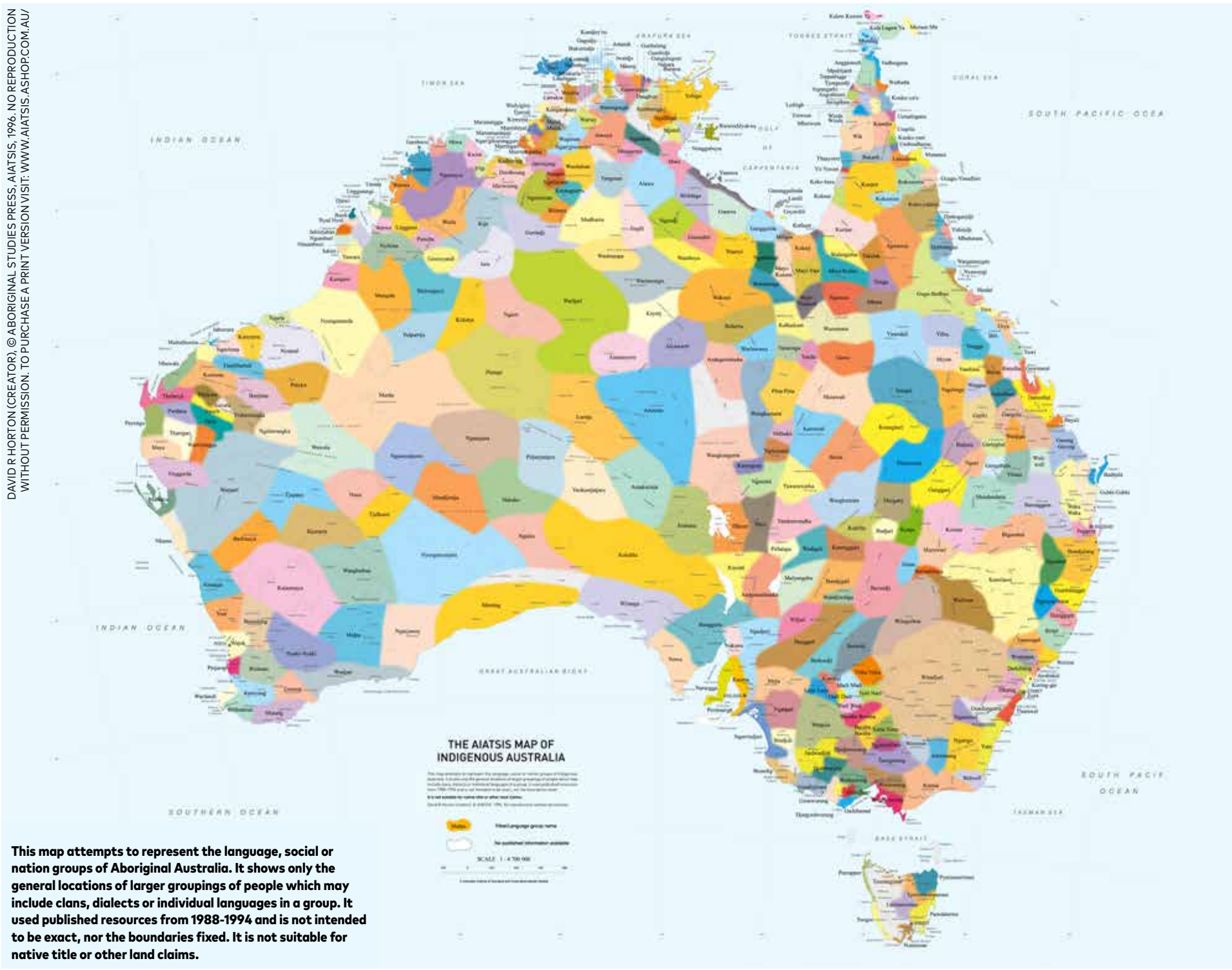

This map attempts to represent the language, social or nation groups of Aboriginal Australia. It shows only the general locations of larger groupings of people which may include clans, dialects or individual languages in a group. It used published resources from 1988-1994 and is not intended to be exact, nor the boundaries fixed. It is not suitable for native title or other land claims.

Aboriginal and Torres Strait Islander health

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Declaration of interest
Dr Tim Senior is employed as medical advisor in the RACGP Aboriginal and Torres Strait Islander Health. This article is not written in that capacity, and does not represent the views of the RACGP or of Tharawal Aboriginal Corporation.

INTRODUCTION

ABORIGINAL and Torres Strait Islander peoples are a diverse group of people from many countries across Australia (see cover image). Before the arrival of Europeans, this great land mass was populated by people from nations such as Gadigal, Awabakal, Arrente, Larrakia or Gurrindji. We now have a single term for many groups of people that can blind us to the diverse cultures represented, but can also make us think that solutions to the problems faced by these communities are all the same.

This How to Treat will set out approaches that are generally applicable to Aboriginal and Torres Strait Islander communities across the country. However, it is important that we remember that while all communities have similar general experiences, each community has their own stories, their own history and their own way of doing things. Local knowledge is important in understanding and engaging with communities. Fortunately, general practices at their best are always engaged and embedded within their local communities.

The solutions and strengths in Aboriginal and Torres Strait Islander communities are familiar to GPs working in this field. The improvements to be gained in Aboriginal and Torres Strait Islander health are those of good quality primary care, with which we are all involved.

The work is necessary and rewarding and all of us working in primary care are invited to join in to make a real difference with people who have the most to benefit from what our profession has to offer.

It does not require anything more of GPs than the simple task of doing well the work about which we are passionate.

WHAT STATISTICS TELL US

ARTICLES such as this one traditionally start by setting out the statistics relating to Aboriginal and Torres Strait Islander health (box 1 contains the Aboriginal definition of 'health'). These statistics tell us why the health of Aboriginal and Torres Strait Islander people is an urgent priority in Australia, but they can give us a sense of overwhelming negativity and a sense of inevitability that misses an important part of the picture.

"Statistics are human beings with the tears wiped off," says Paul Brodeur, a US investigative science writer and author. Many Aboriginal and Torres Strait Islander people don't need to quote the statistics because they are grieving at too many funerals.

Fundamentally, working to improve Aboriginal and Torres Strait Islander health is about working ▸

INSIDE

with people. The health statistics we quote are not inevitable, but are the consequences of dispossession, exclusion and poverty. We see the same effects wherever this is done to a group of human beings, whether this is in other indigenous cultures across the globe, or even the inequalities described in general practice and public health research in Glasgow.[1]

What is sometimes missed in this narrative is the resilience of Aboriginal and Torres Strait Islander people in spite of all the odds, their strong engagement with health systems to effect change, and the ongoing efforts of so many in the health sector to make a difference to people in their communities.

Population data and mortality

The Aboriginal and Torres Strait Islander population has risen over each census, from 2.3% of the population in 2006, to 2.5% in 2011 to 2.8% in 2017.[2] While more Aboriginal and Torres Strait Islander people are reaching older ages, it is still a much younger population than the non-Indigenous Australian population.[2]

One-third of the Indigenous population live in major city areas. In all areas, a large majority of Aboriginal people identify with a traditional homeland.[3]

Between 1998 and 2015, there was a reduction in all-cause mortality rates for Aboriginal and Torres Strait Islander people. The same can be said for non-Indigenous mortality rates, so there was no narrowing of the gap over this time. After adjusting for age differences, the mortality rates were 1.7 times higher for Indigenous compared with non-Indigenous Australians. Over the same period, there was a decline of 33% in child mortality rates, with a significant narrowing of the gap with non-Indigenous babies in states with reliable data. There has also been a significant narrowing of the gap in infant mortality rates.[3]

Life expectancy at birth was 69.1 years for an Indigenous man and 73.7 years for an Indigenous woman, which compares with 79.7 and 83.1 for their non-Indigenous counterparts. This gap has closed slightly from 2005-07 to 2010-12.[3]

CAUSES OF MORTALITY AND MORBIDITY

CHRONIC diseases are the largest contributors to the unacceptable life-expectancy gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. The combination of diabetes, coronary heart disease, cerebrovascular disease and chronic kidney disease is a major health issue.[1]

The leading cause of death for Aboriginal and Torres Strait Islander people is cardiovascular disease, which is responsible for 24% of deaths. Cancer is the second most-common cause of death, followed by "external causes" — injury and poisoning. Diabetes alone was responsible for 7.6% of Aboriginal and Torres Strait Islander deaths. There have been significant reductions in mortality rates for cardiovascular, respiratory and kidney disease, but not for diabetes or deaths due to injury. Cancer mortality has increased.[3]

In addition to the chronic diseases underlying these mortality figures, Aboriginal and Torres Strait Islander people continue to be at higher risk than non-Indigenous Australians for a range of infectious diseases, including hepatitis B, skin and ear infections and STIs, as well as vaccine-preventable diseases, such as *Haemophilus influenzae* type b, invasive pneumococcal disease and meningococcal disease.[4] Rates of rheumatic heart disease in Aboriginal communities in the NT are among the highest in the world.[5]

The morbidity in Aboriginal and Torres Strait Islander communities reflects the mortality patterns, with high rates of cardiovascular, endocrine (particularly diabetes) and respiratory diseases. Renal disease continues to differentially impact on Aboriginal and Torres Strait Islander people. End-stage kidney disease is seven times more common than for non-Indigenous Australians.[4] Disability rates are higher than among non-Indigenous Australians, as are stress levels, with many Aboriginal and Torres Strait Islander people reporting stressors, such as the death of a friend or family member, alcohol- or drug-related issues, contact with police or witnessing violence.[4]

Unsurprisingly, Aboriginal and Torres Strait Islander people have high rates of hospitalisation, particularly preventable hospitalisations, which have been reported to occur at almost five times the rate as those for non-Indigenous people.[3]

Aboriginal and Torres Strait Islander people are also more likely than non-Indigenous Australians to have more than one coexisting chronic disease.[6] Guidelines are often focused on single conditions, based on research evidence that excludes people with multiple morbidities. Thus the importance of clinical expertise and shared decision-making is crucial to making wise decisions.

In contrast to the stereotype, Aboriginal and Torres Strait Islander people are less likely to drink alcohol than non-Indigenous people.

Causes and risk factors

It is tempting to regard being Aboriginal and Torres Strait Islander itself as a risk factor. However, the problem with this is that it can seem that being Aboriginal is the pathology to be treated, in the same way that raised blood pressure or cholesterol is a pathology to be treated. People who are Aboriginal or Torres Strait Islander are likely to have other risks for diseases. However, connection to country, community and culture is protective for health. It is not being Aboriginal that is the problem but it is a marker of exposure to racism, discrimination and exclusion, which are pathological.

In regard to lifestyle risk factors, more Aboriginal and Torres Strait Islander people than non-Indigenous people smoke, but the rates are coming down.[3] In contrast to the stereotype, Aboriginal and Torres Strait Islander people are less likely to drink alcohol than non-Indigenous people; however, those who drink are more likely to do so at harmful levels.[3] Physical activity levels are lower for Aboriginal and Torres Strait Islander adults, but higher for children.[3] Childhood vaccination rates are improving in Aboriginal and Torres Strait Islander communities, such that they are often more fully immunised than non-Indigenous children.[3]

CAUSES OF THE CAUSES

Seeing such disparities can often make us reach for genetic causes. This, however, does not explain the disparities we see. Apart from a very small number of specific genetic diseases, genetics does not play a role in explaining the health disparities between different racial or cultural groups. Genetic variation is larger with groups within the same race than they are between races. The variation between races accounts for only 7% of all genetic variation and almost none of this is responsible for health disparities.[7]

In fact, the proportion of the gap in health outcomes attributable to behavioural and biomedical risk factors is only 8%.

Aboriginal and Torres Strait Islander people experience marked socioeconomic disadvantage and increased life stressors compared with other Australians, contributing to their higher burden of chronic disease and risk of early death.[3,8]

Socioeconomic factors account for 34% of the gap (see figure 1). It is well recognised in communities across the world that there is a social gradient in health. PAGE 20 ▶

Box 1. The Aboriginal definition of health

"HEALTH is not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life."

The Aboriginal definition of health is less individualistic than the WHO definition, and will be understood intuitively by many Aboriginal and Torres Strait Islander patients. It understands health as being rooted in social and cultural connections — disease doesn't get a mention. It opens up the range of solutions to health problems as including involvement in groups and cultural activities, as well as solutions for the individual.

Source: A National Aboriginal Health Strategy. National Aboriginal Health Strategy Working party. Canberra 1989.

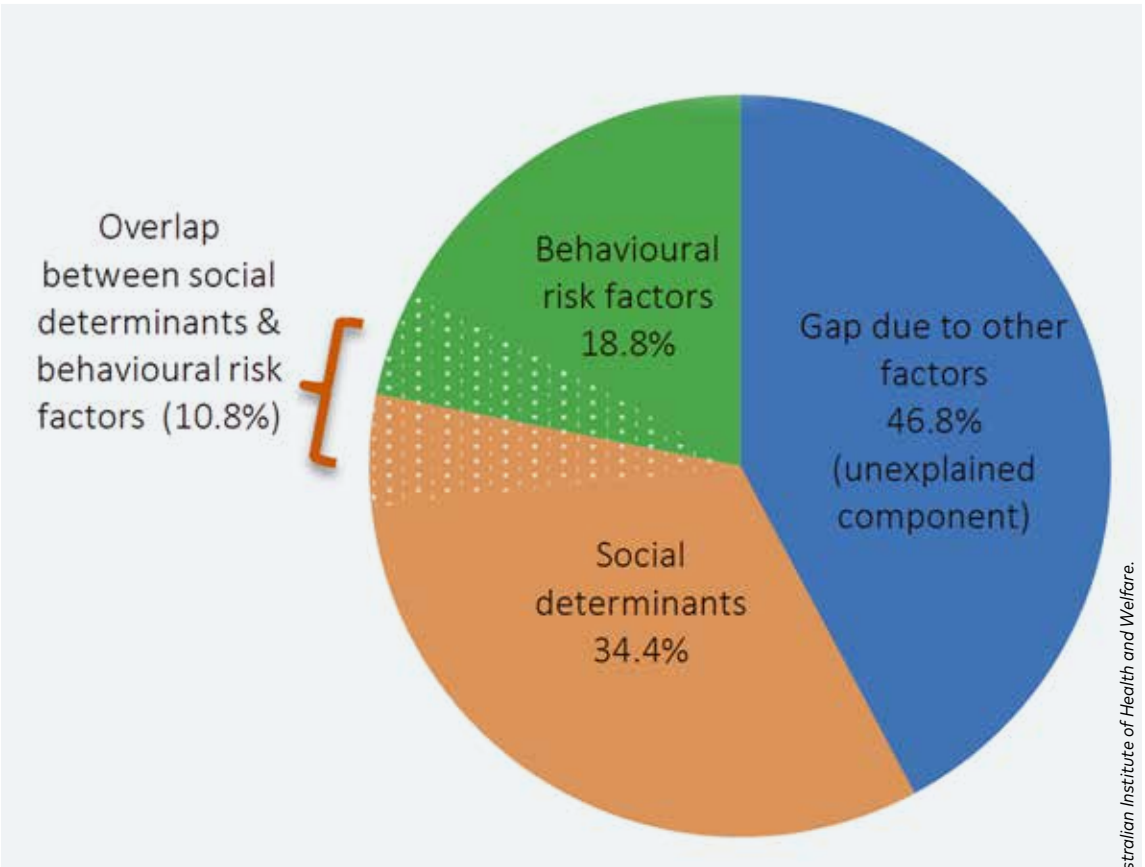

Figure 1. Proportion of the health gap explained.

Source: Australian Institute of Health and Welfare.

◂PAGE 18 That those at the bottom of this gradient have worse health than those in the middle, who in turn have worse health than those at the top.

In Australia, there is a much higher proportion of Aboriginal and Torres Strait Islander people at the bottom of this socioeconomic gradient — with the consequent health effects. At its worst, these are seen in conditions such as rheumatic heart disease or trachoma, which have been eliminated in non-Indigenous Australia. The effect of a lack of income and unemployment can be seen in poor housing, food insecurity, or smoking to relieve stress. All of these have clear health consequences. While these need a policy response at the federal and state level, there are actions that can be taken by local services to mitigate these consequences.

THE IMPORTANCE OF HISTORY

NONE of these health consequences has arisen suddenly out of context. Historical actions are still influential. History hasn't ended, and seeing many events now from an Aboriginal and Torres Strait Islander perspective, it is easy to see why actions we thought might have been consigned to the past look like they are being repeated.

The policy of forced removal of Aboriginal and Torres Strait Islander children from their families went from the late 19th century through to 1969. It is still in living memory for many people.

The *Bringing Them Home* report was the result of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families, and was tabled to Parliament 20 years ago. The recommendations have not as yet been fully implemented.

However, even now, without a formal policy of forced removal, the number of Aboriginal and Torres Strait Islander children in out-of-home care has risen since this report was released.[3,9]

The effects of this across generations are very real. The consequences of being disconnected from culture and country results in a loss of practical cultural knowledge, from parenting to food selection and preparation. Deeper and more importantly, are problems that result from exclusion, discrimination and self-esteem, and mental health problems.

From a health service perspective, doctors, nurses and health services were involved in the removal of children, so it is easy to see how we may start from a position of lack of trust. Without realising this, or understanding the profound effects of removal, we can miss the reasons for someone's discomfort or miss the solutions to symptoms that we see because we don't know enough about someone's background story. Historical interactions play out in our own consultations. We will discuss some of the ways of overcoming this in practice later in this article.

These social, economic and historical circumstances are those in which our patients live and are likely to be very different from the circumstances of many of us working in general practice. They have consequences in lower participation in screening programs, and reluctance, for a variety of reasons, to attend our services for medical care.

The health services we create have cultures of their own, in which many Aboriginal and Torres Strait Islander people can feel profoundly uncomfortable because they recreate the patterns seen through history. By consciously creating a practice culture that is safe for Aboriginal and Torres Strait Islander patients we can create a situation where our Indigenous patients feel comfortable enough to tell us about their lives.

Box 2. Guidance and cultural mentorship

CULTURAL mentoring is used in GP training to support registrars undertaking training at an Aboriginal and/or Torres Strait Islander health training post.[11] Aboriginal and Torres Strait Islander cultural educators and cultural mentors can also help GPs and other healthcare providers to avoid communication pitfalls and provide more culturally competent care.[11,12] Informal support from Aboriginal and Torres Strait Islander people is similarly useful in assisting GPs to work more effectively with this community.

Cultural mentors offer the following advice when providing care for Aboriginal and Torres Strait Islander people:

- Respectful communication is key to establishing rapport and an effective relationship with Aboriginal and Torres Strait Islander patients, as with all patients. In some settings, this requires the use of interpreters, visual aids and careful consideration of differing world views, and how this impacts on communication of health messages.[13] For example, the prescription of lifelong preventive medication, such as for hypertension or lipids, has been misunderstood as a short-term curative therapy in the experience of some cultural educators and mentors.
- Interest in Aboriginal and Torres Strait Islander health is crucial; however, it is also important that GPs have the knowledge and skills to work with individuals and communities — this includes cultural awareness as well as medical knowledge. This can be gained through viewing documentaries, and reading books and papers about local history and culture. In some communities and for some individuals, the gender or the age of a doctor may be a barrier. Understanding the patient's beliefs and needs requires tactful enquiry, and is essential in developing a collaborative, patient-centred approach.
- GPs who are interested in working in Aboriginal and Torres Strait Islander health should be prepared for complexity. Management plans should be realistic, and in some cases, it is appropriate to take a step-wise approach so as not to overwhelm both patient and GP.
- Starting with the patient's priorities is important in gaining trust. The GP is then able to move on to the medical agenda. Allowing time and space in the consultation will also assist. Rushing people and firing questions will often result in a guarded response.

PRACTICE CONSIDERATIONS

THE patient's experience starts at the door as they walk in to the practice. It is here where initial impressions can make a difference for Aboriginal and Torres Strait Islander patients. A waiting room that has a sign or plaque that acknowledges the traditional owners of the land the practice stands on shows an awareness of Aboriginal cultural practices, and is respectful of the history. This may be accompanied by an Aboriginal flag (or Torres Strait Islander flag where appropriate).

Artwork by a local Aboriginal or Torres Strait Islander artist decorates a waiting room in a way that shows consideration of Indigenous people's experiences. Posters and pamphlets specifically for Aboriginal and Torres Strait Islander patients provide information in a thoughtful way. It may be possible to seek feedback from local Aboriginal elders on how to make the practice more welcoming to their community.

Research from Mount Isa shows that these symbols in a practice are only effective if an effort is made by practice staff to develop a respectful personal relationship with Aboriginal and Torres Strait Islander patients.[10] It is important that all practice staff understand this, especially receptionists. Ideally, practice staff should attend local cultural awareness training. Employing Aboriginal or Torres Strait Islander people goes a long way to improving heath, both by putting Indigenous patients at their ease, but also because employment and the development of a workforce of Aboriginal and Torres Strait Islander people is crucial to closing the gap.

The number of Aboriginal and Torres Strait Islander children in out-of-home care has risen since the 'Bringing them Home' report.

All practices should identify their Aboriginal and Torres Strait Islander patients. This is done by asking the simple question: "Are you of Aboriginal or Torres Strait Islander origin?" Crucially, staff should be able to explain the reasons for asking this question — it allows more tailored, culturally appropriate care, informs clinical decisions, such as immunisation and preventive activities, and determines eligibility for certain Medicare programs.

The answer should be coded in the medical record as Aboriginal, Torres Strait Islander, Both or Neither.

Assessment

A proper assessment of the presenting problems of an Aboriginal and/or Torres Strait Islander person is more than an information-gathering exercise about symptoms, signs and diseases, although these are crucially important. A successful assessment will provide a thorough understanding of that person's current circumstances, and an appreciation of historical and cultural perspectives that impact on the patient and their relationship with the GP.

Ultimately, the success of this and future consultations requires the doctor to actively develop rapport with the patient and gain the patient's trust. This can take time and often builds over several consultations.

As described above, the involvement of medical services and doctors in colonisation may mean that we are not automatically trusted. Many Aboriginal and Torres Strait Islander people experience racism within the health system. It means that active efforts should be taken to develop rapport and trust in order to be effective in our clinical care.

Our clinical assessment must have the aim of building rapport, as well as gathering information.

The importance of assistance from Aboriginal and Torres Strait Islander healthcare providers cannot be overstated. Thirty per cent of Aboriginal and Torres Strait Islander people report being unable to access health services in the previous 12 months.[1]

While there are many reasons for this, Aboriginal and Torres Strait Islander health professionals — including Aboriginal and Torres Strait Islander Liaison Officers, Outreach Workers and Health Workers — can assist by providing guidance about the health system, enabling contact

that builds trust, as well as providing non-Indigenous healthcare workers with advice on culturally appropriate care (see box 2).

Learning about Aboriginal and Torres Strait Islander health is often assumed to be about medical conditions that are (or are thought to be) more prevalent in Aboriginal and Torres Strait Islander people. A proper assessment will incorporate the known epidemiology, but also ensure an awareness of other medical conditions that may not be considered to be 'typical' Aboriginal and Torres Strait Islander problems.

Such considerations would mean remembering that Aboriginal and Torres Strait Islander people may develop ischaemic heart disease at a younger age than other Australians and present with atypical symptoms. Knowledge of local epidemiology is important, such as the prevalence of rheumatic heart disease or STIs, which varies greatly between different areas. However, it is also important not to forget conditions such as SLE or breast cancer. These conditions are not usually considered in teaching on Aboriginal and Torres Strait Islander health, yet are more common or have higher morbidity in these communities.

Although clinical assessment of Aboriginal and/or Torres Strait Islander people involves gathering similar information as for other patients, the social history is often very important to understand the potential barriers to becoming healthier.

This may relate to a lack of money for appointments, housing conditions causing ill-health or responsibilities for other family members taking priority over medical appointments. Important cultural obligations, such as funerals, are a common reason for failure to attend follow-up appointments.

Preventive health issues

It is particularly important for GPs to address preventive health issues with Aboriginal and Torres Strait Islander patients, who are at greater risk of a range of conditions that are amenable to preventive activities. The NACCHO/RACGP *National Guide to a Preventive Health Assessment for Aboriginal and Torres Strait Islander people* provides guidance on evidence-supported preventive health activities.[14]

While many of the recommendations are similar to those set out in the RACGP red book (*Guidelines for Preventive Activities in General Practice*), some preventive health recommendations are different for Aboriginal and Torres Strait Islander people because of the different epidemiology. For example, screening for chronic kidney disease starts at age 30 for Aboriginal and Torres Strait Islander people with no other risk factors. An absolute CVD risk assessment is recommended from the age of 35.

Screening programs, such as those for breast cancer or bowel cancer, appear to be less effective at reaching Aboriginal and Torres Strait Islander people, and this should be considered in discussion about preventive health.[15] Influenza vaccination is recommended for Aboriginal and Torres Strait Islander people from the age of 15. Pneumococcal vaccination is recommended from the age of 50 and for those at high risk of invasive pneumococcal disease from the age of 15.[16]

Box 3. Developing and enhancing trust with Aboriginal and Torres Strait Islander patients

- Work with Aboriginal and/or Torres Strait Islander health professionals as often as possible and seek a mentor if possible.
- View the consultation as a meeting of two experts:
  - The doctor is an expert in diagnosis and management of medical conditions, and the treatment options that should be considered.
  - The patient is an expert in their life, context, culture and history. They will know their values and the sorts of things they are willing to try.
- Take an interest in non-medical topics of conversation — family, cultural activities, enthusiasms. Time invested in this will reap benefits. Consider attending community and cultural events, such as NAIDOC Day.
- Ensure people have opportunities to make decisions about their health. Good explanations are crucial for this.
- Check that people hear and understand what you are saying. Remember hearing loss is common in Aboriginal and Torres Strait Islander communities.
- Do not assume particular knowledge or particular reasoning. If in doubt, ask.
- A non-judgemental approach is critical in this setting, where many people have been judged according to stereotypes, including in health services.

Management

There are several key principles of management that should form the core of any GP consultation with an Aboriginal and/or Torres Strait Islander patient.

TRUST

Trust is crucial. Without this, important information is likely to be missed and patients are less likely to engage with a management plan. Working with an Aboriginal and/or Torres Strait Islander health professional is helpful. For example, this may assist when an Aboriginal and/or Torres Strait Islander person does not want to discuss their life circumstances with a stranger. It is easy to miss the fact that the patient does not have a working fridge at home, which has implications not only for dietary changes we might recommend, but also for storage of insulin. Many people are reluctant to admit that their reading and writing may not be as good as they wish, and this has a clear impact on the value of the information leaflets given to them to read at home. Box 3 lists suggestions for building trust with Aboriginal and Torres Strait Islander patients.

GUIDELINES

There are few clinical guidelines focused specifically on Aboriginal and/or Torres Strait Islander people, and for the most part, the medical management is the same as that for non-Indigenous patients. Exceptions to this include guidelines on otitis media and a comprehensive guide on social and emotional wellbeing in Aboriginal and Torres Strait Islander people, called 'Working Together'.[17,18]

Other clinical guidelines specifically address conditions seen mostly in Aboriginal and/or Torres Strait Islander communities, usually in remote areas, such as the rheumatic heart disease guidelines, guidelines for the public health management of trachoma and the *Central Australian Rural Practitioners Association guidelines*.[19-21]

Some generic guidelines have particular recommendations for Aboriginal and Torres Strait Islander people. These include *General Practice Management of Type 2 Diabetes* and the *Chronic Kidney Disease Management in General Practice guidelines*.[22,23] When consulting these guidelines, it must also be remembered that multimorbidity is very common.

EXPLANATIONS

Familiarity with clinical guidelines is important, but good general practice is not about the slavish application of recommendations to people.

This is no different for Aboriginal and Torres Strait Islander patients. It is important to work collaboratively with patients and recognise that they have control over the decisions they make about their health.

An understanding of what someone wants to achieve is important for this, as is an ability to provide consistently good and clear explanations.

Explaining the reasons for doing particular investigations makes it more likely they will be undertaken. So rather than saying, "I just want to do some blood tests", which makes it sound like the investigations are for the convenience of the doctor, explaining the reasons for each investigation can save time in later consultations, and save frustration when people make other choices.

Similarly, explaining the rationale for drug treatments will enable an informed decision.

It is helpful if these explanations are framed by what is important to the patient. A lower cholesterol or HbA1c is not important to many patients and has no impact on day-to-day life. However, alleviation of current symptoms or preventing serious events, such as heart attacks or strokes, which are likely to impact on important activities (including work, family or community commitments) will often provide a compelling rationale for taking medications.

Often people already have a good understanding of illnesses and their impact through the experience of friends and family. It is worth asking about this since, on occasion, this awareness may be part of a lack of motivation to change because there is sometimes a sense of the inevitability of ill health and early death.

Working with an Aboriginal and Torres Strait Islander health practitioner is often crucial in effective explanations and interventions.

LIFESTYLE CHANGES

Managing and preventing most chronic diseases requires attention to lifestyle factors. Similar to other disadvantaged populations, smoking rates are higher among Aboriginal and Torres Strait Islander people, and health professionals should discuss smoking and ways of stopping, as with all patients who smoke.

The *RACGP Supporting Smoking Cessation guideline* is very useful, and motivational interviewing techniques can help too.[24]

Advice on diet and exercise is important, but it should be remembered that access to the healthy food we recommend can be limited by price, geography or even adequate cooking facilities at home. Family and community dietary practices may be ingrained over generations, and have often originated from forced and institutionalised diets that were inferior to the previous traditional diets.

Imaginative solutions are often required to improve the success rate of these dietary and lifestyle changes (for example, using an Aboriginal health assessment to get access to a dietitian or exercise physiologist through the MBS).

Some communities have subsidised fruit and vegetable programs for which there is evidence of beneficial health effects.[25] Working on lifestyle change in supportive groups, such as exercise groups, may be preferable to going solo. Often community-based services and health organisations provide group health promotion activities, although how these are run will depend on the community involved.

In all of this, the relationship GPs have with patients over a long period of time is a distinct advantage because lifestyle changes do not usually happen as a result of a single consultation.

USING MEDICARE

Health assessment for an Aboriginal or Torres Strait Islander person is billable under Medicare (item number 715) and, unlike other health assessment items, is not dependent on the time taken. The same item number covers assessments of children, adults and older people.

Health assessments by the patient's own GP have been shown to be beneficial.[26] There is general awareness of health checks in Aboriginal and/or Torres Strait Islander communities, and they can also be useful as a way of bringing people into a service and developing a relationship. The item 715 assessments also trigger access to five allied health appointments whether or not the patient has a chronic disease, which provides a useful means of accessing additional services for many patients.

Practice nurses or Aboriginal and Torres Strait Islander Health Practitioners can bill the follow-up item number 10987.

Health assessments can generate additional income for the general practice, which may facilitate the longer consultations often required for Aboriginal and Torres Strait Islander patients. The number of Aboriginal health assessments is increasing, but the number of follow-up items has not. Practices can use their recall systems to ensure that follow-up is done after a health assessment, as this is where interventions will have an impact.

The Closing the Gap program aims to improve the health of Aboriginal and Torres Strait Islander people with chronic disease or at risk of chronic disease through reducing lifestyle risk factors and improving chronic disease management. At the GP level, there are two important components of the program: support payments to practices to promote systematic chronic care through the Practice Incentives Program, and PBS medication subsidy for eligible patients.[27]

To be eligible to take part in this program, two staff members from the practice, at least one of whom is a GP, must undertake cultural awareness training within 12 months of signing on to the incentive.

Practices can then access annual PIP payments for registered Aboriginal and/or Torres Strait Islander patients over the age of 15 with existing chronic disease.

Chronic disease is defined for this purpose as a disease that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular illness, diabetes, musculoskeletal conditions and stroke.

GPs are required to offer health checks under the item 715 ('Aboriginal and Torres Strait Islander Peoples Health Assessment'), and regular chronic disease management plans and reviews to patients within this program. Patients must re-enrol annually at the practice of their choice.

Aboriginal and Torres Strait Islander adults who have a chronic disease can be signed up under the PIP – Indigenous Health Incentive.[27]

This provides the general practice with an incentive to become the 'medical home' for their patients, providing reimbursement for a series of consultations, a GP Management Plan and review under Medicare. This enables practices to provide longer consultations and to improve care co-ordination.

Aboriginal and Torres Strait Islander people (including children) who have, or are at risk of, a chronic disease can also be signed up for the Closing the Gap PBS co-payment. This reduces the cost of PBS-listed medications for the patient and is much valued in Aboriginal and Torres Strait Islander communities.[28]

There are also a small number of medications available to Aboriginal and Torres Strait Islander people on the PBS. These include some items for conditions seen more frequently in Aboriginal and Torres Strait Islander communities (such as anti-fungals, ciprofloxacin ear drops and nicotine patches), and some items that have been maintained on the PBS after switching them to over-the-counter medications for all other patients. Examples include low-dose aspirin and iron replacement tablets.[29]

SEEING STRENGTHS

As doctors, we are often trained to look at what is wrong with people. This can also lead us to the view that we possess knowledge and our patients do not. If we start with the knowledge that our Aboriginal and Torres Strait Islander patients have strengths that have aided survival, often in difficult circumstances, this can yield benefits.

Almost all Aboriginal and Torres Strait Islander people have demonstrated resilience in trying circumstances. The medical conditions they present with are just another challenge and often not the most important.

When people have inadequate housing and do not have enough money week to week, they make decisions to prioritise the basics that will enable survival for them and their children.

Most doctors have not experienced this personally. The strength and determination that keeps people going in these circumstances are qualities that can be drawn upon in managing their healthcare.

CASE STUDY

RAY, an Aboriginal man aged 38, comes to see you with a discharge letter from the local hospital where he had been admitted overnight with chest pain. He was meant to attend a priority appointment with the cardiologist after hospital discharge. However, although the hospital doctor had impressed upon him that it was essential to attend this priority cardiology appointment, he missed the appointment because his relative passed away, and he had to travel to his home town for the funeral. He is now worried about attending the appointment and is not sure how he will be received.

Ray has diabetes and had been on metformin in the past. He does not attend your practice for regular healthcare and feels overwhelmed by his new medications, the medical referrals and his new health worries. He explains his father died of a heart attack at 49 after being on continuous peritoneal dialysis for three years, and that heart disease and kidney failure run in his family.

After offering to speak to the cardiologist on his behalf, you review his comorbidities and recommend an appropriate management plan. As Ray has decided to attend your practice regularly now, you arrange a longer consultation for his next visit and enrol him on the Closing the Gap program. This program allows your practice to access the annual PIP payments that incentivise general practice care for Aboriginal and Torres Strait Islander people.

You advise Ray that under this program, you can provide essential regular health checks and reviews without cost to him, as well as access to free or reduced-cost medications. You also work with him to put together a practical and acceptable chronic disease management plan, and discuss what lifestyle

PAGE 24 ▶

◂ PAGE 22 modifications may be possible for him.

You also explain that under the Closing the Gap program, you are able to refer him, at no cost, to a dietitian and an exercise physiologist if you both feel this would assist in managing his diabetes and cardiovascular risk.

Ray's relative youth and multiple chronic comorbidities are a common presentation for an Aboriginal man. It is important to understand the extent to which chronic disease contributes to the higher mortality of Aboriginal and Torres Strait Islander people.

It is also helpful to understand why Ray prioritised his relative's funeral over his own health. 'Sorry business', or bereavement and mourning, including attendance at funerals, is an important responsibility for Aboriginal and Torres Strait Islander people and usually takes priority over individual needs.[30]

Key points

- Chronic diseases are the largest contributors to the unacceptable life-expectancy gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians.
- Medicare and PIP items are available to assist Indigenous patients to access services.
- Mentorship will assist in developing and enhancing trust with Aboriginal and Torres Strait Islander patients.

Cultural obligations are vitally important, and in Ray's case, he may have been leading the ceremony for his relative.

CONCLUSION

THE combined effects of more than 200 years of colonisation have resulted in the health problems we see in Aboriginal and Torres people that make this a national priority. As we get to know our Aboriginal and Torres Strait Islander patients better, we will see the strength and resilience of people helping their communities and their families in circumstances where most of us would struggle.

The truth is that general practice at its best has the potential to be a real ally in achieving better health outcomes. The therapeutic relationships that are central to our role are just what can help people navigate difficult health problems.

Michael Marmot from University College Institute of Health Equity, London said, "Health is dependent on conditions that enable people to live the loves they would choose to live." The history of colonisation is always one of removing control from the lives of Aboriginal and Torres Strait Islander people. Our role is to be among those who choose to give control back.

RESOURCES

- **RACGP Five Steps toward Excellent Aboriginal and Torres Strait Islander healthcare**
  A simple guide to the steps involved for a practice in Aboriginal and Torres Strait Islander health.
  bit.ly/2kihRGj
- **RACGP An introduction to Aboriginal and Torres Strait Islander cultural protocols and perspectives**
  A resource to guide engagement with Aboriginal and Torres Strait Islander communities
  bit.ly/2jayPmH
- **RACGP Supporting smoking cessation guideline**
  bit.ly/2jQBjWH
- **NACCHO/RACGP National Guide to a Preventive Health Assessment in Aboriginal and Torres Strait Islander people**
  Evidence-based guidelines on preventive health interventions for Aboriginal and Torres Strait Islander people.
  bit.ly/2jHxqmM
- **Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (eds Pat Dudgeon, Helen Milroy and Roz Walker). 2nd edition**
  Comprehensive resource on effective mental health and wellbeing in Aboriginal and Torres Strait Islander people
  bit.ly/2kOLbik
- **Indigenous HealthInfonet**
  Comprehensive directory of professional and patient information in Aboriginal and Torres Strait Islander health
  www.healthinfonet.ecu.edu.au
- **PIP - Indigenous Health Incentive**
  bit.ly/2BIo1Ux
- **Lowitja Institute LitSearch**
  PubMed search filter to find Aboriginal and Torres Strait Islander articles
  bit.ly/2BwuYXP
- **Map of Indigenous Australia**
  bit.ly/2sbKtj1
- **Department of Health Medicare Health Assessment for Aboriginal and Torres Strait Islander People (MBS ITEM 715) and Medicare Health Assessment for Aboriginal and Torres Strait Islander People (MBS ITEM 715)**
  bit.ly/2ijwXa7
- **Rheumatic heart disease guidelines**
  bit.ly/2BJ8Wlq
- **Guidelines for the Public Health Management of Trachoma**
  bit.ly/2im605Q
- **Central Australian Rural Practitioners Association guidelines**
  bit.ly/2iSaPrl
- **General Practice Management of Type 2 Diabetes**
  bit.ly/2A2TJ1h
- **Chronic Kidney Disease Management in General Practice**
  bit.ly/2l8auNd

Acknowledgement

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How to Treat Quiz.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

GO ONLINE TO COMPLETE THE QUIZ **www.ausdoc.com.au/howtotreat**

1. **Which TWO statements regarding the background to Aboriginal and Torres Strait Islander health are correct?**
   - **a** Aboriginal and Torres Strait Islander peoples are a diverse group of people from many countries across Australia.
   - **b** While all communities have similar general experiences, each community has their own stories, their own history and their own way of doing things.
   - **c** International experience is applicable in Aboriginal and Torres Strait Islander communities, as it is in Australia in general.
   - **d** Solutions to the problems faced by these communities are all the same.

2. **Which THREE statements regarding Aboriginal and Torres Strait Islander health are correct?**
   - **a** More Aboriginal and Torres Strait Islander people are reaching older ages, but it is still a much younger population than the non-Indigenous Australian population.
   - **b** Between 1998 and 2015, the all-cause mortality rates for were 1.7 times higher for Indigenous compared with non-Indigenous Australians.
   - **c** Between 1998 and 2015, there was a significant narrowing of the gap in infant mortality rates.
   - **d** Life expectancy at birth was 69.1 years for an Indigenous man and 73.7 years for their non-Indigenous counterpart, according to a 2017 report.

3. **What ONE is the leading cause of death for Aboriginal and Torres Strait Islander people?**
   - **a** Diabetes.
   - **b** Cardiovascular disease.
   - **c** Cancer.
   - **d** Injury and poisoning

4. **Which THREE statements regarding Aboriginal and Torres Strait Islander people's health are correct?**
   - **a** Genetic factors play a large role in the disparity between the health of Indigenous and non-Indigenous Australians.
   - **b** Childhood vaccination rates are improving in Indigenous communities, such that they are often more fully immunised than non-Indigenous children.
   - **c** Aboriginal and Torres Strait Islander people are at higher risk than non-Indigenous Australians for a range of infectious diseases.
   - **d** Connection to country, community and culture is protective for health.

5. **Which TWO statements regarding Aboriginal and Torres Strait Islander people's health are correct?**
   - **a** More Aboriginal and Torres Strait Islander people than non-Indigenous people smoke.
   - **b** More Aboriginal and Torres Strait Islander people than non-Indigenous people drink alcohol.
   - **c** Socioeconomic factors account for 8% of the gap.
   - **d** Physical activity levels are lower for Aboriginal and Torres Strait Islander adults, but higher for children.

6. **Which THREE are reasons for practices to identify and record their patients who identify as Aboriginal and Torres Strait Islander origin?**
   - **a** It allows more tailored, culturally appropriate care.
   - **b** It determines eligibility for certain Medicare programs.
   - **c** It allows accurate collection of data for census purposes.
   - **d** It allows more tailored, culturally appropriate clinical decisions, such as immunisation and preventive activities.

7. **Which THREE statements regarding a consultation with an Aboriginal and Torres Strait Islander patient are correct?**
   - **a** A proper assessment of the presenting problems of an Aboriginal and/or Torres Strait Islander person is no different from a consultation with any other patient.
   - **b** A social history is often very important to understand the potential barriers to becoming healthier.
   - **c** Many Aboriginal and Torres Strait Islander people experience racism within the health system.
   - **d** Aboriginal and Torres Strait Islander health professionals can provide guidance about the health system, building trust and offering advice on culturally appropriate care.

8. **Which THREE statements regarding preventive health issues with Aboriginal and Torres Strait Islander patients are correct?**
   - **a** Screening for chronic kidney disease starts at age 30 for Aboriginal and Torres Strait Islander people with no other risk factors.
   - **b** Screening programs, such as those for breast cancer or bowel cancer, appear to be less effective at reaching Aboriginal and Torres Strait Islander people.
   - **c** An absolute CVD risk assessment is recommended from the age of 35.
   - **d** Pneumococcal vaccination is recommended from age 65 and for those at high risk of invasive pneumococcal disease from age 15.

9. **Which TWO statements regarding the management Aboriginal and/or Torres Strait Islander patients are correct?**
   - **a** Aboriginal and/or Torres Strait Islander patients are generally happier discussing their life circumstances with strangers than with members of their community or an Aboriginal and/or Torres Strait Islander health professional.
   - **b** View the consultation as a meeting of two experts.
   - **c** Management and prevention of most chronic diseases always requires medication initially.
   - **d** When consulting guidelines, remember that multimorbidity is very common.

10. **Which THREE statements regarding the management Aboriginal and/or Torres Strait Islander patients are correct?**
    - **a** Explaining the reasons for performing particular investigations makes it more likely they will be undertaken.
    - **b** The use of health assessments does not appear to have any benefit and the inconvenience to the patient does not justify the outcome.
    - **c** Advice on diet and exercise is important, but it should be remembered that access to the healthy food we recommend can be limited by a range of factors.
    - **d** The Closing the Gap PBS Co-payment reduces the cost of PBS-listed medications for Aboriginal and Torres Strait Islander patients.

CPD POINTS

- We have a new How to Treat website (www.ausdoc.com.au/howtotreat) where you can read this article and take the quiz to earn CPD points.
- Each article has been allocated 2 RACGP QI&CPD points and 1 ACRRM point.
- RACGP points are uploaded every six weeks and ACCRM points quarterly.