HEALTH TO THE PEOPLE
A VICTORIAN ABORIGINAL HEALTH STATUS STUDY
BY THE VICTORIAN ABORIGINAL HEALTH

PROPOSAL OUTLINE

Although most authorities recognise the poor health status of Aboriginal people both in Victorian and interstate, it has been very difficult to document such.

Aboriginal people as a response to their own concern have established (or are establishing) primary health care systems throughout the State.

A major limit to these services' ability to develop effective and efficient programs, and for Aboriginal people to undertake major health related action, is the lack of relevant or useful statistical information regarding health status.

It has been well established that there are major differences in morbidity and mortality of Aboriginal people when compared to non-Aboriginal people (e.g. Diabetes, Trachoma) and that health promotional approaches suitable for non-Aboriginal people (e.g. anti-smoking programs) are generally very unsuitable for Aboriginal communities.

It is proposed that a community controlled and operated monitoring program be established to collect and analyse general health status information.

This information would be both confidential and collected in such a way as to assist both individuals and communities to improve their health status i.e. the program would not be academic but action oriented.

The approach is to utilise Aboriginal community controlled Health Workers in conjunction with local community people, to assess on an annual basis the health status of Aboriginal communities in Victoria. The data collected will be collected and analysed within each community while the health team is present.

Any patients requiring follow-up or on-going care will be referred to the appropriate health professional.

We see this program as an important advance in "health" care providing both individual information and community information so as to develop effective preventive health care and health promotional programs, in association with a clinical health care entry point.

AIM

To establish an effective Aboriginal community controlled and operated health status monitoring and education program.

PRINCIPLES

1. That health priorities are best determined and supported when individuals and communities understand their health status. Such knowledge provides a stimulus to action.

2. That once these priorities are established, these communities can use the information to bring about changes both at a community level.

3. That regular community based and operated screening programs can best provide that information. This screening could occur in homes or community centres.

4. That general health surveillance can be best undertaken by local community members with assistance from "experts" when requested and under their control.

5. That a simple recording and evaluation system can be developed that will provide:-

   a) Health status changes (morbidity and mortality).
   b) Population data.
   c) Relative changes over time.
   d) Inter-community variations.

6. That the Aboriginal communities of Victoria have a keen interest in their health and are seeking relevant and appropriate information to try and improve their health.

7. That the Aboriginal communities of Victoria have a higher degree of ill-health than any other identifiable community group with Victoria.

8. That the Victorian Aboriginal communities have a well established community controlled co-operative network with both an interest and competence in health care, thus enabling a state-wide project to operate.

9. That the Victorian Aboriginal communities have a well established and efficient health worker education unit (Koori Kollij) that could undertake any education courses required, both at a community level and for individual health workers.

10 That any data collected, either personal or community based would be released to individuals or groups outside of each specific community, without close consultation and community support and authority.

11 This confidetntially must be seen as essential to any long term and effective surveillance. Any breech of such could destroy the effectiveness and future of such a study.

12. That this program should be developed carefully and at a rate considered appropriate by each community, to prevent misunderstandings and confrontation.

13. That any illness indentified through this screening will be conveyed to the individual and appropriate intervention arranged by the local community if requested e.g. specialist referrals.

14. This program needs to be seen as an action oriented exercise and not an academic one. Problems both at an individual and community level will be discussed with the aim of solving them.

15. If services are lacking to deal with these problems, attention will be drawn to this, so as to improve the services available e.g. better housing, public and personal health facilities.

16. That this surveillance project could be implemented and operating in a short period of time with only limited resoures due to uniqueness of the above principles.

* *

That although reference is made to Victorian Aboriginal communities, there would need to be a link in with communities that closely relate to those Victorian communities e.g. Dareton, Cummeragunga in the Murry River area, if such communities wish to participate. This is important as these communities closely relate to and make use of Victorian health resources at Mildura, Echuca and Swan Hill.

BACKGROUND

Aboriginal communities throughout Victoria have repeatedly expressed their concern over the poor health of their people.

Despite this expression of concern, it has generally been very difficult to actually document this poor health other than through specific serveys (e.g. nutritional), general opinion surveys and the collection of clinic or hospital based data. The Victorian Aboriginal Health Service has undertaken limited general health status surveys. However, these have been either limited to particular region, or particular age groups. All of the data collected has supported the communities' views regarding its poor health status.

The Aboriginal Liasion Unit of the Victorian Health Commision is collecting valuable statistics. Although this collection has encountered major problems due to under-reporting, identification problems, population number difficulties and even reluctance by some authorities to co-operate, the information so far collected is quite valuable. This data has confirmed the overall poor health picture and supports the need for a more detailed morbidity study (as proposed).

In a number of academic studies, the data collected has been poorly analysed or released publicly without adequate community support. some studies have been simply part of an academic career. This has caused considerable community hesitancy as regards statistical collection and a sensitivity that has been very valuable, in that it has encouraged communities to undertake their own research projects or closely control those researchers working with them. This latter approach has enabled a far more effective collection and analysis of data than the former "big brother" type tactics. Out of this experience has grown an expressed need for properly controlled and effective health status surveys to be undertaken.

This proposal has grown out of this concern.

FRAME WORK

It is proposed that a team of speacialist workers be established to initiate this study. This team should consist of:

(3) Aboriginal Health Workers
(1) Doctor
(1) Data programmer

This team would develop a regular program through several Victorian regions (e.g. March and April in Melbourne) when they would work closely with and through local Aboriginal community groups and Health Workers. Any data collected would be confidentially analysed and evaluated, perferably on site using a micro computer.

The data collected would be presented in a tabulated and graphic form to show relevant statistics e.g. ear infection, blood pressure, hospitalisation rates etc, in a manner that the community can understand and discuss. Any specific abnormalities would be handled at a local level, with arrangements for follow up and specialist referral.

These health problems will be discussed at an individual family and community level, where appropiate. We believe that this form of analysis performed at a local community level, will both allow close community input to make the data relevant and be useful to bring about health improvements.

It is currently estimated that there are 20,000* Aboriginal people in the Victorian and associated NSW areas.

If, as proposed 30-50 patients/week are examined, the team could examine 1500-2500 people in the first year. Subsequent examinations would not take as long and possibly 70/ per week could be examined in subsequent years.

It is proposed that the program would be fully intergrated into the local Aboriginal community controlled co-operative health programs and that they run the programs. As people become accustomed to the program much of the history taking, weighing etc, could be undertaken by the person themselves (or parents) working with local community health workers. The data collected could change as different priorities and problems arose and people gained skills. The team structure would need to change as more communities become involved in the program, with an expected need of an ongoing team operating in the Melbourne urban area and in communities that lack established community health programs.

On the basis of a team examining 50-60 persons/weekly, there would be an apparent need for several teams to cover the entire Victorian Aboriginal population. Most of these teams could be incorporated into the appropiate co-operatives programs and developed as the program operated in their region.

A number of these teams would operate on a part-time basis (e.g. 10 weeks per year), but in some areas the need for a full time team could be demonstrated (e.g. Murray Valley area, Melbourne urban area).
Once the initial survey has been undertaken across Victoria and * data adequately analysed further option could be considered.

a) To extend the project in other areas of Australia (if requested)
b) To undertake a comparative study on a non-Aboriginal population.

* As per Victorian Health Commision Aboriginal Liasion Unit, Statics Section.

As a result of this survey considerable general health data regarding the Aboriginal community could be gathered. Any publication of such data could only be considered after a full community consultation.

AIMS AND OBJECTIVES

1. To establish a community based and operated primary health surveillance program within the framework of the VAHS.

2. To undertake an education and skill transfer program to Aboriginal community based health workers, so that this program can be undertaken. This would include an inservice program as well as short course work.

3) To establish a database, referral system and analysis program that can be operated at a local community level.

4) To undertake this program through individual family homes and communities centres, utilising local community and family members whenever possible.

5) To provide framework for annual "health status" checks, that can provide both relevant and action oriented individual and community data.

6) That the team would aim to examine 50-80 persons per week moving through Victorian Aboriginal community, establishing an ongoing program of health surveillance.

7) That a community report be prepared with each community involved outlining in a graphic way the major health problems.

8) That individual health records be kept confidential and appropriate referrals for follow up care be arranged by the team and local community organisations.

9) That any publication of data be carefully reviewed by the VAHS and the local community, prior to publication.

10) That consideration be given to the possibility of developing parallel surveys in other regions and amongst comparable non-Aboriginal populations.

11) That the team provide primary health care when and if appropriate as part of the health survey, i.e., treatment of specific illness, when referral is not appropiate.

PROGRAM TASKS

a) Preparation of : discussion papers
: education program for staff in program
: budget
: record system
: computer software

b) Discussions with and persentation to different Aboriginal co-operatives and with:
: Koori Kollij
: SEAHIO
: VAHRCG
: Victorian and Federal Departments of Health
: Monash and Melbourne University departments of community health
: FMP program and the Academy of general practice
: Medicare
: Department of Employment and industrial Relations.

c) Seeking of appropriate funding.

d) Recruitment of suitable staff.

e) Education program for selected staff.

f) Undertaking of pilot program in:
(i) Urban situation (Fitzroy/ Northcote).
(ii) Western District.

TASKS OF TEAM (When operating).

1) Visit to community by team co-ordinator and medical officer to organise:
a) sites of health screening i) community centres
ii) homes

b) accomodation for staff

c) local community resources to assist with survey, e.g. assistance with screening procedures and referral arrangements.

d) co-ordination with local and regional health resources for specialist referral laboratory and x-ray investigations, follow up etc.

2) a) Primary interview and physical examination of person. Undertaken where appropriate, on a family basis.

b) Nutritional assessment (including BP).

c) Audiometric and Bridge Impedence Tympanometry.

d) Dental screen

e) Visual acuity

f) Urine and Blood tests

g) ECG and Spirometry where indicated.

3) Secondary interview in relationship to results of both individual, family and community records.

4) Data input, primary data to be collected on same day using a micro computer.

5) Analysis of secondary data prior to leaving community.

6) Arrangement with local community for referral and follow up where appropriate e.g. specialist referrals.

7) Presentation of community profile to Aboriginal community controlled co-operative for discussion and action where appropriate.

8) Provision of primary medical care when requested, if appropriate (i.e. illness management).

9) Education and transfer of health skills to local co-operatives, staff and community members.

10) Accurate accounting records for costs.

11) Preparation of general reports for publication.

Note:

Part of the medical examination will include (if requested) a pelvic examination and cytology screen. This would generally need to be undertaken by a female health worker or doctor.

SKILLS REQUIRED BY TEAM MEMBERS

1) Basic history taking - individual and family information.
2) Record keeping.
3) Data transfer and analysis.
4) General physical examination including, height, weight, and BP.
5) Visual acuity testing.
6) Hearing assessment, audiometry and Bridge Impedence Tympanometry
7) ECG recording.
8) Urine testing.
9) Blood testing.
10) Basic spirometry.

PROGRAM RESOURCE NEEDS

CAPITAL ITEMS

		ESTIMATED COST 88-89
Vehicles:		
1/	Sedan	$ 20,000.00
2/	Station wagon (for towing and patient t/sport)	$ 25,000.00
3/	Caravan - equipped with screening and examination area and sound proofed audiology booth	$ 24,000.00
	sub-total	$ 69,088.89
Equipment:		
1/	Micro computers x 2 (one portable unit)	$ 14,000.00
2/	Bridge Impedence Tympanometry/Audiometer	$ 5,325.00
3/	ECG	$ 2,750.00
4/	Spirometer	$ 5,692.00
5/	Dry Chemistry Analyser for cholesterol screening and 500 kits	$ 8,500.00
6/	Computer software packages	$ 3,000.00
	sub total	$ 39,267.00

For Staff Requirements see next page

../2/

STAFF REQUIREMENTS	1988-89	89-90	90-91
1/ 1 program co-ordinator	$ 24,892.00	$ 27,092.00	$ 28,390.00
2/ 3 Aboriginal Health Workers @ 20,250/annum	$ 60,750.00	$ 63,950.00	$ 67,870.00
3/ 1 medical officer	$ 51,000.00	$ 52,700.00	$ 54,950.00
4/ 1 data programmer	$ 19,670.00	$ 20,600.00	$ 21,800.00
5/ secretarial assistance	$ 9,000.00	$ 9,500.00	$ 10,250.00
sub total	$165,312.00	$173,842.00	$183,260.00

CONSULTANTS

VAHS Directors
VAHS Administration
VAHS Health Staff
Paediatrician
Epidemiologist
Statistician
Computer Programmer
Health Education
Audiologist
Nutrtionalist

Estimated consultant fees:	$ 35,000.00	$ 15,000.00	$ 10,000.00

OPERATING COSTS

1/ Accomodation costs @ $75/ per day per person	$ 35,000.00	$ 32,500.00	$ 24,000.00
2/ Vehicle transport costs	$ 11,000.00	$ 11,500.00	$ 11,000.00
3/ Telephone	$ 5,000.00	$ 5,500.00	$ 5,750.00
4/ Administrative costs			
a) preparation of salaries, accounting procedures, photo copying, secretarial assistance	$ 5,000.00	$ 5,500.00	$ 5,750.00
5/ Computer software development	$ 5,000.00	$ 2,000.00	
sub total	$ 56,000.00	$ 57,000.00	$ 46,500.00
TOTAL	$364,579.00	$245,842.00	$239,760.00

APPENDIX. A.

List of organisations.

V.A.H.S. The Victorian Aboriginal Health Service.

The major Aboriginal Health Service in Victoria, operating from Fitzroy. This service provides a wide range of primary care services including medical, welfare and dental. It is closely linked with other Aboriginal co-operatives and bodies involved in Aborigial welfare, housing, sporting, child care etc, as well as health.

N.A.I.H.O. National Aboriginal & Islander Health Organisation.

A body representing the different Aboriginal Health Services, from throughout Australia.

S.E.A.I.H.O. South Eastern Aboriginal & Islander Health Organ.

A section of N.A.I.H.O. representaing Victorian and the Southern parts of the riverina and Murray areas.

V.A.H.R.C.G. Victorian Aboriginal Health Resources Consultative Group.

An advisory body to the Victorian Health Department consisting of representatives from all the different Aboriginal co-operatives involved in health care.

R.A.C.G.P. The Royal Australian College of General Practitioners

F.M.P. The Family Medicine Program

A section of the R.A.C.G.P. involved in education of G.P's.