Medical Specialist Access Framework

A guide to Equitable Access to Specialist Care for Aboriginal and Torres Strait Islander people

RACP
Specialists. Together

Artwork credit: Zachary Bennett-Brook is the artist and owner of Saltwater Dreamtime. A Torres Strait Islander artist born and raised in Wollongong (Dharawal Country), he has a love for the ocean and creating contemporary artworks which represent his culture and passions. Bennett-Brook created an original artwork for the Royal Australasian College of Physicians to represent doctor-patient community engagement.

The red and orange concentric circles on the left symbolise the patient, their family and broader community contexts. The blue concentric circles on the right symbolise the doctor, the health service and the broader medical profession, college and university contexts. The green in the centre depicts the engagement space, where all these individual and contextual elements can connect to promote health and wellbeing. www.saltwaterdreamtime.com

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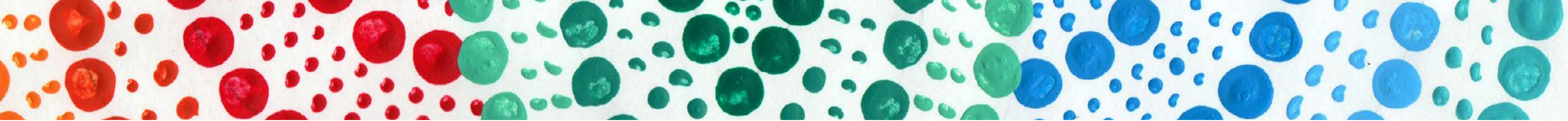

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The RACP Aboriginal and Torres Strait Islander Health Committee

The RACP established the Committee to strengthen the College's capacity to develop a coordinated College approach to improving the health and social outcomes for Aboriginal and Torres Strait Islander peoples in Australia.

Chaired by Dr Tamara Mackean FAFPHM, the Committee comprises at least six members of the College, including the Chair of the College Policy and Advocacy Committee; a College trainee representative; up to four community members, either individual or organisational, comprising a representative of the Australian Indigenous Doctors' Association, a representative of the National Aboriginal Community Controlled Health Organisation nominated by that organisation, and one male and one female Aboriginal and Torres Strait Islander community member.

This Framework is the centrepiece of its work since the 2014 Roundtable and has benefited from the leadership and contributions of its membership over that time, as well as former members.

The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of more than 14,300 physicians – often referred to as medical specialists – and 8,000 trainees across Australia and New Zealand. It represents more than 32 medical specialties including paediatrics and child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

www.racp.edu.au

Executive Summary

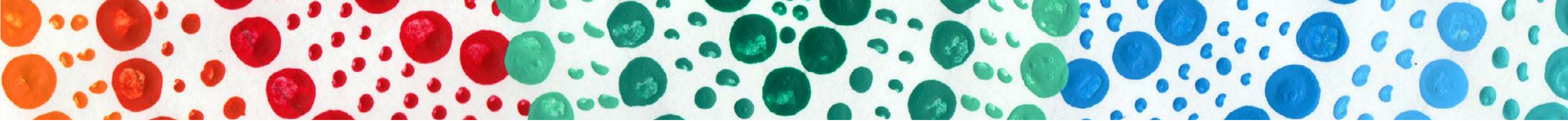
A national framework is needed to underpin a properly networked, coordinated and consistent system that enables equitable access to specialist medical care with complete geographical coverage across Australia.

Aboriginal and Torres Strait Islander peoples have shown, and continue to show, extraordinary resilience and strength, drawing upon their own health and social systems to meet the ongoing challenges of colonisation. The colonial processes of dispossession and disempowerment have, however, had significant consequences for the lives and communities of Aboriginal and Torres Strait Islander peoples. Negative impacts on individual and collective wellbeing have led to major disparities in health outcomes and access to health care, including medical specialist care.

In 2014, The Royal Australasian College of Physicians (RACP) hosted a Specialist Access Roundtable, where participants called for national action to address inequitable access to specialists and replace the current piecemeal, ad hoc approach with a comprehensive and systematic national approach as part of the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP).

The Roundtable reached consensus that:

- a national system is needed that provides equitable access to specialist medical care with complete geographical coverage across Australia;
- a national framework should guide the system and be based on principles that inform best practice in the provision of specialist medical care;
- a framework should incorporate essential elements required for effective and sustainable models of care that draw on the experience and evidence of existing programs and services; and



- the development of the models of care that are implemented must be Indigenous community and primary care led to meet the community's identified needs.

The Roundtable concluded that the principles and elements of equitable specialist medical access should be detailed in a nationally applied framework.

The RACP has developed a Framework which is based on principles supported by the Roundtable participants that inform and support the equitable provision of high quality, effective, accessible, affordable and culturally safe health and specialist medical care for all Aboriginal and Torres Strait Islander peoples.

The Framework

The Framework is in three parts:

1. Principles in practice

The key principles identified by the Indigenous Health sector should be applied at all levels of specialist medical care. The principles should be considered as both a guide and a standard for funders, facilitators and service delivery organisations. The principles aim to provide a consistent approach to specialist medical care delivery.

The Principles in Practice include: Indigenous Leadership, Culturally Safe and Equitable, Person-Centred and Family Orientated, Flexibility, Sustainable and Feasible, Integration and Continuity of Care, Quality and Accountability.

2. Roles and responsibilities

This section outlines the roles and responsibilities of the stakeholders involved in the funding, planning and delivery of specialist medical access.

2.1 Funders and employers

This section highlights the ability of funders and employers to shape the health landscape. The key stakeholders in this group include the Commonwealth and State Governments, Local Health Districts, Local Hospital Networks, private hospitals, Aboriginal Community Controlled Health Organisations (ACCHOs) and Primary Health Networks (PHNs).

2.2 Facilitators

This section outlines the role of facilitators in coordinating the provision of care at the regional level. The responsibilities of facilitators include identifying, planning and coordinating the delivery of care, as well as evaluating and improving it. This group includes PHNs, ACCHOs and non-government organisations (NGOs), and associated planning forums and collaborations.

2.3 Service Delivery and Community

Primary health care services, ACCHOs and Aboriginal Medical Services (AMSs) are responsible for referring to specialist services and providing ongoing coordinated multidisciplinary patient care. This section explores the connection and partnership between primary and secondary and tertiary care. Specialist medical care relies on the conduit and continuity that primary health care services can provide.

Indigenous Community leadership is integral to service provision; self-determination for Aboriginal and Torres Strait Islander people in health requires an engaged local Indigenous Community who are able to provide direct advice and guidance to service providers.

3. Enablers of specialist access

Specialist access is enabled through five key elements:

3.1 Organisational capability, and health practitioners' capability.

This section outlines the factors that are involved in the delivery of specialist care specific to organisations and individual health professionals. These factors include individual and organisation cultural competence, workforce and training, and resources to support them.

3.2 Regional collaboration

This section outlines the importance of collaborating with the stakeholders involved in specialist medical care at the regional level. Regional collaboration allows for effective planning, improving the efficiency of service delivery, building strong connections between agencies and health service providers, identifying gaps in care provision, and facilitating the development of shared solutions.

3.3 Identification, data, and technology

This section unpacks the different uses of technology and data in an increasingly digitised health care landscape. Telehealth, information sharing and digital patient records are central to accessing and delivering specialist medical care. Robust data is an essential component of quality improvement processes for primary health care organisations and hospitals.

3.4 Contracts and service agreements

This section highlights the use of contracts and service agreements to ensure the resourcing and provision of specific services to target populations.

3.5 Meeting patient cost of specialist care, travel, and accommodation

This section considers ways these particular challenges to specialist service delivery can be met.

This Framework examines the issue of specialist access through the lens of concrete achievements, rather than systemic failures. The Framework therefore draws heavily from successful models of care that have been implemented to improve access to specialist medical care for Aboriginal and Torres Strait Islander peoples and health outcomes.

The Framework is the RACP's principal contribution to Strategy 1B – Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.

Health as a Human Right

Health is a human right.

The Universal Declaration of Human Rights, adopted by the United Nations General Assembly in 1948 (and developed in large part by Australian leadership), includes Article 25:

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.[1]

The World Health Organisation (WHO) Constitution, which entered into force in Australia when Australia became an inaugural party to it in 1948, declares that:

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.[2]

The WHO Constitution also indicates the necessity of sector-leadership and partnership with Government:

> Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people.
>
> Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

The Australian Human Rights Commission's Social Justice Report 2005: The Indigenous Health Challenge advocated a human rights based approach to addressing health inequality. That report emphasises the role of monitoring and evaluation arrangements in new and existing government structures, to maximise accountability.

This Framework has been developed cognisant of the human rights approach to health, because it points so clearly to the roles, responsibilities, and accountabilities that the Framework Principles espouse.

Thus understood, human rights are not just targets to be set or standards to be attained—they necessitate individual and community agency within the process of providing health care, and underline partnership as fundamental to successful and sustainable health improvement.

What is the issue?

Australia is a rich country with quality infrastructure and a world-class health system. Despite this, Australia's Aboriginal and Torres Strait Islander peoples have a higher incidence of chronic disease and illness across the life course while accessing specialist medical care at lower rates than non-Indigenous Australians.

As the Aboriginal and Torres Strait Islander Health Performance Framework puts it, "***[o]n a per person basis, average health expenditure for Indigenous Australians in 2013–14 was 1.38 times that for non-Indigenous Australians. However, Indigenous Australians are currently experiencing a burden of disease and illness 2.3 times the rate of non-Indigenous Australians.***"

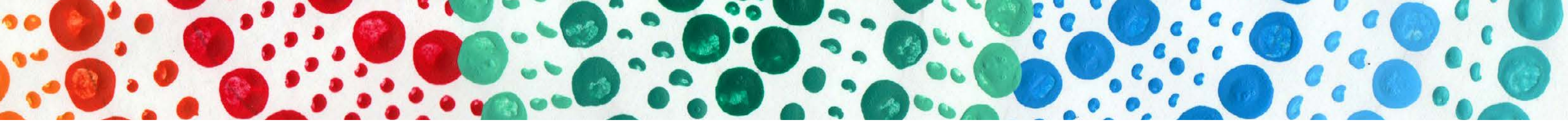
Despite the need for increased and better medical specialist services, MBS data shows that Aboriginal and Torres Strait Islander people access Medicare-subsidised specialist services at a lower rate compared to non-Indigenous Australians. Aboriginal and Torres Strait Islander peoples see specialists about 40 per cent less often than non-Aboriginal Australians. In addition, the access discrepancy between Aboriginal and non-Aboriginal access to GPs, allied health, pathology, diagnostic imaging, and other MBS items is less than the access discrepancy in specialist services.[4]

The low use of specialist services is a contributing factor to the health gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Some excellent work has been done by organisations and individuals to redress this situation – there are examples from across Australia where access to specialist services is working well, and much can be learned from their experiences. However, an overarching problem remains with the lack of a nationally and regionally coordinated system to ensure specialist medical coverage across Australia. Aboriginal and Torres Strait Islander people continue to face barriers to accessing specialist care regardless of where they live – in cities or in rural or remote areas. Many barriers to accessing specialist care relate to communication.

Communication barriers encompass language, literacy, health literacy, navigation of health systems and miscommunication of health concepts. Specialist health services, systems and structures can be complex, requiring patients to have a strong understanding of how systems function and how to navigate them. Difficulty navigating health services and processes can impact a patient's ability to engage with specialist care.[5] Low health literacy, such as difficulty understanding health, disease and treatment, in addition to complex health systems can affect a patient's ability to advocate for themselves and access services when and how they need them. Health systems and health practitioners need to consider how to work with patients to further patient understanding and navigation of health structures.

Communication is key to developing trust and understanding between health practitioner and patient as well as between organisations. Language barriers can exist when English is the second, third or even fourth language for some Aboriginal and Torres Strait Islander people. Translators are not often available, resulting in family members translating, which is not always appropriate.

Communication includes the broader issues of translating concepts of health and healing appropriately. Aboriginal Health Workers and Aboriginal Liaison Officers are key to bridging cultural understandings of health, management and treatment between patients and health professionals. Communication difficulties can



affect the understanding of a health issue for both the patient and the specialist. The dominant Western biomedical model puts emphasis on an individualistic approach to health, while Aboriginal and Torres Strait Islander concepts of health have a holistic and community-focused approach that health professionals can struggle to factor in.

Notwithstanding these barriers, there are examples across Australia where access to medical specialist services is working well. The purpose of this framework is to support locally determined and relevant models of care being comprehensively implemented in all regions across Australia, making sure that Australia's First Peoples are able to access the culturally safe care they need, when they need it and where they need it. There is goodwill in abundance—the challenge is joining up disconnected services, extending and systematising a patchwork of successful models, and developing new and innovative models of care and service delivery that suit the health challenges and priorities of unique communities.

What is the Framework?

The National Medical Specialist Access Framework (the Framework) is a principles-based guide for all health stakeholders that have responsibility for delivering medical specialist care to Aboriginal and Torres Strait Islander people across Australia. It is the RACP's principal contribution to Strategy 1B – Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.

This Framework aims to connect all stakeholders involved in delivering specialist medical care, including recipients of this care. The goal is comprehensive service availability analysis, better resource allocation, logistical coordination, a space to share best practice and act as a mechanism for identifying and addressing gaps in Aboriginal and Torres Strait Islander communities' access to specialist medical care. The Framework includes case studies, tools and resources.

The Framework is designed to support health service implementation at the local and regional level as much as possible, and when it is necessary for people to visit a larger centre or hospital, whether on or off their Country, that this is done in a coordinated and supported way respecting their cultural and personal needs. The intent is to ensure that Australia's First Peoples can access medical specialist health care that is appropriate for them, timely and culturally safe – as they need it, when they need it and where they need it.

THE FRAMEWORK

1. Principles in Practice

2. Roles and responsibilities

3. Enablers of specialist access

Medical Specialist Access Framework

1. Principles in Practice

The Principles of equitable delivery of specialist medical care to Aboriginal and Torres Strait Islander peoples across Australia are an essential foundation to any model of care. These principles must be fully implemented in all levels of health systems to deliver successful health outcomes. The Principles of equitable specialist medical care were initially discussed and agreed at a Roundtable hosted by the RACP in 2014.

- **Indigenous Leadership**
- **Culturally safe and equitable services**
- **Person centred and family oriented**
- **Flexibility**
- **Sustainable and feasible**
- **Integration and continuity of care**
- **Quality and accountability**

Service development and provision should be led by Aboriginal and Torres Strait Islander health organisations, communities and people, recognising the system as a whole taking responsibility.

1.1 Indigenous Leadership

Indigenous leadership is an essential principle of equitable access and delivery of health care to Aboriginal and Torres Strait Islander people. All settings and services should be informed by, and seek to incorporate, Indigenous leaders who are well placed to help shape culturally safe and effective care for their communities. Community leadership and clinical leadership can collaborate to co-design and deliver care appropriate for individual communities. Self-determination is embedded in sovereignty. Personal and community agency have previously been subordinated to institutional control over generations, so meaningful engagement must respect sovereign rights as a point from which advice and guidance to service providers can begin.

To make real, long-term gains in Aboriginal and Torres Strait Islander health, the health system needs to recognise the highly skilled leadership, from both a health and cultural perspective, of Aboriginal and Torres Strait Islander people who are best placed to mobilise action and build the platform for change in areas of health practice[7] and policy. Policy development without community engagement is tantamount to policy failure.

Indigenous leadership in health may come from a range of sources including, but not limited to, community leaders, elected representatives, land councils, elders, academics, as well as Indigenous physicians, other health practitioners and consumers.[8] The knowledge and skills that Aboriginal and Torres Strait Islander leaders provide to health services are critical to ensuring equitable specialist medical care.

Specialist services should address access barriers facing Aboriginal and Torres Strait Islander peoples (including institutional racism) and should provide culturally safe services delivered by well-trained and professional multidisciplinary teams.

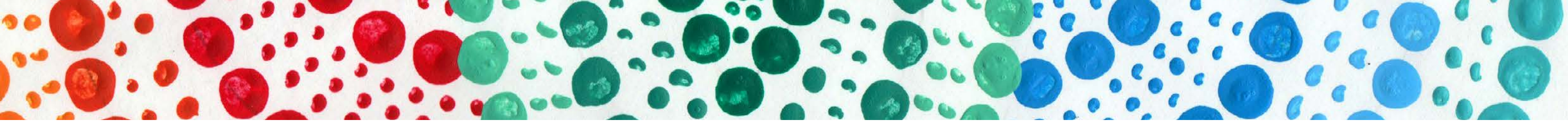
1.2 Culturally Safe and equitable services

Much of the health inequity experienced by Aboriginal and Torres Strait Islander people can be traced to ongoing institutional racism and the impacts of colonisation. Aboriginal and Torres Strait Islander people do not wish to use services in which they feel unsafe, in which they are disrespected, or which are not culturally appropriate. To address the long-term implications of institutional racism, it is important for health services to undertake an honest assessment of cultural safety and the competency of its own organisation as well as its health care professionals.

A culturally appropriate health service is one which considers language(s), beliefs, gender and kinship systems, delivers care in a manner which respects these factors, is free of discrimination and takes account of the need for trauma-informed care.[9,10] The embedding of culturally safe practices in clinical and health care environments across the health system is critical to address disparate health access and outcomes for Aboriginal and Torres Strait Islander peoples.[11] Culturally inappropriate services are a barrier to a patient's access to specialist care.[12] Many patients prefer to attend specialist clinics in Aboriginal Community Controlled Health Services (ACCHs). ACCHs are often a familiar environment where cultural safety is assured and other services are available.

Cultural safety is built through trust and long-term relationships with communities and local health practitioners (of all kinds) and is vital to delivering quality specialist health care. Trust relies on empathy, effective communication and demonstrated commitment over time. A lack of trust can result in low use of services, missed appointments, or disengagement from health services. Building trust can take time; for this reason, long-term services with permanent, or permanently rotating, staff are an important investment. Strong specialist relationships with communities allow for improved appreciation of a community's culture and family priorities[13] and for services to be responsive to community needs.[14]

Patients who require specialist care may have competing priorities in their lives. Aboriginal and Torres Strait Islander patients have cultural and spiritual priorities that are not always understood by service planners or specialists. Pressing issues such as family responsibilities or financial stress can be impediments to seeking specialist health care, treatment and ongoing management of health issues. Respect for patient's time and priorities can be achieved through specialist services being considerate of patient travel distances and life events and avoiding short impersonal or unnecessary consultations.



Specialist medical services should focus on the needs of individuals and understand the role and value of the family in care provision for Aboriginal and Torres Strait Islander peoples.

1.3 Person-Centred and family orientated

Person-centred and family-orientated care involves putting patients and their families, respectively, at the heart of health decision making. This type of care aims to provide Aboriginal and Torres Strait Islander people with choice and control over their own health care across the care continuum.

Person-centred and family-orientated care is particularly important in the Aboriginal and Torres Strait Islander context, where 'health' is defined broadly and holistically. Health is conceptualised as not merely the absence of disease. Rather, it is a complex and multifaceted concept, which encompasses physical, social, emotional and spiritual health, and the well-being of individuals and whole communities. In addition, this definition of health incorporates broader issues of social justice, well-being and equity.[15 16]

Western models of care need to be moulded to the principle of person-centred and family-orientated care.

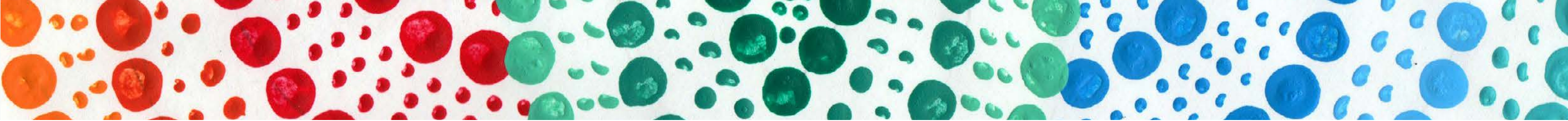
The diversity of populations, nations, languages, locations and health services requires flexible models of care as well as flexible approaches to funding and service arrangements.

1.4 Flexibility and innovation

The diversity of Aboriginal and Torres Strait Islander populations and locations, and the differing burdens of disease between them, means that different types of health services and funding arrangements are needed to meet the health care needs of each community specifically.[17] There is a diversity of jurisdictional policy and funding arrangements that need to be considered across states and territories.

The adoption of flexible models of care—which are sensitive to the context of care provision (both primary health and hospital care) and funding availability—to best meet the needs of diverse Aboriginal and Torres Strait Islander populations is a priority. Implementing context specific models of care requires health professionals and health systems to be culturally competent, including having the skills and knowledge to understand and act within differing contexts and situations.

Innovation and flexibility in service delivery will allow Aboriginal and Torres Strait Islander people choices that take into account cultural and individual preferences. Innovation itself is reliant on a degree of freedom to experiment and develop potentially new ways of working that counter the "business as usual" ethos. Innovations in hospital care include the establishment and evolving role of Aboriginal and Torres Strait Islander liaison



officers and mechanisms that support families to participate in decision making.

The ability to deliver effective medical specialist care requires innovation and flexibility in how to connect with community and respond to feedback from community. Health services may offer social and community services (such as financial counselling) as a means of introducing access to specialist care, or as a means of facilitating the use of specialist care (for example, on-site child care during appointments).

Services need to be based on up to date needs, take account of existing infrastructure and be appropriately resourced to ensure they are sustainable.

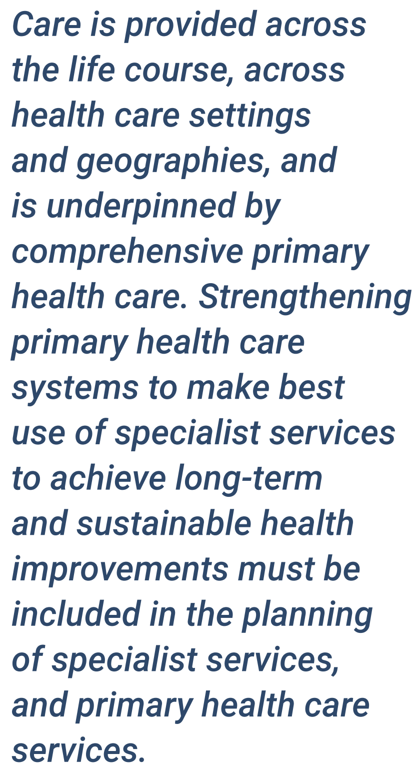
1.5 Sustainable and feasible

Medical specialist services need to be feasible and sustainable in the long term in order to have a meaningful impact on the burden of disease in Aboriginal and Torres Strait Islander peoples.[18] Long-term services create strong relationships with patients and communities, which foster trust and promote effective communication.

Turnover of health care staff can disrupt continuity of care, interfere with multidisciplinary team dynamics and limit community engagement between specialist visits.[19] Turnover of staff is higher in regional and remote areas, however turnover relates to the training of health professionals as interns, residents and registrars will be in positions for a limited time period both in hospitals and Primary Health Care (PHC) settings.

Long-term health care staff play an important role in fostering community relationships and ensuring patients can access services where they are or be prioritised for future outreach visits. Beyond stability of health practitioners, administrative staff are critical to planning and coordinating all elements involved in specialist care. Clinic and outreach planning is key and is an investment in efficiently deployed specialist resources. Medical Outreach – Indigenous Chronic Disease Program (MOICDP) funding can cover administrative support for outreach in some circumstances.[20]

Long-term funding allows services to build capacity. Sustainable delivery of medical specialist care requires direct funding to provide certainty and permit innovation.



Care is provided across the life course, across health care settings and geographies, and is underpinned by comprehensive primary health care. Strengthening primary health care systems to make best use of specialist services to achieve long-term and sustainable health improvements must be included in the planning of specialist services, and primary health care services.

1.6 Integration and continuity of care

Strong connections within primary, secondary and tertiary health care are needed to deliver coordinated and effective multidisciplinary care.

Primary health care is defined as the services that are provided to the whole population (for example, public health and community health services), as well as services initiated by a patient, such visiting a general practitioner. Secondary health care refers to medical specialist care often delivered in a hospital/clinic setting and tertiary health care refers to highly specialised complex care in hospitals. Many health conditions require secondary and tertiary health services as well as primary health care.

Continuity of care is crucial for patients who need coordinated ongoing care between different health services, such as a between a general practitioner, emergency department and inpatient hospital services. Continuity of care is needed to ensure appropriate support is available when returning to the community after receiving treatment and to provide coordinated collaborative care if the patient's ongoing care involves multiple health professionals and communication between them.

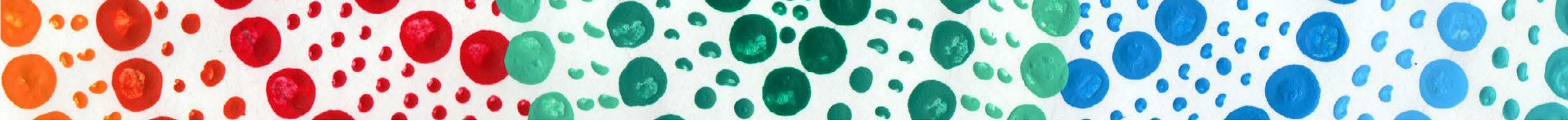
Continuity of care relies on continuity of service provision, as well as minimal and acceptable levels of staff turnover; these in turn depend on funding certainty, good service planning, and appropriate use of technology. Continuity of care also refers to the same teams providing care, not simply the same health service, as a patient's trust and relationship with individual health professionals develops over time.

The right care needs to be delivered at the right time and in the right way with clear accountability at all levels.

1.7 Quality and accountability

The right care needs to be delivered in the right way, every time, with clear accountability at all levels. Quality health care and clear accountability are needed to ensure that the available funding for Aboriginal and Torres Strait Islander health care is most appropriately allocated.

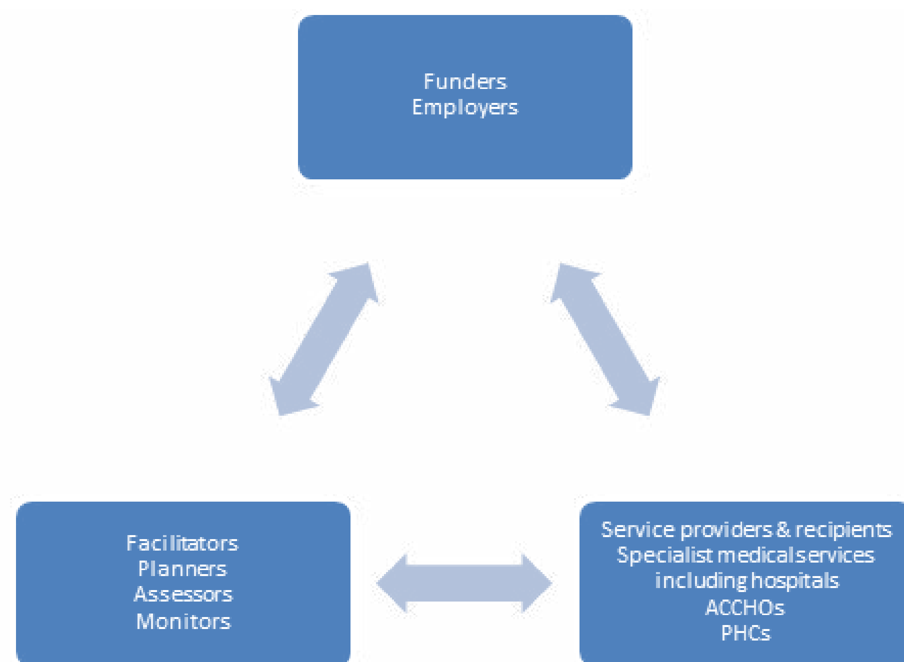
Continuous Quality Improvement (CQI) aims to facilitate ongoing improvement by regularly gathering objective data to analyse how well organisational systems are functioning, and implementing process improvements in response to this data.[21] CQI should be in place for specialist care of Aboriginal and Torres Strait Islander people in both PHC and hospital settings.



National Safety and Quality Health Service Standards new User Guide for Aboriginal and Torres Strait Islander Health is of note, as well as the six specific guides including Setting safety and quality goals for Aboriginal and Torres Strait Islander people in health service organisations. The latter includes key tasks, suggested strategies, and examples of evidence of implementation. Accreditation can be a driver of quality specialist care for Aboriginal and Torres Strait Islander people. Hospitals and health service organisations have an incentive to meet their accreditation obligations and may be receptive to new services, especially approaching reaccreditation. The new user guide specifies that health service organisations now have a safety and quality standards obligation to meet, in addition to contractual service level obligations.

2. Roles and responsibilities

There are three key groups of stakeholders with distinct responsibilities involved in the planning, coordination and delivery of specialist medical care.



2.1 Funders and employers

This group includes the Commonwealth and State Governments, PHNs, Local Hospital Networks/Districts (LHNs/LHDs) and hospitals. Funders and employers shape the health landscape through identifying and funding specific health priorities, population health initiatives, and workforce development as well as providing baseline/core funding for hospital care.

Funders, as the stakeholders financing the delivery of health services, should collaboratively determine appropriate targets and goals for specific populations, noting the issues for ACCHO of excessive reporting and monitoring.[22]

The LHNs/LHDs provide a connection to State and Territory governments, and are a critical resource for delivering equitable specialist access for Aboriginal and Torres Strait Islander people. They receive core funding that is weighted for Aboriginal and Torres Strait Islander patients, and often receive funding related to quality improvement and the employment of Aboriginal and Torres Strait Islander Hospital Liaison Officers.

Specialist services are funded by multiple sources. Most non-hospital patient consultations are MBS billable.

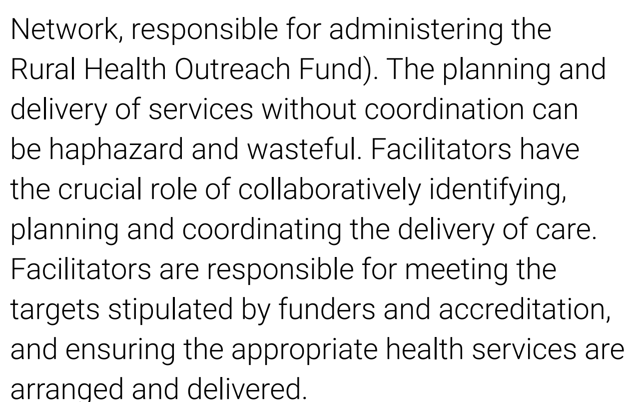
Funding

- The Rural Health Outreach Fund (RHOF) provides a flexible funding pool for initiatives aimed at improving access to medical specialists, GPs, allied and other health providers in rural, regional and remote areas of Australia. RHOF is administered by jurisdictional fundholders; funding generally covers specialists' travel and accommodation costs only, no other costs outside of travel related costs.
- The Medical Outreach - Indigenous Chronic Disease Program (MOICDP) provides funding to support a broad range of multi-disciplinary team based health outreach services that focus on the prevention, detection and management of chronic disease (primary and secondary care) for Aboriginal and Torres Strait Islander people.
- Primary Health Networks – manage the Integrated Team Care (ITC) Activity funding. ITC focuses on assisting "Aboriginal and Torres Strait Islander people to obtain primary health care as required, provide care coordination services to eligible Aboriginal and Torres Strait Islander people with chronic disease/s who require coordinated, multidisciplinary care, and improve access for Aboriginal and Torres Strait Islander people to culturally appropriate mainstream primary care".
- ACCHOs often have numerous funding sources with separate reporting requirements. Within the context of in service specialist care, this has the potential to affect the ability to deliver targeted specialist care as it requires the existence of core funding to support the service as a whole. NACCHO entered into an Aboriginal Community Controlled Health Sector Support Network – Network Funding Agreement with the Commonwealth Government (as represented by the Department of Health) to manage funding to its Affiliates for the provision of services and support to the ACCHSs.

The distribution of funding for Aboriginal Health is unrelated to population size or need, is not indexed for inflation or service demand, and is not distributed equitably within and between the States and Territories.[23]

2.2 Facilitators

Facilitators coordinate and commission the provision of care to people and populations at the regional and local level. This group includes Primary Health Networks, LHNs/LHDs ACCHOs and NGOs (for example the Rural Doctors



Network, responsible for administering the Rural Health Outreach Fund). The planning and delivery of services without coordination can be haphazard and wasteful. Facilitators have the crucial role of collaboratively identifying, planning and coordinating the delivery of care. Facilitators are responsible for meeting the targets stipulated by funders and accreditation, and ensuring the appropriate health services are arranged and delivered.

Key stakeholders that need to be involved in coordinating specialist care are Indigenous community leaders, the local Aboriginal Community Controlled Health Services (ACCHHSs), relevant mainstream health services, the region's Primary Health Network (PHN) and the local hospital networks (LHN).

Mandate and responsibility:

The Primary Health Networks are mandated to improve the coordination of care to ensure patients receive the right care in the right place at the right time. PHNs are required to work in partnership to "increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes".[24]

PHNs have flexible funding available to meet their responsibilities as a facilitator in the health system:

- Connect GPs, other primary care providers, secondary care providers and hospitals.
- Commission new services for identified gaps.
- Connect to the Federal Government, providing a conduit for funding and resource considerations.

ACCHSs play a facilitator role through the coordination of outpatient specialist care delivered in their services. And in collaborating at the regional level regarding medical care across the care continuum.

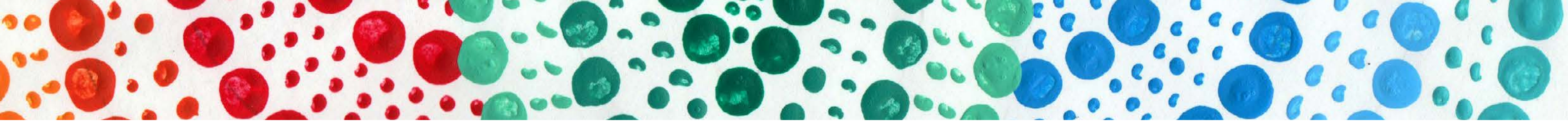
Coordinated service delivery will reduce the occurrence of multiple services being unnecessarily delivered to communities and make best use of funding. Collaborative partnerships (notably with the Aboriginal Community Controlled Health Care sector as an essential, leading stakeholder) are needed to facilitate better coordinated planning and service delivery.

2.3 Service delivery and community

Mandate and responsibility:

Primary health care services, ACCHOS and AMSs are responsible for referring to specialist services and coordinating ongoing multidisciplinary patient care. The connection and partnership between primary and secondary care is essential to specialist care. Specialist medical care relies on primary care services for referral and ongoing management; in turn, primary care can play a role fostering trust as part of the referral process. Service delivery organisations and units within organisations need to systematically assess how their existing service incorporates the 'Principles' of equitable medical specialist care for Aboriginal and Torres Strait Islander peoples. Individual health professionals have a duty of care to ensure their patients' needs are properly assessed and responded to.

Indigenous leadership is integral to service provision. Self-determination is more than just talking to Indigenous leaders or members of a community; it necessitates a genuine understanding of a community's or family's priorities which may be at odds with health professional priorities.



Holistic concepts of health for Aboriginal and Torres Strait Islander peoples must be incorporated into health professionals and health services understanding of the patient experience.[26,27, 28] The involvement of Aboriginal Liaison Officers (ALOs) and Aboriginal Health Workers (AHWs) is proven to increase cultural safety and to improve the rates of hospital discharge against medical advice; however, discharge against medical advice is itself understood to be a gauge of cultural safety, so ALOs and AHWs are necessary but not sufficient..[29] The roles of AHWs and ALOs need to be clearly incorporated in models of care to make the most of their skills. They should be considered part of an effective multidisciplinary team and not as an add-on. Involvement of an AHW or ALO does not remove the responsibility of other health professionals' responsibility for cultural needs and considerations.

3. Enablers of specialist access

Enablers of specialist access are mechanisms that assist stakeholders to appropriately fund, plan and deliver medical specialist access for Aboriginal and Torres Strait Islander Peoples.

3.1 Organisational capability, and health practitioners' capability

Specialist services are enabled by the health services and health professionals they work with. Health services and health professionals must embody the Framework principle of 'Culturally Safe and Equitable'. Culturally safe professionals and services must be supported by organisational policies, workforce development opportunities and resources to appropriately engage with specialist health care for their patients.

The responsibility for cultural safety is inclusive—it belongs to each health practitioner as well as each organisation and constituent part of each organisation, all of which must have (and be seen to have) appropriate professional competence, including cultural competence, as well as resources and organisational policies to support this.

3.2 Regional collaboration

Collaboration between funders, facilitators and service providers is required to support the delivery of complete geographical coverage across Australia. Such collaborative forums for health planning may already exist in your area, e.g. regional forums in WA.

The purpose of Regional Collaboration is to enable need assessment and service planning through:

1. Bringing together the stakeholders responsible for equitable specialist medical care access for Aboriginal and Torres Strait Islander peoples within a defined region.
2. Providing a mechanism to collectively analyse the health needs of the Aboriginal and Torres Strait Islander populations by understanding the population demographics, health status, disease burden
3. Determine available resourcing and identify service gaps and unnecessary service overlaps and inefficiencies, and consider appropriate solutions.
4. Providing a mechanism to plan and coordinate the provision of equitable, principles-based specialist medical care service for identified patient/community needs.

5. Facilitate sharing of knowledge and best practice approaches to engaging Community and implementing integrated patient centred care.

3.3 Identification, data, and technology

Identification

Information about Aboriginal and Torres Strait Islander patients and potential patients begins with identification. The ***National best practice guidelines for collecting Indigenous status in health data sets***[30] includes guidelines for asking the question, recording responses, and putting the guidelines into practice. (The latter includes advice for scenarios that frequently arise, such as a patient being too ill to respond, or when staff are reluctant to ask the question.) Other guides have been developed, including Queensland Health's ***Guide for improving the identification of Aboriginal and Torres Strait Islander people in health care in Queensland***, along with a video, brochures, and posters.[31]

Medicare also has a Voluntary Indigenous Identifier scheme[32], and there are special arrangements for people without documents who can have an approved referee (such as a community elder or minister of religion).[33] A lack of documents may be the result of a lack of birth registration, multiple birth dates and use of different names.

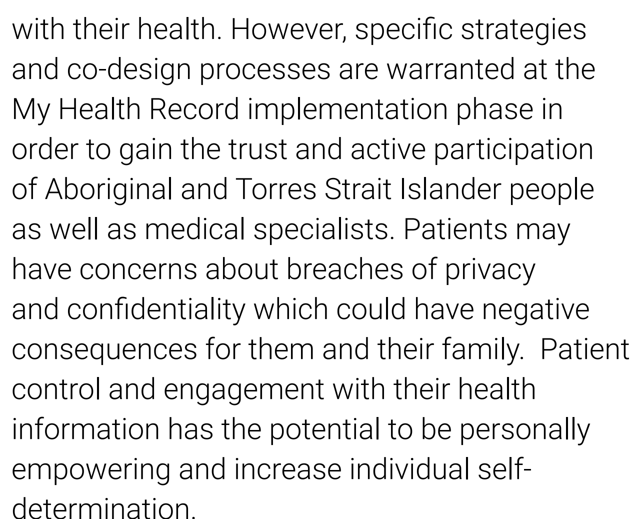
Data

National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care data is reported annually.[34] While focused on more than 240 primary health care organisations that receive funding from the Commonwealth Department of Health to provide services primarily to Aboriginal and Torres Strait Islander people, this data includes information on chronic disease burden, use of Team Care Arrangements, and detailed information on chronic disease management indicators. These KPIs also point to a service gap via a table comparing KPI data with statistics for the non-Indigenous population in Australia or with the Australian total (which includes Indigenous people) when appropriate comparison data are available.[35] Such data, along with detailed statistical information about jurisdiction and remoteness variation figures[36] can be valuable for specialist service planning, integration with primary care, and staffing/administration support planning. ACCHSs also have databases that can usefully be used with appropriate negotiation and assurances regarding use of data.

Technology

Electronic records are key to efficient recording of patient health information, and efficient and timely access to it (by the original recording clinician as well as other members of a patient's care team). The promise a default national opt-out for the Australian Government's My Health Record (My HR) digital health records has potential, once these records are populated with clinically useful information, can be a significant enabler of specialist access as it facilitates an accessible record of a patient's medical and treatment history via a shared health summary, along with MBS and PBS history, medication prescription and dispense records, hospital discharge summaries. The addition of diagnostic imaging and pathology results will also be of clinical use.

Electronic health records are particularly useful for patients who are mobile and/or have multiple health care providers. They can improve collaboration between health practitioners and between health services, reducing unnecessary duplication of tests (and reduce the inconvenience due to preventable appointments), reduce errors from handwriting, and provide for patient control and engagement



with their health. However, specific strategies and co-design processes are warranted at the My Health Record implementation phase in order to gain the trust and active participation of Aboriginal and Torres Strait Islander people as well as medical specialists. Patients may have concerns about breaches of privacy and confidentiality which could have negative consequences for them and their family. Patient control and engagement with their health information has the potential to be personally empowering and increase individual self-determination.

Fundamentally, the promise of electronic health records is more patient centred and better integrated care—including by acknowledging that good records improve safety and patient outcomes, and are therefore intrinsic to quality care.

Telehealth

Telehealth is instrumental in reducing costs of specialist and patient travel, especially in rural and remote areas. It enables the provision of specialist consultations to patients in locations where a specialist is not physically available. Overall, Medicare specialist telehealth service items increased by 33 per cent between June 2015 and June 2017.[37] By supporting telehealth-based services, the Australian Government has been able to respond to inequitable service distribution and reduce travel costs paid for specialist travel, as well as ease the burden on patients, and often their carers, in travelling often long distances to access care.

Effective telehealth for Aboriginal and Torres Strait Islander people and communities is an enabler of specialist care but also requires careful planning and education, including the capacity of primary health care practitioners to facilitate telehealth and support patients "at the other end". The potential for patients' carers and family to participate is of considerable benefit, where appropriate. Medicare has an education guide.[38] The RACP has a range of presentations[39] and has co-developed a nine-step exercise to prepare specialists for telehealth consultations[40], which includes links to a technology directory and a Telehealth Standards Framework, as well as a set of Guidelines and Practical Tips.[41] Telehealth is a useful means of supporting multidisciplinary care and professional development between staff.

The potential for telehealth should not be confined to rural or remote locations. It has proven its use and should be made Medicare rebatable in areas where it is currently prohibited. The 15-kilometre distance requirement for MBS items supporting specialist telehealth consultations should be removed. This is an area of ongoing RACP advocacy.[42]

3.4 Contracts and Service Level Agreements

Contracts and SLAs are the means through which funders can negotiate the provision of services designed to meet targets and goals for specific populations. However, targets and goals need to be appropriate for the context, and must be negotiated collaboratively. The provision of culturally appropriate care may also be included as a contractual obligation for service providers.

Contracts and SLAs can outline specific targets as part of overall deliverables, including specifying timelines. These mechanisms are useful to track multiple stakeholders involved in one area of work and are crucial to monitoring and reporting, which in term assists with managing quality and accountability.

3.5 Meeting patient cost of specialist care (outreach and hospital), travel, and accommodation

Patients face barriers of various types, including financial barriers, associated with specialist care. The cost of accessing specialist care is an obstacle for patients[43], though it is not the most frequently cited obstacle. For example, as a reason for not accessing health services when needed, it is cited less often than cultural appropriateness of service, logistical reasons, and personal reasons.[44]

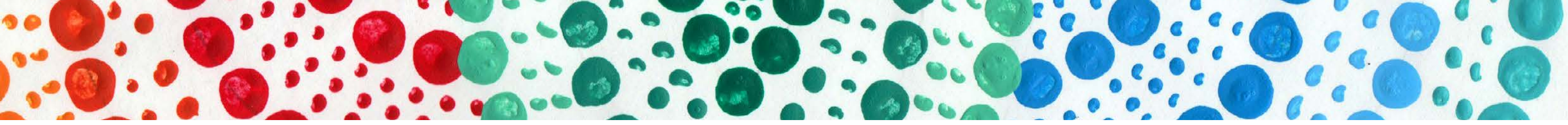
The gap between Medicare reimbursement and the service cost varies. Models of care can access funding streams for the amount over and above the Medicare rebate including Closing the Gap grants, PHN commissioning resources, and the Medical Specialist Outreach Assistance Program funding (now incorporated into the Rural Health Outreach Fund). When designing a service or planning a model of care, exemptions from the Commonwealth prohibition on the payment of Medicare benefits where other government funding is provided for that service may be available.[45]

Some successful models of care, such as the Victorian Aboriginal Health Service and Inala Indigenous Health Service, bulk bill all clinical services delivered in-house or via local outreach. Prescriptions, some diagnostics and tests, and consultations with private specialist services external to the AMS do often incur out-of-pocket costs.

The Medicare Safety Net, Extended General Medicare Safety Net, and the Extended Medicare Safety Net Concessional and Family Tax Benefit Part A have varying thresholds and benefits.[46] Medicare's Indigenous Access Program's Closing the Gap PBS Co-payment Measure means Aboriginal and Torres Strait Islander people can get most prescription medications at a lower price (or free with a Health Care Card).

Medicare provides an Aboriginal and Torres Strait Islander access line for patients to call to learn about funding options for meeting out-of-pocket costs.[47]

Patients in regional and remote Australia often need to travel long distances to see specialists and incur accommodation costs in addition to travel. Travel can also mean time away from family, work and communities, which can be challenging for patients who have family or other care responsibilities.[48] Travel from rural areas can be affected by seasonal or extreme weather (e.g. wet season in the Northern Territory). Safety dictates the need to travel at certain times of the day. Patients living in large regional areas may also need to travel to urban centres for specialist care that is not available at nearby hospitals. States and territories provide a range of travel and accommodation subsidies, including some specifically for specialist care, and in some cases including subsidies for escorts. Subsidies may not include the cost of accommodation for escorts and the cost of patients and escorts travelling between their accommodation and the health service.



Conclusion

Improving medical specialist access for Aboriginal and Torres Strait Islander people requires the systematisation of specialist care that, in some places, is working well, while simultaneously benefitting from innovation and flexibility to meet local and regional needs.

There is cause for optimism: models of care are showing promising results, as the case studies indicate. The challenge is learning from them and building on these and making specialist care available to Aboriginal and Torres Strait Islander people nationwide and in a way that properly addresses the burden of disease.

This Framework will be updated over time, with a second edition planned for late 2018. We will be producing a short Guide for Physicians planned for mid-2018.

Future editions of the Framework will benefit from input and feedback from Aboriginal and Torres Strait Islander leaders, patients, organisations and stakeholders who use this framework and provide feedback to the RACP.

We want to hear from you about potential case studies, especially in areas and specialities not yet covered or that illustrate other elements of the Principles.

Above all the RACP seeks the guidance and advice—from both a health and cultural perspective—of Aboriginal and Torres Strait Islander people who are best placed to mobilise action and build the platform for change in areas of specialist medical care.

Please send any comments, feedback, and ideas to **Indigenous@racp.edu.au**.

Case Studies

Case studies demonstrate successful Aboriginal and Torres Strait Islander access to specialist care across Australia in various health settings.

Each case study exemplifies the principles to greater or lesser degrees, in line with the needs of the patients and communities they serve.

We are grateful to the services who have agreed to be included in this Framework. Elements of each may potentially be replicable. Stakeholders are encouraged to consider how the case studies can inform their own service and practice.

Name	Location	Setting	Key principles demonstrated
Reaching out to People with Diabetes in the Torres Strait	QLD	Rural and Remote	■ Integration and Continuity of Care ■ Sustainable and Feasible
Reaching out to Mums, Bubs and Children in Inner City Melbourne	VIC	Urban	■ Integration and Continuity of Care ■ Cultural Safety
Reaching Out to Mums, Bubs and Children in 'Top End' Communities	NT	Rural and remote	■ Flexibility ■ Family and Patient Centred
An Inner-City Hospital Establishes an Aboriginal Health Unit	VIC	Urban	■ Family and Patient Centred ■ Quality and accountability
Marrabinya: Aboriginal Health in Aboriginal Hands Culturally Safe and Coordinated Care for People with Chronic Disease	NSW	Rural and Remote	■ Indigenous Leadership
Building an Outreach Program in Remote Indigenous Communities	NT	Rural and Remote	■ Cultural Safety ■ Integration and Continuity of Care
Reaching Out to Indigenous People in Outer Suburban Brisbane	QLD	Urban	■ Indigenous Leadership ■ Cultural Safety ■ Community engagement

Tools and resources

Tools and resources can be used by stakeholders to implement the principles in their setting, work with other stakeholders, and to inform the planning and delivery of specialist care.

For a list of resources go to **www.racp.edu.au/advocacy/policy-and-advocacy-priorities/msaf**

Appendix A:

Glossary/Definitions

For the purposes of the National Framework for Medical Specialist Access (the Framework), the following definitions apply:

Aboriginal means – a person of Aboriginal (First Australians) descent who identifies as an Aboriginal and is accepted as such by the community in which they live.

ACCHO means – Aboriginal Community Controlled Health Organisation.

Community means – groups of people who live in the same geographical area; groups of people with a shared history or culture or language; citizens for whom governments are responsible and to whom governments are accountable.[49]

Cultural Competence means – a set of congruent behaviours, attitudes and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.[50]

Cultural Safety means – to provide care in a manner that is respectful of a person's culture and beliefs, and that is free from discrimination.[51]

Equity means – fair or impartial treatment or consideration in the context of Health Service delivery, and the opportunity to access health resources and expertise free from unjust variation.

General Practitioner means – a medical doctor who has specialised as a General Practitioner, and is fellow of the Royal Australian College of General Practitioners or the Australian College of Rural and Remote Medicine.

Health means – a person or group of people's wellbeing. The dimensions of health for the purposes of the Framework include physical, mental and social health.

Indigenous is internationally understood by reference to certain factors, rather than a single definition; the object being to identify rather than define indigenous peoples. Such factors include:

- Self-identification as indigenous peoples at the individual level and accepted by the community as their member.
- Historical continuity with pre-colonial and/or pre-settler societies
- Strong link to territories and surrounding natural resources
- Distinct social, economic or political systems
- Distinct language, culture and beliefs
- Form non-dominant groups of society
- Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities.[53]

In the Australian context, **Indigenous** means a person or peoples of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or a Torres Strait Islander person. **Indigenous** in this Framework is often used to describe the system or service applicable

to both Aboriginal and Torres Strait Islander peoples.

Integrated Care means - care delivered in a way that improves patient outcomes through better co-ordination of services, integrated care also refers to the delivery of services to patients in a way which minimises duplication, and which both relies on, and promotes collaboration between service providers.[54]

Model of Care means - the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. For example, Telehealth services in remote settings may be a particular model of care or outpatient services provided by regional hospitals may be another particular model of care.[55]

NACCHO means – National Aboriginal Community Controlled Health Organisation.

Quality means - the extent to which a health care service or product produces a desired outcome.[56]

Quality Assurance means – Activities and programs intended to assure or improve the quality of care in either a defined medical setting or a program.[57]

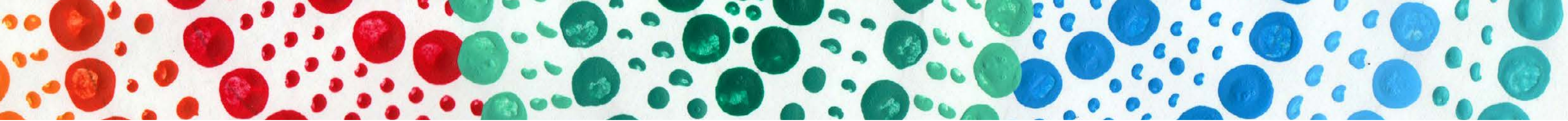
Specialist Physician means – medical doctors who have completed further training in a medical specialty to diagnose and manage complex medical problems. This includes paediatricians who are specialist physicians who specialise in the treatment of infants, children and adolescents. Note that all Physicians are Specialists, yet not all Specialists are Physicians. For example, a Surgeon is a specialist in surgery that has trained with the Royal Australasian College of Surgeons. [58]

Torres Strait Islander means - a person of Torres Strait Islander (First Australians) descent who identifies as a Torres Strait Islander person and is accepted as such by the community in which they live.

Appendix B:

RACP Specialist Access Roundtable Consensus Statement 2014

For a copy go to
www.racp.edu.au/docs/default-source/default-document-library/racp-specialist-access-roundtable-consensus-statement.pdf



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