

Providing excellence in primary health care across Western Australia

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Working at Swan District Hospital, which was an outer metro hospital (rural) at the time consolidated the interest in rural health. This led to an interest in midwifery and she went on to complete her Post Grad Dip (midwifery). Gabrielle has a variety of primary health experience including school health, community liaison and industrial health.

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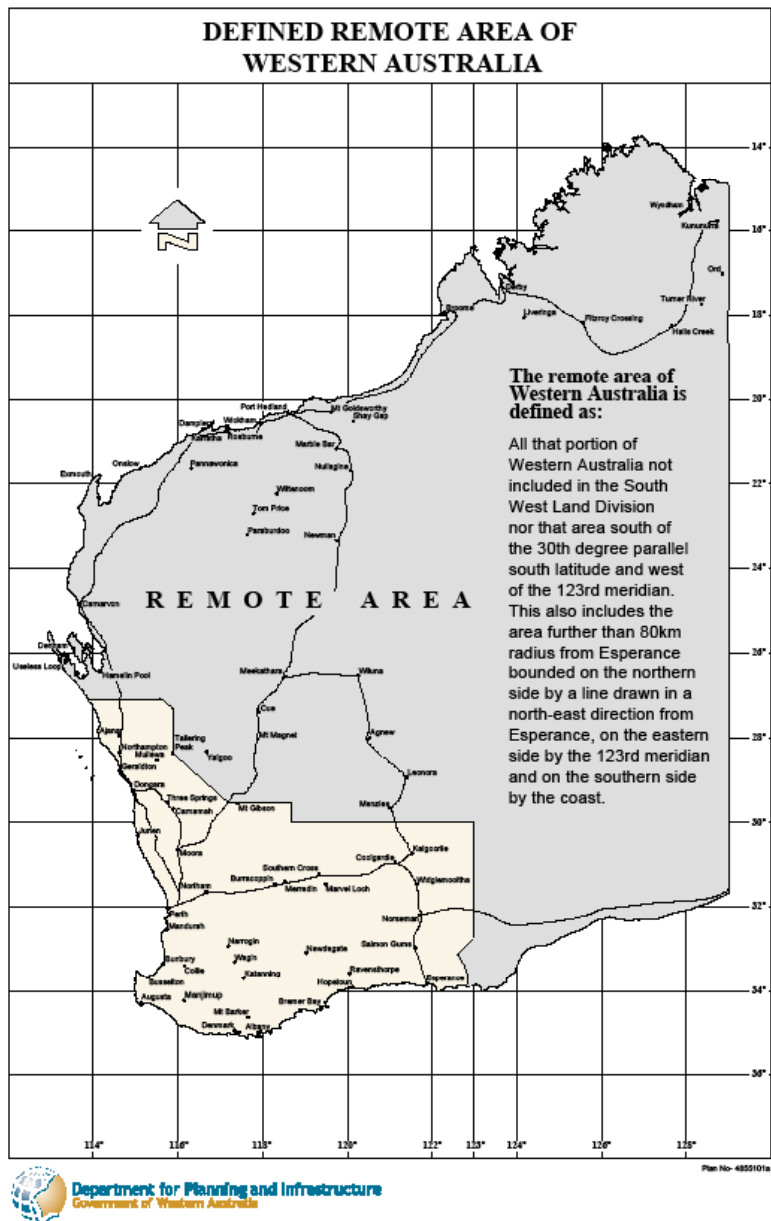
Introduction

“If we accept that we should aim to live in a society that has an equality of health outcomes then by current standards there is considerable room for improvement.” The significant problems that confront the health of residents in rural and remote communities in Australia is well documented in the literature, as is the multitude of programs designed to remedy the problems.^{1,3,5,7,19} To understand the true implications of this statement it is important understand the considerable challenges faced by the health system in this country. One third of all the Australian population lives outside the metropolitan areas with 20% of this one third consisting of rural and remote communities with less than 5000 residents.¹⁸ The provision of health care under such conditions presents a unique set of problems that to date has not been adequately addressed using existing standard models of care. Hence, in order to assure equality in health outcomes in those areas it is imperative to development a primary health care model that is flexible enough to meet the individual needs of these communities.

Western Australia is the largest Australian State. With an area of more than 2 500 000 sq km, a 12 500 km coastline and a span of some 2 400km from north to south, it occupies a third of the Australian continent. Its population of 2.2 million is distributed largely along the coastal margin with 85% living in the south west corner of the state. As can be seen in the map below close to 75% of the WA land area is designated as remote area.

Wakerman¹⁷ quotes the Royal Australian College of General Practitioners (RACGP) definition of remote rural practice as being “practice in communities more than 80 km or one hour by road from a centre with no less than a continuous specialist service in anaesthesia, obstetrics and surgery and a fully functional operating theatre.” However the complexity of access to health care is not merely the issue of geographic barriers. More importantly equality in the ability to access health care does not necessarily equate to equality in health outcomes. There are a huge number of confounding factors that can reduce the health benefits programs deliver to a community including education standards, access to appropriate housing, cultural sensitivity of activities, existing infrastructure e.g. roads, airstrips, clinic facilities, access to clean drinking water etc. this concept is recognised and reported by a number of authors including McCoy¹¹ and Humphries and Wakerman¹⁰ who argue that just because a service is available does not imply that it is appropriate and **therefore used by those for whom it was intended.**

The complexities of providing Primary Health Care to the thousands of Western Australians in rural and remote areas are a constant and increasingly costly challenge to the health system. The unique needs of our Indigenous population, who are more likely to report poor health outcomes and health status compared to non-Indigenous Australians¹⁶, provides an added imperative to develop a sustainable primary health care model that provides the excellence these populations deserve.^{1,2,11,15}



http://www.transport.wa.gov.au/mediaFiles/grants_dra_map.pdf (accessed 28/1/11)

This paper raises the question, what can be done to ensure excellence in the provision of primary health care across Western Australia? It discusses the barriers and explores the successes and achievements of using a multidisciplinary approach and reaching beyond the methods of the conventional medical model to overcome the barriers. The services provided by the Royal Flying Doctor Service Western Operations (RFDSWO) to the communities they visit form the basis for some of the discussions and recommendations.

Primary health care

In order to look at excellence in primary health care it is first necessary to define what is meant by the term. The World Health Organisation (WHO) describes primary health as the part of the health system that focuses on “protecting and promoting the health of people in communities”¹⁹ and refers to primary health care as “... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community ...”¹⁰

Primary health care is often the first level of contact people have with the health system in relation to their health needs. As such it is imperative to make the right “first impression” during this initial contact in order to

continue the relationship and enable health initiatives to make long term differences. This initial contact may be with a variety of health care providers including doctors, community nurses, Aboriginal health workers, Remote Area Nurses (RANs), or allied health professionals.

In developing a successful, sustainable primary health care model it is important to recognise the barriers and enablers that influence the provision and access to care. As part of implementing their primary health care initiatives RFDSWO have had to identify these factors and then work with communities and service providers to ensure the most appropriate approach.

Barriers and enablers

Using the WHO model of primary health care as a reference point RFDSWO acknowledged the numerous varied barriers that could potentially affect their ability to provide sustainable primary health care programs. Alongside these barriers RFDSWO also identified a valuable and encouraging set of enablers that were vital in the successful structuring of many of the programs. The table below represents some of the more specific issues that RFDSWO took into account. It should be noted that these issues have commonalities for both Indigenous as well as non-Indigenous communities.

Barriers	Effect	Enablers
Workforce		
Recruitment and retention issues especially in isolated Indigenous communities	<p>24/7 availability and poor leave cover— increase stress, burnout</p> <p>Housing—quality, cost, availability</p> <p>Lack of infrastructure especially for staff with children</p> <p>Safety and security concerns particularly in single practitioner sites</p> <p>Cost of household basics—food, power, fuel, etc.</p> <p>Poor remuneration</p> <p>Scheduled nursing and medical clinic visits may be cancelled or curtailed</p>	<p>Staff incentives</p> <ul style="list-style-type: none"> • Housing—subsidised, appropriate quality • Professional development opportunities—teleconferencing, short term leave relief, online learning packages—podcasts • Orientation—appropriate to local area, timely. • Collegial support—improved internet access, telephone services and support eg CRANA bush crisis line, RFDSWO telephone advice • Social support—availability of other community professionals e.g. teachers. • Guaranteed regular leave <p>Rural health placements for undergraduates and post graduates— Increased recognition by academic institutions on the importance and benefits of rural and remote placements and placement in tertiary centres for remote area practitioners to enable upskilling.</p>
Employment of overseas medical staff	<p>Inappropriate medical knowledge for the area they will work in</p> <p>Areas of high need are often isolated postings</p> <p>Staff with the greatest need have the least amount of support available</p> <p>Growing resentment from communities—bandaid effect</p> <p>Growing resentment from Drs— difficulty with families in isolated areas with limited infrastructure</p>	

Barriers	Effect	Enablers
Limited provision or ability to access professional development activities	Reduced skill maintenance Poor collegial engagement—feelings of isolation Disengagement and reduction in quality of care Practice not consistent with best practice	
Culture and lifestyle		
Lack of cultural considerations in culturally diverse areas e.g. separate areas for males and females	Programs will be poorly patronised as clients feel uncomfortable e.g. STI initiatives Indigenous health workers will disengage from the efforts Providers will be seen as disingenuous in their efforts—tokenism	Cultural orientation specific to the area of contact Culturally sensitive programs Community consultation Increased access for Aboriginal Health Workers to appropriate professional development and mentoring.
Lack of culturally appropriate staff—positions, training	Poor self determination in health care Deny possible contributions of Indigenous health workers Client disengagement	Appropriate consultation areas—Men’s health, infant health, well women’s programs. Provision and maintenance of clinic vehicles.
Minimal community engagement	Services may not be what the community needs or wants—underutilisation Unanticipated social and cultural gaffes—alienation Efforts risk being seen as paternalistic—disengagement Hinder the community’s right for self determination in health care	Improved access to PATS Appropriate and culturally sensitive accommodation in regional centres—Aboriginal hostels
Highly mobile Indigenous population	Fragmentation in health care as area health boundaries are frequently crossed Follow-ups and appointments get missed Medications get misdirected so clients don’t take them Children get lost in the system—poor child health leads to poor adult outcomes Contact tracing can be difficult	
Trusted relationships		
High staff turnover	Inability for clients and communities to form trusted relationships with providers. Fragmentation of health care—things get missed Over/under servicing Staff dissatisfaction with disjointed service provision Staff and client disengagement—element of trust is never built up	Staff incentives—(as above) Change management initiatives Case management
Management from afar—many programs are managed from distant locations	No real idea of what is needed or what is happening Poor community consultation and involvement—no local “go to” person Inappropriate, irrelevant services	Aboriginal Health Forums feed information back to the State and Commonwealth funding bodies. Recognition of local leaders/elders and their role.

Barriers	Effect	Enablers
Sporadic communication between service providers and individual client care plans are nonexistent	Inability to mount a timely response to changes in need Conflicting decisions and advice confuses and annoys clients who become increasingly at risk of disengaging from the care process and “dropping off the radar”	Peer Review of Closing the Gaps initiatives Initiatives to encourage a stable workforce.
Geographical and environmental issues		
Limited infrastructure—public transport, roads, maintenance of buildings and plant, communication,	Health care providers have difficulty accessing the population Time constraints/level of motivation in adverse weather conditions compromises uptake of health care	Dedicated resources—aircraft charter contracts for clinics, access (although limited) to mail plane and other transport services. Telehealth—RFDSWO clinical support through telephone consultation and planned video and electronic links for disease management
Weather extremes—very high summer temperatures along with very high humidity, onset of the wet season—high rainfall, freezing winters	Roads not well maintained—many are private roads with “right of way” agreements Little or no access to public transport—private vehicles become of increasing importance and poverty affects ability to maintain and fuel a vehicle. Challenge the commitment of staff to the position—difficult to function Clients are disinclined to attend clinics—particularly the sick, elderly and frail High rainfall cuts off access—roads, airstrips become unserviceable.	Airstrip management and monitoring.
Sustainability		
Economically sustainable	Complex funding arrangements involving state and federal government and private providers. Inflexible funding arrangements. Short term funding models	Commonwealth and State reports on episodes of care.
Record keeping	Patient record incompatibilities Highly mobile population—current system of patient records consists of a mixture of paper records and a variety of electronic medical records that are unable to communicate between localities.	
Robust evidence	Poor data collection practice Inflexible program designs— inability to respond to rapidly changing situations	

Adapted from:

- RFDSWO annual report 2009/10¹
- Humphries and J Wakerman^{10,18}
- Personal communication Pilbara, Goldfields and Kimberley Aboriginal Health Forum Meetings 2009/2010
- Duckett SJ⁸
- Baron RJ⁴

Thinking outside the square

With the above barriers and enablers in mind 3 of the programs in which RFDSWO played an active role are discussed below. These programs are important as they don't fit with much of the current health modelling and were an innovative solution to a local problem.

Kimberley Men's Health Week

The need to improve Indigenous Men's health is clearly demonstrated by the Australian Bureau of Statistics figures saying that an "Indigenous male born in the period 2005-2007 could be expected to live to 67.2 years, about 11.5 years less than a non-Indigenous male born at that time."² It is clearly apparent from the RFDSWO clinic attendance statistics that Indigenous men, especially in the 18–25 age groups, are poorly represented in attendance and are difficult to convince of the need for health checks and health education and therefore often miss out on essential help and advice. Statistics from various clinics indicate that in communities such as Yakanarra (Fitzroy Valley) which has a transient population of around 160, 65% of all males are aged less than 24 years.^{1,9}

The implementation of a men's health week activity in the Fitzroy Valley area of the Kimberley in Western Australia is a prime example of the success of implementing health a care initiative using innovative strategies. This activity was programmed to coincide with International Men's Week and was coordinated by the community nurse from Fitzroy Community.

The 2010 Men's Health Week overcame the barriers of distance, environment and cultural reluctance to attend health care clinics and activities. The data showed that 73 men received a complete "Indigenous Australians 15-55 health check" resulting in referrals to specialist services (Ophthalmologist, Dentist, Diabetes Educator, Drug and Alcohol Services) for 38 attendees. Five men were also identified on screening as possible diabetics.

A total of 6 communities were visited over 4 days with the team setting up in locations such as the local men's shed, the football oval and in other outdoor settings. A team of 13 service providers were involved; Aboriginal Health Workers, General Practitioners, Registered Nurses, Environmental Health Workers, a Nutritionist, a lawyer, and a musician, with the aim of covering a diverse range of interests and needs. Providing food and entertainment as well as prizes for attendance provided an added incentive for the men to attend. All data from the health checks was entered into the CommuniCare electronic medical records system including referrals and recall notices. It should be noted that this system is only accessible through direct access to Fitzroy Valley Health Service highlighting the ongoing risks of fragmentation of health care and the necessity to actively pursue a common electronic health record.

Health promotion

Another way in which the health message is delivered to the rural and remote population is the "On the Road" (OTR) program run by the RFDSWO

The RFDWO "On the Road" program delivers primary health care services to people living, working and travelling in the Pilbara and Goldfields Esperance regions and is due to expand on a trial basis to the Kimberley in 2011. The program is sponsored in the Pilbara region by BHP Billiton Iron Ore and the Pilbara Development Commission, and in the Goldfields Esperance region by BHP Billiton Nickel West and the Goldfields Australia Foundation. Individual programs such as skin screening and local activities also draw on a high level of in-kind support from mining companies, local government and local businesses.

A primary health care nurse and a project officer travel in 4WD vehicles to satellite mine and exploration sites, pastoral stations, Aboriginal communities, remote tourist facilities, roadhouses and isolated settlements running health promotion sessions on a range of health topics. The staff hold primary health care education and training activities at schools, hospitals, volunteer emergency service groups and at regional community events using innovative and interesting methods to get the message across to a diverse audience.

After a visit to Tjunjunjarra community school, a 2200km round trip for the Goldfields Esperance team, the nurse reported that although it was difficult to measure the success of the activities except in numbers of people seen she had been privileged to get some feedback from one of the community grandmothers who reported that her grandchild had decided that she wouldn't be drinking Coke again, only water, and that she'd

prefer Weetbix for breakfast not Coco Pops. Feedback from one of the teachers about the enthusiasm of the children and the way in which they retained the health information shared by the OTR team supports the use of this form of primary health care in the remote setting. She said. "I was rinsing the hands of one of our four year olds and he started to hum the happy birthday song, the RFDS had taught him that he needed to wash his hands for the time it takes to sing the song and even though he speaks Pitjantjatjara, he remembered the tune."¹³

To date the On the Road program has provided primary health care services at more than 240 isolated locations; and delivered health education and training services to more than 11,500 remote Western Australia residents.¹³



"On the Road" four wheel drive

Ear health

Doctor Gil Ostberg joined the RFDS at its Meekatharra base in 2009 to practice retrieval medicine and his wife Therese began teaching at the local school. It soon became apparent to Therese that many of school students were suffering from hearing impairment due to ongoing ear infections. The extent of the problem and the ongoing disadvantages of this to the students led Dr Ostberg to team up with community health nurse Amanda Bradley (also the wife of RFDS pilot Scott Bradley) to conduct hearing tests for all students at the school. Working on his off duty time, Dr Ostberg undertook hearing tests on all the students and ensured that infections were treated appropriately, sometimes delivering medication to the children's homes and educating parents to ensure it was properly administered.

By addressing the issue on such an inclusive scale the awareness of ear health within the community as a whole has been raised, leading to parents and children reporting problems when they first arise. Teachers have reported a marked improvement within the student body and Dr Ostberg is now taking his hearing program to Yalgoo, Sandstone and Payne's Find. In the near future he hopes to secure funding to enable

approximately 50 school students with ongoing ear problems to receive the specialist medical treatment they need.¹²

Conclusion

It is important to recognise and reward programs that do not easily fit into a mainstream medical model and try to understand and utilise identified service barriers and enablers to better provide appropriate and targeted remote primary health care.

The above examples of “outside the square”, specifically targeted primary health care initiatives are just three of a multitude of programs that have achieved positive results. One of the common themes that arose was that the success was essentially achieved through the passion shown by the participants to make a difference. Empowering the clients by communicating and providing appropriate initiatives resulted in outcomes that in the short term could be qualified and enjoyed such as the case of the ear health scenario is one approach. The men’s health week is a case of knowing the clientele and employing methods and tools suitable for that individual group. Both of these examples show the power of a multidisciplinary approach, not just involving health care personnel. There are many more such examples in the remote communities that need to be recognised and applauded.

Collection of more long term quantitative data on health outcomes from programs such as this is an ongoing challenge and one that will require the continued passion and “outside the square” thinking that is representative of effective primary health care in rural and remote Western Australia.

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