
 - adopting strategies that support cultural competency and safety at the systemic, organisational and individual levels, including appropriate communication styles, and working through community Elders and kinship networks
 - providing services in non-traditional settings.

What doesn't work

Even given the limited number of evaluations, available literature indicates that the following strategies can be ineffective in improving Indigenous access to health services:

- fee-for-service approaches—these can prevent many low-income Indigenous clients from accessing needed care
- short consultation times coupled with poor health literacy—complex and chronic conditions require longer consultation times
- highly structured programs
- a purely biomedical approach to health promotion and treatment—such an approach fails to acknowledge and demonstrate respect for holistic Indigenous understandings of health and wellbeing
- assumptions that fluency in English means effective communication can occur around culturally specific biomedical conceptions of health and the treatment of illness—Indigenous cultures can differ from non-Indigenous cultures in their views and communication practices about the treatment of illness
- ignoring the importance of kin and kinship systems in caring for an individual patient.



What we don't know

- Although cross-cultural miscommunications between Indigenous clients and non-Indigenous health professionals are commonly documented, there is limited literature providing the necessary range of strategies to overcome these issues.
- Although there is a large amount of literature citing the need for culturally secure services, few authors attempt to define how such services might be practically implemented in any rigorous or comprehensive way.
- There are few evaluations of programs aimed specifically at improving Indigenous access to health services. The available literature describing strategies for improving cross-cultural communications is contained in 'Additional reading and resources' towards the end of this resource sheet.

Introduction

Even though a wide range of health services exist in most urban and regional centres, they are not necessarily accessible. Accessible health services are physically accessible, affordable, appropriate and acceptable (that is, culturally competent and non-discriminatory) (ATSISJC 2009a; Scrimgeour & Scrimgeour 2008).

This paper draws on approximately 30 research studies as well as documented practice experience to explore how to improve accessibility of metropolitan, urban and regional health services for Indigenous Australians.

Scrimgeour and Scrimgeour (2008:1) define urban and regional geographies as:

major towns and cities, where the Aboriginal and Torres Strait Islander population is a minority within a larger total population, and where 'mainstream' (i.e. not Indigenous-specific) health services exist either as the only available health services or as alternative to Indigenous-specific services such as Aboriginal Community Controlled Health Services.

Many of the principles outlined in this resource sheet would be readily applicable in remote settlements. However, remote settlements also have additional access challenges such as physical distance from a service, the difficulties of attracting appropriate staff to remote work locations and the need for an interpreter. These will not be specifically covered in this paper. The majority of studies are Australian, although international evidence has been used where gaps emerged in local evidence.

Background

Accessible health services are those that are physically available, affordable (economically accessible), appropriate and acceptable. There are several key themes in the literature on access to health services for Indigenous people:

- Accessible health services are critical given the complex health conditions that many Indigenous Australians suffer.
- Strengths-based community development approaches represent a sound starting point for improving the physical and economic availability of services, and the willingness of individuals to use them.

There are few quantitative datasets that rigorously demonstrate the degree of access that Indigenous people living in urban and regional towns have to health services. Available data sources typically demonstrate usage of health services by Aboriginal and Torres Strait Islander people. These sources include the Australian Bureau of Statistics (ABS) National Aboriginal and Torres Strait Islander Health Survey, the ABS National Aboriginal and



Torres Strait Islander Social Survey (NATSISS), Medicare data, the Bettering the Evaluation and Care of Health (BEACH) data and the Office for Aboriginal and Torres Strait Islander Health (OATSIH) Services Report. The Australian Institute of Health and Welfare (AIHW) also holds several datasets that include Indigenous health service usage (AIHW 2011a, 2011b), in which service usage and service waiting times are used as proxy measures of access to services (AIHW 2011b).

In 2008, the NATSISS found that about 26% of Indigenous people aged 15 and over living in non-remote areas had difficulty accessing health services (AIHW 2011a); in contrast, only 2.6% of the general population has difficulty (ABS 2012). The main reasons cited were long waiting times, services not being available when needed, difficulties with transport and health-care costs. Less commonly reported reasons included lack of engagement, fear of discrimination and poor treatment arising from previous experiences, and the lack of culturally appropriate services (AIHW 2011a).

Even though the majority of Indigenous Australians live in major urban and regional centres (Stoneman & Taylor 2007b), current per capita expenditure on Indigenous health services is skewed towards remote health services, with four in ten Indigenous-specific services located outside metropolitan and regional centres (AIHW 2012).

In the urban and regional context, most Indigenous people accessing services use mainstream (non-Indigenous specific) services, and this situation is expected to continue (SCRGSP 2012). Consequently, mainstream services need to consider what strategies they can implement, in light of available resources, to improve access (AHMAC 2011). This is particularly an issue for smaller service providers and where the proportion of Indigenous Australian clients is small.

This resource sheet reports on a range of strategies that Indigenous and non-Indigenous specific services alike are employing to successfully address the barriers to access that can apply in any urban or regional location. Through community and consumer consultation, service providers need to ascertain the specific access issues that occur in their area, and selectively adopt relevant strategies from those described in this resource sheet.

Barriers and facilitators to adequate health service access

The literature reveals a fairly consistent list of barriers to Indigenous people's access to the health services they need, as well as a range of strategies for overcoming these challenges. This paper utilises the four related concepts—availability, affordability, appropriateness and acceptability—to analyse these barriers and frame some effective mechanisms for addressing them.

1. Physical availability

Physical availability of health services begins with the existence of those services, but the distribution of services and the medical workforce is not uniform throughout Australia. The concentration of medical practitioners, for example, is highest in *Major cities* (392 full-time equivalent medical practitioners per 100,000 population), and is significantly lower in other remoteness areas, with *Outer regional* having the lowest rate (206 full-time equivalent medical practitioners per 100,000 populations) (AIHW 2011). Even within urban areas, GPs tend to cluster towards higher socio-economic locations, and outer urban areas have been recognised as areas of medical workforce shortages (Boffa 2002). Likewise the number of clinical medical specialists decreases with increasing remoteness (from 142 FTE per 100,000 for *Major cities* to 24 FTE per 100,000 for *Remote/Very remote* areas) (AIHW 2011c).

The physical presence of a health service also does not guarantee the ability to access it. For example, Indigenous people might not have transport to attend centres across town or several suburbs away (AHMAC 2012). Additionally, some general practitioners (GPs) may not provide the types of services required by many Indigenous clients with complex needs. The result can be that Indigenous clients need to travel some distance for appropriate alternative services (Scrimgeour & Scrimgeour 2008).



A range of strategies has been successfully used to improve physical accessibility:

- the provision of transport (Barwick 2000)
- home visitation as part of a multi-faceted engagement and treatment strategy (Barwick 2000)
- the provision of services in non-traditional settings that are located closer to Indigenous communities (Barwick 2000)
- comprehensive health-care services in one location, which has been repeatedly shown to improve Indigenous access to and utilisation of health services (Barwick 2000; Hayman et al. 2009)
- flexibility in the appointment system that allows Indigenous clients to access services at feasible times (Herceg 2005).

2. Affordability

Economic disadvantage, the costs associated with health care, and the prevalence of chronic and complex conditions can combine to make health services unaffordable for many Indigenous people. For example, Indigenous Australians experience higher rates of chronic conditions such as circulatory disease, diabetes and kidney failure, and higher rates of comorbidity. These chronic conditions often need to be managed in conjunction with other health concerns such as substance use disorders or poor mental health (Scrimgeour & Scrimgeour 2008). These complex and chronic health problems demand a certain type and level of care that can be unaffordable for Indigenous Australians. A fee-for-service health system, particularly where longer, regular or multiple consultations are necessary, can be largely unaffordable (Scrimgeour & Scrimgeour 2008).

This is compounded by the fact that, in 2008, around half of Aboriginal and Torres Strait Islander adults had incomes in the bottom 20% of equivalised gross weekly household incomes (AHMAC 2012). In 2008, 32% of Aboriginal and Torres Strait Islanders who had problems accessing services cited cost as a barrier to accessing health services (AHMAC 2012).

Expenditure data gives an indication of access barriers. For non-Indigenous Australians, health service usage rises with illness level: people with one significant medical condition have an MBS usage about 4 times the national average, and expenditure rises to 12 times the average for people with 5 conditions (Dwyer et al. 2004). This pattern is not reflected in Aboriginal and Torres Strait Islander expenditure. Despite morbidity rates 2.5 times higher than non-Indigenous people (Dwyer et al. 2004), the Indigenous to non-Indigenous MBS expenditure ratio per person was 0.67 (AIHW 2013).

ACCHSs address potential affordability problems for Indigenous Australians through employing salaried health professionals so that they do not need to charge a fee for service (that is, they bulk bill) (Hayman et al. 2009; Scrimgeour & Scrimgeour 2008). This strategy also allows practitioners and health workers to spend more time with clients, thereby enabling them to discuss a broader range of concerns in a given consultation.

Other government programs, such as the Indigenous Chronic Disease Package, seek to address cost, as well as other barriers to accessing health care (see Box 6).

An additional challenge is the lack of access to private health insurance. In 2004–05, 15% of Indigenous Australians in non-remote areas had private health insurance, compared with 51% for non-Indigenous Australians. The majority of those without private health insurance (65%) cited cost as the main barrier (AHMAC 2012). Reduced access to private health insurance limits clients' ability to access services involving out of pocket expenses, such as specialists, dentists and allied health services. Among all Australian adults for example, a higher proportion of those with insurance visited a dentist in the last 12 months (71%) compared with those without insurance (48%) (AHMAC 2012).



Medication costs

Pharmaceutical costs are an additional, often hidden, economic barrier to accessible health care. Also, some Indigenous people's lack of confidence or familiarity with using pharmacies to purchase medicines further compounds their poor access to required medications (Stoneman & Taylor 2007a, 2007b).

The elimination of co-payments on medications in some parts of Australia has helped to improve access to medications for Indigenous Australians. A 1999 amendment to the National Health Act—'the S100 Scheme'—allowed approved remote and very remote ACCHSs to bulk-purchase and dispense pharmaceuticals to Aboriginal clients without requiring co-payments (Stoneman & Taylor 2007a, 2007b). This approach has improved access to otherwise unaffordable medications (Couzos 2005; Scrimgeour & Scrimgeour 2008; Stoneman & Taylor 2007a, 2007b).

The PBS Co-payment Measure introduced in July 2010 under the Indigenous Chronic Disease Package complements the S100 Scheme by improving access to PBS medications for, Indigenous Australians with, or at risk of, chronic disease in urban and rural (non-remote) areas. The first monitoring and evaluation report indicates that, in 2010–11, the number of people accessing the PBS co-payment measure under the IDCP has exceeded expectations (KPMG 2013).

3. Appropriateness

Appropriate health services are comprehensive and non-discriminatory services that can support the breadth and variety of complex health needs of Indigenous Australians. Mainstream general practice is a significant source of care for Aboriginal and Torres Strait Islander people, but for most GPs, Indigenous clients are a small proportion of their clients (AHMAC 2012). While some mainstream GPs have developed expertise in Indigenous health, these represent a low proportion of all GPs (AHMAC 2012).

It is important that health services ask the Indigenous status of all clients in accordance with national standards, but the evidence suggests that many do not (AIHW 2010). Only through the identification of Indigenous clients can clinically-appropriate health measures, such as Indigenous-specific MBS and PBS items, be offered to Aboriginal and Torres Strait Islander patients.

The provision of ACCHSs is one of way of addressing appropriateness issues. Although there is variety across the country in the way these services operate, the larger ones often provide multifaceted, ongoing health services and employ a skilled, multidisciplinary workforce (Stoneman & Taylor 2007a). By providing the equivalent of a 'one stop shop' or drawing on established referral networks to the services they do not provide, ACCHSs improve their clients' access to services that are appropriate to their complex needs. Therefore, ACCHSs play a crucial role in providing 'comprehensive primary health care' that can otherwise be beyond reach (for example, Hayman et al. 2009; Scrimgeour & Scrimgeour 2008).

4. Acceptability

The acceptability of a health service is to the degree to which it is culturally appropriate for the target patient base. Acceptable health services operate from a position of cultural sensitivity and respect, and allow the clients' cultural practices to be maintained. Cultural acceptability is an important determinant of Indigenous people's use of needed health services (ATSISJC 2009b; Scrimgeour & Scrimgeour 2008). Among Aboriginal and Torres Strait Islander people who had problems accessing health services in 2008, 7% said that it was because they were not culturally appropriate and 10% said they didn't trust services (AHMAC 2012).

Many factors can inhibit the acceptability of health services. These include a failure to acknowledge differences between Indigenous and non-Indigenous notions of health; lack of awareness of the ongoing effects of colonisation; poor relationships between Indigenous clients and non-Indigenous health professionals, including lack of trust and respect; and poor cross-cultural communications. These factors are discussed in more detail below.



Differing concepts of health and treatment of illnesses

Indigenous Australians' and non-Indigenous Australians' concepts of what constitutes health and wellbeing, and how it is maintained or damaged, can differ (Maher 1999). For example, Indigenous cultures tend to have a more holistic understanding of health, in which 'physical, mental, emotional, spiritual and cultural are all intrinsically intertwined and linked' (NCAHS 2009:48; see also Maher 1999; Swan & Raphael 1995). According to this worldview, ill health can be caused by social or spiritual dysfunction (Maher 1999).

Differing worldviews can affect the responses to ill health and its subsequent treatment. In an Indigenous understanding of preventive health care, for example, good health can be associated with the fulfilment of kin and other social obligations (Maher 1999). Bush medicine and traditional healers may also be held in high regard, and Western medicine viewed as the last resort (Maher 1999).

Reluctance to engage due to colonial history and past injustices

Internationally, studies of Indigenous health in colonised nations refer frequently to the effects of the colonial past on the willingness and confidence of contemporary Indigenous populations to access even the most physically and economically accessible health services (Stoneman & Taylor 2007a). These effects include the following:

- fear, due to forced removals of children or relocation of families (for example, Barwick 2000; Hayman et al. 2009; Homel et al. 2006; O'Neill et al. 2004; Scrimgeour & Scrimgeour 2008)
- ongoing individual, institutional and systemic racism (Gallaher et al. 2009; Homel et al. 2006; Paradies et al. 2008). Some health services fail to deliver care to all without discrimination. It has been found that, compared to non-Indigenous clients with the same medical needs, Indigenous clients were about one-third less likely to receive appropriate medical care across all conditions (Paradies et al. 2008)
- shame and 'shyness' due to previous negative interactions with authorities (Barwick 2000; Maher 1999; NCAHS 2009).

There are many possible causes for feelings of shame. It can result from a person being singled out for attention, losing the security and anonymity of their immediate social group, not knowing the correct way to behave, or being forced to act in a way that does not conform to their social and spiritual obligations (Maher 1999). Additionally, shame can be caused by a perception of being talked down to, harsh judgments of different parental expectations and child-rearing practices (Scrimgeour & Scrimgeour 2008), poor self-esteem leading to a lack of confidence in accessing services (Hayman et al. 2009), and low levels of literacy and numeracy (NCAHS 2009). Shame is arguably a chief reason many Indigenous people do not attend non-Indigenous specific health services (Maher 1999).

'Shyness' is another recurring theme in the literature and is closely related to shame. It is a reluctance to interact with Western health services due to feeling threatened by the perceived social distance and power between the client and professional service providers (Barwick 2000; NCAHS 2009). It can also manifest as a reluctance to expose particular body parts in front of non-Indigenous service providers, particularly where they are of the opposite gender (Finn et al. 2008).



Language and communication barriers

Many studies from all regions of Australia note the problem of miscommunication between Indigenous clients and non-Indigenous health professionals. Coulehan and colleagues (2005) in particular noted a 'pseudo-intelligibility trap' in urban medical settings, where a higher level of English proficiency and cultural understanding of biomedical concepts is assumed. To complicate this further, Indigenous Australians have differing cultural models of what constitutes polite or constructive communication (Coulehan et al. 2005; NCAHS 2009). These factors can affect the extent of comprehension of diagnoses and treatment regimes, appropriate patient consent for treatment, and the preparedness to divulge any lack of comprehension, leading to a gap in staff–client communication.

The evidence shows many health professionals fail to comprehend that this communication gap exists (Lowell et al. 2005; Sinnott & Wittmann 2001). This failure can reduce positive health outcomes for Indigenous clients, or even increase the risk of life-threatening outcomes (Dwyer et al. 2011).

Specific examples of miscommunication include the following:

- eye contact—direct eye contact is considered polite in many Western cultures, but it can be interpreted in some Indigenous cultures as 'asserting power over or reprimanding someone' (NCAHS 2009:35). When Indigenous clients avoid eye contact, it should be understood as a sign of respect rather than rudeness
- saying 'yes' or 'no' by default—shame and embarrassment could result from not fully understanding a question or explanation. Therefore, an Indigenous person might default to answering 'yes' where they do not understand (NCAHS 2009)
- shyness—some clients stay silent about pain during treatment or in situations where they do not fully understand what is being said to them
- avoiding contradictions—in some Aboriginal languages, it is impolite to directly contradict or challenge the propositions of a speaker, especially in contexts of uneven power or unfamiliarity (Lowell et al. 2005). Therefore, some clients respond to questions with what they think the health professional wants to hear
- using metaphors to explain foreign medical concepts—each language has its own set of metaphors and imagery, and these do not always directly translate (Lowell et al. 2005)
- abstract and concrete concepts—Indigenous languages and thought patterns might retain direct links between abstractions and concrete reality, whereas Western abstractions tend to sever that link (Bain 2011). This could result in general statements about health issues being received by Indigenous clients as implied insults, which may offend. Similarly, non-Indigenous health professionals need to exercise care when presenting a range of treatment options in order to fully inform an Indigenous patient. Indigenous clients could interpret the first option being offered as the non-Indigenous health practitioner's preferred approach. In that case, only one option might be considered as the decided treatment (Bain 2011).

Awareness of potential communication challenges is important in ensuring that Indigenous clients have access to the most culturally acceptable health-care services.

Strategies for providing culturally competent health services

Given the lasting effects of colonisation, past injustices and ongoing systemic, societal and individual-level racism, health service providers need to take special steps to develop acceptable, culturally secure services for Indigenous clients. Several strategies are outlined below. These should be selectively applied in accordance with findings from local consultations about specific local needs. More information on strategies for culturally competent health services is provided in the 'Additional reading and resources' section at the end of this resource sheet.



1. Involve the community in planning and delivering services

Building trust, understanding and mutual respect is the most fundamental first step in making services accessible to Indigenous Australians. Community ownership is also clearly vital in implementing culturally acceptable services (NSW Ombudsman 2010), because it empowers Aboriginal communities to make decisions about the provision of appropriate health services (Coulehan et al. 2005; Watson et al. 2001).

Box 1: Promising practice—working with the community

In southwest Brisbane, staff at the local Inala Health Centre General Practice identified just 12 Indigenous clients who utilised their service, out of an Indigenous population of almost 1,100. Therefore, an Indigenous Health Service was established in 1995, initially operating out of three rooms at the health centre. One Indigenous doctor and one Indigenous nurse originally staffed it.

To improve Indigenous use of this health service, the staff built strong links with local Indigenous Elders and consulted with the Indigenous community to find out why they were not accessing the service. The findings were used to improve the acceptability of the service. Several strategies were adopted to improve the service being provided: employing more Indigenous staff; changing staff on the front desk from non-Aboriginal people (who may have ‘shamed’ clients) to Aboriginal staff; displaying Aboriginal art works; playing an Aboriginal radio station in the waiting room; providing cultural awareness training for non-Indigenous staff; promoting the centre in the local Indigenous community; and promoting collaboration with service providers in other relevant sectors. (p. 604)

These actions greatly increased trust with the local Aboriginal community. The community’s utilisation of local health services also increased, with more than 3,000 clients accessing the service during 1995–2008.

Source: Hayman et al. 2009.

Working through local Elders is extremely important, particularly for increasing the acceptability of, and hence access, to health services (Hayman et al. 2009). A community’s Elders are a vital conduit for building trust, acceptance and respect (Scrimgeour & Scrimgeour 2008). Accessible health services build solid relationships with local Elders and consulting regularly and genuinely with them helps to develop culturally secure services.

Kinship structure is also a fundamental feature of Indigenous culture. It is therefore crucial that kin be valued and included appropriately in consultations and treatment processes (Hayman et al. 2009).

Box 2: Promising practice—working through kinship structures

Staff at one health service informed multiple carers of a child’s next health appointment, in recognition that the child might not be living at the same address at the time of the next appointment. The Aboriginal Health Worker then visited several kin to ensure they understood the treatment process and the appointment times, and conveyed any questions back to the health professionals.

Source: Coffin 2007.

When building relationships within a community, health-care providers must not assume that there is one spokesperson for the community. The responsibility for knowledge—and therefore the right to speak or negotiate—may be distributed across multiple kinship groups (Bain 2011). Accurate representation of a community can be achieved by including respected members of each kinship group.

Box 3: Promising practice—working with appropriate kin

In Whyalla and Port Augusta, a culturally safe perinatal care program for Indigenous mothers was developed in close consultation with community Elders (Stamp et al. 2008). Aboriginal Maternal and Infant Care (AMIC) workers provided initial contact through home visits, and they were also present for antenatal check-ups at the participating hospitals. The advocacy provided by AMIC workers provided a mechanism for maintaining important traditions surrounding childbirth and perinatal care:

They need to know the way we deal with people. And I think the good thing is this; they teach us the clinical way and we teach them the cultural way. So it just works really well like that and in the partnership, between the hospital and [the Aboriginal Health Service]. That's the way it should be. That's the way it can work, you know, you feel like you can make a difference for our people if we work that way (Stamp et al. 2008:5–6).

Close female kin were encouraged to attend consultations and the birth, and non-Indigenous midwives noted positive outcomes as a result:

I have been to beautiful births with the mothers, the grandmothers, the aunts and the kids—beautiful. Not all the time; but we have had some; and the girls that have got it are the births that do go right (Stamp et al. 2008:8).

Source: Stamp et al. 2008.

2. Respect and respond to Indigenous relationships and gendered behaviour protocols

Indigenous societies have clear gender demarcation of avoidance relationships surrounding interactions between particular males and females, or between different kin groups. Most Australian Aboriginal cultures have kinship rules that require that people in particular kin relationships to avoid some or all contact. This contact may be classified as avoidance of eye contact, use of name or use of image. It may also involve avoiding physical contact or proximity. For example, a man and his mother-in-law may be prohibited from any contact or physical proximity, and may even be required to avoid using each other's names. Brothers-in-law may similarly be required to adopt formalised relationships and maintain physical distance. (See <<http://www.shareourpride.org.au/topics/culture/kinship-protocols>> and <<http://www.aija.org.au/online/ICABenchbook/BenchbookChapter2.pdf>>.)

Indigenous clients may refuse to use services that breach these norms. For example, having male drivers transporting women to health services has been cited as one reason some women refuse to use free transport to health services (Barwick 2000). Similarly, forcing men and women to sit in the same waiting room (Coffin 2007), or asking relatives in an avoidance relationship to accompany the patient to a health service—let alone translate for them—causes shame and embarrassment (for example, Lowell et al. 2005). Finally, male staff treating female clients and female staff treating male clients can cause deep shame and distress, particularly where dealing with sensitive matters like sexual health (Maher 1999).

Gender separation involves more than just men talking to men, and women to women. It involves a determination of who has the appropriate gender to discuss particular topics (Scougall 2008). Therefore, it could be entirely appropriate in some contexts (for example, health promotion events) for a female to be presenting information to men or vice versa. Topics that are to be addressed by only one gender are generally referred to as men's business or women's business.



To allow for the maintenance of avoidance relationships:

- transport services need to employ drivers who are of the same gender as the clients (Barwick 2000)
- different waiting rooms and different entry and exits for men and women can be created to help clients to maintain avoidance relationships (Coffin 2007)
- procedures such as showering, toileting, catheterisation and genital examinations need to be conducted by health staff of the same gender as the patient (Maher 1999)
- norms of men's and women's business need to be understood and respected to encourage the use of services and prevent shame (NCAHS 2009)
- access to multiple translators and staff must be set up to allow Indigenous staff and clients to maintain any avoidance relationships within their community (Maher 1999; NCAHS 2009)
- health professionals need to familiarise themselves with who has the right and responsibility to discuss a given topic, then ensure that only the appropriate people are involved in relevant discussions.

Box 4: An example of the need for cultural competence—respecting gendered behaviour

Allowing a carer of the same gender to be present as much as possible can provide a more positive experience for Indigenous clients, and help non-Indigenous health professionals navigate unfamiliar gender-avoidance behaviours. In one case, an elderly Aboriginal woman from a rural community was flown to Adelaide for eye surgery. Just before the procedure, she was asked to remove her clothes (including underwear) and put on a surgical gown. She could not understand why she would need to remove underwear for eye surgery and became upset. When four male orderlies and nurses then proceeded to try helping her onto a trolley, she became very agitated 'and began to yell at them, to keep them away'. The hospital staff concluded she was 'uncooperative and violent, and they advised that they would cancel the surgery'. At this point, her female Indigenous carer stepped in and suggested that she take the older lady into a cubicle to change her clothing and then helped her onto the trolley. The older lady consented without further fuss and the eye surgery proceeded normally.

Source: Dwyer et al. 2011:23.

3. Design flexible and well-coordinated services

Flexible programs appear to be more successful in attracting Indigenous clients, with flexibility noted in the literature in terms of:

- day-to-day structure (for example, no fixed appointments, drop-in services) (SNAICC 2010)
- the provision of different entry points to assist clients in maintaining avoidance relationships
- being well-coordinated and working effectively together.

Longer consultations are important to Indigenous clients, due partly to the more complex nature of conditions with which they tend to present (Scrimgeour & Scrimgeour 2008).

Provision of services in non-medical or non-traditional settings can remove some of the fear and shame around accessing mainstream services (Barwick 2000). Barwick's (2000) study of improving Maori access to health services in New Zealand found that where services were provided in a marae (sacred space or community facility), they provided cultural affirmation, a sense of empowerment and some improved health outcomes.



Box 5: Promising practice—providing care in non-traditional settings in remote Australia

Western Desert dialysis clients are often prevented from accessing services due to state boundaries and restrictions in funding of services to residents of that state or territory. Although Alice Springs is the closest regional town with dialysis services for many of these clients, they are often forced to travel to Adelaide or Perth. To overcome this, funding was recently announced for a dialysis truck to service these communities at least in the short term. The truck can cross somewhat random state boundaries to provide services to clients within their communities.

Source: Medicines Australia 2011.

Additionally, treating clients of the same language group together (for example, in dialysis centres) can be beneficial. It enables shy clients to raise concerns, such as issues with pain management and the treatment processes (Coulehan et al. 2005).

Box 6: Indigenous Chronic Disease Package

The results of the evaluations of the Australian Government's Indigenous Chronic Disease Package (ICDP) show that Indigenous people's access to health services has improved.

This package aimed to reduce key risk factors for chronic disease in the Indigenous community such as smoking, improve chronic disease management and follow-up, and increase the capacity of the primary care workforce to deliver effective care to Indigenous Australians with chronic diseases. The package, in general, provided:

- funding for preventive health programs
- funding for more coordinated and patient-focused primary health care in both Aboriginal Community Controlled Health Services (ACCHSs) and mainstream general practice
- an expanded Indigenous health workforce.

The ICDP included a range of health promotion activities, program reform, and funding to expand the capacity of primary care providers (through employees and services) to deliver effective care to Indigenous people. In particular, it supported Indigenous health services and general practices by providing financial incentives to deliver better health care for Indigenous people; removed barriers so that patients can better access essential follow-up services such as allied health, specialist care and Pharmaceutical Benefits Scheme (PBS) medicines; and built the capacity of the primary health-care system to care for patients by increasing the number and skills of the Indigenous health workforce.

Findings of the Sentinel Sites Evaluation 2010–2012, consistent with the findings of the First monitoring report (2010-11) of the National Evaluation of the ICDP, indicated that the package had:

- improved access to primary health-care services and to affordable medication for many Aboriginal and Torres Strait Islander people (Bailie et al. 2013)
- enhanced the capacity and capability of the service system to engage Aboriginal and Torres Strait Islander communities through multiple interconnected elements of the ICDP (KPMG 2013).

continued

Box 6 (continued): Indigenous Chronic Disease Package

The reports indicate that, while it is the combined effect of the various programs under the ICDP that have contributed to the improved results to date, the following elements have particularly improved Indigenous people's access to health services:

- more funded positions that work with providers and community members in many locations to increase access of Indigenous people to primary health through:
 - community engagement
 - practical support (for example, transport)
 - improved identification of Indigenous patients in the mainstream sector
 - promotion of other incentives under the ICDP (PBS co-payment and Practice Incentives Program Indigenous Health Incentive) (KPMG 2013)
- access to medications through the PBS co-payment measure scheme—this reduced financial barriers and had a general flow-on effect of encouraging people to attend care (Bailie et al. 2013)
- more culturally appropriate general practice and other health providers (Bailie et al. 2013)
- improved collaboration between the mainstream and the Indigenous health service sectors. (KPMG 2013).

An important finding of the Sentinel Sites Evaluation is the variation in how well the ICDP was implemented across different part of Australia. Organisations with well-developed approaches and capable staff had more success in implementing the program than organisations which are building their capacity.

4. Community-designed culturally appropriate health promotion campaigns

Health promotion programs are best developed in conjunction with Indigenous community members (Coulehan et al. 2005). Indigenous communities can help to ensure that health promotion materials and programs are relevant, and can situate biomedical information in culturally appropriate forms (Maher 1999). They can also provide advice on appropriate ways to deliver key health content. There is clear evidence that group 'yarning' (sharing stories and ideas) is a powerful means of developing appropriate health messages and integrating biomedical and Indigenous understandings of health (Coulehan et al. 2005; Watson et al. 2001). Overall, community involvement has been shown to improve cross-cultural communication and the uptake of health messages in Indigenous communities (Coulehan et al. 2005).

5. Employ Indigenous staff in non-Indigenous specific services

In non-Indigenous-specific services, Indigenous staff can help bridge the cultural gap (Stamp et al. 2008), playing multiple important intermediary roles, including:

- translation assistance where clients have limited or no English skills
- advocacy on behalf of the patient (Barwick 2000; Stamp et al. 2008)
- health promotion
- providing a welcoming and familiar face 'with whom clients can readily identify' (Barwick 2000:23)
- cultural sensitivity and competency training (formal and informal) for non-Indigenous staff (Baird et al. 2006; Barwick 2000).



Urban health services that treat large numbers of clients from remote settlements can benefit from recruiting and training bilingual Indigenous community members. With training in key health concepts and translation skills, these community members can help non-Indigenous health workers to bridge communication gaps. Where possible, more than one translator needs to be available to help Indigenous staff and clients to maintain appropriate avoidance relationships in their community (Bain 2011).

Recruiting and training Indigenous health workers is another way to effectively overcome the long lead times required to train health professionals (for example, Barwick 2000). These health workers need to be respected, senior members of their communities in order to build effective bridges into non-Indigenous specific health services (Scougall 2008), as well as having a clearly defined and well-supported role within the health service. However, the option to consult non-Indigenous health professionals is also important. Not every Indigenous patient will want to have local community members knowing their business (NCAHS 2009). This ability to protect confidentiality is particularly important in sensitive service areas, such as sexual health (Dwyer et al. 2011).

6. Train non-Indigenous staff in cultural competence skills

Training is an important way for non-Indigenous health professionals and workers to learn about their Indigenous clients' cultures and lived experiences. Any training needs to help staff to understand that there is no single Indigenous identity or experience in an urban setting (Scrimgeour & Scrimgeour 2008). Therefore, Indigenous people must be treated as individuals.

Non-Indigenous staff also need an awareness of power imbalances in the relationship between health professional and client (NCAHS 2009; Scrimgeour & Scrimgeour 2008). A professional health worker's knowledge and skills can potentially set up a power imbalance with Indigenous clients, especially where they have limited literacy and numeracy. Indigenous clients may feel insecure or may lack the self-esteem to approach the services they need. This needs to be addressed to ensure that professionals are approachable (Scrimgeour & Scrimgeour 2008).

Cross-communication skills are also crucial. Although there is limited literature concerning practical solutions to communication challenges, documented practice experience reveals a few strategies for improving cross-cultural communication with Indigenous clients:

- Health workers should avoid asking questions or making assertions that are too direct or confronting (NCAHS 2009).
- Health workers must maintain open, relaxed and non-confrontational body language and postures, and avoid prolonged eye contact (NCAHS 2009).
- Employing a receptionist with appropriate cultural skills (or providing training) can make Indigenous people feel welcome and secure (Scrimgeour & Scrimgeour 2008), as the receptionist is frequently the first point of contact for clients.
- Supportive relationships are crucial for working effectively across cultures (Dudgeon et al. 2010), including with Aboriginal and Torres Strait Islander people—individually as clients, professionally as co-workers, and with the community as partners with services.
- Any effective health program needs to recognise, respect, support and promote the importance of family and country to many Aboriginal and Torres Strait Islander people (Stamp et al. 2008). Aboriginal family and kinship relationships are the primary structures that provide cultural and social and emotional cohesion and support for many Aboriginal people (Walker 2011). This kinship network includes large extended family members, often biological and non-biological.
- As health service providers implement cultural competence training and attempt to integrate culturally competent behaviours into everyday practice, it is important to track and measure the level of competence being achieved (Trenerry et al. 2010). This could involve organisational audits, which can include assessment of workplace practices, policies and procedures that support cultural diversity and reduce discrimination (Trenerry et al. 2010).



Box 7: An audit tool for assessing cultural competence

Walker (2011) identified nine elements in an audit tool to assess cultural competence. These are:

1. Leading and managing change: organisational cultural competence requires leaders with the capacity, commitment and continuous quality improvement mechanisms to develop and maintain culturally responsive services.
2. Creating a welcoming environment: a welcoming, friendly and culturally safe and inclusive environment increases access by Aboriginal families.
3. Developing cultural competence of new and existing staff.
4. Providing culturally responsive care such as improved access, transport, specific Aboriginal programs and drop-in capacity are shown to enhance Aboriginal family access to services.
5. Facilitating culturally inclusive and secure policies and practices.
6. Communicating effectively with Aboriginal people: miscommunication is one of the greatest barriers to Aboriginal people receiving quality care.
7. Building relationships: collaborative partnerships with Aboriginal communities and organisations promote culturally secure care.
8. Improving service delivery: evidence confirms that organisational and practitioner cultural competence improves health outcomes.
9. Monitoring and evaluating the effectiveness of strategies.

Source: Walker 2011.

7. Indigenous-specific health services

ACCHSs provide culturally appropriate health services for Indigenous Australians. They are run by Aboriginal communities, employ high proportions of Indigenous professionals and health workers, and provide a broad range of multi-disciplinary health services in one location (Hayman et al. 2009). The evidence reveals that Indigenous-specific primary health-care agencies are an essential part of a diversified health system. They are also important sites for the training of Indigenous and non-Indigenous health professionals in cross-cultural skills (Dwyer et al. 2004).

Conclusion

The literature provides a wealth of information on the barriers to accessing health services faced by Indigenous people living in urban and regional communities. These barriers can be categorised as obstacles of availability (physical accessibility), affordability, appropriateness and cultural acceptability.

Physical accessibility can be addressed by providing culturally secure transport to get clients to where a service is provided. Additionally, services provided closer to home (that is, closer to residential areas inhabited by large numbers of Aboriginal families), in non-standard settings and providing some services through home visitation may improve physical access.



Employing salaried health professionals (as opposed to setting up a fee-for-service system) is one means of enhancing the affordability of health services for Indigenous clients. Another promising practice in remote and non-remote areas is the dispensing of pharmaceuticals to clients without requiring co-payment.

Appropriateness can be improved by increasing the number of multifaceted, culturally competent and ongoing health programs delivered by a skilled multidisciplinary workforce able to sustain effective long-term treating relationships and links with other providers.

Acceptability can be addressed through a culturally secure approach to service delivery. This includes: allowing Indigenous people a choice between Indigenous-specific and mainstream services; employing Indigenous staff (both professionals and health workers) to bridge cultural gaps; improving the cultural understanding of health professionals; providing services in non-traditional settings; improving cross-cultural communication; and respecting cultural values such as gendered and avoidance behaviours. Incorporating the appropriate kin in consultations and treatment as much as possible is also crucial.

Although available research and documented practice wisdom suggest all of these strategies improve access to health-care services, individual service providers need to consider which practices address the needs of their consumers. Community consultations represent a means of ascertaining specific issues that inhibit access by local Indigenous individuals and families and identifying suitable strategies to address these issues.

Appendix 1

The Closing the Gap Clearinghouse Assessed collection includes summaries of research and evaluations that provide information on what works to overcome Indigenous disadvantage across the seven Council of Australian Government building block topics.

The table below contains a list of selected research and evaluations that were the key pieces of evidence used in this resource sheet. The major components are summarised in the Assessed collection.

To view the Assessed collection, visit <http://www.aihw.gov.au/closingthegap/collections/>

Table A1: Assessed collection items for *Improving the accessibility of health services in urban and regional settings for Indigenous people*

Title	Year	Author/s
A review of 'traditional' Aboriginal health beliefs	1999	Maher P
Improving access to primary care for Maori, and Pacific peoples: a literature review commissioned by the Health Funding Authority	2000	Barwick H
Sharing the true stories: evaluating strategies to improve communication between health staff and Aboriginal patients, Stage 2 report	2005	Coulehan K et al.
Rising to the challenge in Aboriginal health by creating cultural security	2007	Coffin J
Improving access to medicines in urban, regional and rural Aboriginal communities—is expansion of Section 100 the answer?	2007	Stoneman J & Taylor S
Lessons learnt about strengthening Indigenous families and communities	2008	Scougall J
Health care access for Aboriginal and Torres Strait Islander people living in urban areas, and related research issues: a review of the literature	2008	Scrimgeour M & Scrimgeour D
Aboriginal maternal and infant care workers: partners in caring for Aboriginal mothers and babies	2008	Stamp GE et al.
Adapting to difference: another look at Aboriginal–Western interactions	2011	Bain MS
Managing two worlds together: city hospital care for country Aboriginal people—project report	2011	Dwyer J et al.



Table A2 contains a list of Closing the Gap Clearinghouse issues papers and resource sheets related to this resource sheet.

To view the publications, visit <<http://www.aihw.gov.au/closingthegap/publications/>>.

Table A2: Related Clearinghouse resource sheets and issues papers

Title	Year	Author
Anti-tobacco programs for Aboriginal and Torres Strait Islander Australians	2011	Ivers R
Healthy lifestyle programs for physical activity and nutrition	2012	Closing the Gap Clearinghouse
Education programs for Indigenous Australians about sexually transmitted infections and bloodborne viruses	2012	Strobel NA & Ward J
Improving access to urban and regional early childhood services	2012	Ware V-A

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Acknowledgments

Dr Vicki-Ann Ware was a Senior Research Officer in the Closing the Gap Clearinghouse on staff at the Australian Institute of Family Studies in Melbourne. She is currently associate lecturer in politics and policy studies at Deakin University, Melbourne.



Abbreviations

ABS	Australian Bureau of Statistics
ACCCHS	Aboriginal Community Controlled Health Service
AIHW	Australian Institute of Health and Welfare
AMIC	Aboriginal Maternal and Infant Care
BEACH	Bettering the Evaluation and Care of Health
CCHS	Community Controlled Health Service
GP	general practitioner
ICDP	Indigenous Chronic Disease Package
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PBS	Pharmaceutical Benefits Scheme
QAIHC	Queensland Aboriginal and Islander Health Council

Terminology

Indigenous: 'Aboriginal and Torres Strait Islander' and 'Indigenous' are used interchangeably to refer to Australian Aboriginal people and Torres Strait Islander people. The Closing the Gap Clearinghouse uses the term 'Indigenous Australians' to refer to Australia's first people.

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Additional reading and resources

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Queensland Aboriginal and Islander Health Council (QAIHC) <<http://www.qaihc.com.au/>>. (QAIHC's membership comprises community controlled health services (CCHSs) located throughout Queensland. Nationally, QAIHC represents the community controlled health sector through its affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation (NACCHO). Further information on NACCHO can be obtained at <<http://www.naccho.org.au/>>.

QAIHC membership currently comprises 27 CCHSs <<http://www.qaihc.com.au/members/>> operating throughout urban, regional, rural and remote Queensland <<http://www.qaihc.com.au/about/history/>>. Examples of these CCHSs include:

- Apunipima Cape York Health Council: This was established in Cairns in 1994 and was the first community controlled health organisation to cover Cape York. It was a pioneering model in Aboriginal health services <<http://www.apunipima.org.au/index.php?page=our-history>>.
- Wuchopperen Health Services: This service is located in West Cairns, and provides medical services to Aboriginal and Torres Strait Islander persons. It is a busy, multidisciplinary health service owned and managed by the Cairns Aboriginal and Torres Strait Islander communities. Wuchopperen Health Service has been working for 30 years to ensure both Aboriginal and Torres Strait Islander people enjoy better levels of health so their families can contribute to, and share in, the economic wealth, cultural richness and prosperity of Tropical Far North Queensland <<http://www.wuchopperen.com/>>.