

KEYS YOUNG REPORT

1997

*ABORIGINAL AND TORRES STRAIT ISLANDER
PEOPLES' ACCESS TO MEDICARE AND THE PBS
ACROSS AUSTRALIA*

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GLOSSARY

ACCHS	Aboriginal Community Controlled Health Service
AHW	Aboriginal Health Worker
AMS	Aboriginal Medical Service
CDEP	Community Development Employment Projects
CSC	(Medicare) Customer Service Centre
DEETYA	Department of Employment, Education, Training and Youth Affairs
DMO	District Medical Officer
DSS	Department of Social Security
HIC	Health Insurance Commission
NACCHO	National Aboriginal Community Controlled Health Organisation
NAIDOC	National Aboriginal and Islander Day of Commemoration
NTHS	Northern Territory Health Services
OATSIHS	Office of Aboriginal and Torres Strait Islander Health Services
RACGP	Royal Australian College of General Practitioners
RFDS	Royal Flying Doctor Service
VMO	Visiting Medical Officer

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EXECUTIVE SUMMARY

Purpose of Research

The Health Insurance Commission (HIC) is the Commonwealth authority which administers Medicare and the Pharmaceutical Benefits Scheme (PBS).

This research, commissioned by the HIC, was undertaken by the consultancy firm Keys Young to provide information regarding Aboriginal and Torres Strait Islander peoples' access to Medicare and the PBS across Australia. The study also sought to document Aboriginal and Torres Strait Islander people's attitudes and experiences in relation to Medicare and the PBS and the range of strategies currently in place to address problems of access, as well as to identify ways in which service delivery and the provision of program information could be improved for Aboriginal and Torres Strait Islander people.

The HIC successfully sought the support of relevant national peak bodies for the research, namely NACCHO, the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP) and the Pharmacy Guild of Australia.

Background

The main feature of Medicare is the provision of access to free or subsidised medical care and free hospital treatment in public hospitals for all Australian residents irrespective of age, income or health status.

The Pharmaceutical Benefits Scheme (PBS) provides all Australians with access to effective and necessary prescription medicines at a reasonable cost.

When the pharmacist supplies these medicines on prescriptions, the cost is retrieved via a Commonwealth refund and a patient contribution or copayment. Both of these vary according to the patient's entitlement status and the cost of the medicine. The provision of a Safety Net sets a limit on how much a person/family has to spend on pharmaceuticals in a calendar year. The Safety Net threshold differs for concession and non-concession patients.

Research Methodology

The methodology for this research comprised three key components:

- regional case studies involving face-to-face interviews with a broad range of key respondents in eight selected locations; the Torres Strait and Northern Peninsula Area,

Qld; Halls Creek, WA; Nhulunbuy, NT; Lake Tyers, Vic; Moree, NSW; Port Augusta, SA; Perth, WA; Western Sydney, NSW.

- telephone interviews with selected Aboriginal Community Controlled Health Services (ACCHSs) and other health service providers across the country; and
- postal surveys of medical practitioners, pharmacists and HIC staff with frequent contact with Aboriginal and Torres Strait Islander peoples.

In addition, contact was made with other key stakeholders to explain the nature of the research and to provide an opportunity for them to express their views on Medicare and PBS. This included, for example, members of the Aboriginal and Torres Strait Islander Health Council, Heads of Aboriginal Health Units in the States/Territories and the National Aboriginal Community Controlled Health Organisation (NACCHO) State Affiliate bodies.

The fieldwork team comprised eight people, including three Aboriginal consultants, four non-Indigenous consultants and one academic/medical practitioner working in the Aboriginal health area.

The Aboriginal researchers had particular responsibility for consulting with Aboriginal and Torres Strait Islander community members and the non-Aboriginal researchers had particular responsibility for interviewing non-ACCHS service providers and pharmacists. Discussions with ACCHS staff and HIC staff were conducted jointly, where feasible and appropriate.

Study Findings

Medicare and the PBS are exemplary health funding systems which well serve the general community, but the research demonstrates that Aboriginal and Torres Strait Islander peoples everywhere face considerable barriers which impede their full access to both Medicare and the PBS. The nature of these barriers, the degree to which the barriers operate and the attitudes regarding these barriers differ widely from one locality to another. However, even in those situations where the Medicare and PBS systems are working as well as they do anywhere, significant barriers continue to exist for Aboriginal and Torres Strait Islander peoples.

The research revealed numerous instances where the HIC has introduced initiatives and demonstrated great flexibility in seeking to overcome barriers facing Indigenous people. However, the research also suggests that, given the current conditions existing within Aboriginal and Torres Strait Islander communities, the Medicare system cannot in itself be expected to serve as an adequate funding mechanism for

health care for Aboriginal and Torres Strait Islander peoples unless Medicare were to be radically altered.

Medicare

■ The incidence of Aboriginal and Torres Strait Islander peoples having no effective Medicare number/card ranges between 15-38%, as reflected in a recent Queensland survey and supported by evidence gathered in the course of this research. An assumption held before this study began was that relatively few problems would be found in urban areas, however it was found that somewhere in the order of 15-20% of Aboriginal and Torres Strait Islander people using urban health services do not have access to a current Medicare number. The situation worsens in rural and remote areas. This does not necessarily mean that these people are 'not enrolled' in Medicare in the sense of never having been enrolled, but either the people themselves or a service provider reports that they do not have or cannot access a current Medicare card/number. Effectively this means they are *not* enrolled.

This finding is clearly at odds with earlier research conducted by Reark Research in 1990 which found that only 7% of Aboriginal people reported not having a Medicare card. It is extremely unlikely that there would have been such a marked decline in possession of Medicare cards in the intervening years which suggests that the earlier figures are quite doubtful.

■ Aboriginal and Torres Strait Islander people lacking a current Medicare number include adults who have never been enrolled - either because they were part of a community that has not been utilising Medicare or because, as an individual, they have managed to slip through the system. Young children show a particularly high degree of non-enrolment, reflecting administrative barriers around their enrolment. A considerable number of people who are not enrolled (eg newborn babies in hospital, people in prison, children in care) could best be targeted at the institutional level.

As well there are often many Aboriginal and Torres Strait Islander people whose Medicare card has expired, and therefore are not currently enrolled. There are also a considerable number who face great difficulties in determining their Medicare number, with varying levels of success. In practice, it makes little difference as to the reasons Aboriginal and Torres Strait Islander people are without an identifiable Medicare number as the task then is to ensure they are provided with a number.

It needs to be recognised that the absence of a Medicare card/number means that Medicare is basically *not available* to those lacking a card/number.

■ There is evidence of considerable misinformation between the HIC and service providers/consumers. In some instances this is about how Aboriginal and Torres Strait Islander communities and people function and in numerous instances about how Medicare and PBS operate. The confusion results in a multitude of administrative problems for both the HIC, the ACCHSs and for the individual consumer.

■ The heart of the problem of making Medicare accessible to Aboriginal and Torres Strait Islander peoples is that it requires a link between an individual and a unique number and, moreover, this link is generally established through the provision of specific personal data that the client body is often ill-equipped to provide. Having once established the personal data-individual-number linkage, this must be sustained over time and be retrievable. At any point where this linkage is broken, the system falls down.

■ This research reveals, in particular, the enormous barriers that continue to be experienced by many Aboriginal and Torres Strait Islander people in providing acceptable forms of identification, as required by Medicare. In looking at the convoluted process surrounding attempts by many Aboriginal and Torres Strait Islander people to 'identify' themselves it is important to bear in mind the primary purpose that this identification serves - *to determine whether or not a person is a bona fide resident of Australia*. Requiring a person's precise date of birth, the exact spelling of his/her name, the signature of a birth parent etc becomes a barrier to many Indigenous people accessing Medicare when what is principally needed is to determine whether a person is eligible for Medicare - *yes or no*. As one practitioner pointed out '*the collection of Medicare numbers is for the Medicare system*'.

■ Some of these barriers have been recognised for some time and strategies put in place by HIC personnel to overcome them. A particularly effective one is the simple *Proof of Identity* form where a referee can attest to the identity of a person, hence his/her eligibility for Medicare. While various strategies such as these appear to offer solutions to certain problems, they are:

- not utilised extensively in areas where they are needed
- often not known to, or understood by, service providers (even within the HIC)
- often erratically applied even within the same jurisdiction.

As well, there are other barriers for which strategies to overcome them have not yet been developed. Bringing about changes to Medicare procedures to allow Aboriginal and Torres Strait Islander people to self-identify as Aboriginal and

Torres Strait Islanders would facilitate a range of special measures targeting Indigenous people.

■ At the outset of the research it was generally assumed that *'the patients always get what they need. It's the middleman who might not'*, that is, Medicare number or not, people are still able to get medical care. However there is some modest evidence that the patient does not always get what s/he wants or, more importantly, needs. There are an increasing number of specialists refusing to bulk-bill and some refusing to provide care in situations where a patient lacks a Medicare number. Even a few ACCHSs reported withholding services from, or refusing to bulk-bill, people without a current Medicare number. There were also accounts of certain pathology and other technical services being unavailable on a bulk-billing basis - in these instances patients are either made to seek services elsewhere or else delay receiving a service until they can meet the up-front fees. Service providers tend to make exceptions for children who are ill, being much more likely to provide care to them, with or without a Medicare card.

Given what the research has found about the level of reticence often shown by Aboriginal and Torres Strait Islander peoples to seeking health care (which is exacerbated by racism experienced within the wider community), it suggests that being made to 'go elsewhere' or wait for care could very well mean that care is never received. In a number of instances it is only the good-will of individual service providers or a genuine commitment to improving Aboriginal health which ensures that Aboriginal and Torres Strait Islander peoples continue to receive certain services — practitioners being willing, in some cases, to forego individual payments and/or to generally limit their income when working in Aboriginal and Torres Strait Islander communities.

■ Having said this, it is certainly true that it is the service-providers who bear the brunt of managing the procrustean task of making Aboriginal and Torres Strait Islander peoples fit the bureaucratic system of Medicare. (The image of Procrustes seems a very apt one here. A mythological Greek villain, Procrustes used to stretch or mutilate his victims - extending an arm here or lopping off a leg there - to make them conform to the length of his bed.)

Across many ACCHSs a considerable amount of time is spent enrolling patients, seeking to identify and verify Medicare numbers, ensuring claims are properly lodged, maintaining patients' Medicare information for the ACCHS themselves and for other local services to utilise etc. The amount of administrative time spent on these tasks varies greatly from one service to another but the result is a staffing and financial cost to the service - time and/or money that might have been spent on direct

service delivery. There is a level of resentment amongst some service providers that they are being made to assume duties that are not their responsibility. The HIC expresses a concern over not belabouring mainstream GPs with the task of getting clients enrolled yet this has, in many cases, become a taken-for-granted expectation of many ACCHSs. A number of Medicare Customer Service Officers confirmed that *they* had few problems —because the ACCHSs managed to sort everything out. Many ACCHSs are seeking greater involvement by the HIC in enrolment and training processes.

■ The success, or otherwise, of ACCHSs overcoming the barriers to Medicare which face their Aboriginal and Torres Strait Islander patients appears to be a function of numerous factors - some of which relate to characteristics of their clientele (eg level of general education, experience of other bureaucratic systems, extent of traditional cultural practices, 'stability' of the community etc), some of which relate to the ACCHS (eg standard of, and ability to resource, administrative support, use of computer technology etc) and some of which relate to the larger service-delivery environment (eg prevalence of Medicare usage, level of cooperation of Medicare staff etc).

■ Common to the majority of ACCHSs and other health care providers servicing Aboriginal and Torres Strait Islander people was a dissatisfaction with the ability of the Medicare system, as it stands, to adequately remunerate for the services they deliver. This was due to the considerable work taken on by Aboriginal Health Workers and nurses, the high costs often incurred due to remoteness, and the additional time and services that are often required for the provision of holistic health care.

■ While the Medicare system serves the general community very well, current conditions existing within Aboriginal and Torres Strait Islander communities mean that *Medicare cannot in itself be expected to serve as an adequate funding mechanism for health care for Aboriginal and Torres Strait Islander peoples unless the system were to be radically altered for this group.* The complex and multi-problem nature of many Indigenous people's health, the backlog of educational health work to be carried out and the cultural inappropriateness of many Medicare requirements for Aboriginal and Torres Strait Islander peoples make it clear that Medicare, *as it is currently constructed*, is unlikely to ever provide a completely satisfactory mechanism for funding Aboriginal and Torres Strait Islander health services, in a way that ensures equitable access.

As a minimum then we recommend that in the wake of this report an examination be made of the question of how Medicare services for Aboriginal

and Torres Strait Islander peoples can best be organised and funded so as to reflect the principle of equal access for equal need.

The Pharmaceutical Benefits Scheme

■ It was assumed by many service providers consulted in the course of this study that the level of concession eligibility for PBS medication would be very high in Aboriginal and Torres Strait Islander communities. Some noted that this was likely to be a life-time eligibility, in some or many instances. Any barriers arising in establishing a person's eligibility through his/her entitlement or concession card number reduces that person's access to cheaper or free medicines. As with the Medicare number, there are significant problems that many Aboriginal and Torres Strait Islander people experience in identifying and holding on to their concession number. The reasons this continues to be a problem are similar to those operating in regard to Medicare - many people don't retain their cards, they change their names, their family structure changes, the usefulness or need for the card/number varies etc.

■ CDEP participants, who form a significant section of Aboriginal and Torres Strait Islander communities and, in most cases, are eligible for a DSS entitlement card, in many instances did not have one and often did not know they were entitled to one. The necessity of paying the full \$20 for PBS medication while earning a wage equivalent to the unemployment benefit is a major problem for these people. There is a clear need to develop a process to ensure that CDEP participants, who in the vast majority of cases fall into the low-income bracket, are not disadvantaged.

■ While the responsibility for providing proof of entitlement status rests with the patient, in practice this often falls to a service-provider such as an ACCHS worker or a pharmacist. In this circumstance a critical impediment arises as a result of the requirement that an entitlement number only be released by the Department of Social Security (DSS) to the party concerned — rendering a health worker or pharmacist unable to access this information on behalf of the patient. The inability of DSS, in light of privacy and/or security considerations, to release this information to a third-party is one of the two principal barriers to Aboriginal and Torres Strait Islander peoples accessing PBS.

■ The patient copayment requirement is seen by virtually all service-providers as being the second major obstacle to Aboriginal and Torres Strait Islander peoples accessing PBS. A host of reasons were reported as accounting for this, including the low incomes of many Aboriginal and Torres Strait Islander people, and making the money stretch between periodic payments, the high cost of living (particularly for large families),

the low value some people place on medication etc. Both the concessional copayment and the non-concessional copayment were seen as obstacles. It was stressed that people not receiving DSS benefits often experienced the same financial problems as those on benefits.

■ The majority of ACCHSs operate accounts with a local chemist and underwrite the cost of medications for some patients who can't afford to pay for them. The extent of the service depends on the funds available to the ACCHS for pharmaceuticals, patient demand, proximity to a chemist and the policies of individual ACCHSs.

■ The fundamental problem of Aboriginal and Torres Strait Islander people being able to meet the copayment requirement overshadows almost entirely any Safety Net considerations. There appears to be relatively little awareness of the Safety Net except amongst pharmacists, who are best placed to monitor people's eligibility for the Safety Net. However within ACCHSs, attending to the task of identifying entitlement numbers and responding to the need to immediately dispense medication are tasks of primary importance. Ensuring that - down the line - a family gets medication more cheaply or at no cost via the Safety Net, gets little attention as a result.

Even where pharmacists are monitoring expenditure for their customers there are numerous factors that make an accurate assessment particularly difficult for Aboriginal and Torres Strait Islander peoples, eg shifting family groupings, greater mobility and so on.

■ Immediate access to medications by many Aboriginal and Torres Strait Islander peoples when they present at a clinic/ACCHS is generally felt to be necessary by health services personnel. Certainly antibiotics are commonly dispensed or administered on the spot - both because of the need for a timely response and to ensure that the barrier arising when a patient has to take a script to a pharmacy to be filled, is eliminated. Generally, such medication is provided at no cost, overcoming the barrier of the copayment as well.

The pharmaceutical stock kept on hand for dispensing purposes is provided through a variety of means, from application of Section 100 (to provide a comprehensive range of pharmaceuticals) to various 'imprest' systems operating in conjunction with hospitals/clinics, to a simple array of samples provided by the pharmaceutical companies. Again, virtually all ACCHSs dispense some medication directly, even in urban areas with chemists nearby, because they regard it as essential to ensuring a patient receives what s/he requires.

■ It was universally agreed - by health service personnel and pharmacists - that medication compliance among Aboriginal and Torres Strait

Islander people (that is, use of medication in the manner specified) was generally very low. (This related to 'western medicines', not to traditional medicine, where compliance may well be higher.) As discussed in the report, this reflects attitudes to health, the value in which medicines are held, poor labelling systems, the lack of supports and infrastructure to use medication properly etc. For health personnel it is a continuous and on-going struggle to ensure that Indigenous people use, and use appropriately, the medications they need. In this circumstance, using copayments as a 'price-signal' makes little sense at all.

- There are a variety of other specific issues relating to PBS that were felt to be critical to Aboriginal and Torres Strait Islander peoples. Of particular importance was the removal or omission of medication from the list of PBS-subsidised pharmaceuticals, which are used for conditions that are particularly common in Aboriginal and Torres Strait Islander communities, rendering these medications unavailable or unaffordable to many people. These included such items as anti-fungals and topical antibiotics.

Provision of Information

The study found that the current range of HIC information materials were targeted at a market that is literate, reasonably well educated and fluent in English, and that this was not appropriate to many Aboriginal and Torres Strait Islander communities. There is a need to develop culturally appropriate materials on a range of topics for both consumers and service providers (eg Aboriginal Health Workers).

RECOMMENDATIONS

The study brief asked that the consultants define ways in which service delivery and program information can be improved to ensure better access to Medicare and PBS by Aboriginal and Torres Strait Islander peoples or their service-providers. In defining how service delivery/information can be improved there are a number of matters to be considered.

- First, the barriers that have been described have been identified through a consultative process with service providers and consumers. In large part the consultants have not been in a position to validate claims or criticisms raised by people nor any counter-claims made by others in response. For example, special enrolment forms are said to be held in most hospitals for the universal enrolment of newborn babies, yet time and again Aboriginal and Torres Strait Islander people raised the issue that this system appears to have broken down, leaving them with considerable problems enrolling babies and children.

Therefore in some instances our advice takes the form of '*make the system work*' rather than introducing new procedures or practices.

- Where the consultants have been able not only to identify a problem but are able to make a clear recommendation as to how best to overcome a barrier this has been done. In some instances, however, we indicate the way the system would have to change to overcome an identified barrier - the precise manner in which this can be achieved being a matter for the HIC or other appropriate agencies to determine. **It should also be noted that these may not be the only, nor necessarily the best options for addressing the problems discussed and therefore the HIC should not limit itself by excluding other potentially useful ideas that may emerge in the future.**

- Finally, the determination of ways in which the service delivery system could be improved to ensure better access takes the form, in some cases, of relatively simple and easily achievable changes whereas others would require quite radical alterations to Medicare and the PBS. If certain changes were brought about it would obviate the need for other actions - that is, a hierarchy of improvements exists and the more critical or far reaching ones are identified as such.

On the other hand, even if a comprehensive range of improvements to Medicare and PBS could be achieved, it is still possible that Aboriginal and Torres Strait Islander people would continue to experience barriers in accessing Medicare and certainly in accessing appropriate levels of health care. It may be that an alternative to the current system, such as a capitation system (whereby the Department of Health and Family Services would pay capitation grants to all ACCHSs for enrolled clients), is needed. Capitation funding would need to be set at a premium above the national average to reflect the substantially greater health needs of Aboriginal and Torres Strait Islander peoples.

Medicare Enrolment

1. The HIC needs to make the option of enrolling people on the spot available to all ACCHSs through simplified procedures as well as taking greater responsibility for providing support to the ACCHSs in carrying out this function.

2. The HIC needs to assume greater *direct* responsibility for ensuring that people in the community are properly enrolled and should ensure that resources are made available for staff to carry out more fieldwork. Alternatively, the HIC should contract Aboriginal community organisations in remote and rural areas to improve enrolment. If places such as resource agencies

were used this would reduce the burden on ACCHSs.

3. The HIC needs to negotiate with the appropriate agencies to ensure that people who have been in institutions (such as prison, drug and alcohol rehabilitation centres, juvenile detention centres) as well as children who have been in care are enrolled in Medicare before they leave the program/institution.

4. ACCHSs and other service providers should be informed about the existence and rationale of the Medicare card expiry procedure and encouraged to record their patients' expiry dates along with their Medicare numbers.

Alternatively, or as well, the HIC should issue Medicare cards without expiry dates when it is known that the cardholder is an Aboriginal or Torres Strait Islander person (eg when bulk enrolling in communities and/or when enrolments originate from an ACCHS).

5. The HIC should delete the issue number from Medicare cards issued to people who are known or assumed to be Aboriginal or Torres Strait Islander.

6. The HIC needs to adapt its security systems to identify centres which act as agents or clearing houses for patients' Medicare cards to ensure the system does not limit the number of cards that may be sent to that address.

7. It is recommended that the HIC adopt a simple Proof of Identity form, such as that used in parts of Queensland and that it be made universally available to all ACCHSs or equivalent services. Referees should include persons who would normally be available at an ACCHS. The form should include a clause indicating it is an offence under the Health Insurance Act to make a false declaration and should include clear instructions regarding how it is to be used. The form should be available to services regardless of location: those urban ACCHSs consulted were able to convincingly demonstrate that they were able to verify an Indigenous person's identity, at the least to the degree needed to ascertain eligibility (ie residential status).

A Proof of Identity form raises a problem for those services that bill electronically, and this is an area that will increasingly cause problems as more practices move towards electronic billing. However this might possibly be addressed by having the capability on any claim form, to signal that simultaneous enrolment was also being sought.

8. To cut down on paperwork and administration, a simple Proof of Identity form should be married with the enrolment form and used to enrol people

at ACCHSs and perhaps those bulk-billing surgeries with a high proportion of Aboriginal and Torres Strait Islander patients (where they can be identified).

9. It is recommended that an information campaign be directed at Indigenous consumers as well as service providers clearly outlining the minimal proofs of identity needed to enrol in Medicare.

10. The HIC and the Department of Health and Family Services should initiate discussions with the appropriate organisations regarding the introduction of a question on enrolment forms, claim forms etc which asks the consumer whether s/he chooses to be identified as an Aboriginal or Torres Strait Islander person (note that it is important to enable this distinction to be made). This is already a commonplace procedure among other agencies such as the Department of Social Security. Any such move to introduce such an option would have to be accompanied by information and guidelines on how and why the resulting data would be used.

11. The HIC needs to ensure that 'bulk-enrolment' of Aboriginal and Torres Strait Islander peoples, whereby remote service-providers (eg visiting specialists) have patients fill out Medicare enrolment forms at the time of consultation and lodge the forms with their bulk billing voucher, is made standard practice and acceptable to all Customer Service Centres.

12. The HIC needs to undertake more concerted action to assist hospitals (particularly those serving Indigenous communities) in ensuring that Medicare enrolment of newborns becomes standard practice.

13. The HIC should state on the Medicare Claim Form the age limit that applies when adding a newborn child.

14. The HIC should consider raising the age limit for adding a newborn child via the Medicare Claim Form from 6 months to 12 months.

15. The HIC needs to make the acceptability of Health Care Cards as a form of identification standard practice as a number of service providers and consumers noted that Aboriginal and Torres Strait Islander people were often more likely to have themselves and their children recorded on a Health Care Card than have other forms of identification.

16. The HIC should examine how administrative requirements could be changed to grant guardians the authority to either enrol a child on the child's own Medicare card or to be added to the guardian's card in the absence of parental approval, where this cannot readily be obtained. This might also require that the rule that a person

can only be identified on a maximum of two cards be lifted as well.

17. The HIC should monitor those communities where individual cards have been issued in favour of family cards to assess whether this helps alleviate problems or not. Pending this outcome, the HIC could make it widely known amongst ACCHSs that the option of single cards was available and, if warranted, assist ACCHSs in the changeover from family to individual cards. Clearly this is an option that would be adopted according to the needs and wishes of communities and individuals.

Accessing Medicare Numbers

18. The HIC should investigate what changes are necessary to enable aliases to be recorded on Medicare files when a person enrolls and in response to subsequent enquiries, by or on behalf of, the consumer.

19. The HIC needs to develop special guidelines relating to enquiries which accommodate the cultural characteristics of Aboriginal and Torres Strait Islander peoples and provide appropriate training for Hotline staff.

20. Alternatively, a special Hotline number could be established to deal exclusively with enquiries for and by Aboriginal and Torres Strait Islander clients. Staff receiving the calls would know that greater flexibility was required and special conditions might prevail (eg the use of alternative names, the inability to determine date of birth).

21. The HIC should appoint an Indigenous officer to manage the issues surrounding the Hotline at a national level and to coordinate with staff at State and local levels.

Medicare Rebates

22. The Department of Health and Family Services should explore mechanisms which compensate for the clinical work carried out by Aboriginal Health Workers. This might be by introducing the concept of provider numbers for these workers or introducing particular fees for items of service carried out by a Health Worker under the provider number of a doctor.

23. The Department of Health and Family Services should examine the feasibility of expanding the current fee schedule to remunerate for consultations longer than the current maximum of 40 minutes (eg one hour plus). If need be, this could specifically target Aboriginal and Torres Strait Islander peoples and their service providers.

24. The HIC needs to recognise the importance of longer consultations with many Aboriginal and Torres Strait Islander people and doctors working in salaried positions in ACCHSs need to be reassured that if they bill for a greater than average proportion of long visits that this will not automatically place them under suspicion.

25. The Department of Health and Family Services should examine the possibility of a schedule of fees that offers a higher rebate for services delivered in remote areas.

26. A component to cover the cost of specialist 'gap' payments needs to be recognised by the Department of Health and Family Services in relation to grant funding to ACCHSs. It would allow ACCHS doctors to refer patients when absolutely necessary to non bulk-billing specialists. An ACCHS could, for example, negotiate a price for a particular service and organise treatment in a private hospital, if necessary, as has been done in certain areas.

Accessing PBS Concession Entitlement Numbers

27. The Department of Social Security, in consultation with the HIC, needs to address the privacy issue in order to enable pharmacists to access entitlement numbers at source. Clients would need to be made fully aware of what this meant, as there is a general suspicion about the use of private information and the option of refusing the release of the entitlement number should be given.

28. If direct access by pharmacists to entitlement numbers were achieved, the requirement that a concession card be sighted each time a client purchases PBS medication could be relaxed.

29. The Department of Social Security and the HIC need to develop an efficient mechanism for children in the care of someone other than the parents to be included on their guardian's entitlement.

Eligible People Without Entitlement Cards

30. As a matter of urgency, the Department of Social Security and ATSIC, in conjunction with the HIC and the Department of Health and Family Services, should ensure that a system is established in which CDEP participants automatically receive Health Care Cards unless they do not pass the means test (thus reversing the burden of proof) and also that much better information on this matter is continually provided to CDEP coordinators and participants.

Affordability of and Access to Medication

31. If access to the PBS is to be achieved for Aboriginal and Torres Strait Islander people,

adequate funding for ACCHSs, sufficient to cover PBS copayments, is required. The Department of Health and Family Services needs to identify a mechanism for facilitating this, either through PBS or via Department of Health and Family Services grants.

32. The Department of Health and Family Services, in consultation with the RACGP and the AMA, should explore means of raising awareness among general practitioners of the implications for Aboriginal and Torres Strait Islander people of their prescribing habits.

33. The Department of Health and Family Services, the Pharmacy Guild of Australia and training institutions should examine the best means of making educational/awareness programs standard for all pharmacy undergraduates and for pharmacists working in communities with Aboriginal and Torres Strait Islander populations.

34. The Department of Health and Family Services should, as a first priority, seek Ministerial approval to expand Section 100 arrangements to other remote and rural ACCHSs. Consideration should also be given to the possibility of extending Section 100 to urban ACCHSs. Administrative support would need to be provided to some ACCHSs, particularly with tasks such as negotiating with distributors, ordering and managing stocks of medication.

35. The placement of medicine chests in remote/outstation communities which currently have no access to medication of any kind is clearly beneficial. The Department of Health and Family Services should make available to the RFDS to expand this arrangement to more Aboriginal communities.

36. The Department of Health and Family Services should consider paying a modest fee to pharmacists for delivery of medication to Aboriginal and Torres Strait Islander people who are isolated or semi-isolated and for whom there exists no other mechanism for the supply of pharmaceuticals.

Improving Medication Compliance

37. The Department of Health and Family Services needs to collaborate with OATSIHS, pharmacy and health care provider interest groups and the pharmaceutical industry to devise and trial labelling systems which take into account different cultural understandings and different levels of literacy. Any labelling system needs to have the input of Aboriginal and Torres Strait Islander peoples.

38. The Department of Health and Family Services needs to support information provision and

education about medication to Aboriginal Health Workers and to draw on their knowledge and experience to produce the materials.

39. The Department of Health and Family Services should consider meeting the costs of providing medication aids such as customised packaging (eg dosette and Webster Packs).

40. The Department of Health and Family Services, in conjunction with the pharmaceutical industry, needs to ensure that dosages, packaging and listing of medication on the PBS take into account the efficacy of single dose agents in treating Aboriginal and Torres Strait Islander people. Further, pharmaceutical manufacturers should be encouraged to produce single dose agents.

41. When making decisions regarding the PBS list, the Pharmaceutical Benefits Advisory Committee needs to take into account the particular impact these decisions will have on Aboriginal and Torres Strait Islander populations.

Provision of Information

42. The HIC should undertake to actively assist in the of training workers at ACCHSs regarding the application of the Medicare and PBS systems.

43. The HIC should establish and publicise a range of performance standards which would be made available to ACCHS workers and Medicare consumers (eg 'new enrolments will be processed within two weeks').

44. The Department of Health and Family Services should support the HIC in the development of appropriate information materials on matters relating to Medicare and the PBS as well as other health matters for Aboriginal Health Workers and other ACCHS staff. Aboriginal and Torres Strait Islander people need to be involved in the development of any such materials.

45. The HIC should pursue a vigorous program of employing Aboriginal and Torres Strait Islander people, particularly in key liaison and consumer/provider roles.

Implementation

46. It is recommended that the Department of Health and Family Services consider a capitation model as an alternative to Medicare and PBS funding. Capitation funding should be set at a premium above the national average to reflect greater health needs of Aboriginal and Torres Strait Islander peoples.

47. A mechanism should be set in place for ensuring that the issues raised in this report are

considered and that appropriate action is taken. A committee with representation from the departments/ authorities concerned, as well as the appropriate Aboriginal and Torres Strait Islander bodies and relevant non-government organisations, needs to be established to determine the best means of implementing the required changes.

48. A process of consultation with peak bodies and community representatives needs to be set in place to allow feedback on this report and the recommendations made within it.

1.0 INTRODUCTION

The Health Insurance Commission (HIC) is the Commonwealth authority which administers Medicare and the Pharmaceutical Benefits Scheme (PBS).

This research, commissioned by the HIC, was undertaken by the consultancy Keys Young to provide information regarding Aboriginal and Torres Strait Islander peoples' access to Medicare and the PBS across Australia.

The study arose because anecdotal evidence suggested that certain barriers may be preventing Aboriginal and Torres Strait Islander peoples from accessing the two systems, and, by extension, that they may not be receiving the level of health care they require. The Commonwealth's Access and Equity Strategy particularly targets barriers faced by Aboriginal and Torres Strait Islander peoples, thus there was a responsibility to determine, in a systematic manner, whether barriers exist and how they might be overcome.

1.1 BACKGROUND: MEDICARE AND THE PBS

Medicare

Medicare is Australia's national health insurance system introduced in 1984. The main feature of Medicare is that it provides access to free or subsidised medical services through the payment of a rebate and access to free treatment as a public patient in a public hospital through funding arrangements between the Commonwealth and State and Territory Governments. Medicine is intended to be available to all Australian residents irrespective of age, income or health status. State and Territory Governments are responsible, under agreements with the Federal Government, for ensuring that hospital services adequate to meet these entitlements are available.

The HIC maintains an enrolment file through its Customer Service Centres and State and Central Office network. The Medicare enrolment file is an on-line record of eligible persons for Medicare

purposes. It contains first name, second initial and surname, date of birth, gender, card-holder's address and Medicare card number. It is used for checking eligibility and processing Medicare claims. The HIC processing of a Medicare claim that is bulk-billed generally relies on the Medicare number or personal details of the patient matching those in the Medicare enrolment file.

The file is also used to generate Medicare cards. In 1995 the first of approximately 10 million cards expired and was replaced. Medicare card replacement is now a permanent feature of the Medicare program and is carried out both because of the potential physical deterioration of the card and as a means of clearing the files of people who are deceased, no longer reside in the country, etc.

The Pharmaceutical Benefits Scheme

The Pharmaceutical Benefits Scheme (PBS) was established in 1954 to provide all Australians with access to effective and necessary prescription medicines at a reasonable cost to patients and to the nation. In essence the PBS is a Government subsidy on medicines.

PBS medicines are sold to pharmacists at a set price negotiated between the Commonwealth and pharmaceutical companies. When the pharmacist supplies these medicines on prescription, the cost is retrieved via a Commonwealth refund and a patient contribution or copayment. Both of these vary according to the patient's entitlement status and the cost of the medicine. The pharmacist makes a claim for payment from the HIC.

General patients who do not hold a concession card should pay a maximum of \$20.00 (all charges are indexed annually) towards the cost of each PBS medicine. The Government pays the rest. Holders of a Department of Social Security (DSS) or a Department of Veterans' Affairs concession entitlement card pay \$3.20 towards the cost of each PBS medicine. In order to access cheaper or free medicines through the PBS people need to show their DSS concession card to the pharmacist or the pharmacist needs to have the concession number on file. Privacy considerations mean that DSS will only release concession card numbers to

the individual concerned - a third party cannot access a number on a client's behalf.

The PBS Safety Net protects people from prohibitive expenses for prescription medicines by substantially limiting how much they have to spend on prescription medicines in a calendar year. Once general patients and their families have spent \$600 on PBS listed items in a calendar year, they reach the Safety Net threshold and their medicines reduce in cost from a maximum of \$20.00 to \$3.20 for the rest of the calendar year. When concession card holders have spent \$166.40 in a calendar year their medicines reduce from \$3.20 to being provided free of charge.

As would be apparent from even these minimal descriptions of the Medicare and PBS systems they are, by necessity, quite bureaucratic and precise in their requirements. The need for every individual under these systems to be identified through a set of particular personal details and for these to correspond to a unique number (Medicare and/or Department of Social Security/Department of Veterans' Affairs) results in a potentially 'unforgiving' system where gaps in data or imprecise data can lead the system to fail. The research sought to understand how, in practice, Aboriginal and Torres Strait Islander peoples and their service providers manage these systems.

1.2 OBJECTIVES OF THE RESEARCH

According to the research brief the objectives of the research were to:

- provide a profile of the participation and pattern of Aboriginal and Torres Strait Islander peoples enrolling in and claiming from Medicare, and any issues/concerns faced in using the Medicare system;
- provide details of Aboriginal and Torres Strait Islander peoples' and their service providers' attitudes and experiences (including problems encountered) of the HIC's administration of Medicare;
- provide a profile of the usage and retention of Medicare cards and cards issued by the Department of Social Security and Department

of Veterans' Affairs for Aboriginal and Torres Strait Islander peoples representative of different socio-economic and geographic groups;

- comment on the current range of strategies used by the HIC for overcoming service delivery problems to bulk-billing service providers for Aboriginal and Torres Strait Islander communities;
- provide a profile of participation of Aboriginal and Torres Strait Islander peoples in accessing medicine subsidies to which they are entitled through the Pharmaceutical Benefits Scheme;
- describe perceptions and attitudes of Aboriginal Medical Services and pharmacists to Aboriginal and Torres Strait Islander access to the Pharmaceutical Benefits Scheme;
- describe the current range of strategies used for overcoming PBS concessional benefit delivery problems for Aboriginal and Torres Strait Islander peoples where an eligible person's entitlement number is unknown;
- define ways in which the service delivery and program information can be improved to ensure better access to Medicare and the PBS for Aboriginal and Torres Strait Islander peoples and their service providers; and
- comment on the effectiveness of current information material and provide creative strategies and solutions for the development of future information activities.

As specified in the brief, the research sought the views and experiences of the following key interest groups:

- Aboriginal and Torres Strait Islander peoples in urban, rural and remote areas;
- providers who service Aboriginal and Torres Strait Islander peoples (ie general practitioners, specialists, hospital staff);
- pharmacists servicing Aboriginal and Torres Strait Islander peoples in a range of locations;

- Aboriginal Health Services (including centre administration officers, Aboriginal Health Workers and medical practitioners) and
- HIC State and branch office staff, particularly in areas with a high population of Aboriginal and Torres Strait Islander peoples.

Subsequent revision of the research brief lessened the emphasis on consumers, and instead shifted the focus to service providers, as it had been determined that the latter were the main point of contact between the HIC and Aboriginal and Torres Strait Islander peoples. It was also generally assumed that *'the patients always get what they need. It's the middleman who might not'*. In addition to the original objectives, the research was also expected to explore strategies to improve access for Aboriginal and Torres Strait Islander peoples to PBS-subsidised medicines in a *timely* manner and to document broader policy issues where raised.

In considering the resourcing of health care, the rights-based approach proposed by the Aboriginal and Torres Strait Islander Social Justice Commissioner was accepted by the Steering Committee. This approach involves ensuring equitable access to the Medicare and the PBS systems as a right before considering Aboriginal-specific or 'gap-closing' measures. Also, the equity model adopted was one of 'equal access for equal need' where 'need' incorporated both extent of disease and 'capacity to benefit'. (This is discussed further in Section 3.4.)

1.3 ORGANISATION OF THE REPORT

Section 2 of this report outlines the methodology used in the study. Section 3 briefly discusses certain issues which set out the background for any consideration of health care delivery as applies to Aboriginal and Torres Strait Islander peoples.

Sections 4, 5 and 6 draw on the fieldwork, telephone and postal survey data and endeavour to assess the barriers experienced, across Australia, by Aboriginal and Torres Strait Islander peoples in accessing Medicare (Section 4) and the

PBS (Section 5). Section 6 examines the provision and appropriateness of the HIC's information materials. Various existing strategies to overcome service delivery problems are identified and recommendations given for improvements to service delivery and the provision of program information aimed at increasing access by Aboriginal and Torres Strait Islander peoples to Medicare and the PBS.

Section 7 provides a summary of research findings and conclusions.

Detailed case studies of each of the eight research regions are provided at the end of this report. Their inclusion is intended to set the issues discussed in this report in context of the particular settings in which they were reported and to focus on the realities of health care provision for Aboriginal and Torres Strait Islander peoples and their service providers.

It should be noted that this report generally makes reference to Aboriginal and Torres Strait Islander peoples but that some conventional terminology (Aboriginal Medical Services, Aboriginal Health Workers, Heads of Aboriginal Health Units) uses 'Aboriginal' only. We have utilised these conventions in this report but acknowledge at all times the applicability to Torres Strait Islander peoples as well.

2.0 METHODOLOGY

2.1 OVERVIEW

The methodology was developed by the consultant in accordance with the brief and in consultation with the Steering Committee. It comprised three key components:

- regional case studies involving face-to-face interviews with key respondents in selected regions;
- telephone interviews with selected Aboriginal Community Controlled Health Services (ACCHSs) and other service providers across the country; and
- postal surveys of medical practitioners, pharmacists and HIC staff with frequent contact with Aboriginal and Torres Strait Islander peoples.

In addition, contact was made, both by the HIC and by the consultants with other key stakeholders to explain the nature of the research and to provide an opportunity for them to express their views on Medicare and the PBS. This included, for example, members of the Aboriginal and Torres Strait Islander Health Council, Heads of Aboriginal Health Units in the States/Territories and NACCHO State Affiliate bodies (see Appendix 1).

2.2 REGIONAL CASE STUDIES

The main aim of the case studies in selected locations was to provide a high level of detailed information which *reflected the particular settings* of the range of service providers and consumers.

2.2.1 Locations

The eight fieldwork regions were selected by the Steering Committee on the following grounds:

- diversity of health services within a region;
- a range of rural, remote and urban locations across the regions;

- at least one location that did not have a recognised pharmacy and one without an Aboriginal health service; and
- a spread across a range of States and Territories.

The locations selected were:

Torres Strait and Northern Peninsula Area, Qld

A remote location with a State-run health service with reach into Cape York and the Torres Strait region.

Halls Creek, WA

Remote location with an Aboriginal health service but without a pharmacy.

Nhulunbuy, NT

Remote location servicing a large section of East Arnhem land.

Lake Tyers, VIC

Isolated rural location with a distinct Aboriginal population 50 kms east of the regional centre of Bairnsdale.

Moree, NSW

Rural location with an Aboriginal health service.

Port Augusta, SA

Rural location with an Aboriginal health service which reach into northern South Australia.

Perth, WA

Urban location with an Aboriginal health service and a full range of mainstream health services.

Western Sydney, NSW

Urban location with an Aboriginal health service and a full range of mainstream health services.

These were seen as study *regions* rather than a specific set of facilities and the area was defined in consultation with the communities involved. With the exception of Tasmania, the fieldwork was inclusive of all States and the Northern Territory and included some communities in the Torres Strait Islands.

2.2.2 Respondents

Within each location interviews were sought, where feasible, with:

- Aboriginal and Torres Strait Islander peoples who use, and some who do not use, an ACCHS;
- ACCHS staff, including
 - medical practitioners
 - Aboriginal Health Workers
 - nursing staff
 - administrative/managerial staff
- other providers who service Aboriginal and Torres Strait Islander peoples, including medical and administrative staff at:
 - 'private' bulk-billing and non bulk-billing Medical Centres
 - (public) community/primary health centres
 - general practitioners
 - public hospitals
- medical specialists
- pharmacists
- Medicare Customer Service Centre (CSC) staff

It was agreed that as many relevant people involved in service provision as possible would be interviewed in each location, in addition to Aboriginal and Torres Strait Islander consumers/community members. Within individual regions between 30-60 interviews were conducted.

Semi-structured interview schedules were developed by the consultants in consultation with the Steering Committee (Appendix 2). The interview schedules were designed to encourage participants to discuss the issues central to the study while giving them the opportunity to raise other matters which they considered to be relevant. It is important to note that not all issues were relevant to all respondents, for example reception and some medical staff were unable to

comment on budgetary matters and management often knew less about clinic procedures. However the full range of issues was covered across the spectrum of service providers and a larger picture emerged as a result.

All respondents were assured that their responses would be confidential - that is, no names or clearly identifying descriptions would be linked to a particular response.

2.2.3 Organisation of Fieldwork

Fieldwork was organised in accordance with appropriate protocols. It was a major undertaking due to the necessity of locating relevant service providers within each region and coordinating a large number of interviews over a wide geographic spread.

The HIC successfully sought the support of relevant national peak bodies, namely the National Aboriginal Community Controlled Health Organisation (NACCHO), the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP) and the Pharmacy Guild of Australia.

Initially OATSIHS coordinators in each State were contacted for some background information and advice as to the best method of approach to the Aboriginal Community Controlled Health Services (ACCHSs) in the selected locations as a starting point.

Accordingly, the nominated officer (the Director, Chairperson, Administrator or Chief Executive Officer) was contacted by letter, the ACCHS's participation in the study was requested and advice on how best to gather information was sought.

The ACCHS contact and/or the OATSIHS State Coordinator for each location were asked to recommend someone who could act as a local liaison person. In some cases the ACCHS contact saw it as unnecessary and offered to organise interviews themselves, and in some cases the Aboriginal consultant was known to the community and was able to organise interviews efficiently.

The ACCHS contacts were generally able to provide the names of other health services in the area, and by a process of 'snowballing', interviews with relevant service providers were arranged. All service providers were sent a description of the project and a list of the issues to be raised in discussions with them. This proved essential as service providers often had very limited time available and a prior familiarity with the study issues allowed them to give considered responses and more accurate data, where relevant.

At the ACCHSs, an initial interview with the chief officer was conducted before interviewing other members of staff. Interviews were conducted individually or in small groups, depending on circumstances and the time made available.

2.2.4 The Study Team

The fieldwork team comprised eight people, including three Aboriginal consultants, four non-Indigenous consultants and one academic/practitioner working in the Aboriginal health area.

Each two person study team, comprising one Aboriginal and one non-Aboriginal researcher, conducted the interviews either together or separately. The Aboriginal researcher had particular responsibility for consulting with Aboriginal and Torres Strait Islander community members and the non-Aboriginal researcher had particular responsibility for interviewing non-ACCHS service providers and pharmacists. Discussions with ACCHS staff and HIC staff were conducted jointly, where feasible and appropriate.

The researchers attended a day-long briefing and training session prior to entering the field. The training session covered such issues as the aims and objectives of the study, background issues, use of interview schedules, fieldwork arrangements, expectations of each researcher, cross-cultural issues, confidentiality provisions and reporting requirements.

2.2.5 Climate of Interest

Publicity for the study was arranged by one of the Aboriginal consultants prior to the commencement of fieldwork. It was considered important to inform

communities of the purpose of the study and to give as much notice as possible to the communities which were to be included in the study. A press release was issued and an article was published in the *Koori Mail*, which has the widest circulation of any Indigenous newspaper in the country.

Articles also appeared in the AMA newsletter, inviting interested members to identify themselves, in the HIC's newsletter *Forum* and PBS Bulletin, the *Australian Pharmacist* and *Pharmacy Trade*.

2.3 TELEPHONE INTERVIEWS

In addition to the face-to-face interviews conducted in the eight fieldwork locations, a telephone survey was also carried out. A significant amount of time was allocated to telephone interviewing, acknowledging the enhanced quality of information gathered in this manner rather than through a postal survey.

- a pool of 38 ACCHSs, as advised by NACCHO, were surveyed for the study, using the same semi-structured interview schedule that was used in the fieldwork. Contact was made with all of these and 36 in-depth interviews were completed, sometimes with a single respondent and sometimes with multiple respondents (see list in Appendix 3).
- Several medical practitioners and pharmacists contacted the consultants in response to publicity published in professional journals. Each of these was interviewed by telephone.
- Medical practitioners and pharmacists whose responses given in the postal survey warranted following-up were subsequently interviewed.

2.4 POSTAL SURVEYS

In order to canvas as wide a range of service providers as possible, postal surveys comprising a limited number of open-ended questions was sent (free-post return) to the following:

- 115 medical practitioners who had expressed an interest in Indigenous health (names were supplied by the RACGP);
- 60 pharmacists who work in areas with a relatively high concentration of Aboriginal and Torres Strait Islander people (names were supplied by the Pharmacy Guild of Australia); and
- 36 Medicare Customer Service Centre managers who have frequent or occasional contact with Aboriginal and Torres Strait Islander clients.

(Appendix 4 sets out the survey questions.)

About one-third of all medical practitioners and pharmacists responded by completing the questionnaire. In addition another five medical practitioners and two pharmacists independently initiated contact.

Close to three-quarters of the Medicare Customer Service Centre managers responded to the survey.

2.5 METHODOLOGICAL ISSUES

In the course of the study a number of methodological issues emerged which should be noted:

- *Responses to the study were generally positive.* Most ACCHSs were very keen to participate and perceived the research outcomes could benefit them in some way. Of all the ACCHSs approached, only one declined an interview, preferring to respond in writing instead. Other health service providers were also responsive, only one or two declining to be interviewed.
- *The administrative time required to arrange the fieldwork and to carry out the telephone survey was significant.* Provisions for this must always be made in future research.
- *The range of ACCHSs interviewed in this study is not exhaustive nor necessarily representative of all ACCHSs in the country.* However we are confident that there has been a comprehensive

examination of experiences with Medicare and PBS as they relate to ACCHSs.

- *While the research endeavoured to gather some information on barriers to Medicare and PBS experienced by Aboriginal and Torres Strait Islander peoples who are not necessarily users of an ACCHS, the structure of the research meant that, by definition, this was limited.* Too little is known about Aboriginal and Torres Strait Islander peoples' patterns of health service usage and/or the role that ACCHSs play within this to adequately understand the implications this has for the research findings.

- *The interviewing arrangements at each health service and pharmacy varied to some extent, depending upon the amount of time participants had available and knowledge of and interest in the research issues.* The staff at some busy health clinics found themselves unable to give the amount of time they had planned to the study.

- *Responses to questions asked represented a person's perceptions of the matter being investigated.* Respondents differed in their views - often within the same organisation. Thus, particularly when people were asked to enumerate something (eg the number of new enrolments required in a week) caution should be exercised in the weight given to these figures as they represent someone's best judgement, not necessarily fact.

3.0 CONTEXT OF HEALTH CARE FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

In order to fully appreciate the place of the Medicare and PBS systems in relation to health care for Aboriginal and Torres Islander peoples, it is useful to briefly highlight certain issues. These include the current state of Aboriginal health, the antecedents of these health conditions and the shifts in the way in which primary care has been delivered to Aboriginal and Torres Strait Islander communities in recent years. In particular, the place of self-determination or community control is examined. Lastly, the issue of equity is discussed - again, briefly.

3.1 STATE OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES' HEALTH

By almost every measure imaginable, Aboriginal health indicators continue to reveal completely unacceptable levels of mortality and morbidity. This has been documented time and time again, as the statements below indicate.

- *The life expectancy of Aboriginal and Torres Strait Islander peoples is about 20 years shorter than non-Aboriginal Australians. (Dodson M, Social Justice Commissioner, 1994)*
- *Aboriginal death rates are between two and four times those of the general population. (Australian Institute of Health and Welfare, 1992)*
- *Aboriginal infant mortality rates are two to three times those for the whole of Australia. In other words, babies born to Aboriginal mothers are two to three times more likely to die than babies born to other Australian mothers. (Australian Institute of Health and Welfare, 1992)*
- *The prevalence of diabetes mellitus in the 20 to 50 year age group is 10 times higher in Aboriginal than non-Aboriginal people. (Australian Institute of Health and Welfare, 1992).*
- *The death rates for young and middle aged adults from circulatory system disorders are 10 to 20 times higher for Aboriginal people than non-Aboriginal people. (Australian Institute of Health and Welfare 1994)*
- *The incidence of tuberculosis is 15 to 20 times higher among Aboriginal people than non-Aboriginal (Australian Institute of Health and Welfare, 1992).*
- *The prevalence of presumed serious renal disorders in Aboriginal people is 10 times that of the general population. (Australian Institute of Health and Welfare, 1992)*
- *Mortality rates for cervical cancer are close to 100% in Indigenous women in the Northern Territory compared to 12% for non-Indigenous women. (House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, 1993)*
- *Maternity mortality rates are higher for Aboriginal people. Aboriginal mothers account for about 30% of all maternal deaths but less than 3% of all confinements. (National Aboriginal Health Strategy Working Party 1989)*
- *Aboriginal and Torres Strait Islander peoples are 50% more likely to commit suicide than other Australians. (Dodson M, Social Justice Commissioner, 1994)*
- *The health status of Aboriginal and Torres Strait Islander peoples continues to be much worse than that of other Australians. In some cases, it appears that the gap may be widening, especially for women. (Australian Institute of Health and Welfare, 1996)*

As the Minister for Aboriginal and Torres Strait Islander Affairs, John Herron said in his Lyons Memorial Lecture on 15 November 1996:

To say this (evidence of disadvantage) represents a challenge is a massive understatement. There are no easy or short-term solutions to problems of this magnitude. It is a challenge, however, which we cannot ignore.

3.2 PATTERNS AND PRE-CONDITIONS OF ILL-HEALTH

The mortality and morbidity patterns among Aboriginal and Torres Strait Islander peoples can be characterised as principally:

- chronic, 'life-style' diseases such as heart disease, high blood pressure, diabetes etc which are partly determined and influenced by the behaviour of the individual, including diet, smoking, drinking etc
- infectious diseases, eg pneumonia, parasitic diseases, STDs
- consequences of violence, either self-inflicted (suicide) or directed at others

It is also recognised that the immediate causes of Aboriginal ill-health include such factors as poor environmental conditions, nutritional deficiencies, substance abuse etc.

The following statements regarding health risk factors illustrate this.

- *Aboriginal and Torres Strait Islander peoples have considerable risk factors for ill-health.* Although the proportion of Aboriginal and Torres Strait Islander people who drink alcohol is lower than the national average, those who do drink are likely to drink enough to harm themselves. The proportion of Aboriginal people who smoke is *double* the national average (National Aboriginal Health Strategy Working Party 1989).
- *More than one quarter (29%) of Aboriginal and Torres Strait Islander people aged 15 years and over report worrying or sometimes worrying about going without food.* (National Aboriginal and Torres Strait Islander Survey 1996)
- *Disorders of growth and nutrition are prevalent among many Aboriginal people.* (Australian Institute of Health and Welfare 1992)
- *About one in three Aboriginal and Torres Strait Islander people are estimated to be homeless or live in inadequate accommodation.* The substandard living conditions are generally characterised by inadequate water and washing

facilities, poor sanitation and sewerage disposal, and limited food storage and sub-optimal food preparation facilities (Aboriginal Development Commission 1988, quoted in Australian Institute of Health and Welfare 1992).

- Ten per cent or less of Aboriginal households in rural and remote communities have no running water connected, no shower or bath, or inoperative water supplies (Australian Institute of Health and Welfare 1996).

There are, of course, even deeper and more serious factors contributing to the current social, emotional and physical state of Aboriginal and Torres Strait Islander peoples today. A legacy of dispossession from their land, the unresolved issues of native title, the effects of the policies and practices resulting in the 'stolen children' and centuries of institutionalised racism have all taken a marked toll on Indigenous peoples.

Acknowledging these conditions has immediate implications for the nature of primary health care amongst Aboriginal and Torres Strait Islander communities. That is, a heavy emphasis on preventative programs and health education/promotion and measures to address urgent community infrastructure needs are required *along with* the provision of curative, clinical health services. Encouraging Indigenous people to trust and use mainstream health services, where appropriate, is also a challenge.

As well, this raises the basic question of how to see the need to address the significant backlog of essential services and facilities in relation to the provision of mainstream services where it is implied or presumed that a level playing field exists. The question is relevant to this study and the revised research brief instructed that:

In keeping with the rights-based approach proposed by the Aboriginal and Torres Strait Islander Social Justice Commissioner, it is accepted that the equitable access to Medicare and the PBS resourcing of health care should be considered separately from Aboriginal specific or 'gap-closing' measures.

The implication for this research was that a 'two-tiered' approach to the assessment was required. At one level it was essential to focus primarily on Medicare and PBS with the objective of maximising the utility of these systems for Aboriginal and Torres Strait Islander peoples. This meant in the first instance, focussing on the operational systems of the HIC's administration of Medicare and the PBS. In short, the intent was to endeavour to fix at least one discrete part of the total health delivery system. However, it was also critical to at least identify some of the broader policy and practice issues which impact on health service delivery to Aboriginal and Torres Strait Islander peoples, as they emerged in the course of the study, whether related to Medicare or not.

3.3 THE DELIVERY OF HEALTH CARE SERVICES TO ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

Self-determination

The issue of self-determination or community control in regard to Indigenous peoples is a concept which is understood in many different ways. Successive Federal Governments have shifted in their positions and policies in regard to self-determination with implications for the way in which services are delivered in Aboriginal and Torres Strait Islander communities.

ATSIC, of course, was established to provide a mechanism for some level of self-government and self-management of programs and services. In the field of primary health care, however, the existence of Aboriginal-controlled health services predated ATSIC by a considerable period of time - the first community controlled health services having been established nearly two decades ago (in Redfern, NSW).

Supporters of community control would argue that genuine health benefits can best be achieved through community control and ownership of primary care services, particularly given the fundamental social and economic deprivations suffered by Aboriginal and Torres Strait Islander communities. This goes beyond a simple notion that this would result in the provision of *culturally*

appropriate services (although this is certainly a consideration) but that the principle of collective self-determination, as well as being the key to self-responsibility and accountability, is a right. The community controlled Aboriginal health service model continues to be the main form of health care service funded by the Commonwealth Department of Health and Family Services.

ATSIC and OATSIHS

In very recent years there has been a shift in the way in which Aboriginal and Torres Strait Islander health services are funded and administered at a national level. On 1 July 1995 the responsibility for Aboriginal primary health care funding moved from ATSIC to the Department of Health (now Health and Family Services), albeit to the Office for Aboriginal and Torres Strait Islander Health Services (OATSIHS). At that time OATSIHS assumed responsibility for the funding of some 230 Indigenous primary health care and substance abuse services. In the 1996-97 budget the Commonwealth Government announced plans for new primary health care services in 25 remote Indigenous communities, with planning for a further ten to take place in 1997/98.

Currently, ACCHSs receive their principle funding through an OATSIHS grant, with supplementary funds coming from other Commonwealth and State program funds and, increasingly, from Medicare. This results in an interesting mix of Indigenous-controlled services receiving Indigenous-specific health funds in conjunction with mainstream Medicare funding.

A question that arose at the outset of the research related to the usage of ACCHSs amongst Aboriginal people about which there is little systematic information. (In fact, the 1994 National Aboriginal and Torres Strait Islander Survey was initiated because of the general paucity of statistical information about the Indigenous population but was unable to adequately address questions about, say, use of ACCHSs.) In particular the questions raised related to the *role* of ACCHSs in Aboriginal communities - were they used by choice and preference, what place did convenience and access play in their usage,

where alternative services existed to the ACCHSs, which services were used and for what reasons? To the degree possible, the research sought qualitative information on these questions. However, given that records such as Medicare claims do not identify whether a person is an Aboriginal or Torres Strait Islander or not, there are extreme limits on what can be known, quantitatively, about usage of health services by this population.

Grants and Medicare Billing

The mix of funding sources appears, in some instances, to result in certain tensions or ambiguity. This is evidenced, for example, around the history of ACCHSs claiming benefits under Medicare. With numerous ACCHSs getting grants which were to enable them to hire salaried doctors, the question was raised as to whether this precluded them from also conducting a fee-for-service, bulk-billing operation (ie double-dipping). An unknown number of ACCHSs continued to receive a grant *and* to claim under Medicare but were concerned about the legitimacy of the practice. Since a Ministerial announcement in May 1996, this situation has been clarified and now it is policy that all ACCHSs which employ a doctor do have the possibility of attracting medical benefits payments and are encouraged to bulk-bill. Any additional funding received by ACCHSs from bulk-billing can be used to extend their health services/programs in needed areas. At the outset of this research there was primarily anecdotal information regarding ACCHSs' attitudes toward, and level of, bulk-billing. One of the perceptions that was prevalent was that some or many ACCHSs continued to be cautious or anxious regarding the use of Medicare and bulk-billing.

This was thought to result from:

- residual concern regarding the acceptability of bulk-billing by a salaried doctor, or the fear that this agreement would be reversed, leaving ACCHSs operating programs/services for which funds were not available;

- an assumption that the bureaucratic and administrative demands created by the use of Medicare outweighed the benefits;

- a concern that fee-for-service was inappropriate for much of Aboriginal health needs which required a focus on preventative and community health programs;

- a concern that an emphasis on fee-for-service, as provided by a medical practitioner, would distort the nature of care provided (eg emphasise turnover and short consultations) and, in particular, would erode the position and authority of Aboriginal Health Workers;

- suspicion that the encouragement to utilise Medicare is a step towards the longer term reduction or cessation of grants to ACCHSs.

One of the secondary objectives of this research then, was to provide information on the attitudes of the ACCHSs toward Medicare, the prevalence of bulk-billing within the services and feedback on whether (and the degree to which), the use of the Medicare system has altered the way in which health services are delivered. In the near future OATSIHS intends to establish a Minimum Reporting Requirement (MRR) system to determine, among other things, the level of bulk-billing by ACCHSs.

The Commonwealth and the States/Territories

There are also a number of issues arising as a result of shifts in responsibility for Aboriginal and Torres Strait Islander primary health care between the Commonwealth and the States/Territories. Negotiations are being or have been carried out between the Commonwealth and each State and Territory leading to Framework Agreements to achieve better coordination in the planning and delivery of services to Aboriginal and Torres Strait Islander peoples. Agreements have already been signed with most States/Territories. In a number of States and Territories, arrangements are also going through a marked period of transition, particularly in regard to the introduction of the Medicare system. In the course of this research, for example, steps were being taken to introduce and promote use of the Medicare system in the

Torres Strait district and amongst Aboriginal communities in Central Australia.

In other areas, Western Australia for example, health care facilities in rural/remote areas are currently provided almost entirely by the State health system on a non fee-for-service basis. In these circumstances, an ACCHS which seeks to bulk-bill is working on a different basis to the other local health services, thus the Medicare system (and card) might be less salient to the population hence more difficult to manage for those services using it. There are similarly shifts in the use of the PBS system where, for example, it is believed that the practice of hospitals supplying medications directly to out-patients, as well as in-patients, has increasingly been supplanted by use of the PBS system where scripts are written instead. This of course immediately shifts the cost of pharmaceuticals from the State to the Commonwealth.

The pertinence of these factors for the current study is that the overlay of an Aboriginal Community Controlled Health Service network over changing and variable mainstream service delivery systems was expected to result in a quite diverse and complex set of arrangements under which the ACCHSs used and managed aspects of the Medicare and PBS systems for their patients. The case studies reported in this document illustrate how aspects of the ACCHSs' use of Medicare and PBS often do reflect unique local conditions, although there were numerous common threads to the experiences and practices of the ACCHSs.

3.4 EQUITY CONSIDERATIONS

As noted earlier, the HIC is required, like all Commonwealth departments and agencies, to meet the Commonwealth's Access and Equity requirements, and this current research is a response to the need to identify any barriers experienced by Aboriginal and Torres Strait Islander people to Medicare and to the PBS. It was also noted that a particular model of equity was to be applied to the research, based on the work of Dr Gavin Mooney et al as described in the

report *Feasibility Study into the Adequacy of Resources and the Development of a Funding Formula in Aboriginal and Torres Strait Islander Health* (June 1996). Access to health care is often seen in terms only of 'opportunity cost' barriers to use ie the resource costs of time, distance, etc falling on individuals attempting to use the service. Here such costs are considered to be only a part of the barrier and wider considerations related, for example, to cultural appropriateness, convenience, etc are also deemed relevant. For access then to be judged equal requires that different individuals perceive the barriers to use for them to be the same height. The concept of need is seen as being defined in terms of 'capacity to benefit' rather than the more common notion of need as simply the extent of sickness. Additionally and importantly the researchers suggest that there is a higher weight socially attached to health gains for those groups in poorer health (such as Aboriginal and Torres Strait Islander peoples) as compared with the weight that society attaches to health gains to groups in relatively good health.

Developing the discussion of equal access for equal need the authors state:

It is apparent that access is dependent on not just the values of individuals but also their information base. Some individuals will have low use even when they have the same access simply because they are less well informed than those who, with the same access, use health services more. Some individuals will be 'penalised' through not being as well informed as others. Consequently equality of access will unfairly affect those poorly educated in health and health care matters.

In relation to this research, a question arose as to whether any evidence would be found that Aboriginal and Torres Strait Islander peoples appear to see 'health' in a way that differs from the general population and, further, whether this seemed to flow from being less well informed. One indication of this might be if they presented for health care later in the course of their illness than others might, that is, were more seriously ill when seen by a doctor or health care worker .

Leaving aside these issues, attempts to actually determine the current position of Aboriginal and Torres Strait Islander peoples' use of health services are greatly hindered by the inadequacy of existing data. However, Mooney et al go on to state that, despite the paucity of data:

... there is no way in which the current level of spending on health services for Aboriginal and Torres Strait Islander peoples - whatever the precise estimate of that spending is - could be described as adequate. ... were (the proposed equity model) to be adopted, this would result in the ratio of health service spending on Aboriginal and Torres Strait Islander peoples being several times higher than for other Australians.

The authors also address the fact that the Australian health care system has objectives other than equity to consider - most particularly, efficiency. There is, potentially, a major conflict between equity and efficiency in that equity could 'eat into' the goal of maximising the health of the Australian community as a whole. In the current study, there was the potential for conflict to arise between the objectives of increasing access of Aboriginal and Torres Strait Islander peoples to health care services (within a context of rising general health costs) and the need to rationalise and contain expenditure. At a practical level there is also the task of determining how mainstream systems such as Medicare and the PBS could be adapted to be more culturally accessible to Aboriginal and Torres Strait Islander peoples without creating a system that was unmanageable or open to abuse in relation to the rest of the community.

A notion of equity based on principles of *equal access for equal need* and embodying the concept of *capacity to benefit* is a considered and complex one. This concept of equity contrasts with a view that is probably quite common in the community where equity simplistically means everyone gets the same thing, regardless of need. There has to be a concern that the simplistic view of equity that 'everyone gets the same' would very much work against any prospect of providing adequate resources or adequate access for Aboriginal and

Torres Strait Islander peoples given, as indicated above, their well documented much greater needs. There are it seems two issues here. First it appears that many Australians accept that the health status of Aboriginal and Torres Strait Islander peoples is very poor and yet somehow do not make the link between that and the need for adequate resources to address these greater needs. Second there is a view that much has already been spent with little return in terms of health improvement.

Positions around these issues were often raised in the course of this research and, of course, have implications for the role of Medicare and the PBS and the place of other Indigenous-specific funding in Aboriginal and Torres Strait Islander communities. Our research did reveal that the 'everyone gets the same' view of equity is rather common and the political reality of this has to be addressed.

4.0 EXPERIENCES AND BARRIERS IN ACCESSING MEDICARE

In this area, patients are treated solely on their need to be patients and not on their race. There is no evidence of any discrimination by Medicare (as all patients are enrolled) or by the PBS (as all prescriptions are filled). (GP, metropolitan NSW)

It's an absolute nightmare. We're seeing more and more of them (Aboriginal and Torres Strait Islander peoples). It's totally getting out of hand and we're just not getting paid, and it's getting worse. (mainstream practice manager, urban Qld)

To reiterate, the study brief required information on Aboriginal and Torres Strait Islander peoples' experiences enrolling in and claiming from Medicare and any issues/concerns in using the Medicare system. As well the research was to seek details on Aboriginal and Torres Strait Islander peoples', and their service-providers', attitudes and experiences (including problems) of the HIC's administration of Medicare.

Further, data were sought on the usage and retention of Medicare cards amongst different socio-economic and geographic groups. Finally, comment was required on the current range of strategies used by the HIC for overcoming service-delivery problems. This section of the report addresses these issues.

In considering these matters, the consultants have drawn on the fieldwork, the telephone interviews with service providers - especially ACCHSs across the country - and on the postal survey information provided by numerous GPs and pharmacists. In addition the experiences and views of Medicare staff were incorporated.

The reporting of the study findings has endeavoured to describe how Medicare is functioning for Aboriginal and Torres Strait Islander peoples as seen from the perspective of the various key interest groups. To the degree possible we have sought to let people speak for themselves through a copious use of quotes. As well as describing the nature of any problems or

barriers we have also sought to provide some indication as to the incidence of the problem — was it an exceptional or one-off occurrence or is it prevalent across numerous Aboriginal and Torres Strait Islander communities? Moreover, views were sought on how problematic it was for the person or service involved.

The consultants felt it was important to attempt to determine something of the dimension of the problems but caution that respondents' 'enumerations' were quite variable. People sought to provide their best estimate of certain factors but were often limited in not having an objective basis for making those estimates. For example, determining the number of patients not holding a Medicare card was easily and soundly done where a service had this information on computer files or where actual surveys had been conducted. Others endeavoured as best they could to 'guesstimate' proportions of their patients lacking a card. This results in a somewhat unsatisfactory mix of various sorts of data - but the consultants have sought to report only those matters which appear to reoccur again and again.

4.1 ENROLMENT IN MEDICARE

In order to access Medicare, a person must first have a unique, personal Medicare number. To be assigned a Medicare number s/he needs to be enrolled.

Standard enrolment procedures require a completed Medicare enrolment form, giving the enrollee's surname, other names and date of birth. In addition, a person enrolling in Medicare must produce sufficient identification to prove they are the person whose name appears on the enrolment form and that they are eligible for Medicare by virtue of being a legal resident. Standard documentation required for Australian residents includes a birth certificate or an Australian passport or citizenship papers or a foreign passport with an Australian residency stamp plus acceptable identification if not identifiable from a passport photo. Documentation that attests to residential status (eg rates notice) is used to establish eligibility. (Visitors to Australia need to provide a foreign passport and proof of entitlement

where such arrangements exist with the person's home country.) All other enrollees who are to appear on the same card must be able to provide the same information, with the exception of children under the age of six months, who may be enrolled on a Medicare claim form. In some circumstances identification for enrolling children under the age of six months is required.

It is apparent that the requirements for enrolment in Medicare have been developed to ensure that ineligible people (eg tourists, illegal immigrants) are not able to access the scheme; the system, in fact implicitly assumes that the main body of adults yet to be enrolled in Medicare - nearly 15 years after its inception - are newly arrived migrants. However there are large groups of people who have long been resident - including some Aboriginal and Torres Strait Islander people - whose health services have been provided to date by State or Territory Health Departments and thus have never had the need to be enrolled in Medicare, or who for other reasons have never enrolled. As a consequence a number of Aboriginal and Torres Strait Islander people are enrolling for the first time, as this research will demonstrate. It is apparent that, in practice, requirements for establishing identity are to some extent determined at the State and sometimes at the local level.

This research examined the frequency and nature of problems surrounding the enrolment of Aboriginal and Torres Strait Islander peoples - whether in relation to enrolment for the first time or re-enrolment when a Medicare card had expired. It also looked at the matter of differing requirements and procedures that exist in various regions of Australia.

4.1.1 Levels of Enrolment

Health care providers in a number of urban and rural areas reported that a significant minority of Aboriginal and Torres Strait Islander people were not currently enrolled, while in some remote areas where Medicare was just being introduced over half were not currently enrolled. These levels of Medicare enrolment are equivalent to those found in research conducted in Queensland recently

(*Aboriginal and Torres Strait Islander Ambulatory Care Reform Program*, January 1997).

The Queensland study included a survey of Aboriginal and Torres Strait Islander peoples living in one of three distinct types of communities - an urban area (Brisbane South), a rural area (Mt Isa) and a remote community (Bamaga). It was stressed in the report that Bamaga might not be typical of remote communities in that there has been extensive community involvement in the planning and control of health services. Overall nearly one-quarter of Indigenous people reported not having a Medicare card. Within each community the percentage without a Medicare card was as follows:

Brisbane South	- 15%
Mt Isa	- 31%
Bamaga	- 38%

The report indicates that the respondents were 15 years or older. If the study had included younger children then, in light of our research, the overall incidence of non-Medicare card holding would almost certainly have been significantly higher.

A prior assumption made before this study began was that relatively few problems would be found in urban areas, however the current research found that somewhere in the order of 15-20% of Aboriginal and Torres Strait Islander peoples using urban health services do not have access to a current Medicare number. The situation worsened in rural and remote areas. This is clearly at odds with earlier research conducted by Reark Research in 1990 which found that only 7% of Aboriginal people reported not having a Medicare card. It is extremely unlikely that there would have been such a marked decline in possession of Medicare cards in the intervening years and we suggest that the earlier figures are quite doubtful. This does not necessarily mean that these people are 'not enrolled' in Medicare (in the sense of never having been enrolled or that eventually an active number could not be found) but either the people themselves or service providers report that the people do not have a current Medicare card/number. It needs to be recognised that the absence of a Medicare

card/number means that Medicare is basically *not available* to those lacking a card/number.

4.1.2 Adults Never Enrolled

In urban and rural areas it was commonly reported that few people had *never* been enrolled in Medicare. It was frequently said that Aboriginal and Torres Strait Islander people living in cities and rural towns where a range of health service delivery systems exist were generally accustomed to the Medicare process. Reasons for patients *never* having been enrolled included:

- the person was from a remote area where Medicare was not commonly used (eg patients from the Torres Strait, Cape York or Palm Island who go to, say, Cairns or Townsville);
- reasonable health (no need to see a doctor);
- late presentation with illness, resulting in hospitalisation rather than use of a primary health care service;
- transience, resulting in an inability to enrol; and
- problems with identification.

One of the reasons that the levels of Medicare enrolment in remote communities was generally consistently lower than in urban and rural communities is the lack, or recent introduction, of fee-for-service health care in many remote communities. The health services on Cape York and in the Torres Strait and a number in the Northern Territory are State/Territory operated. Patients in those communities do not need, or have not needed in the past, Medicare cards in order to access primary health care. As a consequence, there also tends to be significantly lower levels of awareness about Medicare and the benefits it can provide in these areas.

While more common in remote areas, 'new entry' into Medicare was also experienced by services elsewhere. For example an Aboriginal co-op in central Victoria stated they had only been 'granted' Medicare claiming rights some eight months ago '*so we've got teething problems*' (they received no orientation to the Medicare system nor an information package from Medicare). The worker went on to add, '*People have been coming here*

for 20 years and now suddenly we want a Medicare card'.

As indicated above, it is not only 'communities' that have never enrolled, but also some individuals who slip through the net.

Services report that some Aboriginal people say nothing about minor complaints, so don't use the health care system at all until they are seriously ill and therefore may not be enrolled.

People from the bush only come in when they're nearly on their deathbed. Aborigines don't complain about little aches and pains, they have to be nearly dead. (ACCHS, rural SA)

However, this situation was not exclusive to remote areas:

There was one old fella who was sick and he never got registered in his life, so he had no ID. The [local] Medicare office said they wouldn't enrol him without ID. He ended up running around for days, getting nowhere. Finally he went into the city office and they sorted it out straight away. (ACCHS, urban NSW)

A number of health services observed that many Aboriginal and Torres Strait Islander people who have been in prison, in drug and alcohol rehabilitation centres, in juvenile detention centres and other institutions, as well as children in care, are often not enrolled in Medicare.

4.1.3 Re-enrolment Process

As well as needing to process completely new adult enrolments within Aboriginal communities, it was reported that a substantial number of Aboriginal and Torres Strait Islander people who had once been enrolled were not *currently* enrolled. Again, not being currently enrolled basically means that Medicare is not available to that person. The most frequent reason given was that their Medicare card had expired. It was commonly reported that many clients thought that a Medicare card was 'for life' (like tax file numbers) and therefore did not need to be renewed. (Bearing in mind that it is only in the last two to three years that Medicare cards have started to

expire it is quite possible that understanding of the Medicare card 'renewal' process is little understood by the general population.)

In regard to keeping Medicare enrolment current it is useful to understand the standard card replacement procedures. The first Medicare cards were issued in 1984 and were expected to have a life of five years. A decision was made to let them run longer - they did not carry, at that time, an expiry date. In 1991 all cards were reissued with an expiry date and a cardholder number which contained an 'issue number', so that subsequently issued cards to the same person would bear the same number except for the last digit which would increase by one.

By 1994 cards began to be replaced in accordance with their expiry dates and the HIC developed guidelines for the replacement process. Under the guidelines, new Medicare cards are automatically sent to cardholders for whom the HIC has a recent address, which may be either derived from a Medicare claim made directly by the client in the past nine months, by the client notifying the HIC of a change of address, or by cross-referencing with Telstra records. Clients who have not personally made a Medicare claim in the past nine months, either because they have not received a service which attracted a Medicare rebate or they exclusively visited bulk-billing service providers, and who do not have a current Telstra record, are not automatically sent new cards. This obviously serves as a security check over the issue of cards. A client in this situation is sent a letter at the last known address, three months prior to the card's expiry date, advising him/her of the need to apply for a new card. A bulk-billing service provider who makes a claim for the client during this period is also notified that the card will shortly expire. After the card's expiry date the card number will be accepted by the HIC for a further 75 days.

Aboriginal and Torres Strait Islander people who exclusively use bulk-billing services and/or State-administered primary health care services are far less likely to be sent replacement cards automatically after expiry. There is evidence to suggest that the majority of Aboriginal and Torres Strait Islander people principally use bulk-billing

(or free) services, so this affects a great proportion. There are also many Aboriginal and Torres Strait Islander people, particularly in rural and remote areas, who do not have telephones, therefore they have no Telstra record. Also letters sent to the last known address may not reach clients because of high levels of mobility - particularly over a decade. In many remote areas Aboriginal and Torres Strait Islander people use an ACCHS as their postal address thus there is a better chance of tracking the client down, but this is rare in more urban areas.

Some have been moving around and their cards expired five years ago. Their address is care of the Post Office and they don't always pick it up. Low literacy is a big problem. They bring in letters from Medicare because they don't understand them. Just changing the words will make no difference. (ACCHS, rural/remote NSW)

There was much confusion regarding the procedure for re-enrolling once a card had expired. In many cases neither service providers nor Aboriginal and Torres Strait Islander clients were sure whether they had to apply or wait for a new card to be sent to them. In one rural location the majority of service providers, both ACCHS and mainstream, confirmed that expired cards were their most recurrent problem - 'A lot don't realise they have to go in to apply for a new card' (GP, rural NSW). Some of these health care providers believed many Aboriginal and Torres Strait Islander patients thought the re-enrolment procedure was unnecessary because they had already received medical care.

When the standard enrolment and re-enrolment procedure is adhered to, it causes enormous problems for Indigenous people:

If they're not enrolled, we try to send a letter to the patient and most go and get enrolled, but a lot have difficulty finding three sets of ID. Most have no birth certificate and no driver's licence, no full time job. The three sets is the most difficult. If they cut it down to two, it would be better. Young people would have a

DSS Health Care Card and a bank keycard. (ACCHS, rural NSW)

'Enrolment drives' carried out by Medicare staff in a few remote/rural communities were reported to have been highly successful by both service providers and Medicare staff and the need for a similar effort was expressed by rural ACCHSs for their areas. Some providers felt that enrolment shouldn't be left to the service providers to do: *'Why is it the services' responsibility to get people enrolled?'* (urban ACCHS).

Since a large enrolment program approximately 18 months ago, we would only have contact with maybe one or two (Aboriginal people) a month. (CSC, rural Qld)

They should have a drive to get everyone enrolled. Employ someone to drive out and do it. (ACCHS, rural NSW)

There's not enough information for people about why they should be enrolled, the benefits for people. They are unsure of the process of being enrolled. They don't know how to go about it. It costs us a lot in staff time helping people get enrolled. (ACCHS, rural NSW)

Low literacy levels and poor understanding of Medicare were reported to have left some Aboriginal and Torres Strait Islander people outside the system:

Many when they need to enrol, have poor literacy skills and have never heard of a birth certificate. When they apply (in the surgery) they will be sent a letter in response, requesting detailed information, which may be poorly understood, and remote from current need, hence ignored. This problem presents five to ten times a year. (GP rural Qld)

Some ACCHSs were able to help the patient fill out an enrolment form, while others would send the patient to the local Medicare office to get enrolled. This appeared to be successful when the local Medicare office was close by, however at some practices, staff reported that patients had not returned to the surgery and believed they had not gone to the Medicare office. A number of times

the Medicare offices were described as 'intimidating' to Aboriginal people.

Some ACCHSs act as an agent or clearing house for patients in relation to their receipt of Medicare cards. However a number of ACCHSs indicated that this system broke down when multiple cards were involved. Despite the fact that an ACCHS might possess the sole postal address for a community, an automatic security triggering occurs within the HIC system when numerous Medicare cards are addressed to a single address and as a result they are not delivered.

Another problem raised was the *length of time* required by Medicare to process an enrolment (or re-enrolment). Various ACCHSs spoke of 'six weeks', 'ten weeks', 'twelve weeks' elapsing between the time an enrolment form was sent in and a response received. Some health care providers delayed even attempting to make a claim until a Medicare number was made available, which sometimes resulted in problems if a bulk-billing voucher predated the enrolment. An HIC manager reported that normal processing time of enrolments is closer to two weeks, maximum, unless there are reasons for additional delays from time to time.

Recommendations

1. The HIC needs to make the option of enrolling people on the spot available to all ACCHSs through simplified procedures as well as taking greater responsibility for providing support to the ACCHSs in carrying out this function.
2. The HIC needs to assume greater direct responsibility for ensuring that people in the community are properly enrolled and should ensure that resources are made available for staff to carry out more fieldwork. Alternatively, the HIC should contract Aboriginal community organisations in remote and rural areas to improve enrolment. If places such as resource agencies were used this would reduce the burden on ACCHSs.

3. The HIC needs to negotiate with the appropriate agencies to ensure that people who have been in institutions (such as prison, drug and alcohol rehabilitation centres, juvenile detention centres) as well as children who have been in care are enrolled in Medicare before they leave the program/institution.

4. ACCHSs and other service providers should be informed about the existence and rationale of the Medicare card expiry procedure and encouraged to record their patients' expiry dates along with their Medicare numbers.

Alternatively, or as well, the HIC should issue Medicare cards without expiry dates when it is known that the cardholder is an Aboriginal and Torres Strait Islander person (eg when bulk enrolling in communities and/or when enrolments originate from an ACCHS).

5. The HIC should delete the issue number from Medicare cards issued to people who are known or assumed to be Aboriginal or Torres Strait Islander.

6. The HIC needs to adapt its security systems to identify centres which act as agents or clearing houses for patients' Medicare cards to ensure the system does not limit the number of cards that may be sent to that address.

In relation to both initial enrolments and re-enrolments, the issue of identification is key and this is discussed below.

4.1.4 Identification Requirements

Section 3.1 of the *Medicare Patient Eligibility Policy and Information Manual, March 1995*, states:

It is important to recognise that due to the special circumstances of Aboriginal people in some rural areas, which cause both identification (because of name changing) and identification documentation problems, concessions which have been extended to Aboriginal people in the past should continue.

Policy on Aboriginal enrolment should be determined to fit the circumstances found in each State, but should follow the principle of accepting enrolments, with reasonable precaution, without insisting on the usual formalities. For instance, the basis of the identification might be a letter from a person holding a position of authority in an Aboriginal organisation or from an officer holding a position of authority in a Government department advising that the applicant is recognised under the name on the application as a member of the Aboriginal community or network.

Despite this acknowledgment of the need to adapt the procedures used with (rural) Aboriginal and Torres Strait Islander peoples, the identification requirements for Medicare enrolment continue to be a major obstacle for a number of Aboriginal and Torres Strait Islander people who don't carry identification. This was a particular problem for youths, who may want their own Medicare card but who don't have acceptable forms of ID such as a driver's licence, birth certificate or passport, as well as for the elderly who may never have had ID. These problems were identified across the whole range of ACCHSs - remote, rural and urban.

There are a lot of young people (15 - 17 years) who are not receiving any benefits, not going to school, not necessarily living at home (and not working). We don't turn those people away, but we don't get any Medicare return for them ... It's not their fault they've got no ID. It's legitimate, not a story they've made up (ACCHS, rural Vic)

The type and quantity of identification documents which needed to be sighted by Medicare enrolling officers was not universal. A number of ACCHSs and Aboriginal and Torres Strait Islander people complained they had to provide three pieces of identification, while elsewhere it was two pieces and others said a 'points system' was used. In a number of (primarily rural) areas, a letter from the ACCHS or other Aboriginal organisation, the Department of Social Security, a school principal or an employer was sufficient. It was frequently

reported by clients and ACCHS personnel that Medicare staff required an original birth certificate. This was seen as inappropriate given that many Aboriginal and Torres Strait Islander people don't know their date of birth, let alone have a birth certificate.

In other parts of the country, mainly in States/regions which have a relatively high concentration of Aboriginal and Torres Strait Islander peoples, other forms of identification were accepted. In many parts of Queensland, for instance, a special Medicare document entitled *Proof of Identity - Verification* is used to provide identification for Aboriginal and Torres Strait Islander clients (Appendix 5). It is mainly used by ACCHSs and needs to be signed by a referee, eg a Council Chairperson, a school principal, a member of the clergy, a DSS officer or in some cases a senior ACCHS staff member. The referee confirms that the person named, who is unable to provide proof of identity, is personally known to the referee and that their details are correct. It was reported to be highly successful by those ACCHSs surveyed, though not all ACCHSs in Queensland use or are aware of the form.

The *Proof of Identity - Verification* is acceptable simply because the referee is believed to be able to confirm a person's identity and is trusted to honestly report this. The HIC has been somewhat tentative about making this form more widely available because of uncertainty as to whether it would be workable in ACCHSs operating in, for example, more urbanised communities where the ability to know and confirm a person's identity through personal experience was assumed to be more limited. Staff at major capital city ACCHSs made a convincing case that they were quite able to confirm a person's identity even when s/he was not known personally to them through some questioning and/or a phone call or two. Often, in fact, they needed to verify a person's Aboriginality when a person was presenting for a specialist/ancillary service only available to Aboriginal people - dental care, most notably.

In Western Australia, the standard Medicare enrolment forms are distributed to all ACCHSs, although formal identification documents are not

required. The signature of an ACCHS service-provider suffices to validate the applicant's identity.

In the Northern Territory, some health services located in or servicing remote Aboriginal communities have an arrangement whereby they send to a Medicare Customer Service Centre a list containing the names and dates of birth (if known) of Aboriginal patients seen by an ACCHS for whom it has not been possible to find a Medicare number. Medicare searches for the numbers, enrolls anyone who has no number, and faxes back to the health service a list of the Medicare numbers. (In contrast, enrolling from such a list was expressly prohibited in Western Australia.) One specialist who visits a number of remote communities was reported to send in a list of all patients without Medicare numbers with his claims, and they are generally all processed.

4.1.5 Targeting Aboriginal and Torres Strait Islander People

The research amply documents the 'poor fit' between the Medicare system and Aboriginal and Torres Strait Islander peoples. If the system is to become more accessible and culturally appropriate something needs to change. A basic question is whether Medicare administrative procedures can and should be altered universally or whether they can be altered only as they relate to Indigenous people. However this raises the even more basic question of how Aboriginal and Torres Strait Islander people might be identified so that they might make use of any tailored or special procedures. To some degree this can occur through the surrogate of the ACCHSs and/or provider numbers. Provider numbers of doctors reflect the 'address' or site in which they deliver services; a GP working at an ACCHS will use a different provider number to that used when s/he is practicing in another clinic. However individual enrolments, claim forms etc do not readily identify when a person is an Aboriginal or Torres Strait Islander.

One strategy currently used on many forms, including those from DSS, includes an option where a person can self-elect to identify as an Aboriginal or Torres Strait Islander person - through a simple question.

This would enable a great many of the proposed strategies discussed here to be implemented as well as serve additional information needs (eg Indigenous patterns of health care usage). Many respondents express some concern about 'flagging' Aboriginal and Torres Strait Islander people, for understandable reasons, given the history of how such information has been used to their detriment in the past. For this reason alone, any introduction of such an identifier system will require considerable consultation to ensure its acceptability.

9. It is recommended that an information campaign be directed at consumers as well as service providers clearly outlining the minimal proofs of identity needed to enrol in Medicare.

Recommendations

7. It is recommended that the HIC adopt a simple Proof of Identity form, such as that used in parts of Queensland and that it be made universally available to all ACCHSs or equivalent services. Referees should include persons who would normally be available at an ACCHS. The form should include a clause indicating it is an offence under the Health Insurance Act to make a false declaration and should include clear instructions regarding how it is to be used. The form should be available to services regardless of location: those urban ACCHSs consulted were able to convincingly demonstrate that they were able to verify an Indigenous person's identity, at the least to the degree needed to ascertain eligibility (ie residential status).

A Proof of Identity form raises a problem for those services that bill electronically, and this is an area that will increasingly cause problems as more practices move towards electronic billing. However this might possibly be addressed by having the capability on any claim form, to signal that simultaneous enrolment was also being sought.

8. To cut down on paperwork and administration, a simple Proof of Identity form should be married with the enrolment form and used to enrol people at ACCHSs and perhaps those bulk-billing surgeries with a high proportion of Aboriginal and Torres Strait Islander patients (where they can be identified).

10. The HIC and the Department of Health and Family Services should initiate discussions with the appropriate organisations regarding the introduction of a question on enrolment forms, claim forms etc which asks the consumer whether s/he chooses to be identified as an Aboriginal or Torres Strait Islander person (note that it is important to enable this distinction to be made). This is already a commonplace procedure among other agencies such as Department of Social Security. Any move to introduce such a clause would have to be accompanied by information and guidelines on how and why the resulting data would be used.

11. The HIC needs to ensure that 'bulk-enrolment' of Aboriginal and Torres Strait Islander peoples, whereby remote service-providers (eg visiting specialists) have patients fill out Medicare enrolment forms at the time of consultation and lodge the forms with their bulk billing voucher, is made standard practice and acceptable to all Customer Service Centres.

4.1.6 Enrolment Of Children

Where substantial numbers of Aboriginal and Torres Strait Islander people were not enrolled they were in the majority of cases, children. The proportion of children using services who were not enrolled was reported to range from insignificant to 50%.

Generally newborns are able to be enrolled on the spot at a health service by using a standard Medicare claim form which has a section 'Adding a newborn child', though a few health services reported repeated rejections of these enrolments.

Enrolling new babies: we complete enrolment and send it with the direct bill voucher (as instructed by Medicare) and Medicare fails to process. Mothers rarely enrol babies without this service. This is a problem with about 50% of babies. (GP, urban Qld)

One doctor in a remote community said every enrolment of a baby via a Medicare claim form had been rejected and despite repeated enquiries, he

had not been able to determine why this had been so. Problems also arose in the common situation where an adult who was not the mother or father of a child but was caring for the child brought him/her to a health clinic. For example, the child's aunt or grandmother might bring the child to the clinic, may not know the child's exact date of birth or the name s/he is to be enrolled under and the mother/father could be living some distance away. In such cases some service providers reported they could not enrol the baby or that it resulted in long delays. One rural ACCHS reported being told by Medicare that only the *mother* could enrol a child. The problem was reported by both ACCHSs and private practitioners.

Enrolling babies more than six months old: - often not in the care of birth mother; - often no birth certificate/ identity documents. I usually don't get paid for these consultations. (GP, urban Qld)

There was considerable confusion among service providers and Aboriginal and Torres Strait Islander people as to the age limit for enrolment via the Medicare claim form: some thought the age limit was six months, some twelve months, while one ACCHS reported being told by Medicare that the child had to be less than six weeks old:

Of adults, 80-90% do have a number, but 50% of children don't. They're not enrolled. If they are less than six weeks, they can be enrolled on the spot if the mother has a Medicare number, but if they are over six weeks, they have to have a birth certificate... It used to be six months, but now it's six weeks. It makes it very difficult to enrol children, but we have a policy that sick children must see a doctor. We have a lot of outstanding claims for kids. Around 10% we never receive. People don't realise that babies have to be registered and they have no ID for them. (ACCHS, urban Qld)

Difficulties faced in having to apply and pay for children's birth certificates was the most frequently raised impediment to enrolling children in Medicare. It was frequently reported that Medicare would only accept an original birth certificate as identification for a child over the age of six months.

In some cases a letter from the hospital in which the child was born or the birth registration form from Births, Deaths and Marriages was accepted, but often they were not. Other forms of ID such as the discharge papers or 'baby book' from the hospital were also reported to be unacceptable. *'It's inconsistent that babies can be registered with DSS without birth certificates but not with Medicare'*. One urban Aboriginal woman said Medicare's refusal to accept any of the above has resulted in her not bothering to enrol her infant son: *'It's \$23 every time to get a birth certificate. It's too expensive'*.

They can't pay \$40-80 dollars for birth certificates. Some women have more than five kids. They could have seven kids and only some on the Medicare card, because they can't afford to buy more birth certificates. We still see the client, but we can't claim and if they need to see a specialist, he'll refuse, because he can't bulk-bill. (ACCHS, rural Qld)

The problem was most frequently raised in urban and some rural areas, while very little mention was made in remote areas. However this may be explained by the fact that overall levels of Medicare enrolment in remote areas were lower than anywhere else so that problems caused by children not being enrolled were less pronounced.

It is also likely that the frequency with which this problem is encountered is to a large extent a function of the idiosyncrasies of particular Medicare Customer Service Centres which process enrolments. While some Medicare Customer Service Centres said they accepted a Health Care Card as identification, many Aboriginal and Torres Strait Islander clients and ACCHSs reported that in their experience this was not the case.

It was suggested that as children were more likely to be registered on a Health Care Card, this should be acceptable as a form of identification:

There needs to be some communication between DSS and Medicare. It's the same number of children. Birth certificates are too expensive for the majority, but if you could transfer proof of identity, photocopy

that. The CEO could witness it and we could fax it off. (ACCHS, rural Qld)

Some mothers bring in their children three or four times before they register them.(ACCHS, rural Qld)

Another problem was that new parents often felt confused about the bureaucratic processes they needed to follow while in, and after they leave hospital, and needed assistance with such things as filling out forms:

Mums are given a load of forms at the hospital and they're too ashamed to admit they can't read. (ACCHS, rural SA)

It was suggested in several locations that Medicare enrolment should always take place for newborns at the hospital and that a hospital staff person should have the responsibility of assisting parents to fill out forms. While the HIC provides enrolment forms to most hospitals, the systematic enrolment of newborns is far from universal.

The problem of parental or guardian authority in relation to a child's Medicare enrolment can partially be resolved through existing mechanisms.

Currently, a maximum of two duplicate Medicare cards can be issued and an individual (ie a child) can be nominated on two different cards. Thus, for example it is not uncommon for a divorced man and woman who share custody of their children can each have a separate Medicare card with the children appearing on the cards of each adult. Also, there is no restriction on a person, no matter how young, having his/her own Medicare card with parental approval.

Changes of name (children in some communities are not given a surname until they are about two years old) and family composition were reported to have made the use of family cards impractical. It was reported that issuing each family member with an individual card (as has occurred in some Northern Territory communities) has resolved many of the difficulties associated with tracking a person's - and in particular a child's - enrolment number through the family. This arrangement was not reported to be in place elsewhere, though some communities felt it was necessary - *'The list of families changes daily'* (Torres Strait). Some felt the provision of individual cards would be practical,

particularly when a child went to live with another family member. Others, particularly where people carried their own cards rather than leaving them with a health service, felt it would be impractical because it would be even *more* difficult to track children's' numbers - *'We need as many kids as possible on one card'* (Alice Springs) - and it would be cumbersome for people who have a number of children - *'It's just another card to worry about'* (Gippsland).

Recommendations

12.The HIC needs to undertake more concerted action to assist hospitals (particularly those serving Indigenous communities) in ensuring that Medicare enrolment of newborns becomes standard practice.

13.The HIC should state on the Medicare Claim Form the age limit that applies when adding a newborn child.

14.The HIC should consider raising the age limit for adding a newborn child via the Medicare Claim Form from 6 months to 12 months.

15.The HIC needs to make the acceptability of Health Care Cards as a form of identification standard practice as a number of service providers and consumers noted that Aboriginal and Torres Strait Islander people were often more likely to have themselves and their children recorded on a Health Care Card than have other forms of identification.

16.The HIC should examine how administrative requirements could be changed to grant guardians the authority to either enrol a child on the child's own Medicare card or to be added to the guardian's card in the absence of parental approval, where this cannot readily be obtained. This might also require that the rule that a person can only be identified on a maximum of two cards be lifted as well.

17.The HIC should monitor those communities where individual cards have been issued in favour of family cards to assess whether this helps alleviate problems or not. Pending this outcome, the HIC could make it widely known amongst ACCHSs that the option of single cards was available and, if warranted, assist ACCHSs in the changeover from family to individual cards. Clearly this is an option that would be adopted according to the needs and wishes of communities and individuals.

4.2 DIFFICULTIES ACCESSING MEDICARE NUMBERS

In order for a patient to claim from Medicare or for a health care provider to claim a Medicare benefit on the patient's behalf, a correct Medicare number needs to appear on the Medicare claim form or bulk-billing voucher. Preferably, the patient should present his/her Medicare card at the time of service or claiming. However, if the patient is unable to show his/her Medicare card and the number is not kept on record, the service provider or patient can telephone a Hotline in order to access the number, providing correct details can be provided (as a security check). If the number is not able to be accessed - through the Hotline or by other means - a Medicare benefit cannot be claimed for the service.

All ACCHSs and the vast majority of other service providers reported some problems with Medicare claims, but the extent ranged from so few as to be insignificant to over 50% of claims. The more severe and greater volume of problems tended to occur in ACCHSs rather than in mainstream services. The problem with claims was overwhelmingly about being able to provide correct current Medicare numbers although the provision of other information was also problematic.

4.2.1 Medicare Cards Not Presented

The majority of ACCHSs reported that most patients did not bring in their Medicare cards when they came to see the doctor. While a few ACCHSs

said up to 90% of their patients bring their cards with them, this was not common.

Other service providers generally reported that Aboriginal and Torres Strait Islander clients were less likely to bring their Medicare cards with them than non- Aboriginal and Torres Strait Islander patients, while some reported this was also a big problem with non-Indigenous youths and the elderly.

The proportion of patients who presented their Medicare cards often related to the likelihood that the clientele was local or transient, with a higher proportion of local patients bringing their cards. This did not necessarily correspond to the location (urban/ rural/ remote) of the service, but rather to the service's catchment area. For example, ACCHSs in capital cities often had a large number of non- local, transient patients from rural and remote areas and from interstate. Other ACCHSs located in rural areas had a very high proportion of local patients and experienced fewer problems with patients not presenting their cards. Other factors influencing whether or not patients brought their cards when they saw the doctor included how well bureaucratic processes, and Medicare in particular, were understood by patients and the individual policies of the services. (The manager of one urban ACCHS said that patients who didn't bring their Medicare cards had to pay.)

A number of other mainstream health services, particularly in rural areas, did not bulk-bill. Many of the services that bulk-billed said their Aboriginal and Torres Strait Islander patients were generally better educated and understood how Medicare worked, and so had fewer problems with non-presentation of Medicare cards; some of these said they had more difficulties with their non-Aboriginal and Torres Strait Islander clientele. In contrast, one remote area GP estimated there was a problem with approximately 15% of Aboriginal and Torres Strait Islander patients' cards each week, whereas there was problem with about 5% of cards held by non-Indigenous patients.

Most ACCHSs kept patients' Medicare numbers on file/computer. Problems arose when a new or transient patient presented or when Medicare cards expired, thereby invalidating the number

held on file. All ACCHSs interviewed reported these problems occurring.

Whether or not a service provider went to the effort of locating a patient's Medicare number depended on how busy the staff were, the level of resources the service had, previous experience with the Medicare Hotline, the service's relationship with the local Medicare office and how difficult the procedure was perceived to be. Some services reported that they didn't bother to chase up some claims for one or more of these reasons.

4.2.2 The Medicare Hotline

When a patient or service provider phones the Medicare Hotline, the caller should provide the patient's name, address and date of birth, and if all three pieces of information given match Medicare's records, the number will be provided. (A strict interpretation of the Health Insurance Act means that, technically a Medicare number should not be released to a third party, such as the service-provider or receptionist. However, the imperative of actually making Medicare numbers available has led the HIC to be flexible in applying the rules.)

The Medicare Hotline was widely criticised by ACCHSs and a number of other health care providers on the grounds that some of the operators were insensitive to the cultural differences of Aboriginal and Torres Strait Islander peoples which make meeting bureaucratic requirements difficult.

Many felt that because the call could be answered by an operator in any State, they were unaware of the problems they may have in giving correct details and don't know how to work around the problems. For reasons previously stated, providing names, addresses and dates of birth - the three requirements of the Hotline - is highly problematic. Many service providers felt their contact with Hotline staff was very idiosyncratic, some ringing back and trying again with a different operator when they weren't able to get a number the first time.

If one digit is out they won't give it to you.

It all depends on who you get. Some are hopeless, they won't help you at all.

Especially the men. The women are better. They just don't understand that it's not the same in Aboriginal communities. (GP, remote Qld)

Some service providers said the Hotline was often busy, so getting through was very time consuming. Some Hotline operators only dealt with three enquiries at a time, making it difficult if service providers have collected a number of claims. ACCHSs have had variable success in using faxed lists of inquiries - *'I never get a response'*. In defence a Medicare manager pointed out that up to 2000 inquiries a day are received in one State alone and that peak times (8 am to 4 pm) are the worst.

All non-ACCHS service providers interviewed used the Medicare Hotline to access any patient Medicare numbers they did not have.

Several ACCHSs said they often give up on the Hotline, while some won't use it at all. *'We never use the Hotline'*. (remote NT)

It was stated that clinics that are open after hours needed access to the Hotline at those times.

One ACCHS staff member made the plea that the services' third-party rights to information be recognised by Medicare. *'After all, we're in this together. We're all trying the best we can to make the system work'*.

It should be noted that positive comments were also made about the Hotline:

We get onto the Medicare Hotline. They are helpful if we know the name and address but not the number. (ACCHS, rural NSW)

They are really helpful. They look under mother's name, under the father's name. They really try. (ACCHS, rural Qld)

The women who answer the telephone at Medicare are invariably helpful - often in very trying circumstances. (ACCHS, urban NT)

Our problems were totally solved once we got the 132 number. (specialist's receptionist, rural Vic)

4.2.3 Bureaucratic Hurdles

It was widely reported that the requirement that clients be able to provide personal details which matched those held by Medicare does not take into account aspects of Aboriginal and Torres Strait Islander cultural practices. The following exemplify the sorts of problems commonly encountered:

- the patient enrolled under another name which he is now unable to use for cultural reasons eg following the death of a relative of the same name;
- the patient is a visitor to the community and cannot, for cultural reasons, use her name;
- the patient has the same name as several other people in the community, but doesn't know his date of birth or the address he used for enrolment;
- the patient doesn't know her date of birth and has used a number of different dates of birth over the years;
- the patient is transient and is not sure where he was living when he was enrolled;
- a woman is looking after her sister's child but doesn't know whether the child uses the mother's, father's or another surname;
- each of the children within one family have different surnames.

Uncertainty about registered names was common, particularly with traditional, transient people from remote regions. People may have enrolled under their western name, skin name, current guardian's name, father's name, mother's maiden name, mother's married name or de facto husband's name. Often children may be living with someone other than the person whose card they were enrolled on. In some areas people may have up to six names, which they use interchangeably. Even the ACCHSs can find the complexity of people's situations daunting.

Occasionally they have changed name or used the name of their father instead of mother or own name, especially if they are married to a non-Aboriginal. One Islander woman was married to a white man and

her first kid used the father's name, but the second kid was registered in the mother's name, but the mother used the father's name. Usually children are registered in the mother's name, but sometimes in extended family names, for example, if the grandmother has taken the child and registered in the grandmother's name. They can be very sensitive about telling us things like that. (ACCHS, urban Qld)

Fifty per cent of people don't get their Medicare number. They don't know their date of birth or they have been using several (fictitious) dates of birth. You can send off to Medicare only if you can get the date of birth, name and address. Then they could be using more than one name: their name and their skin name. Also they travel around a lot and their addresses change, so when the card comes, they are gone anyhow. (ACCHS, remote NT)

One person I'm still trying to get a number for has the same name as his father and he's not sure of his date of birth ... There could be three or four people using the same name: himself, father, cousin, uncle, all with the same name and not sure about their date of birth. (ACCHS, rural NSW)

At one ACCHS, an example was given of a particular problem they faced amongst traditional people.

Say a person's name is Henry Jones, the same as his uncle. If his uncle dies, he cannot speak or use the name of his uncle, so he has to change his name. He might come into the clinic and go up to the person on the desk and tell them his name is Bill Jones and she can't find any record of him. Someone else has to tell the person on the desk what his name used to be. (ACCHS, rural/remote WA)

A senior Medicare administrator in the State indicated having no knowledge of such a practice.

The use of 'aliases' is recognised in the *Proof of Identity - Verification* form used in parts of Queensland. As well as the full name of the claimant, 'other names used (nickname, skin

name)' are also recorded. The researchers were informed that in States with a significant population of traditional Aboriginal people, use of aliases in the court system was commonplace. Again a Medicare administrator in one State indicated that it was not possible for aliases to be recorded on Medicare files - the use of them being illegal.

4.2.4 Other Means of Accessing Medicare Numbers

Some ACCHSs were reluctant to use the Hotline because of difficulties they have experienced in the past, and because they have other means of accessing the numbers. These include telephoning the patients' relatives, other service providers the patient has used, a hospital liaison officer or the local Medicare office (if this relationship exists). Where services had a good working relationship with the local Medicare Customer Service officers and were permitted to phone the office directly, there tended to be a higher rate of success in locating numbers.

Success at locating numbers is judged by some of the ACCHSs as being high:

It would be quite rare that we don't find a Medicare number somewhere. (ACCHS, rural SA)

In other instances, success is much lower or very problematic:

We have a lot of trouble. They never bring it (the card). Never. They don't know they have it. The receptionist has to follow it up: ring up, write, send the driver to fetch it. It's a big expense ... There is a problem with maybe 60 per cent. The AMS absorbs the cost. (ACCHS, remote NT)

Proximity to a Medicare Customer Service Centre generally increased the likelihood of getting a Medicare number. One ACCHS was located opposite the Medicare office and was able to send patients across to get their own numbers. Another service provider in the same town said it was often easier to send patients to the Medicare office two blocks away than to go through the Hotline.

Some ACCHSs used to send a claim form along with an enrolment and application but 'we're not allowed to do that any more. They'll accept

“Aboriginal” on the enrolment forms but not on the claim form’. Another service indicated that this approach led to claims being rejected ‘as the date on the claim form might predate that on the enrolment form’. Moreover, use of electronic claiming makes it all but impossible to simultaneously claim on and enrol a person.

While it was not common, a few mainstream health services said they would not see patients if their enrolment was not current, or reported such incidents occurring.

I’ve seen a child with severe asthma refused to be seen by a visiting paediatrician because the Aboriginal child did not have a Medicare card with them! (GP, remote NT)

It’s coming to the stage that the doctors are refusing to see them. It’s getting beyond a joke when you’re not getting paid. (mainstream practice manager, urban Qld)

Patients at this practice were generally referred to casualty, though were attended to if the matter was urgent. One ACCHS had a policy whereby patients who were not enrolled had to pay for the consultation, though they waived this rule for sick children.

A number of ACCHSs and bulk-billing service providers commented that staff were too busy to chase up Medicare numbers as it diverted them from their primary service role. Also, as staff are often occupied at the time of consultation, they might leave the number-chasing until a later time. Some collect enquiries and try to sort them out altogether once or twice a week. A consequence of this is that if the patient’s details are incorrect, the patient is no longer there to check details. This is a particular problem in areas with high levels of transience and where many people are not on the telephone - in such cases service providers write off the claim.

We tend to miss out rather than the patients, ie the patients get their service and we have to try and find a number etc. (GP, rural NSW)

I have seen some patients on holidays who have no card/money. I generally haven’t chased these if relatives of my regular families. (GP, rural Qld)

Recommendations

18. The HIC should investigate what changes are necessary to enable aliases to be recorded on Medicare files when a person enrolls and in response to subsequent enquiries, by or on behalf of, the consumer.

19. The HIC needs to develop special guidelines relating to enquiries which accommodate the cultural characteristics of Aboriginal and Torres Strait Islander peoples and provide appropriate training for Hotline staff.

20. Alternatively, a special Hotline number could be established to deal exclusively with enquiries for and by Aboriginal and Torres Strait Islander clients. Staff receiving the calls would know that greater flexibility was required and special conditions might prevail (eg the use of alternative names, the inability to determine date of birth).

21. The HIC should appoint an Indigenous officer to manage the issues surrounding the Hotline at a national level and to coordinate with staff at State and local levels.

4.3 REJECTED CLAIMS AND NON-CLAIMS

Health care providers reported that rejected claims resulted either from clerical errors or because particular details of the claim were incorrect or missing. Many non- ACCHS health care providers said clerical errors accounted for the majority of their rejected claims. However more of the ACCHSs reported incorrect details and/or expired cards as the reasons for claim rejections.

The proportion of rejected claims varied enormously. One ACCHS in a stable, non-transient, remote community reported losing about 1% of claims. Two ACCHSs in rural areas with significant remote catchments reported 2-3% of claims were rejected. To provide some basis for

comparison, a large (mainstream) 24-hours, bulk-billing medical centre in an urban area claimed a 10% rejection rate, mainly due to incorrect Medicare numbers.

A specialist servicing very remote Indigenous communities where Medicare is not used for primary care reported that 25% of his claims are rejected. One pathology lab servicing a number of remote communities reported 25% of samples are not accompanied by a Medicare number and a further 25% for which Medicare numbers exist are rejected because the details are incorrect. The ACCHSs described the lack of current Medicare numbers as leading to the situation where:

They usually get to see the doctor, but we lose the revenue. We follow it up, but over \$30,000 was lost one year, despite chasing it up. (ACCHS, rural NSW)

The tendency is to 'write off' amounts owing from such unenrolled people who are bulk-billed. This is not satisfactory as our service operates on a shoestring and we can't afford to forgo the revenue. Continuing care of common and serious Aboriginal health problems is very problematic as things stand. (GP, urban SA)

It is important to note that a number of health services did not have as high a rejection rate as they might have done because they had predicted that certain claims would not be processed and so had not lodged them. Also, the majority of ACCHSs had kept at least a few claims (and sometimes many more) 'in the drawer' awaiting Medicare numbers, but had to throw them out because the six-month time limit on claim lodgement had passed.

Aside from clerical errors (eg typographical errors, the dollar amount of the consultation not inserted, the date not entered, the particular family member seen not indicated on the claim form) the main reasons for claim rejection were as follows.

- *The Medicare number was incorrect.* This may have occurred because:
 - the number was entered incorrectly;
 - the card had expired;

- the patient had received a replacement card, but had shown an old, now invalid card;

- the health service kept the Medicare number on file, but the patient had received/applied for a new number, thereby invalidating the old number.

- *The patient had not signed the assignment form.* Often health services are very busy and doctors and administrative staff sometimes forget to make sure the patient signs the assignment form. One ACCHS said they had two entrances with the result that a patient could easily leave without signing the form. Another problem in areas of low literacy was that a number of patients could not sign their names. Several ACCHSs said that a cross ('X'), which is all many people who can't write are able to manage, is not accepted by Medicare (though they say the Department of Social Security and the banks do accept this). One ACCHS said they get around this by having the reception staff write the patient's name below the mark. One Medicare administrator stated that a cross was acceptable, but service providers in that State described such claims as having been rejected, pending the signature of a doctor confirming the legitimacy of the cross.

- *The patient's name did not match the Medicare number.* Sometimes a different name was used (as discussed earlier) or a different spelling was used. One ACCHS reported claims being sent back because Medicare *believed* the name was misspelt, when in fact it was the correct spelling of an Aboriginal name. It needs to be remembered that a doctor or receptionist's spelling of a traditional name was generally based on phonetics, which often resulted in a variety of spellings.

A major complaint by health services was the time and expense involved in chasing up Medicare numbers after claims have been rejected. Many didn't bother and frequently wrote off the claim as an unrecoverable debt.

If it's easy and we have the time to look up the details we will, but a lot of times we

just tear them up and put them in the bin.
(ACCHS, rural SA)

4.4 TIME LIMIT ON CLAIMS

Bulk-billed Medicare claims must be lodged within six months of the time of consultation before they become void. Under certain circumstances (eg compensation cases, hardship cases) the Minister may waive the time limit.

A number of ACCHSs and some other service providers said the time limit was a problem, particularly where there was high proportion of transient patients or patients from areas remote to the clinic. Often health service staff found that the details provided by the patient were incorrect or different to those held by Medicare, or the claim was rejected, by which time the patient had left the area. Difficulties were also experienced with patients who were not on the telephone and/or who lived in a remote area some distance from the clinic. The only option in such cases was to wait until the patient presented at the clinic again, and there was no guarantee that this would happen within six months.

In contrast one rural NSW ACCHS described Medicare as *'pretty understanding'*, saying they accept claims past the six month period if a reason is given (eg patients can't read or write). Other GPs complained this had not worked:

Medicare not paying because it's more than 6 months since service and when Medicare office is contacted in writing to explain reasons why, Medicare has not responded. (GP, rural WA)

To some extent, implementation of previous recommendations should reduce the need to seek permission to lodge late claims. This, however, cannot be guaranteed, and therefore special circumstances provisions need to be retained.

4.5 LIMITS ON ADMINISTRATIVE EXPERTISE AND TIME

ACCHSs frequently complained of the extensive staff demands of administering Medicare. As well,

services - particularly those located outside urban centres - had difficulties attracting and holding skilled administrative staff who understand the Medicare system. Turnover of staff necessitates frequent retraining, the resources and the skills for which are limited. Several ACCHSs said they needed an extra worker to administer Medicare. Indeed, some ACCHSs have employed someone, full or part time, specifically to sort out problems with Medicare. It was reported that where Medicare had sent staff to Aboriginal communities, it was generally only for a few days, and needed to be ongoing/repeated.

The extent of staff knowledge about claimable items affects the amount services can successfully claim from Medicare. Remote services tend to attract a relatively high proportion of foreign doctors with temporary registration and recent graduates, both of whom usually have little or no experience of Medicare and often do not know how to maximise their claims.

Reception staff often have to spend a great deal of time chasing Medicare numbers before they can lodge claims, and after claims have been rejected. Some ACCHS staff commented that by default the task of chasing up Medicare numbers had fallen to them:

Because of the general disempowerment of Indigenous people, many regard this and other bureaucracies as the business of the clinic staff and so take no responsibility for looking after their cards - and very many lead such disorganised lives that it would be impossible for them to do. (ACCHS, urban NT)

4.6 NON-CLAIMABLE WORK

The fact that nurses and health workers at ACCHSs cannot claim for any of the work they do was raised as a problem by a lot of people, including medical practitioners. At all busy ACCHSs, whether in urban, rural or remote locations, nurses and Aboriginal Health Workers see a significant proportion, and often the majority, of patients. They tend to adopt a screening role, treating those patients they can (eg for dressings,

injuries, cuts, stitches etc) and referring patients to the doctor when necessary. In some rural and remote areas there is no full time doctor and the nurses/Health Workers see almost all patients. Nurses and in some cases Health Workers often have a role in diagnosing and treating illness as well as supplying medication.

We do a lot of the work that doctors do. Health Workers do a lot independently of the doctors and involve the doctor just at the end to get the Medicare form signed. It undermines the authority of the health workers in some ways. The doctor just looks at the notes. The Aboriginal Health Worker does the same work. It's ironic that as they get more skilled, we get less money for them (because they don't need the assistance of the doctor). (ACCHS, remote NT)

We had 15,000 patient contacts last year, where the Aboriginal Health Worker identified the treatment required and dispensed the drugs. Doctors are limited. Health Workers do a doctor's job, but can't claim anything for it. (ACCHS, rural/remote WA)

There's a need for people to be serviced by people from their own culture, not just because of cultural awareness, but they need to do more skilled jobs for the self esteem of the community. It's important to have Aboriginal Health Workers and this applies in urban settings as well as remote. The fact that a doctor can bulk-bill adds kudos to that work, it recognises the value of that work. They need to develop respect for their own workers, rather than everything being seen as doctor driven, because only the doctor can claim. (ACCHS, urban Qld)

There's enough work for two doctors, but we only have one, so the work goes to the nurse and the Aboriginal Health Workers. We can't get through the clients otherwise. Also, it has come up that we have a male doctor and Murri women like to address women's problems with women, so they

prefer to see the health worker. (ACCHS, rural Qld)

A number of ACCHS doctors also complained that a lot of the work *they* do does not attract a Medicare rebate. This work includes training of Health Workers, telephone consultations, making specialist appointments, developing public health programs, consulting with specialists and other staff members, sorting out problems which might arise at hospitals, community education and generally maintaining a presence in the community. This was particularly of concern to ACCHSs which rely on Medicare rebates to pay the salaries of doctors (which all up, can cost in the order of \$195,000 a year).

One doctor interviewed was concerned that the fee-for-service system could result in a drift away from the community health model to a straight clinical model, with emphasis on maximising consultations which attract a rebate under Medicare. Across all the ACCHSs there was little or no evidence that this was happening. Numerous ACCHSs pointed out that it was *impossible* to operate a health care service offering the services that Aboriginal and Torres Strait Islander people required on the basis of Medicare rebates alone. All regarded the grant and program funds they received as essential in running a viable health care service that did not require them to cut corners (eg rely on short consultations and turnover).

Some ACCHS staff, including GPs, commented on the relation of bulk-billing to services provided - for example, the fact that salaried doctors have no immediate incentive to ensure claims are made for all services covered by Medicare. A doctor newly coming into one metropolitan ACCHS pointed out that the service could have long billed for a number of commonly provided services. Conversely, a number of GPs expressed some sense of guilt that they weren't carrying out more billable work although none of them indicated that pressure was ever exerted on them to see more patients, limit length of consultations etc.

Recommendation

22. The Department of Health and Family Services should explore mechanisms which might compensate for the clinical work carried out by Aboriginal Health Workers. This might be by introducing the concept of provider numbers for these workers or introducing particular fees for items of service carried out by an Health Worker under the provider number of a doctor.

4.7 LEVEL OF REBATES

Several service providers reported that the Medicare rebate schedule did not adequately provide for the longer consultations which are fairly consistently needed with Aboriginal patients. Some urban ACCHSs see a number of people from rural and remote areas, who may come to the city once or twice a year and come to the doctor with a 'shopping list' of health problems. Some patients are seriously ill at first presentation, and screening for early detection of common problems like diabetes is time-consuming (though justified by the high level of detection of previously unidentified conditions when an initial consultation is carried out at an ACCHS with a patient previously seen only in a mainstream practice). Because ACCHSs generally try to be holistic in their approach to medicine, medical staff often spend longer counselling patients and coordinating their ongoing treatment.

You'd go hungry in a private practice doing Aboriginal health. They often have multiple problems, social problems and you need to liaise with other services and the hospital and there's prevention time. Medicare is not suited to this style of practice. We give holistic care and they are not always seen by a doctor so we can't claim, therefore we need grants. We can't rely on a Medicare income. (ACCHS, urban Qld)

Some doctors reported family consultations as a problem:

Sometimes they come with the whole family with only one appointment and they all see the doctor, but it's difficult to make three or four claims for the mother and three kids. (ACCHS, rural NSW)

In some areas language is a factor which results in longer consultation times; it can also mean that an Aboriginal Health Worker is needed to translate, thereby making the consultation highly labour-intensive.

Sometimes I'd have to seek permission to touch or do something to the patient from the family, who might all be there... especially with children. (GP, remote NT)

This was reported also by non-ACCHS doctors:

At present a GP bulk-billing can earn \$20.85 for a six to ten minute consultation. Most Aboriginal patients take at least half an hour, as they have so many problems. For all this work, the GP can only earn \$37.65... To make matters worse, GPs are 'counselled' by HIC officials if they have too many long consultations. (GP, urban SA)

Other doctors also reported they felt uneasy about spending longer with patients because they were concerned about being investigated by the HIC for overservicing.

It was suggested by some that remote-based Medicare rebates needed to be revised so that they realistically reflect the higher costs of isolation, due to factors such as travelling long distances, higher costs of consumables, freight, the building of accommodation and the higher costs associated with providing health care to Aboriginal people. In addition, the differential rebate (with the gap growing larger) for non-vocationally registered doctors was felt by some ACCHSs to disadvantage remote services because such services tended to attract these doctors (who had more limited choices available to them). As a result, services in remote areas, where costs are higher and health problems often more complicated will always be disadvantaged by a standard Medicare rebate system.

Recommendations

23. The Department of Health and Family Services should examine the feasibility of expanding the current fee schedule to remunerate for consultations longer than the current maximum of 40 minutes (eg one hour plus). If need be, this could target Aboriginal and Torres Strait Islander peoples and their service providers.

24. The HIC needs to recognise the importance of longer consultations with many Aboriginal and Torres Strait Islander people and doctors working in salaried positions in ACCHSs need to be reassured that if they bill for a greater than average proportion of long visits that this will not automatically place them under suspicion.

25. The Department of Health and Family Services should examine the possibility of a schedule of fees that offers a higher rebate for services delivered in remote areas.

4.8 PAYMENT FOR SPECIALIST MEDICAL SERVICES

Any difficulties that ACCHSs have in utilising the Medicare system can be compounded when their patients require specialist medical care, pathology tests etc, depending on the way in which the secondary health care system is organised. In some circumstances - remote Western Australia for example - specialist care is provided almost totally by the State, on a non-fee basis. In these circumstances an ACCHS can readily refer a patient on to a specialist, the problem being one of availability of the specialist rather than the cost.

In other circumstances, and certainly in most urban settings, much specialist care is available on a fee-for-service basis although 'free' care is also provided through public hospitals. Increasingly, however, numerous State-administered hospitals are seeking to privatise specialist care and services - establishing private clinics and private practitioners within the hospital environment. ACCHSs in these situations develop networks of

specialists and services which either bulk-bill or are provided, under the public health system, at no direct cost to the patient. Needless to say, the pool of specialists and services used is generally in flux - partly because of changes in relation to their fee/non-fee structures but also because of specialists' availability. A number of ACCHSs commented on the long delays to see a specialist in the public health system so that often there was a trade-off between timely service and financial cost.

There is an urgency with Aboriginal health. You need to deal with the patient here and now, because they may not be around next week... you can't wait for waiting lists to diminish. (ACCHS, urban NSW)

A number of health care providers, particularly in urban areas, reported that it is becoming increasingly difficult to find bulk-billing specialists.

The local X-ray service (there is only one... and they also service the hospital) is threatening to only bulk-bill people with current Health Care Cards. This would effectively render X-ray (and ultrasound) services inaccessible to half of our patients. Moves like this based on gross misunderstanding of Indigenous people and their health needs are all too common. (ACCHS, urban NT)

Specialists who do not bulk-bill require either a full payment upfront (a portion of which may be claimed from Medicare by the patient after the bill has been paid) or a payment equivalent to the difference between the practitioner's fee and the Medicare rebate (often called a 'gap payment'). It was widely reported that an inability to pay the 'gap' or the full cost was an impediment to Aboriginal and Torres Strait Islander patients receiving secondary care. Sometimes the ACCHS meets the cost of these services.

One ear specialist wanted \$87 for a consultation up front. The person needed urgent treatment, but they were not attended to. It happens regularly. People don't keep their appointments. They are afraid and embarrassed because they have no money. (ACCHS, rural NSW)

One woman needed \$80 to have a brain scan and she had to save up for it. (ACCHS, rural NSW)

People need Medicare numbers to get pathology tests done. They do accept a photocopy of their enrolment form, but radiology is less accommodating. We can't get a rapid number. There is two weeks wait. To see a radiologist through casualty means six hours wait. Occasionally the AMS pays for radiology, but there is no form to claim it back. We only have them briefly. We can't get them back to sign. (ACCHS, urban Qld)

In rural and remote areas, where a patient has to travel to a larger centre for specialist care, the financial barriers are almost immediately greater.

If they have to stay more than one or two days and have to pay for accommodation it's a problem for them to see a specialist. If they've got no money, it's a shame job and they may not go. (ACCHS, rural/remote SA)

Specialists who are willing to charge only the standard fee/bulk-bill generally appear to be motivated by a desire to be of service to Indigenous people, as long as they can continue to draw a reasonable income. For example, one ophthalmologist who has serviced remote communities in Queensland for over a decade says he is only able to do so because of the special arrangements, minimising overheads, which he has negotiated with local hospitals and clinics. He felt that as long as income generated from community visits continues to be low, few specialists will undertake the work: *'You'll never make a fortune out of it. You may only see ten patients in a day'*.

A higher rebate for services performed in remote areas (as set out in Recommendation 25) could encourage more specialists to service remote Aboriginal and Torres Strait Islander communities.

Recommendation

26.A component to cover the cost of specialist 'gap' payments needs to be recognised by the Department of Health and Family Services in relation to grant funding to ACCHSs. It would allow ACCHS doctors to refer patients when absolutely necessary to non bulk-billing specialists. An ACCHS could, for example, negotiate a price for a particular service and organise treatment in a private hospital, if necessary, as has been done in certain areas.

4.9 USAGE OF ACCHSs

Interest was expressed, at the outset of this study, in any information that could be gathered to help in understanding the place of ACCHSs within Aboriginal communities. It is important to have an understanding of ACCHS usage when addressing issues and problems relating to Medicare. To reiterate, information was sought on what role convenience and access played in their usage; where alternative services existed to the ACCHSs which were used and why; and what role choice and preference played in their usage. A further question arose in the course of the research which related to the extent to which the ACCHSs were used by non-Indigenous people and their reasons for doing so. A systematic survey approach would be essential to providing definitive answers to these questions, but this current research can throw some light on how and why people use ACCHSs¹. Various factors which appear to impact on usage are discussed here.

¹ The National Aboriginal and Torres Strait Islander Survey (NATSIS), conducted by the Australian Bureau of Statistics reported on the *Health of Indigenous Australians* in 1996. In this report, information was provided about people's access to a range of services, including Aboriginal Medical Services. The results indicated that about one-third of Indigenous people (32.6%) reside within 10

Cost of Service

The fact that ACCHSs provide health care to patients at no cost to them (whether through bulk-billing or through grant funding) is essential in their usage. In areas where other 'free' primary health care is available (eg hospital accident and emergency departments, other bulk-billing medical practices) some community people are quite likely to use alternative services - either exclusively or in addition.

There is some evidence that, where alternative services exist, ACCHSs are seen as serving a more 'welfare' role to the community. Certainly it was clear that some people used an ACCHS because they knew they could do so without having a Medicare card, unlike at other bulk-billing services.

A number of ACCHSs (particularly some urban services) commented that where alternative bulk-billing services were available, these services were likely to attract some Aboriginal people who were employed/better off.

Working people can manage to use the other services. Educated blacks wouldn't come here. They'd be shamed, especially if they had a white partner. (ACCHS, rural Qld)

Where certain services were provided free by ACCHSs which were not otherwise available at no cost - most particularly dental care - then the ACCHSs would also attract 'better-off' Aboriginal patients for these specialist services. Of course, in rural/remote areas where an ACCHS may be the only service available it would, by definition, be serving the entire community. No evidence of the 'factionalism' that sometimes is a factor in relation to the use of management of other Indigenous community services was observed.

km of an AMS - and this ranges from 18% in Tasmania to 57% in South Australia. However, while questions were asked in the survey about actual usage of - not simply distance to - the nearest Aboriginal Medical Services, the ABS statisticians are not comfortable that the usage data are reliable.

While these observations are only tentative it does suggest that some or most ACCHSs might be servicing the more disadvantaged sectors of their communities which means that their role in assisting people to access to Medicare and PBS becomes even more critical.

Cultural Environment

Clearly, ACCHSs everywhere provided an environment that was immediately inviting and comfortable for the Aboriginal and Torres Strait Islander patients they served. The fact that, oftentimes, key medical staff were not Indigenous did not appear to alter the sense of 'ownership' of the service by the Aboriginal and/or Torres Strait Islander community. With traditional communities, staff at the ACCHSs are more likely to speak the local language or be able to arrange interpreting services.

Many ACCHSs also provide a social atmosphere that appeals to clients. In some communities the ACCHS acts as the community centre, where one can always go for a bit of a chat. Some ACCHSs attempt to use this social atmosphere as something of a magnet to attract potentially isolated people (eg young single mothers).

Conversely, many Indigenous people experience and/or expect to meet with racist, intimidating attitudes from mainstream service- providers and so avoid them. Negative and racist attitudes were sometimes revealed in consultations for this study with non-Indigenous services.

Confidentiality

The community 'ownership' of the ACCHS, can be a double-edged sword, in that some community members expressed some reservations about potential breaches of confidentiality within a service where everyone knows everyone else. One urban ACCHS, for example, has a practice of holding all Medicare information on a form attached to the outside of the patient's files, to reduce opportunities for breaches of confidentiality. However it is the perception of patients that counts, in the end.

Preferences for Practitioners

In some instances, the doctor-patient relationship was a determining factor in people's choice of facility where a choice existed. This could work as either an aversion or affinity - with a negative experience driving a patient to another facility or a good relationship keeping a patient using a particular facility or following the doctor if s/he moved. Linked to this is the effect that an experience with one service or another can have on a patient and, subsequently, others within his/her sphere of influence. For example, in some communities, the death of someone - say in hospital - can lead others to avoid using the facility. A situation was also described, where an Aboriginal Health Worker might be subjected to 'pay back' if s/he were unsuccessful at treating a patient.

Reputation

There is an indication that the reputation of an ACCHS as providing good, professional health care, with a high standard of equipment etc has an influence on some users. If an ACCHS is seen to offer the 'best' care - either directly or through its network of specialists, then an ACCHS can attract some patients they might not otherwise attract.

Accessibility to Services

The ACCHSs differ in their hours of operation - some working a five-day, business hours operation, others holding clinics in the evenings and weekends. Where hospitals exist locally, they generally operate on a seven day, 24 hour basis and this can be a determinant of what service a person will use on any one occasion. Sometimes it is the assurance that a patient will be seen, the existence of appointments or an appointment-free service etc that also determine a patient's preference.

Certainly, physical accessibility plays a role in usage of services and, frequently, this means access by public transport. Thus an ACCHS need

not be close to a person's place of residence if it can be reasonably accessed by public transport. Clearly the clinic transport provided by many ACCHSs was also a factor in making the service available and attractive to people. The issue of accessibility also relates to intra-State transport as well - ACCHSs centrally located in a capital city could very well draw on the entire State for its clientele.

Access to Free Medication

There is evidence that one of the attractions of some ACCHSs is the fact that they will dispense medication directly, at no cost, and also other 'health' supplies (eg dressings, skin creams).

Range of Services Offered

The sizes of ACCHSs differ enormously as does the range of services they offer. At the smallest end, an ACCHS might operate a few days a week with a part-time doctor or, in some instances, with no doctor. At the other end of the spectrum extremely large urban ACCHSs provide a wide array of clinical and community health services and programs and a range of other social welfare services as well (eg social workers, housing officers).

In Perth, for example, clients might come to the AMS centre to seek assistance with a housing problem - in the course of which it becomes apparent that a medical report is needed by the housing authority. These people are then referred on to a medical practitioner at the AMS. (It has also been found that people presenting with a housing problem can actually be sicker than those presenting with a health problem and so they are seen immediately as well.)

Clientele of ACCHSs

Most ACCHSs ostensibly have a policy of providing services to anyone in the community - whether Indigenous or not. Basically all ACCHSs include, in their clientele, non-Indigenous people who are married to, or otherwise related to an Aboriginal or Torres Strait Islander person.

In most instances, the very great majority of ACCHS patients are Aboriginal or Torres Strait Islander - often 85-95%. In a few selected situations, a considerable proportion of patients are non-Indigenous - one ACCHS in rural South Australia 'guesstimated' that as many as 25-40% of their clients were non-Indigenous. They attributed this to a lack of options if the only GP in town is fully booked and also because this GP does not bulk-bill, while the ACCHS does.

In certain tourist areas, ACCHSs are likely to attract more visitors - a good proportion of whom will not be Aboriginal or Torres Strait Islander.

4.10 THE ROLE OF ACCHSs IN OVERCOMING BARRIERS LIMITING ACCESS TO MEDICARE

The research clearly shows that, as Australian citizens, a great proportion of Aboriginal and Torres Strait Islander people are not accessing the Medicare benefits to which they, by right, should have access. It is only through the efforts of the ACCHSs, where they exist, and selected other service-providers that many Aboriginal and Torres Strait Islander people are able to make use of the Medicare system at all. It is a matter of conjecture what this means for Aboriginal and Torres Strait Islander communities where ACCHSs or their equivalent do not exist. Across the localities included in the research it was consistently reported that Aboriginal and Torres Strait Islander people under-utilise health services - that they use them too little and too late. A considerable proportion of the work of the ACCHSs is spent actively working to engage their communities in health-supporting activities and practices. In these circumstances any additional impediments imposed by barriers around *payment* for health services can literally be fatal. Thus, to the degree possible, the ACCHSs endeavour to make Medicare work for their patients. Without the efforts of ACCHSs Medicare would fail Aboriginal and Torres Strait Islander peoples.

This raised, for many people working in the field of Aboriginal and Torres Strait health care, a fundamental question as to what level of intervention is appropriate. Generally health workers sought to act for their patients to

overcome any barriers faced in accessing health care. Thus they often take on the responsibility of organising enrolment in Medicare, the provision of appropriate forms of identification, 'brokering' between the patient and Medicare, DSS, specialists etc, conducting outreach programs which fairly aggressively require patient involvement, providing transport, meeting financial costs directly etc. However numerous workers expressed a concern that they might be fostering a dependency in their patients - they are constantly assessing the appropriate balance between overcoming barriers *for* their patients and working to enable their patients to do so for themselves. More often than not it was Aboriginal workers that expressed this concern. In part, this was a reaction to an apprehension that a 'welfare mentality' would be fostered and/or that this left Indigenous people politically exposed. Thus there was some anxiety that resources for such services as ACCHSs, might suddenly be cut off - leaving Aboriginal and Torres Strait Islander communities adrift.

However, as one medical practitioner at an ACCHS stated:

There are many skills that Aboriginal people require to deal with the alien society imposed on them, however depriving people of access to necessary health care when they are ill would not seem to be a sensible way to improve these skills for those who do not have them. If they survive the illness it might teach someone a lesson, the question is what would the lesson be and who would learn it ...

As the research indicates, the level of difficulty Aboriginal and Torres Strait Islander peoples have accessing (and services have 'managing') Medicare differs significantly from one location to another. There is no simple or readily understood pattern to explain why this occurs, undoubtedly because a broad range of factors seemed to influence accessibility, differentially. These are identified below.

- *Period of time using Medicare* - those services which have been bulk-billing for many years are obviously more likely to have worked the system

out, to have higher levels of enrolment in their community etc.

■ *Prevalence of Medicare amongst the wider range of health services* - if other GPs in the community bulk-bill, and secondary health care providers use Medicare, it is more likely that the community members will be enrolled, have access to their Medicare cards/numbers etc.

■ *Degree of urbanisation of the Aboriginal and Torres Strait Islander community* - community members who are accustomed to bureaucratic systems, to form-filling, who have established personal identification etc are clearly going to be better equipped to access Medicare.

■ *Stable, 'closed' communities* - where the makeup of a community is fairly static, with relatively few transients coming and going, the ability of service providers to manage Medicare for their patients is greater.

■ *Cooperative Medicare staff* - reflected in both policy-level 'special arrangements' such as the *Proof of Identify Form* and in the level of cooperation at a personal level (eg counter staff, Hotline operators) can make an enormous difference in increasing people's access to Medicare.

■ *Level of general education, use of English, level of employment etc amongst the community* - the existence of these personal resources certainly makes it easier for people to access Medicare.

■ *Level of non-traditional cultural practices* - the degree to which community members have adopted 'European' ways (eg limited name changes/aliases) clearly makes access to a 'European' system like Medicare easier.

■ *Standards of administrative support* - when a health service has well developed training and administrative procedures etc and relatively little turnover of experienced staff, Medicare, of course, works more smoothly for its patients.

■ *Use of computer technology* - services which have adopted fairly sophisticated computer systems to help manage their services are far better able to monitor, track and access information on its clients, thus eliminating some of the barriers to Medicare.

■ *Direct assistance from Medicare* - those communities that have had Medicare staff visit and actually enrol people, clear files, explain procedures and train staff have benefited a great deal in getting the system operating well and thus becoming more accessible.

■ *Immediate physical access to a Medicare (and DSS) office* - being able to direct a patient to an office within easy walking distance appears to reduce some of the problems of enrolling, getting a number etc.

Any prior assumption that a simple urban - remote dimension would explain the existence of barriers in accessing Medicare proves too simple. Moreover, it is the interaction of these various factors, operating in various permutations, that results in this complex picture.

None of the barriers described in this report as operating in Aboriginal and Torres Strait Islander communities is necessarily unique to these communities. However it is the multiplicity and compounding impact of these factors operating together on Indigenous people that is unique.

5.0 ISSUES RELATING TO THE PHARMACEUTICAL BENEFITS SCHEME (PBS)

This stream of the research examined, as required by the study brief, the participation of Aboriginal and Torres Strait Islander peoples in accessing medicine subsidies to which they are entitled through the PBS, the attitudes/perceptions of ACCHSs and pharmacists around Aboriginal and Torres Strait Islander peoples' access to PBS, the usage and retention of concession cards by Aboriginal and Torres Strait Islander people and the current range of strategies employed to overcome PBS concessional benefit delivery problems where an eligible person's entitlement number is unknown. In addition, some understanding of whether the system works to provide medicines in a timely way was also sought.

Again, the sources of information drawn on included the fieldwork telephone interviews with ACCHS and other service-providers and the survey data - especially those conducted with pharmacists. In some ways the patterns emerging in relation to PBS were rather clearer than those relating to Medicare probably because the problems were more universally apparent and the 'corrective' strategies less diverse.

5.1 INTRODUCTION

Concession entitlement cards are issued by the Department of Social Security (DSS) and the Department of Veterans' Affairs to eligible persons. DSS issues two types of entitlement card. A Pensioner Concession Card is issued to all pensioners and people over the age of 60 who have been in receipt of another DSS benefit for more than nine months and is valid for the year printed on the front of the card. A Health Care Card is issued to a range of benefit recipients and low income earners and is issued on a three-monthly or six-monthly basis, depending on the type of benefit received. Dependants may be included on a Health Care Card or may be added after sufficient proof of identity has been shown.

Entitlement card holders are able to purchase PBS medication at a concession rate of \$3.20, as opposed to the full rate of \$20.00. The patient copayment is intended in the first place to retrieve some of the costs of providing subsidised medicine, and secondly to act as a price signal to prevent people obtaining unwarranted medications.

5.2 ACCESSING ENTITLEMENT NUMBERS

In order to receive concession-priced medication, clients are required to produce their entitlement card at the time of dispensing to confirm their entitlement and to check it is within the prescribed dates. It is the responsibility of the client to produce this evidence. This number must be recorded on the prescription form. Prescriptions sent to the HIC without an entitlement number are invariably rejected. In practice, a pharmacist will often have the entitlement number on computer for a client who is known to them and may write the entitlement number on the prescription. However, the pharmacist relies on the client who is not known to him/her being able to produce a valid entitlement card.

Across various regions, it was estimated that between 60 - 100% of local Aboriginal and Torres Strait Islander people were in receipt of a benefit of one kind or another and were eligible for entitlement cards. (It is also noted that some people will be beneficiaries for life.) Receipt of benefits among Aboriginal and Torres Strait Islander people in a number of *remote* areas was close to 100%. Most ACCHS patients and the patients of GPs operating in rural/ remote settings, were generally eligible for entitlement cards. Many health services in larger rural and urban locations said that a significant number of their Aboriginal and Torres Strait Islander patients were employed and so the entitlement number issue was less of a problem. The overwhelming majority of benefits for Aboriginal and Torres Strait Islander patients/clients were paid by DSS - usually Aged Pensions, unemployment allowances and family payments. Benefits paid by the Department of Veterans' Affairs were not reported in the fieldwork.

The difficulties associated with acquiring clients' correct entitlement numbers was one of the biggest problems associated with the PBS, as consistently reported by pharmacists and other service providers. They generally reported that the problem existed also with non-Indigenous clients, but most said it occurred more frequently with their Indigenous clients. Where an Aboriginal or a Torres Strait Islander patient was unable to provide an entitlement number, one or more of the following courses of action would take place:

- The pharmacist would telephone the ACCHS or prescribing doctor for a number. Often this was successful - *'There's a reasonable chance you can get the number'* (ACCHS, rural SA) - although some ACCHSs reported it was a strain on administrative resources. Often the number held by the ACCHS on file was incorrect or out of date, resulting in rejection of that prescription by the HIC. This is a particularly difficult problem to resolve with postal orders, as it is difficult to chase the matter up when the client lives some distance away.

It usually ends up being a lot of phone calls. (ACCHS, rural SA)

- The pharmacist would ask the client to telephone DSS to get the entitlement number. Privacy provisions do not allow third parties to obtain entitlement numbers and the DSS officer must speak to the client personally. However, nearly every pharmacist/ service provider surveyed reported that waits in excess of an hour can occur when calling DSS, a wait few pharmacists or clients are willing to tolerate.

It was also reported that many Aboriginal and Torres Strait Islander people, particularly those who are illiterate, do not know how to use the 'Q Management System' (which requires callers to follow a series of recorded prompts), and would not telephone DSS themselves for that reason, or were very shy about using the telephone and divulging private information to a stranger.

- The pharmacist would 'threaten' to charge full price unless the client found his/her concession card. One service provider said that patients often found their cards as a result.

- The pharmacist would dispense the medication at full price (\$20) and tell the client they could get a refund if they returned with their entitlement number. Generally pharmacists who did this gave the client several weeks to return before submitting the claim. *'They usually come back a while later with the card'* (dispensing GP, remote SA). Often, however, clients do not purchase the medicine in this situation.

- The pharmacist would charge the full price for the medication and issue a receipt which could be taken to a Medicare Customer Service Centre for a rebate. *'I never give it at the concession rate without a number - no exceptions'* (Pharmacist, rural SA). Medicare Customer Service Officers reported Aboriginal and Torres Strait Islander clients very rarely applied for a rebate.

- If the client was well known to the pharmacist, and the goodwill was present, the medicine would be dispensed at the concession price, and the client would be asked to come back with his/her entitlement card or telephone with the number. One pharmacist in an urban area said clients usually do phone through with their numbers. Another in a major rural town had 15 to 20 scripts in his drawer pending entitlement numbers.

- Some pharmacists would give certain clients a few days worth of medication and tell them to come back to get the rest with their concession number. Often the clients did not come back after the 'starter' medication. This informal arrangement generally only occurred with a small number of Aboriginal and Torres Strait Islander patients.

- If there was a DSS office in town, the pharmacist would tell the client to go to the office to be issued an interim entitlement slip. This was reported to be successful in locations where the DSS office was nearby, but less successful where the chemist was located some distance away.

- Where an arrangement existed, the pharmacist would charge the full cost of the medication to a ACCHS account. This occurred frequently in some instances, but depended on the financial resources of the ACCHS. However, some ACCHSs had a policy of restricting the account to concession-priced medication only: one such ACCHS would 'lend' patients the money by placing

a full-priced medication on account, but asked them to pay the money back.

■ A few ACCHSs said they had a 'good relationship' with a local DSS office or DSS Aboriginal Liaison Officers, who gave them entitlement numbers over the phone. They were aware the practice was not legal and regretted they were forced to take such steps. *'If we didn't have that relationship, things would just fall apart'*.

Some ACCHSs and pharmacists said they felt the requirement of showing the entitlement card every time patients buy prescription drugs presents difficulties.

The need to sight documentation is onerous and places the pharmacist in the position of police person. If this requirement was to be relaxed our position would be so much easier. (Pharmacist, rural NSW)

You've got to present your card. The old pharmacy was good and used to keep the numbers on computer and they were not forced to insist on seeing the card every time. It was a ruling by DSS. It makes things very difficult. Things were easier when we just had the Medicare number and the pension number on file and they didn't have to produce it every time. This happened in the last couple of months. 80-90% of our patients would be eligible. We see a lot of older people and they have problems losing their Health Care Cards and the alcohol dependent and young mothers - their kids get into their purse. It's only cardboard, so if it goes through the wash... (Pharmacist, rural/remote WA)

Several pharmacists and community people commented that the current cardboard Health Care Cards were easily destroyed. They complained that the numbers could be easily washed or scratched off, and rapidly disintegrated until the numbers become illegible:

The 1997 cards seem to be very bad for washing off the relevant numbers. (remote Qld)

While patients were more likely to have all of their children listed appropriately on their Health Care Card than on their Medicare card, there were still some problems. For example, many children live with relatives other than their parents, in order to attend school or for some other reason. The name they are registered under and their precise date of birth may not be known to the relative looking after them.

Another problem was fluctuating eligibility. For example, a woman and her children might be eligible while living alone, but become ineligible when she enters into a de facto relationship.

Recommendations

27. The Department of Social Security, in consultation with the HIC, needs to address the privacy issue in order to enable pharmacists to access entitlement numbers at source. Clients would need to be made fully aware of what this meant, as there is a general suspicion about the use of private information and the option of refusing the release of the entitlement number should be given.

28. If direct access by pharmacists to entitlement numbers were achieved, the requirement that a concession card be sighted each time a client purchases PBS medication could be relaxed.

29. The Department of Social Security and the HIC need to develop an efficient mechanism for children in the care of someone other than the parents to be included on their guardian's entitlement.

5.3 ELIGIBLE PEOPLE WITHOUT ENTITLEMENT CARDS

While individual people may be eligible but not possess an entitlement card, there is at least one identifiable *group* of such people who appear to be at risk - CDEP participants.

The Community Development Employment Projects (CDEP) is the program whereby

Indigenous people agree to forego unemployment benefits in return for the opportunity to undertake paid employment for an Aboriginal and Torres Strait Islander community organisation for a wage equivalent to unemployment benefits. Some 30,000 Aboriginal and Torres Strait Islander peoples 'enjoy' the distinction of working for the dole.

The research found a great deal of confusion over the eligibility of CDEP participants to pharmaceutical entitlement (Health Care Cards). Some of this confusion was reflected in the difficulty encountered by the consultants in clarifying the matter. In a sense CDEP is anomalous: it is essentially 'working for the dole', (equivalent to a DSS benefit) but is a Department of Employment, Education, Training and Youth Affairs program, and is run by ATSIC. As low income earners, CDEP participants are eligible for a Health Care Card providing they pass a means test. Whereas unemployment benefit recipients automatically receive a Health Care Card, anyone moving into CDEP has to apply to DSS for the card. According to DSS, participants should receive a Health Care Card application when they register with a CDEP program. It was evident from the interviews conducted during this study that this frequently did not happen and that some CDEP coordinators were unaware of the conditions and procedures relating to Health Care Cards.

Major problem - CDEP Aboriginal people do not have a pension, therefore do not often have pensioner number to then get rebated medicines. I understand there is a form for CDEP holders to apply for a number, but I have never had access to these (kept in community office) and so often Aboriginal patients were expected to pay normal PBS rates if they wanted their prescription. (GP, formerly remote WA)

At best, only a portion of the CDEP participants in any of the communities which participated in the study had Health Care Cards although in some instances this could reflect the means test. Almost one-third of the members of one particular isolated community participated in CDEP programs, though it was reported that not **one** had a Health Care Card. As a consequence, inability to pay full-price

for medication was the biggest impediment to CDEP participants getting their medication in this community. A common perception was that CDEP participants automatically lost their entitlement to all concessions, although their real income may amount to less than the unemployment benefit.

Another group which generally did not have entitlement cards included people from remote areas where medication was supplied through the local hospital or ACCHS (in many cases free of charge). Problems arose when members of these communities travelled or moved to areas where medication is supplied through the PBS.

If the person has a Health Care Card, we can pay the \$3.20. If they don't, we're up for \$20. In the communities on the Cape, it's not necessary to have a Health Care Card, so when they don't have one, we foot the bill. It can take three to four weeks to get a card and they have to go in to Social Security. On the Cape there's work for the dole, so they're all entitled, but they have to apply for it, but there's no need on the Cape. Sometimes we can give them drugs from the imprest stock, but sometimes they need something we haven't got. If we're not sure that they have the money, it's far better for us to provide, otherwise they're embarrassed and just don't fill the script. (ACCHS, urban Qld)

Recommendation

30. As a matter of urgency, the Department of Social Security and ATSIC, in conjunction with the HIC and the Department of Health and Family Services, should ensure that a system is established in which CDEP participants automatically receive Health Care Cards unless they do not pass the means test (thus reversing the burden of proof) and also that much better information is continually provided to CDEP coordinators and participants.

5.4 BARRIERS RESULTING FROM PBS

COPAYMENTS

5.4.1 Inability to Afford Medication

The affordability of medicine was a major impediment, in every location, to Aboriginal and Torres Strait Islander people filling their prescriptions. It was consistently reported that many Aboriginal and Torres Strait Islander people with valid entitlement cards were unable to afford the copayment, while those without entitlement cards, or who for one reason or another were unable to produce one at the time of supply, were unable to manage the non-concessional payment. The point was also raised numerous times that the people who were not eligible for a concession were, in many instances, employed in low-paying jobs and were similarly unable to afford medication.

They tend not to have money available to pay for a script - that's common. (ACCHS, rural NSW)

Those who work and do not have a Health Care Card often have a struggle with \$20 prescriptions - especially if they have a few children... I think cheaper scripts should be available to all lower-income families. (GP, rural NSW)

Sometimes they don't have the \$3.20. They say they'll come back later, but they don't and next thing you hear the child is in hospital. The gap is too much. (Pharmacist, rural NSW)

The single most important factor in access to medication is not having the required \$3.20 at the time of dispensing. (Pharmacist, remote SA)

At first we carried a list of clients who couldn't pay, but 50% couldn't. Sometimes we let them run up a small account if a child was sick and would have to wait three-four days to get antibiotics. Most borrow the money, borrow from the health

workers or some wouldn't do anything (ie go without medication). (ACCHS, rural Qld)

They're supposed to go and get their scripts filled, but if a woman and her two kids all need antibiotics, then she can't afford \$3.20 each. It is a barrier. If it's very urgent, we use our account at the pharmacy and they owe us. Sometimes they pay it back and sometimes they don't... We lose about \$60-80 a month. (ACCHS, rural NSW)

Lack of money prevents access. They say 'I will get the antibiotics on pension day'. I first documented this in Bourke in 1972! (GP, urban WA)

A great many ACCHSs keep accounts with one or more local chemists for patients who cannot afford to buy their medication, generally attaching a sticker on approved scripts. However use of the account is limited by the funds budgeted by the ACCHS for medication and the policies of individual ACCHSs. Some ACCHSs agree to pay for *concession* priced medication only, while others regard it as an 'emergency fund'. A few ACCHSs run the account as a 'loan system': one ACCHS said it had the 'loaned' amount deducted from workers' and benefit recipients' cheques each fortnight. One consequence identified in relation to this 'loan system' is that some patients are deterred from returning to the ACCHS because of embarrassment over their debt. It was evident that a number of ACCHSs do not have the funds to provide for all those who need it. When it is difficult to find entitlement numbers, it was reported to cost ACCHSs up to \$1500 per month to maintain an account.

About half our patients are eligible (for entitlement cards), but we have to pay the \$3.20 top-up for some of them. We put a green sticker on the script and the pharmacist bills the AMS for the \$3.20. They have to give consideration to their extended family's needs first. Old people may be looking after their grandchildren, but they get no childcare money. Often they'll walk out if they have no money and

drop the script in the bin. Staff have often paid \$15 out of their own pockets to help someone get antibiotics. We have a licence to dispense, but we do it selectively, in emergencies. (ACCHS, rural SA)

In the past people didn't have to pay if they were on a Health Care Card. Now it's \$2.60 [sic], but if you can't afford it, you shouldn't have to pay. We can't send away everyone without the \$2.60 for a bottle of pills so they end up in hospital. (ACCHS, rural/remote WA)

Health care providers were particularly concerned about the health consequences of non-compliance due to inability to afford medication.

There was one woman who was schizophrenic and she needed a Modicate injection, but she said she had no money. 'I'll have to wait 'til next week', she said. But she needed it then and there. So I ended up phoning the pharmacy. (mainstream practice manager, rural SA)

Aboriginal patients often get very sick because they run out of medication and do not have the money to get the repeat prescription from the chemist. (GP, remote NSW)

It was reported a number of times that the copayment was unaffordable for people who required multiple scripts, such as the elderly, chronically ill and parents with a number of children.

If you're a single mum with eight kids and they've all got scabies or flu, you can't pay the gap for all of them. (ACCHS, rural Qld)

\$3.20 is too much. Older people often have three or four scripts to get. (ACCHS, rural/remote Vic)

Another frequently reported problem was that children are often not listed on their guardians' entitlement cards. It was often difficult for the guardian to afford \$20 for the child's medication. It was commonly reported that they would go without the medication, or in a few cases pharmacists

would 'bend the rules' by filling the script in the guardian's name. A similar problem was reported to occur when children went to boarding school (common in remote areas) and are often not given an entitlement card or number. In these cases, either the school pays the full cost of the medication or it is left up to the students to sort out, which invariably means they go without their medication. One pharmacist reported that students often have difficulty tracing the family's entitlement number through DSS because of name/ family changes.

The ability to fill scripts on personal credit is entirely at the pharmacist's discretion. The majority of pharmacists said that they would not allow inability to afford medication to prevent a sick child getting medication, though this was not generally the case with sick adults. Pharmacists might give credit to regular or 'trustworthy' clients: often this was a judgement they made on the spot. A couple of pharmacists said they *never* gave credit to people under 18 years old, and almost all did not give credit to clients who didn't pay their accounts. Some chemists have a strict 'no credit' policy. Those pharmacists who give personal credit invariably wind up absorbing the costs of any unpaid accounts. One rural pharmacist, for example, said he always gives credit for entitlement card holders and children, though he rarely receives the copayment. He estimated a loss of up to 20% of the revenue from PBS transactions with Aboriginal and Torres Strait Islander clients.

A few ACCHSs expressed concern over some patients exploiting the ACCHS's subsidy by always claiming they can't afford medication, but interviews with service providers and patients revealed many hardship cases. The low incomes of the majority of Aboriginal and Torres Strait Islander people usually mean that they are just able to meet their daily living expenses and do not have money left over to put aside for a time when they or their families get ill.

We tried to get people on pensions to put money in ahead [for medications], but it doesn't work. (ACCHS, rural/remote Vic)

There were numerous instances recounted, as well, of people delaying having a script filled until pension day, when money was available. As some health professionals stated:

The biggest problem with timely supply was the copayment as many prescriptions for antibiotics etc would be held for patients until Thursday when welfare money was received. (Pharmacist, rural Qld)

I may give antibiotics (script) to a child with a severe ear infection on a Monday and find they could not get it 'til the Thursday. (GP, rural NSW)

Sometimes prescriptions are not collected after being dispensed due to lack of money. Sometimes prescriptions for antibiotics are not presented for dispensing for some days after being written and then not collected for some more days. I particularly notice this phenomenon when small children are involved. (Pharmacist, rural NSW)

In remote areas, the situation is even more critical. Because living expenses are considerably higher than in urban areas (consumables can cost up to 400% more than they do in the city) family budgets are stretched to the limit. This is a major reason many health care providers feel the supply of medication without charge in a number of remote areas must be ongoing.

You couldn't get people to pay for medicines. It would be detrimental to their health and they wouldn't come to the clinic. (GP, formerly remote NT)

We pay the extra - otherwise they wouldn't take it. (ACCHS, remote NT)

A few pharmacists reported that some GPs in town do not appear to be aware of the cost effects of prescribing non-generic brands of medication; this was confirmed by some GPs themselves. It was reported that the higher cost is enough to deter a number of clients. It was felt that GPs needed to be made aware of this so they could take cost into account when prescribing. Similarly, it was reported that specialists in city hospitals often start

patients off on non-PBS medication which turn out to be very expensive. The result is many patients are not able to continue the medication once the hospital dose is finished.

Recommendations

31. If access to the PBS is to be achieved for Aboriginal and Torres Strait Islander people, adequate funding for ACCHSs, sufficient to cover PBS copayments, is required. The Department of Health and Family Services needs to identify a mechanism for facilitating this, either through PBS or via Department of Health and Family Services grants.

32. The Department of Health and Family Services, in consultation with the RACGP and the AMA, should explore means of raising awareness among general practitioners of the implications for Aboriginal and Torres Strait Islander people of their prescribing habits.

5.4.2 Attitudes of Pharmacy Staff

In the course of this research, the consultants met with a number of extremely dedicated pharmacists who demonstrated a high level of understanding of, and commitment to addressing health inequalities in Indigenous communities. There was also a significant number, however, who were considerably less understanding of the health issues which disproportionately disadvantage Aboriginal and Torres Strait Islander people, and, frankly, a level of racism that is alarming amongst professionals who are relied upon to provide health care to whole communities.

As far as we are aware there is no discrimination against Torres Strait Islander people or Aborigines regarding the PBS scheme. (GP, rural NSW)

I don't believe Aboriginal people are disadvantaged at all in obtaining medication on PBS. (Pharmacist, rural NSW)

They may be unwilling to pay but money doesn't seem to be the main problem. They seem to have enough for chips, Coca Cola and videos... Health care is not

a priority. Even their children's health doesn't seem to be a high priority. They'll pay for Serapax but 'can't afford' the antibiotic. (Pharmacist, rural Vic)

Everyone wants to be an Aboriginal. (Pharmacist, rural SA)

There is no problem for the access of medications for this group. The Department of Social Security notifications to social patients indicates the Pharmaceutical allowance of \$5.40 per fortnight, these people are not disadvantaged at all and should they find that a patient has no money for medicines the local Aboriginal Medical Service run an account with a local Pharmacy to allow such medicines to be charged to the Service ... 'double dipping'. (Pharmacist, rural NSW)

You could tattoo them. (Pharmacist, rural SA)

The inability to pay for medication is often a 'shame matter' for the people involved, whether they are dealing with an Indigenous health service or a mainstream service. This embarrassment could be used to deter people simply by the placement of a sign in, say, a pharmacy stating that no drugs would be dispensed unless they were paid for, as does occur. Similar experiences were encountered in the course of the Queensland study, *Aboriginal and Torres Strait Islander Ambulatory Care Reform Program, 1997*.

Probably the most visible barrier to accessing pharmaceutical services observed by the team was the existence in a number of rural and remote hospitals of a prominently displayed sign stating that if a person did not have any money then they wouldn't be supplied any medication. The team felt the signs deterred people without money from seeking treatment at all (p.40).

It would seem that education/awareness programs - perhaps as part of undergraduate training programs - are needed, particularly for those

pharmacists working in communities with Aboriginal and Torres Strait Islander populations.

Recommendation

33. The Department of Health and Family Services, the Pharmacy Guild of Australia and training institutions should examine the best means of making educational/awareness programs standard for all pharmacy undergraduates and for pharmacists working in communities with Aboriginal and Torres Strait Islander populations.

5.5 THE SAFETY NET

The PBS Safety Net is a financial protection which limits the amount an individual or a family need spend on pharmaceuticals and is described in Section 1.1 of this report.

While many pharmacists keep track of their clients' spending on PBS medicines, the responsibility lies with the client to record expenditure. Prescription Record Forms are available to keep track of spending if more than one chemist is used. Most pharmacists surveyed were able to tally regular customers' spending on computer, though one chemist reported her software was incapable of keeping track of clients' expenditure. Difficulties arise when clients use more than one chemist:

There would be quite a few who would qualify, but very few make use of that. If all drugs came from the same pharmacy it would work, but they don't always go to the same pharmacy, so there needs to be a state register. (ACCHS, urban Qld)

Many pharmacists played an active role by telling clients nearing the Safety Net that they should obtain spending records from other chemists they have used. A few said they did not take an active role because it was the client's responsibility. In locations where there was only one pharmacy, the situation was simpler. There was a general feeling among ACCHSs that the Safety Net was the responsibility of the pharmacist, though medical

staff could make patients aware that the measure exists.

Transient people were said to have difficulty with the Safety Net because it depended on them keeping a Safety Net Record. Many were highly unlikely to do this for all the reasons previously outlined regarding the keeping of documents, even if they knew to ask for it. There was even some confusion as to whether a Safety Net Record Form was valid in other States. Some Aboriginal and Torres Strait Islander people reported being told they couldn't use their Safety Net Record Form when they travelled across State borders.

Pharmacists and ACCHSs generally concurred that there is little awareness among Aboriginal and Torres Strait Islander people about the Safety Net. Many thought this was because so few were eligible, though it was also admitted that most wouldn't know what it was. It was reported that very few Aboriginal and Torres Strait Islander people were accessing the Safety Net at the time of the survey.

Most Aboriginal people wouldn't have any idea about how the Safety Net works.
(Pharmacist, rural SA)

A number of ACCHSs thought the Safety Net threshold was too high.

The Safety Net is too high for unemployed people. Very few qualify and more should. If you have a chronic illness, you have to see them a long time before they get it free. For diabetics or people who've had a stroke, they need the drugs to stay alive, but it's a lot of money. The pharmacies send the AMS a printout of who's close, but what if they don't go to the AMS and go to different pharmacies. Some would be too ashamed to ask the pharmacist to put the script on the card. (ACCHS, rural Qld)

There seemed to be little awareness that the Safety Net applies to families, not only to individuals. In families where members have different surnames, eligibility is more likely to go unnoticed: *'It would be a nightmare to link up the families'* (Pharmacist, Vic). Shifting family relationships, confusion over names etc make it

difficult to ensure that all relevant expenditure on pharmaceuticals is identified for the family unit.

5.6 PHYSICAL ACCESS TO PHARMACEUTICALS

Ensuring that Aboriginal and Torres Strait Islander patients get access to medication in a timely manner needs to address the problems they face in *physically* accessing the medicines as well as being able to afford medication.

Aboriginal and Torres Strait Islander people living in urban areas with a range of pharmacies do not, on the whole, experience problems physically accessing a supplier of PBS medication. However people living in remote areas, and even certain rural areas, do experience severe problems - in some instances because the suppliers do not exist or because a lack of public transport coupled with limited access to private transport hinders them in getting to a pharmacy.

We've got nowhere yet with the PBS.
(ACCHS, rural NT)

PBS is largely unobtainable. (GP, rural/remote location)

The problems in remote areas are better understood and a range of strategies have long been in place to start to meet these problems. Briefly, these include:

- the *'doctor's bag'* - where a medical practitioner carries a limited supply of pharmaceuticals to respond to acute needs, eg antibiotics. This is available to all GPs; the availability of a GP in remote areas then becomes the issue.
- *the medicine chest* - where a wider range of pharmaceuticals is distributed in specially numbered compartmentalised boxes and administered to remote settlements/stations (generally through the Royal Flying Doctor Service). The chests are intended for use under the instructions of an RFDS doctor either in person or by telephone/radio.
- *Section 92 (of the National Health Act)* which can approve a pharmaceutical service to be

supplied by a specified medical practitioner in a particular geographic area.

- *Section 100* - which permits, in special circumstances, certain service providers (for example, an ACCHS) to purchase and directly dispense a comprehensive range of pharmaceuticals, the full cost being borne by the Commonwealth Department of Health and Family Services.

- *ACCHSs' in-house supply of pharmaceuticals* - funded through general OATSIHS grants or through pharmaceutical-specific State/Territory grants.

- *directly dispensed pharmaceuticals* and/or use of the PBS system through a range of other services administered by the State/Territory.

Because few of the above mechanisms are available to all Aboriginal and Torres Strait Islander communities, or because they work imperfectly, problems continue to exist in physically accessing pharmaceuticals in a timely manner.

The large distances separating chemists, GPs and more isolated Aboriginal and Torres Strait Islander communities result in frequent delays in dispensing medication. Some communities have a weekly drop of medication/ collection of scripts. However if a script is dropped off late or given to a patient after a delivery, it could be two weeks before a patient receives his/her medication. Some communities are affected by seasonal weather changes, and at times transport is not possible to more remote areas. Other communities (on the train line) receive medicines by post. It was reported that it could take up to five days from the time a script is written to the arrival of the medicine. In addition, extra freight charges were reported to exacerbate the problems associated with medication costs. Some pharmacists who dispense to remote communities by postal order had major concerns about their inability to advise clients about taking medication properly.

A lack of public transport to chemists was reported to be a barrier in some rural areas. This was overcome in one isolated rural community by the employment of a driver who runs scripts in to the

chemist daily. Other communities do not have this resource, however, and rely on infrequent courier services. Even in urban areas poor transport was cited as a barrier, especially for the elderly and the sick. Several ACCHSs reported that many patients will not walk to the chemist if it is more than a few blocks away. Consequently, a number of ACCHSs run scripts or patients to the chemist and then home, but this is seen by some as an inefficient use of resources. Numerous ACCHSs have responded to this problem by supplying such patients with medication out of their own stock, whether purchased or simply samples provided by the pharmaceutical companies.

Most ACCHSs have at least a small supply of medication which they give out on-the-spot and free of charge (in some cases these are dictated by the samples supplied to them). For some ACCHSs this is limited to dressings and mild pain killers, while others have an extensive range of S1 to S4 medicines. One rural ACCHS spent \$100,000 on pharmaceuticals last year, and has a policy of supplying patients they believe won't get their medication otherwise. It is reported that the advantages of direct supply by the ACCHS are that doctors can be sure the patient gets the medication, acute illnesses can be treated straight away, patients are more likely to present at an earlier stage of illness because they know they will be given medication and it circumvents the problems associated with entitlement numbers. The disadvantages include higher costs for the ACCHS, the potential creation of dependency and a window for abuse (*'While the system is in place, people will use it'* (rural ACCHS)), problems associated with making discretionary choices between patients, setting up parallel systems which can cause resentment amongst the wider community, and the possibility of upsetting pharmacists who would lose business. In practice, the ACCHSs' direct dispensing of medications complements the use of measures such as pharmacy accounts, especially as it is generally cheaper to put medication on account at the chemist (using PBS) than to purchase stock.

ACCHSs with large remote catchments often use an imprest system to service outlying communities (re-stocking their supplies through local hospitals).

It was generally thought that physically providing medication to these people was the only way they would get the medication. One health worker in a remote community commented that it was difficult enough to encourage patients to take the medicine they received free of charge at the time of treatment and it would be highly unlikely that anyone would make their way to a pharmacy where they had to pay for their own medication.

The need to supply medication directly, at minimal or no cost to the patient, has led some ACCHSs to dispense medicine on the spot but then to write a script which would be used to replace the dispensed medication. Such steps were taken when the cost of pharmaceuticals would otherwise be a serious draw on the ACCHSs' general grant and overall operating budget.

Recommendations

34. The Department of Health and Family Services should, as a first priority, seek Ministerial approval to expand Section 100 arrangements to other remote and rural ACCHSs. Consideration should also be given to the possibility of extending Section 100 to urban ACCHSs. Administrative support would need to be provided to some ACCHSs, particularly with tasks such as negotiating with distributors, ordering and managing stocks of medication.

35. The placement of medicine chests in remote/outstation communities which currently have no access to medication of any kind is clearly beneficial. The Department of Health and Family Services should make available to the RFDS to expand this arrangement to more Aboriginal communities.

36. The Department of Health and Family Services should consider paying a modest fee to pharmacists for delivery of medication to Aboriginal and Torres Strait Islander people who are isolated or semi-isolated and for whom there exists no other mechanism for the supply of pharmaceuticals.

5.7 COMPLIANCE WITH PHARMACEUTICAL REGIME

Compliance is very poor as a general rule. This has a myriad of causes. Much of it comes down to (a) cross cultural communication barriers between medical workers and patients; (b) passive resistance by 'conquered' peoples to the resented authority figure of the doctor; (c) fundamental conceptual differences in the definition of health and wellbeing between Aboriginal peoples and European/Western beliefs. (GP, formerly rural Qld)

Even when the barriers facing Aboriginal and Torres Strait Islander peoples in accessing PBS are overcome, there still exists extremely severe problems in ensuring that patients take their medication in the manner intended. This latter issue was cited time and again by GPs, pharmacists, ACCHSs etc. The causes of poor compliance are numerous and include the following factors:

- *Differing concept/standards of health* - many Aboriginal and Torres Strait Islander people are reported to see their own state of health in quite a different light to non-Indigenous people.

Non-Aborigines have had education much longer than Aborigines and understand things differently - most Aboriginal people don't see chronic illness as being sick and they don't see a doctor unless they have a major sickness. (AHW, rural/remote WA)

Aboriginal people do not traditionally have a 'germ theory' of disease and often don't understand their own health issues very well, what medicine they're taking or why. It is common for patients to not complete a course of medication, to share it with others and to borrow inappropriate medication. (GP at ACCHS, metropolitan NSW)

- *Lack of appropriate 'cues' to health status* - common problems described with Aboriginal and

Torres Strait Islander peoples included failure to complete a course of antibiotics because, soon after starting the course, they began to feel greatly improved. Conversely, it was also hard to persuade people to continue with medication for chronic long-term diseases (eg diabetes, hypertension) because the patient doesn't notice any obvious effect of taking the medication.

Non-compliance is also common for conditions without any obvious symptoms because people don't feel unwell. (ACCHS, rural/remote NT)

Compliance especially in diabetes and hypertension with no symptoms - poor. Have to wait for pension day to get and pay for their medications. (GP, rural Qld)

A lot of people who should be on long-term medication (eg for diabetes or hypertension) will get sick of it after they feel well (despite what I think is good education). (GP, rural NSW)

■ *Lack of supports needed to use medications properly* - it is of little benefit to instruct a patient to take certain medication at four-hour intervals if s/he does not have a watch. A family lacking a refrigerator cannot store some medications properly. Instructions to 'take with meals' can mean no medication is taken if a person doesn't eat. When counting to four is not possible in an Aboriginal language, 'take four times a day' is not a clear instruction. Limited literacy means instructions on labels are often useless; identification of medication by sight ('*The big red pills*') means that changes in the drug supplied can result in confusion.

Where do these people keep their drugs without simple facilities like pockets and cupboards? (Pharmacist, remote SA)

We have found a large problem with the timing of their medication - they do not understand the importance of 'even' dosing for their diabetes medication and regular meals. (Pharmacist, rural Qld)

I have had a problem with all patients when a medication is labelled 'with meals'. The patient does not take it if they don't eat and thus may not take the medication on the first day on time if too sick to eat. Thus they get worse. (GP, rural Qld)

The need for legible, understandable instructions is certainly not limited to Aboriginal and Torres Strait Islander people, by any means. A major survey of Australian literacy was conducted by R Wickert in conjunction with the Sydney College of Advanced Education in 1992. In one study 1,500 people aged 18 years or over, randomly sampled from throughout Australia, were given the back panel of a leading brand of analgesic medication (reproduced below) and asked the correct dose for a child.

For relief of pain and discomfort in rheumatic, muscular and neuralgic conditions, headache and colds; and following dental procedures. Reduces fever.
 DOSAGE: Adults: one to two tablets (maximum 8 tablets per day). Children: (7-12 years): half to one tablet (maximum 4 tablets per day). Take every 3 or 4 hours if necessary.
 CAUTION: THIS MEDICATION IS FOR THE RELIEF OF MINOR AND TEMPORARY AILMENTS AND SHOULD BE USED STRICTLY AS DIRECTED. PROLONGED USE WITHOUT MEDICAL SUPERVISION COULD BE HARMFUL.
 Store below 30°C
 USE ONLY IF FOIL SEAL OVER TABLET IS INTACT.

Some 46% of respondents were unable to correctly identify the correct dose for a child.

- *Alcoholism* - numbers of ACCHSs indicated that some patients fail to take their medication properly when they are drinking heavily. In smaller communities someone may ensure that the health service is aware of the situation so that appropriate steps can be taken to address the problem.

Alcohol and other problems affect compliance. (ACCHS, rural/remote, NT)

Alcoholism in some people adversely affects compliance. (Pharmacist, remote SA)

- *Lack of personal 'monitoring'* - a clear message from ACCHSs, medical practitioners, pharmacists etc was that a good one-to-one relationship with a Health Worker was essential in many cases to ensure continuing compliance. Even when the why and how of medication-taking was explained to a person, it was generally necessary to periodically repeat the messages to reinforce them.

It is my experience that compliance is only effective where medications are given directly by qualified nursing staff - but the staff turns over so frequently that little or no trust is built up ... permanent medical and nursing staff is a necessity in remote (tribal) communities. (Pharmacist, remote SA)

We have a good rapport with the Aboriginal and Islander Community Health Centre and if we suspect a problem they sent out a case worker or health nurse to the patient to check on the situation. (Pharmacist, rural Qld)

- *'Doctor shopping' and hoarding of medication* - these problems were reported to be common and resulted in the patients taking the wrong medicines for certain conditions, sharing of medication or avoidance of all medication.

I did a recent 24 km house call to child screaming with otitis media. Told no medications at home. Found 11 unopened bottles of amoxicillin and 5 of paracetamol syrup. (GP, urban WA)

'Doctor shopping' means that they may get multiple medications. Unused medications are sometimes given to other members of the family. The patient fails to understand the instructions as to how the medications are to be taken. (GP, rural WA)

- *Less skilled service providers* - in a few instances, the issue was raised about problems arising from less qualified staff endeavouring to help a patient manage medications.

Very often, however, the staff are unqualified - so that drug delivery is far from perfect. (Pharmacist, remote SA)

Mechanisms used to address compliance problems include extensive outreach work where Aboriginal Health Workers, in particular, would visit people in their homes (to oversee their medication and attempt to educate them regarding use of drugs), the use of dosette boxes and Webster Packs (which measure out individual doses) and greater use of single dosage medications - most particularly single high dose antibiotics. One pharmacist (who estimated a non-compliance rate of about 10% among his clients) noted that *'Sometimes the extended family in an Aboriginal and Islander situation is of benefit as the older women become the carers'*. (Pharmacist, urban Qld)

Where these efforts are not successful, the results can be dire.

The consequences are that the children end up in accident and emergency with asthma attacks. We have had a death due to non-compliance of the 16 year old mother for her child. (Pharmacist, rural Qld)

- *Bush medicine* - a number of Aboriginal and Torres Strait Islander people indicated they continue to use traditional or bush medicine in treatment of illness or ailments - sometimes exclusively and sometimes as a first option. Belief in, and use of, these medications appears relatively common in remote and some rural communities, therefore we need to bear in mind that 'compliance with medication' actually means compliance with Western medication. At the same time some people, as in the wider population, have 'lost faith' in the efficacy and health benefits of Western pharmaceutical medicine, preferring natural remedies or other treatments such as traditional Chinese therapy.

Clearly the factors identified as underlying non-compliance compound each other. A person who does not clearly understand the place of medicine in the treatment of illness and who does not necessarily recognise certain conditions as reflecting 'un-wellness' cannot be expected to put a high priority on expenditure for medicine. The relative lack of importance placed on medication also makes it more difficult to communicate with a

patient as to how s/he should take medication properly.

Employment of Aboriginal Health Workers is a vital part of the solution - to provide appropriate explanations to patients and also to the non-Aboriginal health staff. For example to explain why a particular patient may not want to use a particular medication, so the matter can be resolved.
(GP, remote NT)

Clearly all of this implies a long-term commitment to a multi-faceted education process to go hand in hand with the removal of the immediate barriers facing Aboriginal and Torres Strait Islander peoples in accessing PBS.

Recommendations

37. The Department of Health and Family Services needs to collaborate with OATSIHS, pharmacy and health care provider interest groups and the pharmaceutical industry to devise and trial labelling systems which take into account different cultural understandings and different levels of literacy. Any labelling system needs to have the input of Aboriginal and Torres Strait Islander peoples.

38. The Department of Health and Family Services needs to support information provision and education about medication to Aboriginal Health Workers and to draw on their knowledge and experience to produce the materials.

39. The Department of Health and Family Services should consider meeting the costs of providing medication aids such as customised packaging (eg dosette and Webster Packs).

40. The Department of Health and Family Services, in conjunction with the pharmaceutical industry, needs to ensure that dosages, packaging and listing of medication on the PBS take into account the efficacy of single dose agents in treating Aboriginal and Torres Strait Islander peoples. Further, pharmaceutical manufacturers should be encouraged to produce single dose agents.

5.8 LISTING OF PHARMACEUTICALS ON THE PBS

Many health care providers and pharmacists criticised certain decisions relating to the listing of pharmaceuticals on the PBS as being particularly deleterious to Aboriginal and Torres Strait Islander communities. The removal of the following medications from the PBS was reported to have made treatments for conditions common in Aboriginal and Torres Strait Islander communities unaffordable to many Aboriginal and Torres Strait Islander people:

- clotrimazole and other anti-fungals (eg Canesten)
- topical steroids (eg Hydroform)
- Lyclear cream (for treatment of scabies)
- Fefol (iron and folate replacement)
- antihistamines
- analgesics
- topical antibiotics
- emollients

Several doctors and pharmacists thought Ritolin (for treatment of attention deficit disorder) should be on the PBS. Although there is an alternative on the PBS, it was reported that some children do not respond well to the PBS-listed drug and they are therefore forced to use Ritolin, which is generally too expensive for people on low incomes to afford.

One doctor admitted that the expense of certain non-PBS drugs sometimes forced him to prescribe medication which was not ideal for the patient's condition:

We are left having to prescribe inappropriate medicines or antibiotics for things. Ethically and scientifically we shouldn't do it, but we can't do nothing.
(GP, rural SA)

The same GP cited extremely high levels of antibiotic consumption as evidence of

inappropriate prescribing and believes it leads to 'doctor-shopping':

They think, 'Maybe the next doctor will give me something cheap'. The result is they end up with a whole lot of prescriptions which they may or may not get filled.

Current Pharmaceutical Benefits Advisory Committee guidelines do not demonstrate that the special needs of Aboriginal and Torres Strait Islander populations are given adequate weight in decisions regarding the listing of pharmaceuticals on the PBS.

Recommendation

41. When making decisions regarding the PBS list, the Pharmaceutical Benefits Advisory Committee needs to take into account the particular impact these decisions will have on Aboriginal and Torres Strait Islander populations.

5.9 HIC REGULATIONS AND PROCEDURES RE PHARMACEUTICALS

A number of HIC rules and procedures were felt to limit efficient provision of pharmaceutical services to Aboriginal and Torres Strait Islander communities.

A few doctors raised the issue of authority scripts as a problem. In order for a doctor to prescribe a designated authority item s/he must first get authority from the HIC and to receive this approval s/he must be able to provide identifying information, eg Medicare number, name and address or entitlement number. It was reported in the field, however, that in practice a name and address were not sufficient and that a Medicare number was required.

Inappropriate procedures and prescribing patterns were identified as deficiencies in the PBS:

My experience in the 1970s (admittedly a long time ago) in remote areas and in an administrative capacity showed a mismatch between PBS and the pattern of

illness in Aboriginal communities (availability, complex procedures to obtain supplies, quantities prescribable eg family packs). The problem is very reminiscent of the recent 'Rocaltrol' case where a legal challenge resolved the problem. Let's hope the same does not happen here. We need to match availability to community illness pattern (à la Hep. B). (GP, urban NSW)

One pharmacist was irritated by the HIC's requirement that a doctor write the exact quantity of allowable repeats. She fills a number of scripts from ACCHSs and the Royal Flying Doctor Service, a number of whose doctors are temporary residents of Australia, and who are often not familiar with the quantities permitted. Because they service remote communities which have access difficulties, they usually write something like 'maximum quantity and maximum repeats' on the scripts in place of the quantity. These scripts are reportedly invariably rejected, and it may take months to get the doctor to correct the repeat order, by which time the script may be out of date.

I'm not trying to defraud the system - the patient has the medicine. If the HIC is concerned about Aboriginal health they shouldn't be jumping down throats. They should be more pragmatic. (Pharmacist, rural/remote NT)

Some pharmacists complained of the difficulties posed by the 20-day rule, which prevents the filling of a repeat for 20 days after the date of supply. They argue that some Aboriginal and Torres Strait Islander patients who are travelling or patients from remote areas need to have all their repeats at once. The doctor can override the 20 day rule by using Regulation 24, however they often do not write this on the script and it is left as a problem for the pharmacist. Many thought pharmacists should have the authority to use Regulation 24.

of hours, when the chemist is shut, to get medicines for free.(VMO, remote NSW)

5.10 THE ROLE OF PUBLIC HOSPITALS AND PHARMACEUTICALS

Currently drugs may not be dispensed from a hospital pharmacy under PBS. Hospital pharmacies dispense directly to inpatients and sometimes those seen in an accident or emergency situation, though it was reported that some hospital pharmacies also dispense to out-patients, particularly in remote areas. Salaried hospital doctors are permitted to write PBS scripts for out-patients if the hospital is without a pharmacy. If a hospital with a pharmacy makes medication available to an out-patient, the patient is obliged to pay for the medication.

Many hospital pharmacies, particularly in major rural towns, supply medication to remote hospitals and clinics, ostensibly for inpatient use. However, the reality of health care in remote areas tends to mean that many patients visiting a doctor need medication more quickly than it can be dispensed and transported from a community pharmacy. The remote hospital often dispenses and thus carries the cost of providing such medication. A few hospital pharmacists complained that there was no provision within PBS to restock hospital supplies dispensed to out-patients. They see it as an equity issue as well as a financial one:

At the moment the hospitals give multiple starter packs, but that comes out of the State health budget. Where's the equity in that? (Hospital pharmacist, rural SA)

While several service providers in some locations believed the local hospitals freely dispensed medication from its stock to out-patients (*'They go to the hospital because they know they can get medication there'*), this was generally refuted by the hospitals themselves. The hospitals, however, often supply necessary medication to those who come through casualty and in many cases supplied urgently needed medication after hours via starter packs. One visiting medical officer thought this was abused to a certain extent:

Aboriginal people never have the money to buy PBS medicines, so they turn up out

Individual hospitals are said to have particular programs which subsidise/ supply certain necessary medication to low -income groups. However these arrangements were not consistently reported. A number of health care providers and pharmacists said that non-compliance with medication, which many cited as the number one treatment problem in Aboriginal and Torres Strait Islander communities, in a lot of cases lead to hospitalisation.

5.11 SUMMARY

It became evident in the course of the research that wide gaps exist in the level of access enjoyed by many Aboriginal and Torres Strait Islander people. While the factors contributing to the continuing disadvantage experienced by this group are many, a few key themes may be identified as major obstacles.

Entitlement numbers Clients often are unable to provide a valid entitlement number to the dispensing agent, despite being eligible for concessions and benefits.

Copayments Inability to afford either the concessional or full copayment was a major barrier, regardless of location. A consequence of these two problems is that the ability to obtain medication inevitably depends on the judgement of the pharmacist, ACCHS etc.

Immediacy of supply Factors such as isolation, inability to afford medication and lack of entitlement numbers frequently result in delays in obtaining prescribed medicine, which in many instances has serious health consequences.

Funding of PBS pharmaceuticals Certain medications felt to be of particular importance to Aboriginal and Torres Strait Islander communities were rendered all but unaffordable if they were not listed on the PBS.

6.0 INFORMATION MATERIAL

6.1 Effectiveness of Current Information Material

Frankly, little attention was, in the course of this research, given to an examination of information materials which were either Medicare or PBS related. It quickly became apparent that conventional forms of material eg brochures, were largely irrelevant or of low salience to the communities being consulted.

As already indicated, a not uncommon term used in relation to Medicare offices was 'intimidating'. The same could be said for its printed materials. While the explanatory brochures appear to be well presented, informative, graphically attractive etc they can be bewildering to an average community person. One Medicare Customer Service Officer acknowledged this, saying s/he frequently observed an Aboriginal person come into an office, pick up a brochure or claim, study it for a time and then put it back - and then leave. The materials/information presented in most of the Medicare and PBS brochures is quite demanding, detailed and 'intimidating'.

Particularly in remote/rural areas (but not exclusively) materials produced by Aboriginal and Torres Strait Islander organisations are dramatically different. Often the concepts discussed are simpler, and generally limited to only one message at a time. Cartoons and art work are used more heavily and the language is informal or colloquial, eg a Pap smear is described as a test to '*stop cancer in your baby bag*', a female GP is a '*lady doctor*', and a health worker can say '*never mind, don't get shame*'.

As could be expected, many Aboriginal and Torres Strait Islander people rely heavily on ACCHSs to 'broker' information for them in any case. Thus the target audience for much of the Medicare and PBS information is actually the service-provider. The information needs of these people are, of course, somewhat different and more demanding in nature. As people who have to manage the Medicare system from the service-providers' and patients' point of view they warrant particular attention and tailored information. *What is obvious*

is that, currently, there are significant breakdowns in the information flow between HIC and service-providers, particularly ACCHSs. A plethora of misinformation seems to exist - on anything from the age of a child able to be enrolled on the claim form to larger issues like whether it really is permissible to bulk-bill when receiving a grant. The fact that an administrator of an ACCHS (which has an account at a pharmacy to enable patient copayments to be paid) was not aware that the copayment had risen from \$2.60 to \$3.20 at the beginning of the year illustrates how difficult it is to maintain an effective information flow.

The information breakdowns do not occur simply in communications from Medicare to service-providers and clients - there was considerable evidence of failure of Medicare personnel to 'read' its customers and service-providers. Generally Customer Service Officers appeared to have the view that, on the whole, there weren't many problems 'out there'. They were reasonably confident that their information materials were satisfactory and that people were adequately informed. In some instances, as well, there was a demonstration of quite blatant ignorance about Aboriginal and Torres Strait Islander cultural matters. This did not happen across the board, however.

Some particular Medicare personnel were extremely well informed about the community, generally because they actively worked out in the community. These people were notable in their commitment to, and in the regard with which they were held by, members of various Aboriginal and Torres Strait Islander communities.

The key to this is the *personal* contact and involvement directed at keeping good information flows between Medicare and its users. Certainly for communities like the Aboriginal and Torres Strait Islander ones, dependence on passive print material will never be satisfactory. Certainly, where good relationships have been established between an ACCHS and a local Medicare office, administrative problems were minimised.

Lastly, it is points of contact such as the Hotline which largely determine perceptions of the institution 'Medicare' for many Aboriginal and Torres Strait Islander people and services. The

overworked operators on the Hotline apparently can do a real disservice, in that bad experiences with the Hotline strongly colour attitudes to Medicare.

6.2 INFORMATION MATERIALS NEEDED BY CONSUMERS

Information about the following issues, was reported to be needed:

- the benefits of having a Medicare card
- how to get a (new) Medicare card
- enrolling babies/children
- how many Medicare cards you are allowed to have
- the Medicare and the PBS Safety Nets
- the benefits of a Health Care Card
- benefits and eligibility for CDEP participants
- taking medication, particularly for people with chronic illnesses
- the documents remote people should take with them when they go to town

It is important to recognise that there is considerable diversity in the markets to which information should be directed. These include:

- illiterate/semi-literate people; visually impaired people (common in Indigenous communities)
- different language groups
- different educational levels
- different age groups, particularly young people

The current range of HIC information materials is targeted at a market that is literate and reasonably well educated (though note the point made in section 5.7 about very limited literary levels across the general community). Pamphlets are translated into a number of community languages, but there is nothing provided specifically for Aboriginal and Torres Strait Islander people. Materials need to be in forms which are easily understood by illiterate people - 'fewer words, more pictures' being a

general rule-of-thumb. Emphasis should not be on 'slickness' but on appropriateness. The following forms should be considered.

- Videos can be shown in ACCHS waiting rooms, where there is a captive audience. They should not be 'lecture' style programs, but short dramas or skits, featuring Aboriginal and Torres Strait Islander people. Animation could also be used to good effect. Consideration to the ability to 'dub' into different Indigenous languages should be given.
- Posters designed by and featuring Aboriginal and Torres Strait Islander people, with minimal reliance on words should be developed. ACCHS walls are typically filled with posters, generally specifically aimed at Indigenous consumers. The kinds of images presented are all-important to their impact, therefore involving Aboriginal and Torres Strait Islander people in the design is essential. Again, it needs to be remembered that certain images will be more appropriate for an Aboriginal audience whereas others may be needed for a Torres Strait Islander audience.
- Comics such as the *Streetwise* magazines and locally produced materials are often found in ACCHS waiting rooms and other Aboriginal and Torres Strait Islander community organisations. They are reported to be popular and effective in conveying serious health information in an accessible, culturally appropriate and humorous form.
- Simple, pictorial leaflets using language which is familiar to the target consumers (colloquial, particular Indigenous languages) could be made available in ACCHS waiting rooms and communal areas. Again, narrative styles are generally more effective than a straight, 'lecture' style.

English is a second if not a third language in many communities and some Indigenous people speak no English at all. For information materials to be effective, they must be tailored to the needs of different communities. A 'blanket' approach can be expected to fail. The HIC should consider having the materials produced locally in communities to

ensure their accuracy and appropriateness and to support local employment.

6.3 INFORMATION MATERIALS NEEDED BY SERVICE PROVIDERS

Despite the existence of *Mediguide* (which explains Medicare arrangements in what the HIC believes is a simple, non-technical format) many service providers did not clearly understand Medicare and PBS procedures. Consideration must be given to the fact that not all service providers have the same educational attainments, levels of literacy or English proficiency. Medicare administration in ACCHSs is often the responsibility of less skilled workers, but there is currently no guide which may be used easily by these staff.

The HIC needs to produce a guide or package for use by these less skilled/less educated workers. It is advisable to seek the input of the workers in producing the materials to ensure they are appropriately targeted. The package needs to include information on:

- enrolment/identification procedures
- enrolment for children in the care of adults other than birth parents
- replacing lost/stolen cards
- expired card replacement procedure
- alteration of enrolment details
- getting duplicate Medicare cards
- locating Medicare numbers - what may be expected of the Hotline
- 'trouble shooting', eg what to do if no Medicare number is found.

The HIC should also make explicit what is considered standard practice (ie performance standards) in the administration of Medicare so that users of the system know what to expect.

The HIC could develop a newsletter specifically for Aboriginal health workers and other ACCHS staff. The language and format would need to be

accessible and could include additional items about general health matters. This would not only provide information as well as Medicare and PBS data, but serve to 'humanise' the HIC/Medicare in the eyes of Indigenous workers and clients.

Recommendations

42. The HIC should undertake to actively assist in the of training workers at ACCHSs regarding the application of the Medicare and PBS systems.

43. The HIC should establish and publicise a range of performance standards which would be made available to ACCHS workers and Medicare consumers (eg 'new enrolments will be processed within two weeks').

44. The Department of Health and Family Services should support the HIC in the development of appropriate information materials on matters relating to Medicare and the PBS as well as other health matters for Aboriginal Health Workers and other ACCHS staff. Aboriginal and Torres Strait Islander people need to be involved in the development of any such materials.

45. The HIC should pursue a vigorous program of employing Aboriginal and Torres Strait Islander people, particularly in key liaison and consumer/provider roles.

7.0 SUMMARY AND CONCLUSIONS

Medicare and the PBS are exemplary health funding systems which well serve the general community, but the research demonstrates that Aboriginal and Torres Strait Islander peoples everywhere face considerable barriers which impede their full access to both Medicare and the PBS.

The nature of these barriers, the degree to which they operate and the attitudes regarding these barriers differ widely from one locality to another. However, even in those situations where the Medicare and PBS systems are working as well as they do anywhere, significant barriers continue to exist for Aboriginal and Torres Strait Islander peoples.

The research revealed numerous instances where the HIC has introduced initiatives and demonstrated great flexibility in seeking to overcome barriers facing Indigenous people. However, the research also suggests that, given the current conditions existing within Aboriginal and Torres Strait Islander communities, the Medicare system cannot in itself be expected to serve as an adequate funding mechanism for health care for Aboriginal and Torres Strait Islander peoples unless Medicare were to be radically altered.

ENROLMENT IN MEDICARE

■ The incidence of Aboriginal and Torres Strait Islander people having no effective Medicare number/card ranges between 15% in urban areas to 38% in more remote areas, as reflected in a Queensland survey and supported by evidence gathered in the course of this research. This is clearly at odds with earlier research which found that only 7% of Aboriginal people reported not having a Medicare card - a finding that now appears quite doubtful.

It needs to be recognised that the absence of a current Medicare card/number means that Medicare is basically not available to those lacking a card/number.

■ Aboriginal and Torres Strait Islander people lacking a current Medicare number include adults who have never been enrolled - either because they were part of a community that has not been utilising Medicare or because, as an individual, they have managed to slip through the system.

Young children show a particularly high degree of non-enrolment, reflecting administrative barriers around their enrolment.

■ Some public hospitals systematically enrol all newborn babies prior to discharge, using a special Medicare enrolment form provided to most hospitals. A few patients reported that the process was simple because they filled in all necessary documents for the baby at the same time. However, this system often does not operate successfully leading to significant problems as the child gets older.

■ The standard Medicare claim form includes a section headed 'Adding a Newborn Child' which permits easy enrolment simply by putting in the child's name, gender and date of birth. However, as was evidenced in the research, there was considerable misunderstanding and confusion of what constituted a 'newborn child'.

■ As well as people *never* having been enrolled there are a very considerable number of Aboriginal and Torres Strait Islander people whose enrolment has expired, and therefore are not currently enrolled.

■ A number of health care providers questioned why a Medicare card had to expire at all. It was repeated that expiry dates unnecessarily complicated the system, although the HIC uses this mechanism of limiting the life of a card as a security device to control use of any fraudulently held card.

■ The issue number is the final digit in a Medicare number and is always one digit higher than the one which preceded it. Under current arrangements, whenever a Medicare card is replaced (because it has expired, been lost etc), the new card bears a number the same as the old number, except for the higher issue number.

This results in problems if people lose their cards and have to be reissued with one as it renders

invalid the previous number - a number that may, for example, be the one on file at an ACCHS.

ENROLMENT PROCESSES

■ ACCHSs see a large proportion of Aboriginal and Torres Strait Islander people, thus they experience more problems with unenrolled patients than do mainstream services. A number of ACCHSs already keep Medicare enrolment forms and send them to Medicare on behalf of patients. While this simplifies the enrolment process for the patient, some ACCHSs are concerned that the responsibility is shifted to them, when staff resources are often stretched to the limit already. A number of ACCHSs made the case for the HIC providing Medicare administrative training and support, saying it was not their responsibility to unravel Medicare complexities.

■ Currently the practice of ACCHSs acting as an agent or clearing house for patients in relation to their receipt of Medicare cards exists in some situations. The merit of this approach is that it at least allows the ACCHSs to record the Medicare number on computer or paper file before passing the card on to the client. Alternatively an ACCHS might actually retain the card.

Clearly this is an administrative practice that is available to ACCHSs and to their patients already - thus can be used by mutual agreement. However a number of ACCHSs indicated that this system broke down when multiple cards were involved. Despite the fact that an ACCHS might possess the sole mailing address for a community, an automatic triggering occurs within the HIC system when numerous Medicare cards are addressed to a single address and as a result they are often not delivered.

■ A number of health services observed that many Aboriginal and Torres Strait Islander people who have been in prison, in drug and alcohol rehabilitation centres, in juvenile detention centres and other institutions, as well as children in care, are often not enrolled in Medicare and that this could best be addressed at the institutional level.

■ Some specialists who visit remote communities carry Medicare enrolment forms which they have patients fill out at the time of service. Alternatively,

they might simply develop a list of names of patients lacking a Medicare number. When they return to the town/city they are based in they send the forms or list to Medicare if they are unable to find a number. Some State HIC offices indicate this is not an acceptable procedure.

■ In a number of locations Medicare staff have visited Aboriginal and Torres Strait Islander communities and enrolled all their members. Where this has taken place, the volume and frequency of subsequent enrolment problems were reported to have fallen significantly or been greatly minimised.

PERSONAL IDENTIFICATION

■ **This research reveals, in particular, the enormous barriers that continue to be experienced by Aboriginal and Torres Strait Islander people in providing acceptable forms of identification, as required by Medicare to either enrol or to identify their existing Medicare number.**

It is important to bear in mind the primary purpose that this identification serves - to determine whether a person is a *bona fide* resident of Australia or not.

■ A particularly effective response to this problem introduced by Medicare is the simple Proof of Identity form where a referee can attest to the identity of a person, hence his/her eligibility for Medicare. While various strategies such as these appear to offer solutions to critical problems they:

- are not utilised extensively in areas where they are needed
- are often not known to, or understood by, service providers (even within the HIC)
- are often erratically applied even within the same jurisdiction.

The reasons that simpler identification processes have generally been limited in application to selected rural/remote areas is that it was assumed that, in urban areas, service providers would be less able to 'verify' a patient's identity. Those urban ACCHSs consulted convincingly demonstrated that they were able to verify an

Indigenous person's identity, at least to the degree needed to ascertain eligibility (ie residential status).

■ Many forms, including those from the Department of Social Security include an option where a person can self-elect, through a simple question, to identify him/herself as an Aboriginal or Torres Strait Islander person.

This would enable a great many of the proposed strategies discussed in this study to be implemented as well as serve additional information needs (eg Indigenous patterns of health care usage). Many respondents express some concern about 'flagging' Aboriginal and Torres Strait Islander people, for understandable reasons, given the history of how such information has been used to their detriment in the past. For this reason alone, any introduction of such an identifier system will require considerable consultation to ensure its acceptability.

■ A number of service providers and consumers noted that Aboriginal and Torres Strait Islander people were often more likely to have themselves and their children recorded on a Health Care Card than have other forms of identification, and as such this should be acceptable as a form of identification. Several Customer Service Officers reported that they do accept the Health Care Card as a form of identification, though in some cases only as a secondary piece.

■ Numerous Aboriginal and Torres Strait Islander children do not live with their birth parent(s) or do not do so on a permanent basis, often residing with another relative in the extended family. This can result in problems accessing a child's Medicare number. (The rules applying to nuclear families do not readily work when applied to extended families.)

■ Problems arise when family units shift in their composition, particularly when the family (or other) grouping included on a Medicare card changes. As has already been discussed, this can be a particular problem around children, but is certainly not exclusive to them.

A number of Northern Territory communities have arranged with their Medicare office to have only individual cards issued, as opposed to family

cards, an option that received quite a mixed response from other ACCHSs.

MANAGING THE MEDICARE SYSTEM

■ It is the service-providers who bear the brunt of managing the Medicare system for Indigenous peoples.

Across many ACCHSs a considerable amount of time is spent enrolling patients, seeking to identify and verify Medicare numbers, ensuring claims are properly lodged, maintaining patients' Medicare information for the ACCHS and for other local services to utilise etc. This has in many cases become a taken-for-granted expectation of many ACCHSs. A number of Customer Service Officers confirmed that they had few problems because the ACCHSs managed to sort everything out.

■ A Hotline exists as a means of consumers and their service providers accessing people's Medicare numbers when they are not known. However, those working in Indigenous communities were quite critical of the service provided by the Hotline.

Health care providers repeatedly called for the need to sensitise Hotline operators to the cultural differences which make fitting Indigenous people into tight bureaucratic models unworkable.

■ The success, or otherwise, of ACCHSs reducing the barriers to Medicare which face their Aboriginal and Torres Strait Islander patients appears to be a function of numerous factors - some of which relate to:

- characteristics of their clientele (eg level of general education, experience of other bureaucratic systems, extent of traditional cultural practices, 'stability' of the community etc)
- the ACCHSs themselves (eg standard of and ability to resource administrative support, use of computer technology etc)
- the larger service-delivery environment (eg prevalence of Medicare usage, level of cooperation of local Medicare staff etc).

■ There is evidence of considerable misinformation between HIC and service providers/consumers.

In some instances this is misinformation within the HIC about how Aboriginal and Torres Strait Islander communities and people function and in numerous instances misinformation among services-providers about how Medicare and PBS operate. The confusion results in a multitude of administrative problems for the HIC, the ACCHSs and for the individual consumer.

THE NATURE AND COSTS OF HEALTH CARE

■ The large proportion of clinical and community work done by Aboriginal Health Workers and nurses is currently not met by Medicare. These workers in some communities virtually do the job of a doctor, as in many instances a doctor only visits infrequently. In order for Medicare to appropriately resource health care in Aboriginal and Torres Strait Islander communities, it would need to cover the salaries of these personnel.

■ Procedures performed in remote communities by general practitioners and visiting specialists are carried out at a higher cost resulting from transport, accommodation, on-the-ground staff costs, hospital charges etc. However it was also said that the cost of treating a patient in his/her community is considerably lower than the cost of bringing a remote patient to a city for treatment.

■ The majority of ACCHSs related that addressing Indigenous health issues holistically resulted in more demanding and complex consultations. At some ACCHSs, nurses and Aboriginal Health Workers took care of many time-consuming services, which helped to keep consultations with doctors shorter, but in services with fewer staff, the doctors had to spend more time with each patient.

■ The threat of being investigated by the HIC for overservicing causes some doctors to worry about longer consultations. It was reported some doctors tend to understate consultation times to avoid suspicion, with the ACCHSs missing out on rebates as a result.

■ There are an increasing number of specialists, pathology and other technical services refusing to bulk-bill and some refusing to provide care in situations where a patient lacks a Medicare number. Even some ACCHSs reported

withholding services from, or refusing to bulk-bill, people without a current Medicare number.

In these instances patients are either made to seek services elsewhere or else delay receiving a service until they can meet the up-front fees.

■ **Given what is known about the level of reticence often shown by Aboriginal and Torres Strait Islander peoples in seeking health care, it suggests that being made to 'go elsewhere' or wait for care could very well mean that care is never received.**

■ One of the key factors about Medicare in the primary care setting is that only *use* attracts payment and the level of that payment tends to reflect the cost of provision of services in settings where there are no or fewer barriers (such as language or other cultural issues) hence where the costs of provision are lower. As has been touched on in this report, there have to be continuing concerns as to whether a fee-for-service system is at all appropriate for the funding of health services for many Aboriginal and Torres Strait Islander communities. Certainly there can, for example, be higher fees paid for longer consultations but the costs involved more generally in the provision of primary care services for Aboriginal and Torres Strait Islander peoples, particularly in remote areas, are such that if fee-for-service is to be retained there is a strong argument for a separate fee structure for Aboriginal and Torres Strait Islander people (or perhaps communities), with higher than average fees and almost certainly structured differently. Otherwise it would seem that we will not even get to the point of equity defined simplistically as 'everyone getting the same'.

To go further and get to equal access for equal need, the equity principle the consultants have been asked to adopt in this work, would require either a major look at alternative funding arrangements than fee-for-service, or at least a detailed look at how a fee-for-service system might be devised to reflect this equity principal for Aboriginal and Torres Strait Islander peoples. As things stand we believe that without that change from a fee-for-service system or without a major change in the basis of the fee structure, Medicare

cannot embrace the equity principle we have been instructed to adopt.

As a minimum then we recommend that in the wake of this report an examination be made of the question of how Medicare services for Aboriginal and Torres Strait Islander peoples can best be organised and funded so as to reflect the principle of equal access for equal need.

THE PHARMACEUTICAL BENEFITS SCHEME

■ As with the Medicare number, there are significant problems that many Aboriginal and Torres Strait Islander people experience in identifying and holding on to their concession entitlement number. The reasons this continues to be a problem are similar to those operating in regard to Medicare records - people don't retain their cards, they change their names, their family structure changes, the usefulness or need for the card/number varies etc.

■ Some pharmacists felt the requirement to actually sight an entitlement card every time medication is dispensed is onerous. Many admitted that in practice they often rely simply on the number held on computer.

■ While the responsibility for providing proof of entitlement status rests with the patient, in practice this often falls to a service-provider such as an ACCHS worker or a pharmacist. In this circumstance a critical impediment arises as a result of the requirement that an entitlement number only be released by DSS to the party concerned.

There was a consistent call from pharmacists, ACCHSs and GPs to establish a means of accessing clients'/patients' entitlement numbers at source. The restriction on third party access to the numbers was universally felt to be a marked barrier to patients getting their medication, with the consequent health risks, time-consuming administrative burden and financial strain on ACCHSs and patients.

■ **The inability of DSS, in light of privacy and/or security considerations, to release this information to a third-party is one of the two**

principal barriers to Aboriginal and Torres Strait Islander peoples accessing PBS.

■ Often children are cared for by people other than the mother or father. In many cases grandmothers and aunts who receive a Social Security benefit are the carers, but it is frequently reported that they are unable to purchase medication for those children at concession price because they are not included in their guardian's entitlement. The frequent result is that the medications are never purchased at all.

ACCESS TO MEDICATION

■ Immediate access to medications by many Aboriginal and Torres Strait Islander people when they present at a clinic/ACCHS is felt to be necessary by most health workers.

Certainly antibiotics are commonly dispensed or administered on the spot - both because of the need for a timely response and to ensure that the barrier arising when a patient has to take a script to a pharmacy to be filled, are eliminated.

■ Virtually all ACCHSs dispense some medication directly, even in urban areas with chemists nearby, because they regard it as essential in ensuring a patient receives what s/he requires.

■ The pharmaceutical stock kept on hand for dispensing purposes is provided through a variety of means from application of Section 100 to various 'imprest' systems operating in conjunction with hospitals/clinics, to a simple array of samples provided by the manufacturers.

■ There are a number of other means of providing immediate access to medication to Aboriginal and Torres Strait Islander people and communities. They include the medicine chests, supplied by the Royal Flying Doctor Service, special provision for selective medical practitioners to also dispense drugs and the use of rural/remote hospitals and clinics.

PBS CO-PAYMENTS

■ **The patient co-payment requirement is seen by virtually all service-providers as being the second major obstacle to Aboriginal and Torres Strait Islander peoples accessing PBS.**

■ A host of reasons account for this including the low incomes of many Aboriginal and Torres Strait Islander people and making the money stretch between periodic payments, the high cost of living - particularly in large families, the low value often placed on medication etc. **Both the concessional co-payment and the non-concessional co-payment were seen as obstacles.**

■ The majority of ACCHSs operate accounts with a local chemist and underwrite the cost of medications for some patients who can't afford to pay for them. The extent of the facility depends on the funds available to the ACCHS for pharmaceuticals, patient demand, proximity to a chemist and the policies of individual ACCHSs.

■ There was a common belief that CDEP participants were not eligible for a Health Care Card and this was borne out by the large numbers of CDEP participants who did not have one. CDEP wages are typically low - often lower than the unemployment benefit - and the necessity of paying full price for medication is a major impediment.

■ Under Section 100 of the National Health Act, the Minister may permit an incorporated health service to supply medication under the PBS in some isolated areas where there is not reasonable access to a pharmacy. The health service purchases the drugs directly from distributors, and, after supply, the Commonwealth is billed for the cost of supplying those drugs (inclusive of transport costs). The service may not charge a copayment nor receive a dispensing fee. Currently the arrangements are restricted to a very few remote ACCHSs and need to be extended.

PBS SAFETY NET

■ There appears to be relatively little awareness of the PBS Safety Net except amongst pharmacists. The fundamental problem of

Aboriginal and Torres Strait Islander people being able to meet the co-payment requirement overshadows almost entirely any Safety Net considerations.

■ There are numerous factors that make an accurate assessment of spending on PBS medicines, hence eligibility for the Safety Net, particularly difficult for Aboriginal and Torres Strait Islander people, eg shifting family groupings, changing names etc.

LISTING OF MEDICATIONS ON THE PBS

■ Many health care providers and pharmacists reported that there are conditions prevalent in Aboriginal and Torres Strait Islander communities which are treated with a range of medications which are currently not on the PBS. These include anti-fungals, tropical antibiotics, antihistamines, scabies treatments and analgesics. A result of these medications not being PBS-subsidised is that they are often too expensive for many people to consider buying. Subsidy of medications particularly affecting Aboriginal and Torres Strait Islander communities would be seen as a positive step.

MEDICATION COMPLIANCE

■ **It was universally agreed - by health workers, GPs and pharmacists - that medication compliance among Aboriginal and Torres Strait Islander peoples (that is, the use of medication in the manner specified) was very low. In this circumstance, using co-payments as a 'price-signal' make little sense.**

■ Labels carrying instructions on how to take medication need to take into account the level of literacy of the patient - Indigenous or non-Indigenous. Pictorial instructions were used by some providers, eg a sunrise and a moon representing times of day.

Some instructions, either given verbally or written on the script/label can be confusing and may result in the patient not taking the medicine properly. Providers need to ensure that the patient understands the method of taking medication.

■ It was widely understood that employing Aboriginal and Torres Strait Islander peoples in health care roles was essential to improving compliance and the general health of Indigenous communities. Aboriginal Health Workers are seen as 'linchpins' between the health service and the community, with particular abilities for gaining trust and communicating with the people most at risk in the community

■ Customised packaging such as dosettes and Webster Packs were favoured by a number of Aboriginal and Torres Strait Islander people, pharmacists and medical practitioners, particularly for the elderly and mentally ill. The main limitation to the use of these is the cost of purchasing and filling the packages.

■ A lot of medical staff prefer, where possible, to administer single dose medication to avoid problems of non-compliance. This is reported to be effective but is limited by the range of such medication currently available.

APPROPRIATE INFORMATION MATERIALS FOR CONSUMERS REGARDING MEDICARE AND THE PBS

■ The current range of HIC information materials is targeted at a market that is literate and reasonably well educated. While many people, particularly Medicare staff and mainstream service providers, thought that adequate information was already being provided, it was clear that this material was inaccessible for many people with poor literacy skills or who do not speak English as their first language.

Materials need to be in forms which are easily understood by less literate people - 'fewer words, more pictures', a greater use of colloquial English, more narrative and less lecture-style approaches etc. The development and production of such materials should involve Aboriginal and Torres Strait Islander people. The study identifies a number of products and the content of information materials that appear to be needed most by consumers.

■ Despite the existence of Mediguide (which explains Medicare arrangements in what the HIC believes is a simple, non-technical format) many

service providers did not clearly understand Medicare and PBS procedures. Consideration must be given to the fact that not all service providers have the same educational attainments, levels of literacy or English proficiency. Medicare administration in ACCHSs is often the responsibility of less skilled workers, but there is currently no guide which may be used easily by these staff. The study identifies a number of products and the content that appears to be needed most in communicating with Indigenous service providers.

ALTERNATIVE TO MEDICARE AND THE PBS

■ While a comprehensive range of improvements to Medicare and the PBS might be achieved, it is still possible that Aboriginal and Torres Strait Islander people would continue to experience barriers in accessing Medicare and certainly in accessing appropriate levels of health care.

Another model that might need to be considered is that of a capitation system where the HIC would pay capitation grants to all ACCHSs for enrolled clients (possibly deducting claims made elsewhere in the system). If this were not feasible to be applied to all ACCHSs, capitation type grants could be trialled in specific areas (eg remote areas, areas with no private services etc). Capitation funding should be set at a premium above the national average to reflect the substantially greater health needs of Aboriginal and Torres Strait Islander peoples.

McDermott & Beaver (1996) have, for example, established a methodology for determining appropriate levels of health fund expenditures for a notional, remote Aboriginal community, based on differing assumptions and models of equity.

Their results were as follows:

1. *Equal expenditure per capita = \$700*
2. *Equal expenditure adjusted for demographic structure = \$1,400*
3. *Equal expenditure for equal need = \$2,600*
4. *Equal access for equal need: 3. plus access margin = \$2,917*

5. *Equal use for equal need: 4. plus use margin = \$3,022.*

The rationale for capitation type funding is the same as the rationale for coordinated care trials. The existing fee-for-service system focuses on increasing the number of services to increase income, and services generally have to be provided by a doctor to generate income. This can encourage over servicing and discourages increasing the responsibility of Aboriginal health staff who are generally not doctors. Funding per enrolled patient allows services to be creative and culturally appropriate in the provision of services, and to provide a greater number of services using less expensive (and more suitable) staff than the present system requires. Funding that could be incorporated in such a system could include (i) Medicare payments to doctors seeing patients in the community, (ii) PBS payments to pharmacies, (iii) Medicare payments for pathology tests, (iv) Medicare payments for radiology. Payments for services provided in hospital would probably not be included.

Enrolling clients could be a problem although if the system was phased in it could be carried out as people are seen. There would be no need for any restriction on patients accessing other services and the HIC could deduct any Medicare payments claimed for people who accessed other services from payments to the ACCHS, possibly quarterly. The use of other services could still be kept confidential with funding in the following quarter reduced by the total amount of other services used. Some care to ensure reasonably steady funding would be required and this would need to be negotiated carefully with the ACCHSs.

Accountability could still be maintained in such a service by requiring reports of activities including doctor, nurse and Health Worker services and specific targets for things such as immunisation rates, screening proportions (eg percentage of diabetics screened for retinopathy, percentage of hypertensives with BPs in a set range etc). In addition longer term studies to examine health outcomes could be set up, although these would obviously need to be over a minimum of five to ten years to measure real health changes.

The important issue would be for the Department of Health and Family Services, for the Commonwealth Government, to pay this capitation fee as part of its obligation to pay for health services based on need to all Australians. OATSIS could then top this up to provide additional 'gap closing' funding to attempt to reduce the inequality in health status between Indigenous and non-Indigenous Australians where this was required.

Recommendation

46. It is recommended that the Department of Health and Family Services consider a capitation model as an alternative to Medicare and PBS funding. Capitation funding should be set at a premium above the national average to reflect greater health needs of Aboriginal and Torres Strait Islander peoples.

IMPLEMENTATION

The seriousness of many of the issues raised in this report are such as to warrant urgent attention. It would seem to be appropriate, therefore, to maintain the momentum by setting in place mechanisms for implementation.

Recommendations

47. A mechanism should be set in place for ensuring that the issues raised in this report are considered and that appropriate action is taken. A committee with representation from the departments/ authorities concerned, as well as the appropriate Aboriginal and Torres Strait Islander bodies and relevant non-government organisations, needs to be established to determine the best means of implementing the required changes.

48. A process of consultation with peak bodies and community representatives needs to be set in place to allow feedback on this report and the recommendations made within it.

REGIONAL CASE STUDIES

REGIONAL CASE STUDIES

Full descriptions of each of the regions selected for the fieldwork are included here. Each describes a unique situation where the Medicare and PBS systems operate in somewhat variable ways to accommodate local conditions. These case studies describe three remote locations, two rural locations and two capital city locations.

TORRES STRAIT AND NORTHERN PENINSULA AREA, QUEENSLAND - REMOTE

■ Background

The Torres Strait Islands

The Torres Strait Islands are a remote group of 18 islands off the tip of Cape York in far north Queensland, the distance between the nearest and the farthest, from the mainland, being about 180 kilometres. The commercial, transport and communications centre and the island with the largest population is Thursday Island, 20 kilometres from the mainland and a two hour flight by regular service from Cairns. The population of Thursday Island is about 4 000, around 80% of whom are Aboriginal/Torres Strait Islander.

Just over an hour by regular ferry service from Thursday Island and a direct flight from Cairns is the Northern Peninsula Area (NPA) on the mainland, consisting of five communities. Bamaga, with a population of around 1300, 75% of whom are Aboriginal/Torres Strait Islander, is the main town. There is a small shopping centre (with a supermarket, bakery and milk bar), a council headquarters, a police station and a State school. Seisia (population 132 - largely Islander) is on the coast, three kilometres from Bamaga and is the site of the wharf. Injinoo (population 500) is six kilometres from Bamaga and has its own school campus. New Mapoon, an Aboriginal community of about 250 people and Umagico, with a largely Islander population of about 280 are about four kilometres from Bamaga. The roads between the communities frequently become flooded during the wet season, though there are plans to upgrade them. From November to May the roads south are

generally impassable, though during the dry season the area is visited by around 20,000 tourists a year.

The outer islands are accessed by private boat or charter aircraft, there being no scheduled ferry or air service.

The population of the region is 8000 -10 000. The 1994 Indigenous population estimate was 6300. The Aboriginal and Torres Strait Islander population comprises 77.4% of total population (1991 census). The population also includes people from Papua New Guinea (PNG) and the Pacific Islands (Fiji, Tonga).

Cairns

Cairns is the main regional city in far north Queensland, with a population of close to 100 000. Aboriginal & Torres Strait Islander peoples account for 6.4% (12 600) of the population of whom up to 5000 are Torres Strait Islanders.

Cairns, along with Townsville, is a major centre for Torres Strait Islanders. Cairns offers the nearest post-secondary education facilities and many medical services which are not available in the Torres Strait. There is a relatively large resident Islander population in Cairns and relatives from the islands visit during the year.

■ Range of Health Services

Structure of the Health Service

Health services in the Torres Strait and on Cape York are almost entirely the responsibility of the Queensland Health Department. Torres Strait and NPA District Health Service is a district-based sector of Queensland Health and operates solely with State health funds. Queensland Health funds hospitals and primary health centres, paying the salaries of medical officers, nurses and allied health professionals. Around 400 staff are employed throughout the islands and NPA.

Prior to 1991, health services in North Queensland were operated by hospital boards which did not include community representatives. In 1991 all hospital boards in Queensland closed down and regional authorities were introduced. The Torres

Strait and NPA Health Council was set up to provide community input into the provision of health services. Each island health service has a Committee of Management which determines the needs of the communities. They report to the Health Council which communicates directly with the Minister. The District Director is answerable to the Health Council and to the Minister.

The Health Service's objective is to develop an integrated health care system. They feel a single provider of health care in the area is appropriate because they can make sure patients get the help they need rather than rely on several providers to look after their own specialty.

Private GP services are inappropriate in this area as most ailments are conditions requiring a total primary health care approach.

Community control - even if not community-ownership - is the preferred model of health care provision in this region. Wherever possible Indigenous managers and workers are employed. Policy development, corporate planning and the direction of services are overseen by Indigenous management committees and the Health Council.

Major illnesses include diabetes, obesity, trauma, parasites, skin infections, respiratory diseases, hypertension, alcohol and smoking-related illness/injury and infectious disease epidemics (eg Japanese encephalitis, dengue fever). Fluctuations in the water supply between seasons is an important environmental health factor. When water is in short supply there is a higher incidence of infectious diseases, skin diseases, etc. This has important implications for infrastructure development, where a secure supply of water is essential and also for health budgets:

A public health crisis can blow your budget straight away... The dengue epidemic last year blew it in one hit.

The district's health budget is calculated on the basis of people resident in the area. However the service says the budget does not take into account the 20 000 tourists who come through each year, some of whom are treated at the hospitals and given pharmaceuticals free of charge.

Around 80% of people in the Torres Strait and NPA have a concession entitlement card (Health Care Card).

The Framework Agreement

Changes are in progress which will allow salaried medical officers to bulk-bill. The plan will see Medicare rebates come back to the Torres Strait and NPA District Health Service and allocated as needs require. The arrangements are yet to be finalised in a Framework Agreement, which members of the Torres Strait and NPA Health Service Executive hope will ensure the State and the Commonwealth maintain current levels of funding for the next three years.

The Health Service has a number of reasons for wanting to participate in the Medicare Benefits Scheme. The point is strongly made that they are not an Aboriginal and Torres Strait Islander-specific service, rather they are the *mainstream Indigenous service* with secondary, tertiary as well as primary health care designed specifically for Aboriginal and Torres Strait Islander health conditions and cultural needs. As such, it is argued, they should by right have access to the pool of resources available to other mainstream services. They feel extra funds are needed to expand program work and employ more medical staff, and that there should be a mechanism for paying for the large numbers of tourists (many of whom are eligible for Medicare services) who receive free medical care and pharmaceuticals because they are not included in budgetary calculations.

Bulk funding from Medicare was seen as disadvantageous because of a perceived loss of rebate-generated income. It was felt that fee-for-service would allow them to claim all they were entitled to.

Equity issues

There was a strong belief that health services had to focus on *outcomes* rather than *activities*. Apart from the generally poorer health of Aboriginal and Torres Strait Islander peoples and the need for additional programs (eg health education, ante-natal classes), it was said that specific issues of remoteness and environment required higher

levels of funding. For example, fluctuations in the water supply between wet and dry seasons create health problems: in the dry, infectious diseases tend to increase because of poor sanitation and personal hygiene.

Thursday Island Hospital

The 38-bed hospital is the major medical facility in the district and provides pathology, radiology, maternity, ante-natal, dentistry and a number of other services as well as having an accident and emergency department. There are five doctors (three service the outer islands), two dentists, one pathologist and one assistant, a radiologist, nursing staff and a number of technicians/assistants. Specialists - including a paediatrician, obstetrician, ophthalmologist, cardiologist, internal medicine specialist, diabetes specialist and a kidney doctor - make regular visits from Cairns/Townsville up to eight times a year. Virtually all the specialists are public hospital-based and therefore provide non-fee services. The exception is an ophthalmologist, who bulk-bills all consultations.

The hospital pharmacy supplies inpatients and all patients in outer islands and Bamaga. Pharmaceuticals for residents on Thursday Island are obtained from a community pharmacy located in the main shopping area.

A primary/community health care centre is located in the grounds of the hospital and is staffed on rotation by hospital medical staff. There are no GPs in private practice in the Torres Strait and NPA area.

NPA Health Service

There is a 16 -bed hospital staffed by two full time Medical Officers, nine Registered Nurses, seven Health Workers as well as administrative/ancillary staff. It is open 24 hours, seven days a week, with an after hours staff of two. One of the doctors is without a Medicare provider number at the moment because he has a temporary resident's visa.

Pharmaceuticals for all communities are provided through the hospital dispensary. Following a Queensland Health directive last year, the hospital

began charging patients for pharmaceuticals, mirroring the PBS schedule of fees. They manage to retrieve money from about 50% of patients and the rest are not chased up. The Head Nurse supplies medication and the Thursday Island Hospital pharmacist visits weekly to make checks, restock and collect payments.

There is a primary health care centre in each of the five communities, staffed by health workers and administered from the Bamaga Primary Health Care Centre. Patients generally go to the local clinics for dressings, Panadols etc. The two doctors alternate between hospital consultations and community consultations. Each clinic is visited once a week by one of the doctors. All clinics are drop-in with no appointments. Each clinic is centrally located in the communities and is open Monday to Friday. After hours patients have to present at the hospital for treatment, which can be difficult for those without transport.

The NPA is in need of another doctor. At present the doctors take it in turns to work at the hospital and go to the communities and they would like a third doctor to do community visits full time.

Cairns health services

Cairns Base Hospital services Cairns and surrounds, Atherton, Yarrabah and provides services to the whole of far north Queensland and the Torres Strait Islands through outreach programs and visiting specialists programs. There is a private Catholic hospital nearby.

Wuchopperen ACCHS, located in the centre of Cairns, services a large proportion of Aboriginal and Torres Strait Islander peoples from Cairns and within a 50-60 kilometre radius. It also runs satellite clinics and remote clinics once a week. Wuchopperen see 60 patients per day (95% of whom are Aboriginal and Torres Strait Islander), though only about one quarter of those would see a doctor, the rest being attended to by health workers and nursing staff. The centre is open long hours and most patients are from Cairns.

There is a 24 hour medical centre (accident & emergency, primary care, X-ray, pathology & pharmacy). Between six doctors they perform two to three thousand procedures each week. 30-40%

of clients are Aboriginal and Torres Strait Islander. There is also a pharmacy located in the building which is open extended hours.

In Cairns city and suburbs there are 25 pharmacies - including one pharmacy frequently used by the ACCHS (though still with a fairly small Aboriginal and Torres Strait Islander client base of 250-300). There are about 85 GPs in the region and 70-80% of Aboriginal and Torres Strait Islanders in Cairns have Health Care Cards.

■ Issues Relating to Medicare

Any comments about Medicare in the Torres Strait district are limited by the minimal experience people have had with the system. Until now, patients have only needed Medicare cards if they have needed to see a bulk-billing specialist or have gone to mainland towns such as Cairns or Townsville for any length of time. However, given the imminent introduction of bulk-billing in the area, Medicare enrolment and claiming are relevant issues for these communities.

Awareness and understanding of Medicare

Knowledge and understanding of Medicare is very limited. Many people have no idea what a Medicare card is used for. Once Medicare is introduced an education/awareness campaign is planned.

They don't realise the importance of their card and so they lose it.

They're probably not aware of a need for Medicare cards.

Enrolment

On Thursday Island and in NPA, around 50-60% of people are enrolled in Medicare. There has been a recent drive to enrol people, but so far Medicare has only been used by a couple of visiting specialists. The health workers now enrol every person who comes to each clinic using the *Proof of Identity - Verification* forms, which are signed by the health coordinator. During the consultants' visit, one woman came to a clinic to enrol her baby

in Medicare, but she did not know why she needed to.

At present newborn babies are enrolled in their communities by health workers, not at the hospital. One woman said she went to Townsville to have a baby and enrolled the baby there. When her new Medicare card arrived, it listed the new child but left her other children off.

While many people in communities are enrolled, often those who aren't are teenagers who have left school and need their own cards. It is suggested that the only way Medicare could work is for every person to have his or her own card and not to use family cards. *'The list of family members changes daily'*.

Staff at a Cairns clinic felt enrolment was less of a problem than chasing up numbers, mainly because around 90% of Aboriginal and Torres Strait Islander patients were regulars, were enrolled and had their Medicare numbers kept on file. Patients who aren't enrolled are generally sent up to the hospital unless they are in need of urgent attention. They also said they keep enrolment forms at reception, fill them out for patients and take a bundle of them down to Medicare three times a week.

One clinic sees a number of patients whose cards have expired. In these cases, they update the number by raising the last digit and at the same time get the patient to fill out an enrolment form and run it down to Medicare. Usually the enrolment form has been received by the time the claim comes back.

Medicare numbers

When a bulk-billing specialist visits the Torres Strait district, a health worker or other member of staff generally accompanies the doctor in the communities and sorts out administrative details. The health workers put up a sign in the clinics telling patients to bring their Medicare cards when they see the specialist. However patients frequently do not bring their cards with them.

When specialists come it's a nightmare chasing up the numbers and it ties up the phone for ages.

Problems arise as many patients are known by different names (people have up to four names which are frequently used interchangeably, as well as an Island name), several people in the one family use the same name (eg Robert Senior, Robert Junior) and dates of birth are often not known or are incorrect (one staff member reported seeing eight modifications to the date of birth on one patient's chart).

Because specialists may only visit the district once a year, it is imperative that all correct details are collected while there, otherwise there is little chance of chasing them up. Often telephoning the Hotline is not possible because of situational constraints (eg no telephone, mobile phone is out of range, too many patients) One specialist's strategy is to fill out an enrolment form and *Proof of Identity* form for patients who do not have Medicare cards/ accurate details and check the details later. If necessary, he sends in the enrolment form and waits several weeks before sending in the bulk-billing voucher. Most of the time the claims are processed, but sometimes an entire batch is rejected on the grounds that the bulk-billing voucher was dated prior to the patient's enrolment. While he reported that the rate of rejection used to be much worse (and still is in other communities), it is still around 10% for his Torres Strait patients.

The significant number of visiting PNG nationals complicate Medicare matters in the Torres Strait. Health care providers generally do not refuse treatment to PNG nationals on humanitarian grounds, though they are unlikely to be paid. As a result, the non-salaried specialists tend to wear the cost of these consultations. Because a number of PNG-born people are resident in the Torres Strait, it is often difficult to distinguish residents from non-residents. However, health care providers were aware of the need to enrol only those who were eligible for medical benefits: '*We understand the need for preserving Medicare for Australians*'.

One Cairns doctor said some numbers are impossible to get hold of because surnames sometimes change, people remarry and don't change their name on the register and birth dates are often wrong. Frequently patients arrive from Palm Island without Medicare numbers. This

doctor wrote off one or two claims a week, usually for transient patients. One private bulk-billing medical clinic reported '*a humungous problem*' with rejections from the HIC. Their rejection rate is about 10% of all claims, mostly because of incorrect Medicare numbers but also human error (eg form isn't signed, amount not written in). This clinic said around 16 person hours per day were spent sorting out Medicare claims.

Several health care providers reported having a lot of problems with the Medicare Hotline. Some complained that the Hotline operators were unhelpful or did not understand the difficulties involved with getting the information required from Aboriginal and Torres Strait Islander peoples, particularly in remote areas. It was also reported that the Hotline is frequently busy and it is difficult to get through. A 24 hour clinic reported difficulties accessing Medicare numbers after hours.

A universal Medicare number wasn't seen as a viable option for Cairns because of the difficulty of identifying people as part of an Aboriginal or Torres Strait Islander community. It was not discussed in Torres Strait because the experience of Medicare is limited.

Forms and procedures

It was thought that for the Torres Strait district, which is a fairly self-contained region, the amount of information contained on an enrolment form could be reduced to the first name, surname, date of birth and address.

It was felt that the only way Medicare could work in the district was to have all cards initially sent to Thursday Island Hospital, from where they could be distributed to the cardholders throughout the islands. This way the hospital could capture the numbers as soon as they arrived and enter them into the computer. As soon as the planned computer network is operational the numbers will be available throughout the islands. It was also believed that this would make it simpler for city clinics who see a Torres Strait Islander patient because they would know his/her patient's address when they phone the Medicare Hotline. '*We have a major health status problem here and the last thing we need is to complicate the system*'.

It was also recognised that doctors, who often have more experience with Medicare, need to assist patients/receptionists with procedures.

It was suggested by a mainland clinic that the *Proof of Identity* form and the enrolment form be merged to cut down on waste, particularly as practices move towards being paperless.

Non-claimable work

Because of a shortage of doctors in the region and the fact that the greater portion of primary health care is overseen by health workers and nurses, it was felt that Medicare rebates would be limited. The Health Service Executive thought that claiming some health workers' and nurses' work would be appropriate because of the remoteness of the location and believed that any such arrangement could be quarantined to the Torres Strait area.

Nurses and Health Workers need provider numbers for things like PAP smears and things.

A potential impediment to effectively bulk-billing is the difficulty some doctors experience getting provider numbers. When a locum is required, they often get non-Australian doctors who are willing to 'do a stint'. These doctors often find it difficult to get provider numbers. It was suggested that location-based provider numbers would be more appropriate for a remote post such as the Torres Strait and would simplify the already difficult process of attracting doctors to the region.

Levels of misinformation

There was some confusion over the purpose of the *Proof of Identity* form. One doctor thought the form was asking for verification that the patient was not from PNG. He was not aware that the form was used outside the Torres Strait region. Another doctor working largely with Aboriginal people on the mainland was entirely unaware of the existence of the form, and thought it would solve many of his problems.

■ **Issues Relating to PBS**

Currently most people in the Torres Strait region do not access the PBS because aside from the pharmacy on Thursday Island, there are no community pharmacies in the district. Medication on the other islands and in the NPA is supplied by a nurse from the hospitals or primary health clinic and comes out of the State health budget. Thursday Island Hospital pharmacy services 15 communities and fills 1000 scripts a month. Residents of Thursday Island must get their medication by prescription from the pharmacy in town.

The pharmacist at Thursday Island Hospital wondered if an agreement similar to the Medicare one could be struck with the PBS. This would apply only to the areas not already accessing the PBS (ie not on Thursday Island). They could be given special dispensation because of remoteness to send in scripts to the HIC. *'If the salaried doctors can access Medicare, the pharmacy should be able to access PBS funding'.*

Entitlement numbers

At the moment concession numbers are not a big issue in the Torres Strait and NPA (except Thursday Island) because medication is supplied by Queensland Health. However in the last year or so they have started to charge patients for their medication, mirroring the PBS schedule of fees. The registered nurses are able to supply medication from the hospital and collect the patient contributions. They do not have to write concession card numbers on the scripts, but they are supposed to sight it every time. They photocopy the card as soon as patients get it and attach it to their file (but if they don't have their cards with them they don't worry about it: the staff generally know who has a Health Care Card and who hasn't). About 50% of patients pay for their medicine - the rest aren't chased up.

On Thursday Island there is a community pharmacy in the town which all outpatients on Thursday Island have to use. The pharmacist has a lot of problems with entitlement numbers. About five or six are thrown in the bin each month because a number cannot be found for them.

If I phone Social Security they won't release the numbers to me and then if the

customer phones the department from my phone, the phone is held up for about 20 minutes while they are waiting for their number.

The pharmacist reported that the numbers wash off the Health Care Cards, which frequently happens because quite a few clients travel in boats. It was suggested that plastic cards, similar to the pension cards, be issued.

A pharmacist frequently used by the ACCHS in Cairns said entitlement numbers were his biggest problem. Although the ACCHS generally writes the entitlement numbers on the scripts, they are frequently incorrect or invalid. With 90% of cases a phone call to the ACCHS can resolve the problem, but ideally direct access to numbers was needed.

Another pharmacist has a pile of scripts for which he has no entitlement numbers; about half of these would be for Aboriginal and Torres Strait Islander patients and it was thought there was about five or six of these per week. He generally takes their telephone numbers and asks them to come back or telephone with their entitlement numbers. Most do, and it's only with about 5% of scripts that he can't get a number.

One pharmacist reported having a frequent problem with children whose names are not on a guardian's Health Care Card.

Lack of money

In the Torres Strait district patients are asked to pay a contribution towards the cost of their medication but are not hounded by Health Service staff and Queensland Health currently absorbs the cost. However some CDEP participants and other workers said they had to pay full-price for their medication. *'Sometimes they lose out because patients can't afford medication, but not many do.'* One patient said that sometimes medication is too expensive, especially if she needs two or three different medicines, in which case she doesn't get them. On Thursday Island the pharmacist runs around 300 accounts and it is common for patients to get medicine on credit.

In Cairns, one pharmacist felt lack of money was more a problem with the non-Indigenous community. This is explained by Wuchopperen

ACCHS allowing patients' medication to go on account when necessary, irrespective of whether it's the full or concessional amount.

One pharmacist said that doctors generally prescribe medication that is on the PBS. It was reported that occasionally medication was too expensive and patients would not buy it.

Scheduling of medication

Several practitioners and pharmacists complained that all anti-fungals had been taken off the list. Fungal conditions are especially prevalent in the tropics.

The Safety Net

The Safety Net was largely an irrelevant issue in the Torres Strait district. Only a few clients on Thursday Island were said to be eligible for Safety Net benefits. The pharmacists in Cairns and Thursday Island believed people generally were not very aware of the Safety Net.

■ Other Health Delivery Issues

Shortage of medical personnel

There is a shortage of doctors in the Torres Strait & NPA District, but there is also a reported shortage of funds to pay them. Often they can only get foreign doctors who may have difficulty getting provider numbers. It was suggested that location-attached provider numbers would allow foreign doctors to work in remote locations but not elsewhere.

The Health Service would like to employ a second pharmacist to do community visits on other islands and in NPA, but they currently lack the resources to do so.

A limited number of specialists visit Thursday Island Hospital. Most are from the public hospital system and therefore don't bulk-bill. Currently only one bulk-billing specialist visits the region though they are hoping to attract others. It was reported that an ear, nose and throat doctor used to make visits but had so many problems with Medicare claims that he did not return. One specialist commented that those outside the hospital system

are unlikely to make the effort to visit the communities because there is not adequate remuneration: specialists in private practice still have to maintain their rooms and staff while they are away and unless all their travel, accommodation, equipment and on-the-ground staff costs are met, visits to remote communities will never be viable.

Another felt the public hospital specialists are the ones who would go but are so often limited by inadequate resources and their inability to drop their hospital workload. Some specialists said if they could bulk-bill their consultations in remote communities they could get a replacement for the period they were away from the hospital.

The reality is that the Medicare system is not paying for either primary or specialist care for remote Indigenous communities, and that the state health services are having to pick up the load without getting Commonwealth funds for it. I desperately need another staff member to properly provide outreach specialist care. How about Medicare funding it? Much cheaper than all the use of Medicare by metropolitan Caucasians. (Specialist).

Compliance with medication

While compliance is fairly poor in the Torres Strait district, it is said to have improved. One pharmacist felt that charging for medication and the counselling roles of health workers had improved compliance. However one health worker said they generally don't follow up on patients' use of medication.

Several people in the communities said they stop taking their medication once they (and their children) started feeling better. Some said they don't get their medication because it's too expensive. One woman said that while she lets her children stop taking medicine once they start feeling better, she generally takes the whole course.

Compliance was seen as being similar for Indigenous and non-Indigenous people in Cairns. One pharmacist felt compliance had greatly improved since the ACCHS had taken on the role

of managing medication and counselling patients. It was said that the ACCHS had a very 'hands-on' approach to medication compliance: staff from the ACCHS run scripts to the pharmacy, bring the medication back and give it to the patients as well as drive around to ensure patients are taking their medication.

Transport

In the Torres Strait district transport was a concern to the Health Service staff: a number of patients have missed their specialist appointments because they couldn't get to the wharf to catch the ferry to Thursday Island (this was of concern to the hospital because they had to pay some of the cost of the passage to the ferry company whether the patient turned up or not). There used to be two regular bus services, but one has ceased operation and the other only goes to a couple of the communities. In Umagico, there is currently no bus service. These problems in part account for a high level of non-presentation.

There is a twice-daily ferry service between Thursday Island and Seisia but it is relatively expensive (\$75 return). Bamaga Hospital pays the cost of an ambulance from the hospital/home to the airstrip, but not to the wharf at Seisia to go to Thursday Island. Regular ferry services do not run to other islands, though boats and light aircraft may be chartered. Chartering is expensive and people tend to wait until a few people can go and then charter a plane. People also get between islands in small privately-owned boats or dinghies.

Bush medicine

It was reported that traditional healing is used, especially in the islands. Bush medicines are sometimes used instead of pharmacy medication, especially by older people, but more often 'a bit of both' is used. Common bush remedies were the use of almond bark for thrush and remedies for skin rashes and toothache. However young people don't tend to use bush remedies.

They use it on the weekends (when the hospital dispensary is closed.)

They still use traditional medicine - that's why they don't come here! (to the health clinic)

It's common for patients to arrive at the clinic with leaves still attached to the wound.

■ **Satisfaction with the HIC**

No problems with the HIC were reported in the Torres Strait district (but it should be remembered that they haven't had any cause to make contact).

One health care provider was critical of the HIC's apparent insensitivity to the specific needs of after-hours clinics. It was said that after-hours access to Medicare numbers and some financial assistance with setting up a complex computer network was needed.

Culturally specific information materials

A number of Health Service staff and some patients said information in Kriol would be useful. The Health Council would like the materials to be produced locally (funded by the HIC) to provide employment and ensure the material is accurately written and presented. They thought that videos in Kriol could be used by health workers throughout the islands. At the moment many community health centres prepare and photocopy their own materials.

Information materials covering drug, alcohol and smoking prevention, general good health and dental care are said to be required in the Torres Strait:

People need to be educated about what a doctor can do, that they don't always tell you to take a Panadol and go home.

HALLS CREEK, WESTERN AUSTRALIA - REMOTE

■ Background

Location and context

Halls Creek, in the East Kimberley region of Western Australia is located some 550 km due east of Broome and some 300 km due south of Kununurra. While there are high standard sealed roads between Halls Creek, Broome and Kununurra, flooding during the wet season (October/November to March) can make roads impassable for periods of time. Halls Creek district has a population of some 2,500 people (an estimated 1,200 people in the town itself), some 80% of whom are Aboriginal. The major industries in the area are cattle farming and tourism and, of course, the town serves as a local service centre with numerous stores, roadhouses, accommodation, two primary schools and a range of Aboriginal facilities (eg a radio station, cultural centre etc).

The town is fairly 'loosely' developed, that is various housing areas - Redhill, Nicholson Block, Mudiwa Loop - sprawl on the outskirts of town. As well there are numerous more distant outstations in the Halls Creek region whose populations range anywhere from two couples (a homestead) to 2 - 300 people. At some of the outstations, the population swells at certain times of year (holiday peaks, for example). The demographics of the various outstations differ also, with some being resided in by mixed-aged populations and others primarily by older people.

The outstation movement is the second significant population movement in the Kimberley in this century. Following mass evictions and walkoffs of Aboriginal people from cattle stations in the period of the 1950s to the early 1970s (a result of the requirement to pay equal wages to Aboriginal workers and moves to shift families of workers off the stations) fringe camps developed around centres such as Halls Creek. The State Health Department centralised health services in towns in response to this move. However very quickly

Aboriginal people again began to move and return to traditional land, generally adjacent to the pastoral stations where they previously lived. This, of course, has resulted in marked problems in relation to the delivery of services to these outstations - including basic health services and infrastructure. Thus a town like Halls Creek which is defined as 'remote', makes the smaller, satellite communities away from these centres *excessively* remote.

Range of Health Services

Halls Creek is serviced by Yura Yungi, the Aboriginal-controlled health service, the Halls Creek District Hospital and a Community Health Centre - the latter two operated by the State Health Department. There are no privately operating physicians nor is there a pharmacist in town. There is a limited range of other health-related programs and services operating in the town.

■ Description of Yura Yungi

Yura Yungi was established in 1987 and operates with the support of the Kimberley Aboriginal Medical Services Council (KAMSC). The latter organisation provides administrative services, training, public health program development, central purchasing, advocacy work etc for the Aboriginal-controlled health services in Halls Creek, Kununurra and Broome.

Yura Yungi staff consists of: 1 administrator; 1 administrative assistant/bookkeeper; 2 receptionists; 1 doctor; 1 clinic coordinator; 5 Aboriginal Health Workers plus trainees; 1 cleaner and 2 field officers (responsible for maintenance and transport on a rotating basis)

While available to the non-Aboriginal community, the service largely sees only Aboriginal people. There is a fairly stable permanent population in the town and district but, over time there has been some movement of people from the desert region in the south into Halls Creek. As well, the population swells at certain times of the year, with 'regular-transients' - at Christmas, for example, or during the rodeo etc. The five outstations that Yura Yungi services include: Ringer's Soak,

Chinaman's Garden, Ngunjiwirri and Lumbu Village. Each outstation is visited at least once a fortnight and Chinaman's is visited weekly but only Ringer's Soak has a regular visit by the doctor - fortnightly. People from the outstations come into town (often weekly), and they have the opportunity of visiting Yura Yungi or the hospital on these visits.

Aboriginal Health Workers are based at some of the outstations, with varying levels of success. While the size of the largest outstation, Ringer's Soak - with its population of 2 - 300 people - warrants having a resident nurse (and Yura Yungi has the funds for a nurse) there is no suitable accommodation available at the site. (Yura Yungi has three houses in Halls Creek - one for the doctor, one for the administrator and one for the clinic coordinator). Yura Yungi hopes to get a second doctor to service these outstations.

There is no appointment system operating at Yura Yungi, although those who are more critically ill are seen first. A patient may present at Yura Yungi and request to see a doctor, otherwise a health worker will see the person and either refer them on to a doctor or, for more routine matters, attend to the person directly.

A critical element in the operation of Yura Yungi is its computer database *Health planner* that permits the service to intervene with patients in a highly opportunistic manner. Thus, when a person presents at the service, the database will show not only the patient's past medical history but it will identify any overdue and/or up-coming tests or treatments that should be administered. Thus if a person presents with a condition requiring immediate clinical attention (eg an infected wound) this is seen to, but the opportunity is also taken to administer to other more routine matters (eg vaccinations, Pap smears etc). The database also enables the service to recall, from the records, a list of patients who have not been recently seen but are, similarly, due for some screening or follow-up process. In this way a fairly aggressive approach can be undertaken to ensure that preventative health surveillance programs can be effectively carried out. This proactive and holistic approach characterises Yura Yungi and

distinguishes it from, for example, the clinical services provided by the district hospital.

District Hospital

The hospital provides both in-patient and out-patient services and operates 24 hours a day, seven days a week.

The hospital is funded for four beds although it sometimes accommodates up to seven or eight in-patients (sometimes on the back verandah, particularly for heavily alcohol-affected patients). The cases admitted are often adults suffering from an alcohol-related ailment (eg bashings, gastric bleeding) or children with severe gastric problems, chest infections etc where monitoring and surveillance are required. Patients are kept under observation for up to 24 hours and if warranted are evacuated to the hospital at Derby.

There is some pressure, locally, for the hospital to provide obstetric services, as women are otherwise directed to shift to either Kununurra or Derby when they are about 38 weeks pregnant. The Halls Creek Hospital is said to lack both adequate surgical facilities and a sufficient properly refrigerated blood supply to safely respond to even what are judged low-risk births. (Some women circumvent this by simply not presenting to a medical service until they are about to give birth - in the past two months the hospital has delivered five babies).

The hospital's outpatient clinic provides primary care to both the non-Aboriginal and the Aboriginal populations - *'at some time or another everyone comes to the hospital'*.

Given they both provide primary health care, the choice of which service to use - Yura Yungi or the hospital - appears to be a function of:

- access, with the hospital being open 24 hours a day
- convenience - one or the other being marginally easier to get to (although they are only a few blocks apart)
- preferences for a particular medical practitioner
- confidentiality, with the hospital being seen by some as offering more privacy

- experiences with one centre or another (eg 'If someone has had a relative die at the hospital they may be reluctant to go there')
- The culture of each place, with Yura Yungi being community-based and Aboriginal-controlled and the hospital being a more formal organisation. Yura Yungi is also better able to support people who are unable to read and write and are intimidated by mainstream services.

It was noted by a number of people that some patients shop around for care, going straight from the hospital to Yura Yungi and vice versa.

It was believed that this might have to do with the person seeking a particular kind of treatment or medication but, clearly this uncoordinated 'doubling up' could result in risk for the patient. When medical staff at the hospital and Yura Yungi are aware of this doubling-up in respect to a particular patient, both endeavour to communicate back and forth regarding the patient.

While both Yura Yungi and the hospital provide primary health care to, in many instances, the same population it is almost impossible to envisage that they would ever integrate patient information and files. (There seems to be general agreement that Yura Yungi's computer database on its patients is a more comprehensive and up-to-date system than that operating at the hospital.

There are two doctors based at the hospital and it was suggested that this is in excess of need. This perhaps offers an opportunity for more out-reach work at outlying outstations. Currently, the hospital regularly services Yiyili, an outstation midway between Halls Creek and Fitzroy Crossing: a nurse visits weekly and a doctor fortnightly. After-hours care at the hospital is rostered between the hospital's doctors and Yura Yungi's doctor. There is an Aboriginal liaison officer at the hospital and Aboriginal people hold other positions in the hospital's administrative and clinical sections.

A very broad range of medical and dental specialists (almost completely funded through the State) schedule regular visits to Halls Creek to hold clinics, although hospital medical staff call Perth-based specialists three to four times a day to confer, ask advice etc. Communications costs

are, as a result, considerable. Access to specialists is only as good as the supply of specialists from the larger centres and capital cities. For example, funding cuts to the renal unit of a major Perth hospital are likely to have a direct flow on to the visiting specialist services in Halls Creek. Similarly, there was an extended period recently when no gynaecologist visited as it proved impossible to attract one.

Pathology tests are handled in this way - samples are batched up and, at the end of the day, taken to one of the local roadhouses and put on a bus to Derby, with the results being communicated back by fax in the following days.

Community Health Centre

The State-run health centre operates a range of clinics and community health programs, including those focussing on child health (including a school nurse), STD, diabetes and other chronic diseases, women's health, vaccinations, dental services, nutrition, etc. A psychiatric nurse also regularly attends the Health Centre. The Centre is not intended to serve as a primary health care service but, instead, focuses on community education, preventative programs etc. No-one is expected to present a Medicare card/number at the Health Centre. Again, these programs service both the Aboriginal and non-Aboriginal communities.

There are moves to better integrate programs with Yura Yungi - a newly-established child health clinic has been established at Yura Yungi which is run by the Child Health nurse from the Community Health Centre. The clinic currently attracts about 10-12 mothers each week. Similarly, Yura Yungi and the Centre have endeavoured to coordinate their vaccination programs. Some years ago a *Halls Creek Plan for Health* was produced which sought to develop an integrated health service delivery system and there was marked progress made at that time in this direction. Apparently efforts have since lapsed, although individuals are still seeking to coordinate particular programs.

A particularly sensitive role of the Community Health Centre is identifying children at-risk, or mothers who are not coping. In this general region, a very high proportion of adults had been taken away from their natural families, so that the

matter of at-risk children must be handled with *extreme* care. Typically the child health nurse meets with the family along with someone from Child and Family Services to negotiate a family solution. It is the need to function in roles like these which reflect the authority of the 'state' which would clearly distinguish the Health Centre from a facility like Yura Yungi.

Alcohol Education Treatment Centre

A coalition of community groups and individuals have recently established an alcohol treatment centre, which operates both men's and women's groups. It is seen to serve the Aboriginal community exclusively, a decision which has been criticised in some quarters. There is also a sobering-up shelter for overnight stays for people who are very drunk.

A medical practitioner at the hospital observed that a very high proportion of the hospital's work was directed at a relatively small number of chronic alcoholics in the town. As in other towns, efforts are being made to address the alcohol problem in a more systemic way. Thus new controls have been put into place to limit the hours in which alcohol can be sold, to limit liquor licences, to restrict the sale of glass bottles (to reduce the injuries caused by broken glass) etc.

Frail Aged Hostel (Menkawum Ngurra)

A long-term or short-stay respite care hostel has been established for older and disabled people, under the auspices of the Halls Creek People's Church. Yura Yungi is hoping to schedule a monthly visit by a doctor and a health worker once a week.

Priorities for Additional Programs/Services

Various Yura Yungi and State medical personnel identified the unmet health needs that existed in Halls Creek and the type of programs/services needed. It was acknowledged that alcohol was a fundamental problem and that the treatment centre and other initiatives needed to be supported. There was a need for nutritional education programs, environmental health workers, a response to violence and crime in the area and a need for economic development and job creation

programs. (The idea of establishing a CDEP project around the creation of a market garden has been mooted - thus serving the dual purpose of job creation and enhanced nutritional resources - given that all fresh fruit/vegetables have to be trucked in. However the cutbacks in CDEP have made this impossible.)

■ Medicare and Yura Yungi

Administrators of Yura Yungi indicate that in a normal week about 60 Medicare claims are made - about ten people per week lack a Medicare card and do not have a number on file. The Medicare Hotline is used to locate missing members when a person is enrolled. About ten adults or children are newly enrolled each week - it is said the process is simple, taking about 10 minutes to carry out.

Approximately 20 Medicare claims a month are refused, for a variety of reasons. In addition Yura Yungi freely treats people that they do not even try to claim for, although they generally try to maximise appropriate claiming. It is estimated that a full two person days of administrative time is spent each week on handling Medicare paperwork.

The mix of clinical treatment and health promotion that is provided at Yura Yungi means that a significant proportion of the services offered there are not covered by the Medical Benefits Scheme. This is obvious from the fact that, of the 14 or so staff at Yura Yungi only one is a medical practitioner able to claim under the Medical Benefits Scheme. It is inherent in the nature and principles guiding Aboriginal community-controlled health services that considerable efforts be directed at addressing the real causes of ill health hence disease prevention and health promotion.

One particular area of service for which benefits cannot be claimed is the local transport offered as part of Yura Yungi's outreach efforts. A full-time driver is available, who serves to notify patients about specialist appointments and check ups etc (bearing in mind the absence of telephone connections), and also picks patients up to attend clinics, appointments etc. For example, when the Child Health Clinic is held a driver travels about to

remind mothers and offer to drive them to Yura Yungi. Some decide to walk up whereas another may say 'Could you come back in half an hour - I'm just going to have a shower'. The spread-out nature of the town and the importance of patients' attendance at the medical centre leads to this use of the transport service. This contrasts with the attitudes of the hospital administration where the policy has been established that transport is only to be provided in cases where it is absolutely impossible for the patients to come in by themselves or with family assistance. While the hospital's Aboriginal liaison officer will visit homes to notify people of appointments with specialists etc. he only makes transport available in exceptional circumstances. This policy is predicated on the belief that patient dependency is otherwise bred. A story was recounted, for example, of an elderly woman who arrived at the hospital a day early for a specialist appointment - she was asked to come back the next day and did, albeit at the wrong hour. This anecdote was offered as an example of a situation where a person's own capabilities would have been underestimated and undermined by the assumption that she needed transport. In contrast, the Kimberley Aboriginal health organisations explicitly identify one means to Aboriginal empowerment as being 'assistance with transport'.

Transport issues are, of course, not limited to local town transport. Yura Yungi covers the cost of the regularly chartered aircraft used in servicing Ringer's Soak. It's recalled that the Royal Flying Doctor used to fly regularly to Ringer's Soak but that a local doctor, with his own aircraft, established the practice of doing the trips to Ringer's Soak in his own plane. When that doctor left, Yura Yungi began to charter flights - funded out of its general budget - but is beginning to query whether this cost could be met by the Flying Doctor. (The Royal Flying Doctor does, of course evacuate people in critical need of hospital care, which might happen two to three times a week from Halls Creek. The costs - some \$4,000 per trip, are met by the Flying Doctor Service).

Aside from services for which no claim can be made there are as well numerous problems in ensuring that those scheduled items that can be claimed under the Medical Benefits Scheme are in

fact claimed. Not the least of these problems are the administrative demands and need for understanding of the Medicare system. While these problems would also be experienced by a suburban medical practice, the problems are exacerbated at a service like Yura Yungi. Clerical and administrative staff who are well educated, well trained and experienced are obviously better able to master and manage the Medicare system. Yura Yungi has been able to attract and hold skilled staff but not consistently. A story was recounted about the departure of one administrative staff person which revealed a drawer full of unclaimed Medicare claim forms worth thousands of dollars. Turnover at a location like Yura Yungi is certain to be higher and the pool of good prospective workers lower than at a suburban, capital city practice.

Similarly with the medical practitioners themselves Halls Creek is seen as a hardship post and it is difficult to attract doctors. (It was noted that 'Even Broome, which is a tourist centre can't easily get doctors'.) A number of consequences flow from this which have immediate financial implications. First, the cost of remunerating doctors is higher. As noted, Yura Yungi provides a house for this doctor, but also provides other 'sweeteners' eg cost of travel to Perth, long-service leave etc.

Secondly, overseas-trained doctors with temporary registration and new graduates are disproportionately more likely to work in a place like Halls Creek, simply because of the constrained options open to them. They have little or no understanding of the Medicare system and have to be trained in how to make claims and, as well, how to maximise appropriate claims. The previous doctor at Yura Yungi acknowledged that, on first arriving at Yura Yungi, she failed to claim on a fair proportion of what she could have.

Thirdly, it was felt that the vocational registration system has had unintended negative consequences for a practice like Yura Yungi. This system requires an intern who intends to practice as a GP undertake further training and supervised practice until s/he can successfully sit the examination set by the RACGP and become vocationally registered. When the scheme was introduced in the early 1990s a differential rebate

was established which saw a non-vocationally registered doctor being able to charge a lower fee than the vocationally registered doctor. (Vocationally registered status allowed differential access to a new set of 'content-based' rather than 'time-based' fees. The latter have been frozen since then while the former have been indexed - resulting in a growing price differential.) Again, the hardship - post quality of a placement like Yura Yungi means that they are more likely to be able to attract only non-vocationally registered doctors with the financial penalty this brings with it.

This spills over into other areas. Yura Yungi, for example, was able to attract a modest Better Practice Grant (of some \$10,000). However a condition of the grant is that 90% of the consultations have to be carried out by a vocationally registered doctor. With only one doctor practicing at Yura Yungi this, of course, means *'either 100% or zero consultations by a registered doctor'*.

A further consequence of Yura Yungi/Halls Creek finding it difficult to attract doctors is a greater reliance on the use of locums and services providing locums. The fee that a personnel service charges is in the order of \$300 for each ten days service over and above the salary of the doctor. While the use of such services are minimised to the degree possible at times it becomes necessary to use them.

Medicare and the District Hospital

At the hospital, outpatients are asked to show their Medicare card if they have it - the number is recorded but if they can't provide a card they are still treated. Sometimes specialists that patients are referred to will call the hospital to get a Medicare number - but this does not happen often. Only in selected situations, therefore is a Medicare card actually needed. One of these instances is when an optometrist is visited - they are not salaried and the cost needs to be recovered from Medicare.

■ Pharmaceutical Arrangements

Yura Yungi

Given that Halls Creek lacks a pharmacy, Yura Yungi administer pharmaceuticals under Section 100 - one of very few communities currently operating under these special arrangements.

Pharmaceuticals are bulk-purchased through KAMSC and regularly transported to Yura Yungi. The Section 100 provisions allow for 100% Commonwealth reimbursement of PBS-listed pharmaceuticals - the policy does not allow a dispensing fee to be charged nor a copayment. The wholesale prices for certain pharmaceuticals under this arrangement may, in some instances, be higher than the cost under PBS whereas in other instances the prices may be lower. Generally, it is felt that the price struck is better than that available to the State hospitals. All the administrative work associated with purchasing and reimbursements is carried out by KAMSC. A monthly standing order is sent in and the goods shipped out - there are variations to this order as, month by month, the size of the population increases or decreases and/or pharmaceutical needs change. The shipping of pharmaceuticals from Perth to Broome, to be forwarded to Halls Creek is, in itself, problematic. The drugs might be four to five days in transit, travelling under canvas at ambient temperatures, at times, of 40 degrees with even higher temperatures resulting under canvas. The option - shipping in refrigerated vehicles - would add significantly to the cost. It was pointed out that the heat stability of medications is not well-known - particularly in regard to medications commonly used for treatment of heart conditions, hypertension etc.

Yura Yungi provides medication to those outstations it services as well as to patients coming into Yura Yungi. Generally, people are administered medications directly but scripts are also written for patients. When scripts are written it is necessary to take them to the local caravan park (which serves as an 'agency') where the scripts are forwarded onto the chemist in Kununurra once a week. If a script is urgent is it faxed up instead. The pharmaceuticals are batched up and sent back down by bus on a Friday. If a script arrives too late, it means another week's delay in getting the medicine. The chemist

endeavours to ship the medication back to the communities in the most cost-effective way - this means packing the goods to meet the minimal shipping charges, at least. Emergency medications sent on their own attract a premium shipping cost which patients generally balk at paying.

The medication is delivered COD - a person is expected to pay the costs to the caravan park operators when picking up their medication. A service/transport fee of \$1.45 is added to the cost of the script - if the money is not paid the medication is returned to the pharmacist. Pharmaceuticals for scripts written by a Yura Yungi doctor are generally batched up and collected from the caravan park by someone from Yura Yungi where they are then distributed at an individual patient level. Efforts are made to discourage people who could afford medication from treating Yura Yungi as a free pharmacy.

Pharmaceutical Arrangements at the District Hospital and Health Centre

The Halls Creek hospital (and the doctors holding clinics at Yiyili) generally dispenses medication directly to patients when it is needed immediately - antibiotics, for example. In the case of Yiyili the community is then billed for the medication. The hospital doctors also have the latitude to supply medication where they believe it is necessary in order to have the patient comply. Otherwise they may provide starter packs and will write a script - particularly for medications regularly taken for chronic illnesses. The patient is required to take the script to the caravan park and pick up, and pay for the medicine, when it is delivered. Scripts will be faxed by the hospital to the pharmacy when a quicker turn-around is warranted. Close to 1,800 scripts are written in Halls Creek a year, with about three-quarters of them prescribed by doctors at the Hospital.

At the Community Health Centre itself, scripts are not normally written although in certain instances (eg a child with renal problems) certain medications might be routinely administered on the basis of a standing order.

Entitlement Numbers

The degree to which correct concession numbers are supplied appears, largely, to be a function of the proficiency of the service providers and this is variable.

The caravan park operator (a trained nurse) noted that lots of new doctors etc don't know to get patients' concession numbers so that the full price is charged - undoubtedly resulting in instances of people not paying for and picking up their medication.

It was estimated by the servicing pharmacy that 3% of scripts for Halls Creek do not bear entitlement numbers or have incorrect numbers on them (and it was assumed that close to 100% of patients were likely to be eligible). This does not take account of missing/erroneous entitlement numbers on scripts written by Yura Yungi where the cost of the copayment is borne by the service.

With patients who live in Kununurra (or are visiting the town), the chemist is able to check health cards - if information is lacking people are directed to the DSS office which is directly across the street from the pharmacy. However, under the conditions operating in this region, the chemist obviously cannot sight the health cards of patients living in remote areas. In some instances, the chemist is able to judge - simply by looking at a number provided - that it is wrong. The periodic changes in the construction of the concession card number (eg the use of two letters at the beginning or end of the number) allow him to know certain numbers are clearly out of date or otherwise incorrect. Where this is apparent the chemist will call Yura Yungi (when scripts are written there) and endeavour to get a correct number - generally with success.

It is reported that the Halls Creek Hospital is somewhat less likely to be able to supply an up-to-date concession number. A hospital representative indicated that when a concession number is needed they first contact Yura Yungi and if this does not result in the number the Hospital's Aboriginal liaison officer assists patients in contacting DSS. Usually, the number is identified.

If an incorrect number is used on a script and it is processed, a notification is received by the chemist that the number is invalid. A short grace period allows time for the number to be corrected, but difficulties in communication in the region mean that rectifying the number is more difficult and another script might be written before the matter is corrected. So far, the rate of rejection by HIC after the one mandatory warning has been negligible.

In a very few instances the chemist has worn the cost where a concession number proved invalid. More commonly, the chemist charges the full price for the medication when a number is not provided - the full cost may or may not be paid by the patient. In reference to the operation of Section 100, it was noted by the chemist that *'At \$20 some drugs are still cheaper than what it would cost to buy at wholesale prices'*.

Safety Net

If medical practitioners/workers and patients find the whole Medicare and pensioner concession card system confusing, the Safety Net is even less well understood.

However, the fact that the Kununurra pharmacy would supply much of the PBS medication for most of the residents in the East Kimberley makes the operation of the Safety Net scheme more practicable, and the chemist does assist in managing the system. Pharmacies in Derby and Broome are also used, if less consistently.

The chemist does endeavour to keep Yura Yungi informed about the Safety Net and sends the appropriate forms to them (or, in some instances, to individuals) to be filled out by the patient. This is done when the chemist's records show that a person/family is approaching the Safety Net threshold. A fundamental problem is that the Safety Net applies to a person and his/her dependants nominated on the Prescription Record Form - this may or may not be the same people as are nominated on the Medicare Card. Moreover, shifting 'family' relationships, confusion over names etc make it difficult to ensure that all relevant expenditure on pharmaceuticals is identified for the family unit identified for pharmaceutical purposes.

■ CDEP

People in CDEP obviously have ready access to the medical care provided by Yura Yungi, the hospital and the hospital-organised specialists without needing a health concession card. However, it is reported that CDEP participants are effectively excluded from the State-run dental scheme and from the national Hearing Aid Scheme. The dental service operates to a capped budget and someone seeking treatment applies and a *dental* assessment is carried out and put in a queue for service. However dental work is not approved until it is determined that there are sufficient funds to carry out the work. Allocations are made quarterly and, should funds be insufficient, the person goes back in the queue. Even in the best of circumstances, a person is likely to be out of pocket some \$40 - 50.

In relation to hearing aids, even full pensioners need a supporting letter from DSS stating the termination date, if any, of their pension. Since CDEP participants cannot provide such a letter they are effectively unable to get assistance with a hearing aid.

■ Management of Medications

The medical staff at all of the health services in Halls Creek believe that requiring a patient to take a script to the caravan park to be sent to Kununurra and then return to pick up the medication almost certainly reduces the chances of the patient actually getting and using the medication. All supplied medication directly when it was essential that a patient take the medication and begin as soon as possible (eg with antibiotics). To get a script filled on their own required patients to manage the system, face a delay of at least a week and be able to pay the copayment, if not the full charge. Some measure of the effect of this is provided by the pharmacist at Kununurra. Some years back he monitored, in the East Kimberley district, the proportion of pharmaceuticals that were not being picked up but were returned and found that this happened in up to 25% of cases where an acute need was evident

(eg antibiotics, pain killers) with psychotropic pharmaceuticals showing a return rate of up to 75%. This is a fairly stark measure of non-compliance. Currently the rate of returns is down to 10%.

Doctors, nurses and health workers are largely able to judge only from secondhand accounts what happens when a person actually acquires the medication. These accounts are inconclusive - there are stories of people gambling and using pills as currency, of people seeking repeats of medication because the children 'were playing' with the medicine, of people letting the use of long-term, regular medications lapse. It was noted that if the benefits of using a particular medication can't be observed and felt by the patient then it is more likely that s/he will be less diligent about maintaining use. Conversely persuading a person to finish a course of antibiotics even though s/he feels better is another common battle. Regular education and training in the use of medications is seen to be necessary; some health workers note successes over time, with some people who learn to manage their own medication use.

The more experienced workers have learned to adjust their instructions to suit the situation of their patients. Few people have watches, so that instructing people to take a pill at four-hourly intervals is useless. Instructions that say '*Take a pill when you get up and then again at lunch time ...*' are more appropriate.

Others note that re-visits every week or fortnight are often needed to reinforce instructions about taking medicines - that without maintaining the educational efforts people may again lapse in their appropriate use of medication.

It was reported that problems of ensuring good management of medication often influenced the therapy chosen by the doctor. Thus there was a greater reliance on single dose medication, long-lasting injections etc.

Other aspects of patients' living conditions also have to be recognised in relation to their use of medications. If a person does not have refrigeration for medication that needs to be kept cool, s/he may be required to come into Yura Yungi three times a day to take the medicine there.

In some instances a person is lent an Esky, which, with ice, is used to keep essential medication cool over the weekend when Yura Yungi is closed. In a number of situations dosette boxes are used where weekly doses of medication (including multiple medications) are measured out. This was not without problems, however. A story was related of a situation where the dosette box was tipped over and the woman was too ashamed to return to the health worker to have it re-assembled.

It was acknowledged that some individuals are fairly dysfunctional and that they, even with family support and assistance, may not be able to manage medication well, with or without a dosette box. One such case was a woman who was drinking heavily and her dosette box showed she was not taking her medication. She was told to either take the medicine on her own or come to the clinic each morning where it would be administered. After three weeks of daily visits the patient opted for the dosette box and self-management. In a small community it is more likely that the word will get around town as to who is or is not complying with their medication (eg when someone is hitting the grog heavily), and this usually results in a visit from a health worker. A contrary view expressed regarding the place of dosette boxes in self-management was that the dosette boxes were over-used - that a literate adult should be able to use medicines properly and that use of a dosette box in these circumstances was 'disempowering'.

One nurse stressed the **severe** warnings she gives patients in regard to medication - for example, that Panadol, if administered in excessive doses to a child, could kill the child. The same nurse indicated that a collection of unused medicines has never been carried out and is probably warranted as there was a concern about it falling into the hands of children, being misused etc. The effects of alcohol, inadequate nutrition and poor eating habits meant that even more careful management of medications was warranted.

The use of standing treatment orders and the management of medications by Aboriginal Health

workers was by necessity, not uncommon, but raises legal and medical issues.

A criticism raised by some people working at the health services was that some patients have come to expect any and all medical type supplies to be provided to them free when the goods were available at the local shops, eg Vitamin A cream, headlice treatment, Panadol, tissues etc. Again, this was seen as disempowering and fostering a welfare mentality. More than once the view was expressed that people wasted money (eg gambling, the grog etc) instead of spending it on necessary items like health supplies.

In this regard, it is also very problematic that there is a heavy reliance on 'book down' - where goods are bought at the shops on credit. (A story was recounted of the community-run store at Yiyili, which incurred a \$6-7,000 debt due to unpaid accounts. Credit is said to have been stopped and the debt repaid and now the cash system is functioning.) The cost of goods in Halls Creek is already inflated and buying goods on credit, rather than for cash further blunts buyers' sensitivity to costs. Observations during the fieldwork suggests that some shops systematically overcharge customers without their awareness. By the time it comes to pay an accrued bill for charged goods it would be all but impossible to determine this. It is not uncommon that when a pension cheque comes in it might all go to clear a debt at one of the local stores. This, of course, has implications for peoples' ability and willingness to pay any copayment for pharmaceuticals.

NHULUNBUY, NORTHERN TERRITORY - REMOTE

■ Background

Location and Context

Nhulunbuy is a coastal town on the Gove Peninsula, 75 minutes flight east from Darwin. It is accessible by four wheel drive only during the dry season. It has a population of approximately 3,500 people, most of whom are non-Indigenous and employed by Nabalco (the local bauxite mine).

Nhulunbuy is the only large town in Arnhem Land and is the supply centre for the East Arnhem Land region. There are about 17 different Aboriginal clans in and around Nhulunbuy, with nearly as many distinct Aboriginal languages.

There is no Medicare office or Aboriginal health clinic in Nhulunbuy, though a clinic is due to open mid 1997.

Nhulunbuy is surrounded by a number of smaller Aboriginal communities. These include Marngarr, which is located ten kilometres from Nhulunbuy and has an all Indigenous population of about 170, and Yirrkala which is 20 minutes drive from Nhulunbuy and supports a population of nearly 900 Aboriginal people.

Other East Arnhem Land Aboriginal communities include Galiwinku (Elcho Island) which is a 35 minute flight from Nhulunbuy with a population of 1,800 and Gapuwiyak (Lake Evella) whose population stands at around 900 and which is a 20 minute flight from Nhulunbuy. Other communities in East Arnhem Land (which were not visited by the researchers) include Maningrida, Numbulwar and Ramangining.

Apart from the sizeable communities described above, the East Arnhem Land region is populated by people living in outstations or homelands. These small communities may have between 10 and 120 people (sometimes 200 in the dry season). While nearly all homelands are linked by telephone or short-wave radio, they are generally inaccessible, especially during the wet season - Aero-Medical Services will not fly to some outstations due to the poor quality of airstrips.

Outstations up to four hours drive from Nhulunbuy are serviced by community health because mainstream services have not historically gone there. In cases of acute medical problems, an ambulance will sometimes meet people half-way. There is usually someone in each outstation employed (through CDEP) as a health aide, who has responsibility for a first aid/medicine chest which contains non-prescription drugs such as Panadol.

In recent times, Arnhem Land has seen an increase in the number of people returning to the homelands.

Apart from the transport and service delivery difficulties experienced in these extremely remote areas, the cost of living is exorbitant - fruit and vegetables, for example, are up to four times the price found in Darwin. A litre of milk costs more than two dollars.

■ Range of Health Services

General

Aboriginal people in East Arnhem Land rely heavily on health services provided by Northern Territory Health Services (NTHS). NTHS operates health services in each of the major communities, though Nhulunbuy itself is only serviced by the hospital and a private health clinic (though Miwatj will soon be operating a health clinic in Nhulunbuy). NTHS provides doctors to each of the services (which are staffed daily by nurses and Aboriginal Health Workers) on a part-time basis (one or two days per week).

Miwatj, the coordinator of community controlled health services in East Arnhem Land, also operates clinics at Marngarr and provides doctors (on a part-time basis) to Gapuwiyak, Yirrkala Homelands and Galiwinku. Miwatj is also responsible for providing health care to people living in outstations. Doctors (as well as nurses and Aboriginal Health Workers) visit homelands, by four wheel drive in the dry season or small plane in the wet, around Yirrkala and Gapuwiyak. Each homeland is typically visited once a month (less often by a doctor) and people in the homelands are evacuated to Gove Hospital when

necessary (two to three people are picked up every week and the cost of this is borne by the homelands service). Health service staff commonly assist people with admission to hospital. NTHS provides some contracted outreach health care to the outstations surrounding Ramangining and Maningrida.

There is a medical centre in Nhulunbuy which is staffed by five bulk-billing general practitioners but this is rarely used by Aboriginal people.

Gove District Hospital has recently closed its casualty unit but continues to operate acute care and specialist services, including radiography and paediatrics. There is a pharmacy at the hospital which supplies the bulk of medicines to the East Arnhem Land region. General admission to the hospital does not require the patient to show a Medicare card, however, specialists in the hospital try to bulk-bill.

Other specialists, including an optometrist, ophthalmologist, dentist and chiropractor also visit the peninsula at regular intervals, most of whom bulk-bill and require Medicare numbers before they will provide treatment. All pathology samples from East Arnhem Land are sent to Darwin (either to Western Pathology or Queensland Medical Laboratories).

Funding

Some NTHS clinics in East Arnhem Land are funded through Grant In Aid (GIA) funding. GIA provides government controlled/funded clinics and it is the government which decide which doctors go where. Grant in Aid to some communities, however, goes directly to a Community Council which runs a local health service. Some communities, such as Gapuwiyak, have experienced difficulties in managing the services while others do not necessarily have a dedicated health board, so the funding is not always reaching its target. Communities which manage their own health service have experienced difficulties in attracting doctors to the community, often because they have to provide suitable accommodation as well as a salary. The Aboriginal Medical Service Alliance Northern Territory (AMSANT) has been lobbying the government for three years to move

away from GIA and to be given block funding with complete community control.

Miwatj is funded by OATSIHS for operations and staffing (it employs 2.5 doctors) (with NTHS providing some funding for special projects) and is able to supplement its budget through mainstream funding sources. Last year, about \$23,000 was recouped through Medicare.

Miwatj sources most (around 60%) of its pharmaceuticals through NTHS via Gove Hospital at cost plus 25% and also pays a further 28% surcharge for administration. The remainder of Miwatj's pharmaceuticals are bought through the local pharmacist at the PBS concession rate so long as a health care card number is provided, otherwise the full cost is borne by Miwatj.

Nhulunbuy

There are currently no ACCHSs operating in Nhulunbuy proper, though as already noted, Miwatj will soon open a clinic. Aboriginal patients used to use the outpatient ward at the Hospital but now that it is shut, *'they wait until it's a crisis and go into hospital'* rather than visit the local GPs.

Apart from the Hospital, the local private pharmacy is the only one in East Arnhem Land. There are very few 'off the street' Aboriginal clients, but it does supply some of Miwatj's pharmaceuticals. The pharmacy holds an account for Miwatj but has no other special arrangements for Aboriginal people. The pharmacy has reported bad experiences with other community controlled health services not paying their accounts.

Marn Garr

Located ten kilometres from Nhulunbuy, Marn Garr clinic has been servicing the local population for about 12 months. It is jointly funded by NTHS and the Commonwealth. NTHS provide funding for a nurse and health worker, while the Commonwealth, through Miwatj funds, provides a doctor two days per week and funding for administrative costs. The clinic once employed a receptionist/administrator, however, the person left and a replacement has not been found (Lack of accommodation is a critical factor in obtaining staff). A CDEP worker was also in training to be a health worker but recently decided to resign. The

clinic is currently staffed by a nurse (30 hours a week) and a doctor (two days a week).

The service is also funded to provide health education; however, there is reportedly little that the service can do in this area (on top of providing a basic health service) due to a lack of staff.

Medicare rebates are used to 'top-up' the grant funding where possible, though the administrative burden impedes this practice. In about 70% of cases, an attempt is made to bulk-bill for the doctor's consultations. The nurse estimated that two of her 30 hours per week were spent chasing Medicare numbers.

This was the only health clinic visited which made any attempt to directly obtain PBS medicines through the local pharmacy in Nhulunbuy. Patients are rarely handed a prescription to have filled themselves. Rather, someone from the clinic will pick up the prescription on their next visit to town and deliver the medicine to the patient in person.

Yirrkala

There are two separate health services at Yirrkala - NTHS run Yirrkala Health Service which services the town, and Laynhapuy Health Service which is assisted by Miwatj to service the homelands. Yirrkala Health Service is visited by specialists at regular intervals. Laynhapuy Health Service is staffed by nurses and health workers and is visited by a doctor one or two days per week. Two and a half days per week are spent in the homelands (one day with a doctor). Some 23 different outstations are serviced by Laynhapuy Health Service. Nurses' and health workers' salaries are funded through NTHS while the doctor is provided by Miwatj.

During the dry season, the homelands are visited using a 4WD; access is only possible by air during the wet season. Health aides in each outstation are able to provide basic care and are in constant contact with nurses at Laynhapuy Health Service.

The Miwatj doctor makes some attempt to claim rebates from Medicare for the patients that are seen but a lack of funding for administrative support makes the claiming process problematic. Medicare records for people living in the homelands are kept at Yirrkala (NTHS) clinic but prove difficult to manage - a drawer full of

unopened Medicare and Health Care Cards was discovered during the researchers' visit.

All pharmaceuticals are given free of charge to the patient and are obtained from NTHS through Gove Hospital. Both nurses and health workers are able to dispense medications, depending on experience, and in accordance with NTHS protocols. No pharmaceuticals are sourced through the private pharmacy in Nhulunbuy.

Laynhapuy Health Service is also funded to provide health education to communities but the problems involved with distance make these activities difficult to coordinate in a cost effective manner.

Galiwinku

Some 15 years ago, missionaries handed over 'control' to the Community Council. They now receive GIA (core funding) in the order of \$800,000-\$900,000 from the NTHS. '*We give you the money, you run the service*'. It is the only health service on the island and does all emergency work, screening work and women's health. They concentrate on the major health problems of the area and biannual syphilis tests. Health promotion helps somewhat in terms of letting people know about substance abuse etc. They have funding for an education worker but no housing for the worker and so the position remains inactive at present. Medical Clinic staffing includes: 1 doctor four days per week; 2 joint managers; 1 registered Senior Health Worker; 3 registered health workers; 1 dental worker; 6 trainee health workers; 2 clerical trainees; 1 health aide/cleaner; 1 trainee admin officer; 1 assistant Aboriginal Health Worker (CDEP); 2 registered midwives; 2 registered nurse (one of which is a registered psychiatric nurse).

Trainees and clerical trainees are paid through DEETYA/ABSTUDY. Visiting specialists include a dentist every six weeks, an optometrist every six months, a paediatrician every six months, a physician every three months, a surgeon every three months, an ophthalmologist every four months and, rarely, a physiotherapist. There is no specific funding for clerical or cleaning work so these duties become the responsibility of the trainee health workers.

Gapuwiyak

The clinic at Gapuwiyak is community controlled and staffed by a NTHS doctor two days per week and a Miwatj doctor two days per week. The Miwatj doctor generally provides treatment to people living in the outstations surrounding Gapuwiyak while the NTHS doctor services the townspeople. The clinic also employs two nurses, Aboriginal Health Workers and an administrator. The community wants to employ its own doctor but is having difficulties coming up with the necessary funds.

Day-to-day health care is provided by the resident nurses and health workers who are able to dispense drugs according to NTHS protocols, though a doctor must write prescriptions for ongoing treatment of chronic illnesses. Nurses have access by telephone to the District Medical Officer (DMO) at both Gove and Darwin Hospitals for advice and authorisation before commencing treatment. All pharmaceuticals are sourced through Gove Hospital (with a 25% surcharge) via a special agreement with NTHS and the service bears the cost of freight. The costs of medications dispensed and prescribed through the clinic are between \$5,000 and \$6,000 per month. The service has not approached the pharmacy in Gove for obtaining prescription medicines but may in the future. It was noted however, that few people in the community would have a Health Care Card, though many would be eligible for one.

Medicare records are maintained by the administrator, with cards kept in the patient's file. While the service does not attempt to bulk-bill, Medicare numbers are required for visiting specialists or when a patient is referred to a specialist in Darwin or Nhulunbuy.

Emergency evacuations are arranged and paid for by NTHS through the Aero-Medical Service.

It is hoped that the Aboriginal Health Workers in training will eventually manage and run the clinic - *'In 20 years time, we shouldn't be here'*.

Darwin

People from the East Arnhem Land region are often sent to hospital in Darwin or are referred to see a specialist there. At Darwin Hospital, Medicare numbers are not required of public

patients (though this is rumoured to be changing) but numbers are needed if a specialist is seen.

Royal Darwin Hospital has an Aboriginal Liaison Unit which assists when patients come from remote and island communities. Community health services in East Arnhem Land are reportedly becoming more cooperative in providing Medicare numbers for people they refer to Darwin Hospital.

Pathology from East Arnhem Land is sent to one of two laboratories in Darwin. One of the laboratories must bulk-bill for all its services and experiences a lot of problems with pathology coming from East Arnhem Land. These problems were thought to be due to health services in the area being totally funded by NTHS and so there is little to encourage services to chase up Medicare numbers. If a test comes from a service in East Arnhem Land, there is a 25% chance that no Medicare number will be included and a further 25% chance that the number and other details provided are wrong (and the claim is rejected). The pathology is performed regardless of whether there is a number, though a lot of time is expended chasing up numbers through the communities - *'Health workers try and chase up the numbers but they're not clerical staff'*. Some services are reportedly more cooperative than others in locating Medicare numbers.

If a claim is rejected, a private account is sent out (through head office in Brisbane which isn't fully aware of the problems) but is often returned marked 'not at this address' which was said to be *'about as useful as an ashtray on a motorcycle'*. At the end of the day, a lot of this company's pathology work is written off. It was reported that if the situation did not improve, it would have to 'make a business decision' to pull the business from the area.

The other pathology laboratory, on the other hand, is funded through a Commonwealth grant to provide discounted services to specific Aboriginal communities because of the problems involved with claiming through Medicare. This accounts for about 15% of its business.

■ Medicare

The dominance of free NTHS Aboriginal health services in Arnhem Land means that very little use is made of mainstream funding for health services through Medicare, the exception being specialists who rely on bulk-billing for their income. There also appears to be a general belief that grant funded services were not allowed to receive funds through Medicare ('double-dipping') or that the grant would be cut if too much money was being received through the mainstream. For the purposes of making referrals to specialists, services have typically held and maintained Medicare records on behalf of patients. If a person is referred to, say, Darwin Hospital, their Medicare number is included on the letter of referral.

However, the emergence of community-controlled health services has seen an attempt, for the first time, to access Medicare in this region. While some individual services understand that Medicare funds are available, there are still many problems which are preventing their reliance on Medicare as a source of funding.

For the Aboriginal people themselves there is little that can be said about difficulties they may, individually, experience in accessing Medicare as they have been used to receiving health services free of charge and have had, where necessary, their Medicare records held and maintained by health services. It would probably be fair to say that most Aboriginal people in Arnhem Land would never have heard about Medicare. This situation has arisen out of circumstances - attempts to educate people about particular health issues have reportedly been poorly understood, let alone attempts to encourage people to carry and present their own Medicare cards or purchase their own pharmaceuticals.

The proportions of people who have been enrolled in Medicare range from 62% at Gapuwiyak to 86% at Yirrkala. It is not known, however, what proportions of these people currently are enrolled with an up-to-date Medicare number.

Combination of Grant in Aid Funding and Medicare

Fee-for-service (Medicare rebate) is difficult in practice, when combined with grant funding, as

there is little incentive for doctors to do the paperwork while they are salaried. With a secure source of funding, services have not typically given any priority to recouping funds through Medicare (especially as they are already under great pressure simply providing a service).

Miwatj and other ACCHSs are currently lobbying for block funding through Medicare, based on an estimation of consultations for that year, rather than having to organise a fee-for-service system. This however, creates the problem of underestimating the number of consultations. As one doctor said '*A block grant through Medicare would be the ideal situation...HIC to work out the estimation*'.

Administrative Burdens

In an environment where health services are taking responsibility for people's Medicare records, a significant amount of work is involved with maintaining accurate records. Cultural factors in Aboriginal communities, such as having multiple names, changing names due to the death of a relative, unknown date of birth, not having a signature, children not being named until up to a year after their birth, transience and not having a fixed address all mean that Medicare claims run a high risk of containing incorrect details and therefore being rejected. Health services in Arnhem Land report a significant administrative burden in simply making claims and a further burden in attempting to establish correct or additional details for rejected claims. In many cases, the effort is '*just not worth it*'.

Services are able to contact either the Medicare Hotline or the Medicare office in Darwin to 'chase up' people's Medicare details. The Hotline was held in fairly low regard in terms of the cultural sensitivity of the operators (an operator in Melbourne is unlikely to understand the complexities of Aboriginal naming systems) and the 'three enquiries per call' policy which is especially cumbersome given that some services may receive 20 or 30 rejections in a week. It was generally felt that the Darwin office was far more helpful and understanding than the Hotline operators and that the staff there were becoming increasingly aware of the special problems faced by services operating in remote Aboriginal

communities. One clinic was lucky enough to have an administrator whose sister worked in the Medicare office!

Miwatj makes use of the computer database *Healthplanner* (see below) which, apart from aiding in monitoring individual patient's medical histories, allows Medicare and Health Care Card records to be maintained. The system currently holds about 6,000 patient records in East Arnhem Land and is, reportedly, invaluable in terms of making successful Medicare claims. It is, however, a substantial task to maintain these records.

Health workers and nurses are generally too busy providing treatment to take on the administrative burden of making Medicare claims (as doctors often expect them to). It was commonly reported that a full-time administrative position would have to be created within each medical service in order to make full use of funds available through Medicare. When health workers are doing outreach work, whether at people's homes or at the outstations, they have to remember to take all the correct claim forms etc if a Medicare claim is to be made. This can be difficult and time consuming in practice.

Healthplanner

The *Healthplanner* system is an on-line database for maintaining medical records. It allows health workers and doctors to keep track of a person's medical and treatment history even if the person presents at different services in different communities. *Healthplanner* also allows multiple names and aliases to be recorded to ease identification. As noted, Medicare and Health Care Card numbers are also recorded in each file. *Healthplanner*, although outdated in terms of technology, is reportedly very useful in accessing people's Medicare numbers so that claims can be made. The system is currently working in Nhulunbuy (at Miwatj), at Yirrkala, Galiwinku, Marn Garr and Gapuwiyak.

As with all information systems, *Healthplanner* is only as useful as the amount of time which can be expended on maintenance of the system. An administrator at Miwatj spends a great proportion of her time querying and maintaining the system. However, the lack of administrative support

available to individual health services means that record maintenance is lacking and the usefulness of the system falls short.

The other unfortunate aspect of *Healthplanner* as a tool to keep Medicare records is that records are not always consistent with those kept by Territory Health and/or Medicare. There is an argument for a common or compatible information system for use by Territory Health as well as community-controlled health services, with adequate resource provision for the system's maintenance.

Reliance on Medicare

The view was expressed that for communities to move towards a purely fee-for-service operation, huge pressure would be placed on the service to see large numbers of patients each day. It was said that this would change the focus of the service to seeing as many people as possible rather than providing quality care. Even after receiving a grant through the Rural Incentive Program, a community would have to ensure that the doctor saw at least 17 patients per day if the doctor's salary was to be paid for through Medicare rebates. Nurses and Aboriginal Health Workers, understandably, see this situation as a threat to their professional status and development, believing they would become de-skilled if the service was pressured to direct even the smallest health problems to the doctor. This is in stark contrast to the above-mentioned ideal service which is managed by Aboriginal Health Workers with advice and training provided by a doctor, and indeed, to the current situation where the vast bulk of health care is provided by nurses and Aboriginal Health Workers.

A doctor at one service reported that she saw very few patients in person but spent most of her time advising and training nurses and health workers. This doctor expressed some guilt in not recovering more of the service's costs for the community, but felt that it was more important to concentrate on providing an efficient and effective service.

Although Medicare can provide a lot of recoverable income, grant funding was seen as providing security without the administrative burden of making difficult Medicare claims.

Current Medicare standard consultations were also cited as a potential difficulty if community controlled services were to rely solely on bulk-billing. Language difficulties, as well as the magnitude of the health problems that most patients present with, mean that a standard consultation in East Arnhem Land is far longer in duration than the national average.

Specialists and hospital services that bulk-bill (eg X-rays, paediatrics) generally report that they are able to obtain correct Medicare details through the patient's community (either through Miwatj or the health service direct) or through the Medicare office in Darwin. If a person's details do not exist, or cannot be found, some specialists and the hospitals will send an enrolment application to the HIC with the claim form and generally report success in making claims this way. Some specialists provide treatment or service but absorb the costs while others simply refuse to provide treatment.

Some communities reported that bulk enrolments took place when doctors were first sent and Medicare staff visited the communities, but that problems now exist with re-enrolment - *'Whole new palava of going through the process again'*. Renewed cards are commonly intercepted at the local post office and then sent directly to the local health service. However, it is often unclear who the cards belong to. For example, a card addressed to M. Yunipingu could be one of 20 people in the community.

■ Pharmaceutical Benefits Scheme

As with Medicare, the Pharmaceutical Benefits Scheme is barely accessed by Aboriginal people in East Arnhem Land, and if it is, it is unlikely that they are aware of it. Nearly all pharmaceuticals dispensed to people in this area are given free of charge by the health services. NTHS clinics dispense medicines (including S8 drugs) via nurses and health workers and prescriptions are written by doctors, filled by the pharmacy at Gove Hospital and hand-delivered to the patient. Miwatj health services operate on similar principles but do source some of their stock from the local private pharmacy, and providing that a correct Health

Care Card number is supplied, receive PBS medicines at the concessional rate (otherwise the full cost is borne by Miwatj). Because pharmaceuticals are generally supplied to the patient free of charge, Health Care Cards are not widely held, though nearly all of those resident would be eligible - *'Never seen a concession card in the community'*. Some 40% of people at Marn Garr and only 1% of people at Gapuwiyak have health care card records maintained by the health services.

Only one service made any attempt to directly obtain PBS medicines through the pharmacy. Marn Garr clinic, because a reasonably high proportion of the community have Health Care Card records, is able to write PBS prescriptions for some medicines, but collects the prescription from the pharmacy on behalf of the patient and personally delivers it. The staff at Marn Garr clinic were responsible for obtaining Health Care Cards for people through DSS.

Prescriptions which are filled via Miwatj, may also be sourced through the local pharmacy and a Health Care Card number is provided if possible. If the pharmacist does not receive, or cannot read the number, he will simply charge the full price without making any attempt to establish the correct details. Miwatj rarely has the time to spend in finding the correct details for PBS scripts if the numbers are rejected either by the pharmacist or the HIC.

The DSS office in Nhulunbuy is reportedly very helpful in providing health care records for people visiting health services. The local DSS office in Nhulunbuy is aware of the difficulties faced by health service providers and every effort is made to provide assistance and information where possible - *'If we didn't have that relationship, things would just fall apart'*

Apparently, DSS used to renew concession cards every six months and issued a new number for each person. Since this has been changed, there have been far fewer problems with lost concession card numbers. There is also a widely held belief that people on CDEP are not eligible for Health Care Cards because they are working.

As with Medicare, services in East Arnhem Land generally felt that the difficulties in properly maintaining Health Care Card records for Aboriginal patients was such a large administrative burden, that the current system of grant funding for pharmaceuticals and purchasing them through NTHS was the favoured option - *'Cumbersome problem to introduce PBS'*.

Cost of Pharmaceuticals

Most people living in the remote communities are on Social Security but there is no remote allowance despite services and food stuffs costing up to 400% more. When two litres of milk can cost \$4.00 alone, it is easy to see that there could be little left for prescription drugs. However, there were mixed views as to whether Aboriginal people should be charged for medications which are currently provided at no charge. Some health service staff felt that if people were forced to pay for medications then they would most likely go without. Others felt that charging even a nominal fee might encourage people to comply with directions - *'Make people pay for their medication and make them more conscious of taking them'*. It was generally thought, however, that charging for medications in Arnhem Land and making people responsible for obtaining them through the pharmacy is problematic - *'If we wanted people to pay you'd have to get it on pay day...patients tend to have other priorities'*.

The costs of pharmaceuticals is a large component of health service budgets - Gapuwiyak clinic spends about \$1600 per month on prescription medicines and about \$3000 per month on imprinted medicines.

The PBS Schedule

Because services in Arnhem Land are generally able to obtain most pharmaceuticals through NTHS, the issue of which drugs are or are not on the PBS list is not a great one. However, several of the services noted that many of the medicines they currently dispense are not on the list. For example, antibiotics which do not need refrigeration and which are inexpensive are widely used but are being replaced on the PBS list by more expensive, perishable drugs. It was also noted that the local

pharmacist could not possibly supply the volume of the medicines that are used in East Arnhem Land.

There was a problem reported by a nurse that pharmacists didn't fully appreciate the difficulties of getting pharmaceuticals to people at outstations. One resulting problem was that prescriptions have to be delivered to outstations at particular times (so that people can continue with their course uninterrupted) but that it is difficult to *time* these deliveries to supply multiple patients, especially when different courses of medicines have different durations and are packaged in set quantities that do not lend themselves to supplying people in remote areas.

Compliance with Medications

Compliance with medication directions is very poor among people in East Arnhem Land, particularly for chronic illnesses - *'About 2% compliance...most throw them away unless they can see an immediate affect'*. Nurses and doctors report that language problems make it extremely difficult to communicate the importance of compliance with directions.

Where health workers are present there is reportedly more chance that people will take their medication, although if the patient is from a different clan to the health worker, problems still exist. Very few, if any people see a whole course of medication out. It's common for medication to be given to a patient who will immediately throw it out. Medication has often been found discarded outside health services.

To deal with poor compliance rates, one nurse suggested that single dose therapy is a good option. Other people reported making use of certain types of medicines, purely because of their packaging. The Webster Pack was praised as it is sealable (so pills do not get lost) with a fully labelled system that shows whether people have at least tried to take the pills. Webster Packs are very expensive however. The packaging of Amoxyl (with symbols rather than written instructions) was also said to help with compliance.

There were several reports of people taking medications which had not been prescribed for them.

Bush Medicine

People in East Arnhem Land make a lot of use of traditional 'bush medicines', particularly for skin ailments such as scabies and boils. Aboriginal people will apparently try traditional medicines before they will present to a health clinic, and staff at health clinics generally encourage the use of bush medicines providing they are not detrimental to the peoples' health. Eating clay to alleviate hunger, for example, is discouraged while eating traditional foods is encouraged.

While Aboriginal people seem to have faith in western medicines and treatments, *'If they see someone dying at the clinic, they won't go there'*.

■ **Health Education**

Many services have budgets for health promotion and education but have no staff to carry out the work. The logistics of providing health education to such a scattered and diverse population is also problematic. However, recent attempts at providing culturally appropriate educational materials have seen some success. It was reported that resources developed in other areas are rarely of any use to the people in East Arnhem Land - for example, harm reduction type materials as are produced in Sydney are seen as highly offensive by people in this region.

The priorities for health education in this region are dietary related issues, drug use (including alcohol, kava and nicotine), compliance with medication and basic hygiene.

LAKE TYERS/EAST GIPPSLAND, VICTORIA - RURAL

■ Background

Lake Tyers is an Aboriginal community about 25 km west of Lakes Entrance and 10 km off the Princes Highway. Bairnsdale, the nearest regional centre, is about 60 km away. The area is known as Bung Yarnda and the Indigenous people are the Gunai.

The Lake Tyers community was established as a church mission in 1861 and until 1970 was managed by a series of government welfare boards. Under the Victorian Aboriginal Lands Act 1970 the Lake Tyers Aboriginal Trust was granted communal freehold title to 4 000 acres of land. Today the community is managed by the Trust, comprising shareholders who may or may not live at Bung Yarnda.

The population at Lake Tyers is 250-300, peaking at around 500 during holidays and on ceremonial occasions. Some 99% of residents are Koorie, a few being non-Koorie spouses and visitors. Around 50% of residents receive a pension (being elders, invalids or unemployed). Just over 70 people participate in highly successful CDEP projects, working either full time or part time in the brickworks, the cattle industry, manufacturing surfboards or for Trust administration/maintenance.

Nowa Nowa is a small nearby community of about 200 people, 20 of whom are Koorie. Thirteen kilometres from Lake Tyers, it is the closest community with a school, a few shops and a health service.

Lakes Entrance, 25 kilometres east of Lake Tyers, is the nearest town, with a population of 6-8000, about 350 of whom are Koorie. Residents from Lake Tyers go to Lakes Entrance to shop, to get their pharmaceuticals, to see the doctor and conduct other business.

Bairnsdale, with a population of 11 000, about 600-700 of whom are Koorie, is about 60 km away. Residents from Lake Tyers rarely have need of

going to Bairnsdale. The nearest Medicare and Social Security office is located in Bairnsdale.

■ Range of Health Services

Lake Tyers Aboriginal Trust Medical Clinic

The Lake Tyers community is serviced by a small health clinic located inside the main administration building. It is open five days a week and is staffed by a full time registered nurse and a Koorie Health Worker (who is also the HACC worker/ after hours medical attendant/drug and alcohol worker). There are two full time drivers and one part-time after hours medical driver. Alcohol treatment sessions are held once a week and they are in the process of setting up Women's and Men's Healing Centres. A doctor based at Nowa Nowa visits twice in a pension week and once in non-pension weeks. On visiting days, the doctor is booked up all day: she sees 20-30 patients a week. While the resident population is around 250, the medical clinic actually services a population closer to around 400 once visitors and non-residents are counted. A paediatric nurse visits once a week from Lakes Entrance.

Almost all residents in the community use the service, except those who have a preference for a particular GP elsewhere. Because the doctor is only at the clinic one or two days a week, residents frequently need to use the health clinics in Nowa Nowa and Lakes Entrance as well.

The health clinic receives State and Commonwealth grants and the doctor bulk-bills her consultations. She has serviced the community for a number of years despite having officially retired and is personally committed to the community and to the improvement of Koorie health. There is some concern that when she does finally retire, there will be no one to take her place because other doctors may not consider the job financially rewarding.

Clinic facilities are cramped: the staff share one room and when the doctor visits, they have to shift to the general reception area of the Trust. The Trust hopes to convert an adjacent building into a new health clinic but at the moment lacks the funds to do so. A high priority for funding is a blood

dialysis facility. A couple of residents need weekly dialysis and one needs dialysis three times a week. The nearest units are at Sale and Traralgon. Basically one of the two medical cars for the whole community is tied up with one patient's transport three full days a week.

The most commonly reported illnesses in the community include ischaemic heart disease, diabetes, alcoholic liver diseases, scabies, renal problems, respiratory infections, impetigo, injury and mental health problems. Alcohol and substance abuse are also reported.

Fostering a culture of reliance was a concern in the community. Patients are seen in the community, are driven and scripts taken into town, picked up and often paid for. One resident pointed out that Aboriginal people get into a bad cycle when there is only one doctor to consult: *'They think the doc knows best, the doc knows everything'*.

The Trust expressed concern over reported plans to transfer management of the health service to a non-community based, non-Indigenous health organisation - the consequence of questions around the service's budgetary outlays, which the Trust feels did not take into account the actual service population of the clinic.

Community Health Centre, Nowa Nowa

When Lake Tyers residents need to see a doctor on non-visiting days, Nowa Nowa is the closest option. There is a community health centre attended by two doctors in rotation three days a fortnight, a full time registered nurse and a domestic violence counsellor. It provides services such as needle exchange, maternal and child health, home nursing for frail, aged or disabled patients and childhood immunisations. About one-third of their clientele is Koorie, increasing to around one half during holiday periods, with only a small number resident in Nowa Nowa. Between 20 to 30 people see the doctor each week and about as many again are attended to by the nurse.

The nearest pharmacy is at Lakes Entrance, which does a courier run each Wednesday: the clinic faxes the scripts in the morning and the courier brings the medication at 2.00 pm, picking up the

scripts and money. If the patient hasn't picked up the medication by the following Wednesday it is sent back with the courier.

Health Services, Lakes Entrance

At Lakes Entrance most Koorie people (including many from Lake Tyers) go to the Community Health Centre which has six doctors and a range of allied health services including maternal and child health, HACC, drug and alcohol counselling, occupational therapy and housing services. The health centre handles ante-natal care for new mothers from the nearby communities. There is also a private medical practice but it is used by very few Koorie people.

There is one pharmacy in Lakes Entrance which also services the communities at Lake Tyers, Nowa Nowa and Metung. They run a medication courier service once a week to Nowa Nowa.

District Hospital

Bairnsdale District Hospital services the East Gippsland region as far as Sale in the west and Orbost in the east. The hospital has the closest maternity services to the Lake Tyers and Nowa Nowa communities and is where most women in the region have their babies. The Hospital has a Koorie Liaison Officer who assists patients visiting the facilities.

A sudden drop in admissions to the hospital 12 to 18 months ago was reported and was thought to be related to the deaths (following admission) of two members of the community. It was thought the community might be avoiding the hospital because of the deaths.

Gippsland and East Gippsland Aboriginal Co-Op

In Bairnsdale the Gippsland and East Gippsland Aboriginal Co-Op provides a comprehensive medical service with doctors two days a week, a full time registered nurse, a clinic co-ordinator and a health worker. Around 90% of patients are from Bairnsdale, but the population is very mobile. Common illnesses include non-insulin dependent diabetes, drug and alcohol related illness and skin diseases.

The clinic keeps a small stock of pharmaceuticals, but the bulk of medication is by prescription. The ACCHS has an account with a local pharmacy which covers the cost of medications for patients who can't afford them.

Patients are encouraged to assume responsibility for their own health care. They attend the ACCHS or local doctor, take their own paperwork to Medicare and have their own scripts filled. There is no patient transport, though assistance is provided for the elderly and frail.

Health Services, Bairnsdale

There are two large medical practices which do not generally bulk-bill, but do bulk-bill concession entitlement card holders. Only one of these practices reported having a significant Aboriginal clientele. There are several other individual general practices in town, though none of them bulk-bills.

There is a physician and two surgeons based in the town, but most specialist services are provided to the region through Bairnsdale Hospital. Specialists visit regularly from Sale (70 km) and Melbourne (300 km).

There are three pharmacies in Bairnsdale, one of which holds the account for the Co-Op and has a Koorie clientele of about 1%.

■ Medicare

Medicare enrolment

The doctor who attends the Lake Tyers community bulk-bills all patients and accepts Medicare rebates as remuneration for her services. People are aware that this arrangement may end once the doctor retires if they are unable to attract a doctor who is willing to do the same. The nurse and health worker administer Medicare claims and enrolments for the doctor.

It was reported that most people in the community were enrolled, though there were frequent problems with expired cards. Clinic staff do not know when cards expire until a claim is rejected, as few patients bring in their Medicare cards or notify them when they get a new number. If there

is anything complicated it takes a long time to sort out. Frequently they are told by Medicare that the patient has to go to a Customer Service Centre in person to sort it out. However Bairnsdale, 60 kilometres away, is too far to travel for most people when there is no public transport.

Problems with the length of time it takes to have a baby enrolled, which prevented claiming for the weeks prior to the issue of a new card, were common to the services in Lake Tyers, Nowa Nowa and Lakes Entrance. It was thought that for a while Bairnsdale Hospital stopped enrolling newborns, which caused problems for the service providers. *'It's essential that babies are enrolled at the hospital. They need a card as quickly as possible.'* It was also suggested that the baby books given out at the hospital should have a space for a Medicare number.

As Koorie children can have more than one carer, they may have two or more surnames. This makes it difficult to locate a Medicare number when the child is looked after by relatives other than the parents, who may not live in the community. It was suggested that giving each person - including babies and children - an individual card might resolve the problem. A number of patients said that they only had one card for the entire family which included several children. They were often unaware they could apply for duplicate cards.

One community health centre reported that nine out of ten Koorie patients don't know their date of birth. This is particularly a problem with the substantial transient population which passes through the region. Lake Tyers Trust provides a letter verifying community members' identity to other service providers and this is accepted by the HIC. There was felt to be a need to simplify the enrolment process for Aboriginal people who often don't carry the identification documents Medicare requires.

Medicare numbers

At Lake Tyers the clinic staff sometimes try to chase up Medicare numbers, but they don't go to the ends of the earth. The doctor's 'love jobs' used to be more frequent, but now there is about one per month. Hardly anyone brings their Medicare card to the clinic, but they keep the numbers on

file. As mentioned previously, expired cards are the major source of rejected claims. The doctor personally bears the loss for claims that can't be lodged or are rejected. Difficulties getting numbers from the Hotline has deterred the clinic from using it. If they can't get a number from one of the other services, they generally forget about it. They generally know if a claim is going to be rejected in which case they don't bother lodging it.

The community health centre in Nowa Nowa phones the Lake Tyers clinic for Medicare numbers, and failing that will ring the Hotline. The majority of patients don't bring in their card, though they keep the numbers on file when they get them. Their biggest difficulty is locating Medicare numbers for the many people in transit at funeral and holiday times and often find the Hotline service unhelpful.

Keeping the cards at any one of the health services was not seen as viable because patients regularly use up to three of them in the area.

Specialist referrals/ billing

The most common referrals from the Lake Tyers and Nowa Nowa communities are to ear, nose and throat specialists, paediatricians, obstetricians, gynaecologists and orthopaedic surgeons. Most specialists bulk-bill Koorie patients because it says it is unlikely they will be paid if they don't and Koorie patients are rarely issued with accounts. Sometimes they have to negotiate and pay the equivalent of the rebate. If they are given an account they generally take it to the Trust, which often pays it. The nurse at one health clinic has written to several specialists who have sent Koorie patients bills, saying the patient is a Health Care Card holder and not to write again.

Some of the specialists who see Koorie patients said they don't really get problems of non-enrolment because the patients have been 'filtered' or sorted out by the time they get to the specialist.

One optometrist said he was very concerned that so few Koories came in, because he is sure that a lot of diabetes-related problems are left undiagnosed until it's too late. The Koorie patients who do come in often need immediate treatment, but even though he arranges a specialist

appointment and medication, they don't turn up for the appointment. He has one patient who is legally blind, but continues to drive a car and refuses to get specialist treatment. He believes that there is too little communication between the branches of eye care and that many people don't realise that eye tests are covered by Medicare. It was suggested that Medicare targets optometry in its promotions.

Medicare and the hospital

Bairnsdale Hospital is required by Victorian Public Hospitals to record Medicare numbers on admission forms. Quite often Koorie patients don't have their cards and don't phone the number through later. The Koorie Liaison Officer chases these up. Sometimes they ring the referring doctor or the AMS to get the number.

■ The Pharmaceutical Benefits Scheme

The clinic at Lake Tyers has a small stock of S2, S3 and S4 medication (paracetamol, insulin, cough elixirs) but the nurse is only permitted to give out one or two doses and may not make up dosettes because any more would be considered 'dispensing'. Compliance is a major problem, with the expense of medication preventing many people from getting it in the first place.

Entitlement numbers

The medical driver at the Lake Tyers Trust does a script run into Lakes Entrance once a day. Health Care Cards are photocopied and sent with the medical driver when he drops off scripts. However many people don't have their Health Care Cards when they go to pick up the scripts, and the pharmacists invariably ask to see the card. There is a sign behind the counter informing clients of the need to show their Health Care Cards every time. The pharmacists explain that some cards have expired and that the HIC requires them to sight the card. Often the person who collects the medication is not the patient for whom the medicine is intended, and does not have the patient's entitlement card.

The community health centre has a very good relationship with the Koorie Liaison Officer at the

Department of Social Security. She comes out once a week and sorts out concession card problems. The centre has never tried to access a Health Care Card number. If a patient can't find their Health Care Card the centre often ends up covering the gap payment.

One pharmacist reported regular movement of Koorie clients between East Gippsland and Shepparton, and quite often 'new' children come under the care of local people. The pharmacist wasn't sure what to do in these circumstances. Another 'grey area' was when the parents had separate Health Care Cards and the children are listed on one card but not the other.

Lack of money

Poverty was a major barrier to Koorie patients getting their medication. The Trust had an order book system, whereby medications from the pharmacy could go onto a Trust account and when pension/pay day arrived, the Trust was repaid/deducted the amount owing from patients' cheques. This was workable for pensioners because they generally owed \$3.20 but others, mainly CDEP workers, experienced extreme hardship having to pay \$20 for their medication.

It was generally believed that CDEP participants lost their rights to rental assistance and all concessions, including pharmaceutical discounts. It was reported that not one CDEP participant had a Health Care Card and that this frequently prevented them from getting the medication they needed.

The copayment was thought to be a barrier for many people as well, such as pensioners. Because many older people need to get several scripts at once, \$3.20 per script was often unaffordable.

Some patients found it difficult to get medications on credit when they couldn't afford them. One patient reported urgently needing penicillin for his baby who was running a high fever and he didn't have any money, but a pharmacy refused to give him even a day's credit. The pharmacy said they give seven day credit to clients who have a good track record.

Some pharmacists felt that money was not the problem because the patients seemed to them to be able to afford other things such as cigarettes and videos. They were of the belief that health was not a high priority for many Koorie people.

One pharmacy reported having a large pile of uncollected scripts. This concerns them because some are for children and they don't understand why the medications aren't collected. Inability to pay was cited as a reason for not collecting medication: patients often 'sit it out' or start feeling better after taking some Panadol or starter medication.

One patient said he got scripts but didn't get them filled because he was only after a doctor's certificate for work. Another said there was a sign at the local pharmacy saying '*gotta pay for drugs*' so she knows that if she doesn't have the money she can't get any medicine.

Scheduling of PBS medication

The removal of Canesten and antihistamines from the PBS list was seen as retrograde for Aboriginal communities. One patient felt that chronic diseases such as asthma and diabetes should attract greater support from PBS and Medicare because of the high costs involved.

A particular issue was raised in relation to Ritolin, a treatment for attention deficit disorder primarily in children, which is not on the PBS. There are two medications for the condition - one is on the PBS and the other is Ritolin. However some patients do not respond well to the PBS-scheduled medication and it is known to cause severe side effects in some children. The pharmacy at Bairnsdale Hospital supplies Ritolin free of charge to a number of low- income families, several of whom are Koorie. The cost of this has run to \$10 000 a year, and as a result has had to be limited to entitlement card holders only.

The Safety Net

The pharmacy does not keep track of Safety Net entitlement because they say their computer program is incapable of doing so unless they tag the client. They don't know who is on the Safety Net and leave it to the client to record. They also

felt it would be a difficult task to determine the members of Koorie families due to different surnames being used within the one family unit.

It was generally thought that few Koorie people knew about the Safety Net or would have known how much they had spent on medication.

■ Other Health Issues

Transport

Transport is a major problem for the communities outside the towns in East Gippsland. The medical car from Lake Tyers will pick up Koorie people from Nowa Nowa, but there is no regular public transport to either community. A bus stops on the main road (10 km from Lake Tyers) going into Lakes Entrance once a week, but it turns around straight away, making it impossible to do the round trip in one day. Some acknowledge the limited independence and culture of reliance this fosters. The only transport option is to use one of the Trust vehicles and to rely on drivers to get anywhere. However, it was commented that State and local authorities must bear the blame for off-loading their infrastructure responsibilities to the community.

Poor transport impacts on the ability to get medications quickly. The Nowa Nowa community does not have a medical car and relies on a weekly courier drop from the chemist in Lakes Entrance. When the courier arrives patients are expected to be there to pay and show their concession cards. Despite the awkwardness of this system, it was thought to work quite well.

Compliance

Compliance is a big problem in the communities. Getting the medication in the first place is a big hurdle - *'They're often too hard-up to get medication'*. Even if patients get their medicines they frequently won't take the whole course. *'I don't always take the whole course 'cos I get better and so it's a waste of time'*. The clinic can supply starter packs, but patients often see them as a whole course rather than the beginning of a course. Other patients made a conscious decision to stop taking prescription drugs when they started

feeling better because they wanted to limit the amount of synthetic drugs they consumed. Some would complete the process with herbal remedies.

The pharmacy is concerned when the person for whom the medicine is intended does not pick up the medicine because they are unable to advise him/her about taking medicine properly.

Some patients did not have scripts filled because *'you always get the same medicines every time you go in because the doctor feels he has to give you something'*.

In regard to general health care, a bush nurse who used to work in an East Gippsland community with quite a few Aboriginal people reported that the Koorie families tended to delay seeking help and waited until they were quite sick.

Bush medicine

In the communities it was reported that *'most of the families'* used some form of bush medicine. Some used traditional healing and/or alternative medicine. Few people used traditional medicine *instead of* western medicine, rather they were used together. One person said she and people she knew used bush medicine for conditions such as insomnia, headaches, burns, asthma, rashes, skin problems and bee stings. A bush nurse reported urine being commonly used to treat conjunctivitis.

Some people used bush medicine after conventional medicine had failed: *'Nothing's helped so we'll try our own'*.

Hospital discharge medicine

Patients didn't seem to have any problems with discharge medicines from the hospital. Some went back to have dressings changed or received pain killers for broken limbs.

Upon discharge patients get 'some' medicine but need to see their GP to get a prescription for ongoing medication because the RMOs at the hospital are not allowed to write external scripts.

■ Satisfaction with the HIC

There were no serious complaints about the HIC, apart from difficulties with the Medicare Hotline and problems with identification requirements. It was felt by some service providers that the HIC needed to be more flexible when dealing with Aboriginal communities.

Information needed

It was felt that definitive information regarding the position of CDEP workers and concessions was needed including answers to questions such as *'Do I have any rights to concessions and which ones?'* and *'What happens if I stop working?'*

One patient felt that Aboriginal people were denied access to information: *'Outta sight, outta mind'*. Most patients received information they needed from their doctor or chemist. Many said they had a good relationship with their chemist. They were usually helpful in explaining inserts and how to take the drugs. One person reported getting health information by word-of-mouth, using the doctor as a last resort.

One health care provider suggested that the HIC develop a 'better practice program', whereby the HIC rewards doctors who prevent patients from doctor-shopping and doctors who have a certain percentage of Aboriginal patients. An optometrist suggested developing leaflets/ posters targeting optometry and ophthalmology and highlighting that eye tests are covered by Medicare.

Cultural sensitivity

There has been an ongoing problem where a woman has tried to have her deceased husband removed from her Medicare card, but the HIC won't do it until they have seen the death certificate, which the patient doesn't have. The matter causes her a great deal of distress and they wonder why a simple transfer can't be done.

MOREE, NEW SOUTH WALES - RURAL

■ Background

Moree has a population of about 9,500. While 1991 Census figures show 2,500 of these to be of Aboriginal descent, local government (Moree Council) and other estimates place the current number of Aboriginal people in Moree as closer to 3,500.

The Aboriginal population in the area is referred to as 'Murrie'. The town of Moree has two satellite suburbs of Aboriginal people - Mehi Crescent and Stanley Village. Stanley Village is situated one kilometre east of Moree township and Mehi Crescent is three kilometres south-west of the township.

Moree is a service centre for the outlying towns of Mungindi and Collarenebri which have sizeable Aboriginal communities. It is also the closest major NSW town to Toomelah, a large, disadvantaged Aboriginal community 70 minutes north of Moree near the Queensland border. However as Toomelah is significantly closer to Goondiwindi in Queensland, Goondiwindi provides most health services to Toomelah.

■ Range of Health Services

Pius X AMS

The town has an Aboriginal Medical Service (AMS) - Pius X Aboriginal Medical Corporation, which is managed by a Board of Directors and funded chiefly via a Commonwealth Department of Health and Family Services annual grant. This service is located 2 km south-west of Moree township, near Mehi Crescent Aboriginal Community. The Service employs a full-time nurse (non-Aboriginal), Senior Health Worker (Aboriginal) and a part-time HIV/AIDS/STD Worker (Aboriginal). In addition there are 3 full-time and two part-time administrative staff, including the executive officer.

The service has vacancies for a dental technician and a women's health nurse - as a result the service's visiting dentist and women's health clinic have not been operational in recent months. In addition the services' Chief Executive Officer has

recently decided to resign after 13 years at the service.

Approval has recently been gained to conduct women's health clinics in one of the consulting rooms at Pius X AMS, once a new women's health nurse is found. Up until now, it was reported that there have not been adequate facilities to conduct Pap smear screening for at-risk Aboriginal women. As a result, women have been asked to attend the town surgeries for such screening with varying success. The AMS does not service any remote areas.

The AMS has a medical clinic three mornings per week, from 9am - 12pm. One doctor from town attends on each occasion, on a roster system. The clinic makes use of a 'drop-in' approach rather than booked appointments. Patients arrive, put their names on a waiting list and are seen in turn.

For any complicated problems detected by doctors during clinics, patients are asked to come in to that doctor's medical centre. One group practice doctor reported that 50% of the time such patients would not attend their practice for further treatment. Doctors observed that some Aboriginal patients seemed threatened by the environment of the town practices. The AMS Aboriginal Health Worker reported that this lack of attendance was even worse for patients at the practice requiring patients to pay \$33 or more up-front.

Pius X Aboriginal Health Workers reported that the AMS would follow up patients who were unwilling to see the doctor in town and ensure that at least they returned to the Pius X medical clinic when necessary.

It was estimated that the AMS sees about 85 patients each week, the majority being from Moree and the remainder from outlying towns such as Mungindi and Collarenebri. While the majority of the patients seen were Aboriginal, it was not uncommon for non-Aboriginal partners of Aboriginal people, non-Aboriginal people of low socio-economic status and itinerant workers to make use of the Service.

Over the course of a year at Moree's AMS it was estimated that 3,500 clients would see nursing staff, 1800-2000 would see doctors and 1000-1200 would see a dentist.

The clinic has a small dispensary from which approximately 50% of prescriptions can be immediately filled by the nurse. Patients are bulk-billed for medical services and no payment is required for medications available at the clinic dispensary (however a donation is usually requested). The AMS obtains its pharmaceuticals from Moree District Hospital - this expense is part of the AMS budget and consequently grant monies cover this. Moree Hospital's dispensary records reveal that the AMS had ordered \$12,000 of pharmaceuticals in the last 12 months.

The AMS dispensary maintains a supply of commonly prescribed medications such as pain-killers, antibiotics, antifungal creams and antiseptics.

For medications not available at the AMS dispensary, patients are asked to take their prescriptions to one of the two town pharmacies.

The Moree AMS also offers immunisations on an ad-hoc basis, a women's health clinic three days per month and home visits when necessary. Approximately 30-50 home visits are carried out by a nurse or health worker per month. Normally, the services dental clinic screens each Aboriginal infant once yearly.

The Aboriginal pre-school pupils in the adjacent building (80 three to five year olds) undergo eye screening once yearly and ear infection screening twice yearly.

Pius X staff reported being happy with the grant-based system of funding they operated under. This system was reported to make health care delivery much simpler for Aboriginal people in the area and enable basic medical service delivery to patients who have no ready cash are not willing to spend money on health care or are not willing to seek medical services in a non-Aboriginal environment.

It is important to note that one of the main positive findings of the Moree fieldwork (amongst both service providers and consumers) was the high levels of familiarity of the majority of the Murrie community with both the Medicare and the Pharmaceutical Benefit Scheme. Thus it needs to be remembered that the barriers and difficulties in accessing these systems outlined below affect

only a minority of the Aboriginal community (unless otherwise indicated). Indeed, many of the problems identified were noted as equally prevalent amongst non-Aboriginal patients.

There was a strong feeling amongst the general practitioners interviewed that the provision of an AMS in Moree with Aboriginal health workers and nurses was a necessary pre-requisite to ensure adequate health care to a significant portion of the Aboriginal community.

While there was a general consensus that most Aboriginal people in the area were able to make active use of the available health services in Moree, it was reported by AMS staff that a certain proportion of their clients had to be 'fetched' by AMS staff and physically driven to the AMS clinic or general practice to ensure they kept appointments.

The health care providers interviewed explained that this approach was necessary as Aboriginal clients often did not give priority to their own or their children's health care. A lack of transport and a tendency to forget appointment times were also reasons why some in the community needed to be picked up by AMS staff.

Interviews with both Aboriginal people and health care providers indicated that the Aboriginal community tended to present to health services late (whether that be Medicare to re-enrol or doctors to investigate ill health). Hospitals were regarded by many as a place of death (ie no return) and thus to be avoided. Doctors and their surgeries were associated with hospitals by many.

Moree District Hospital

Moree is serviced by a district hospital of 52 beds; 21 of these are medical, 21 surgical and 10 allocated to obstetrics. The hospital offers two operating theatres and paediatric facilities (though no specific paediatric ward). The hospital is staffed by 47.5 nurses and also employs 11.5 community nurses, two physiotherapists, three mental health workers, three alcohol and other drug workers and one each of the following: occupational therapist, welfare worker, early childhood specialist, sexual assault worker, Aboriginal health worker and Aboriginal liaison

officer. There is also a part-time early intervention worker.

The hospital has no resident doctors but is serviced by nine Visiting Medical Officers on a roster system. It was estimated by the hospital's manager that thirty to forty percent of all patients seen through casualty are Aboriginal (or 260 per month).

Most of Moree Hospital's Aboriginal patients were reported to be from the township and satellite towns.

Moree's hospital operates a dispensary and employs a full-time pharmacist. (The position is currently vacant). The dispensary is responsible for providing pharmaceuticals to the hospital, local nursing homes, and Aboriginal Medical Services in Moree and Toomelah. In addition, Moree Hospital's pharmacy supplies Bingara, Warialda and Collarenebri hospitals with their pharmaceuticals. The dispensary is also responsible for administering a local methadone program to supervised patients. (However it was reported that there were currently no patients on this program). The pharmacy does not provide any other medications to individuals.

Moree's Medical Surgeries

The town has a total of thirteen doctors all of whom work as general practitioners. Three of these doctors are also qualified in general surgery. All but one of these doctors work in one of two group practices (seven in one and five in the other). One operates as a sole practitioner.

Two of these three practices would bulk-bill patients who were unable or unwilling to pay their own accounts, although they did not advertise this fact. The other large practice however had a strict policy of insisting upon up-front payment of \$33 for each consultation. As a result, this practice was reported to see a smaller share of Aboriginal patients.

Pharmacies

As mentioned, Moree has two pharmacies, both in the main street and within one kilometre of each other. Both are owned by the same franchise operator. The main pharmacy operates from 9:00

am Monday to Fridays, closing between 6.30pm and 8pm depending on the day of the week. The main pharmacy is also open on the weekends, for six hours on Saturdays and three hours on Sundays.

Specialists

Moree is serviced by a limited number of visiting specialists from Tamworth, Armidale and Sydney. These include a physician, a paediatrician, an ENT surgeon, an orthopaedic surgeon, an ophthalmologist and two psychiatrists. These visits to Moree are generally one day a month or less. Some of these specialists visit the hospital, some use the medical centre facilities, and one psychiatrist visits the AMS one afternoon every two months.

The AMS reported that some Aboriginal patients had poor compliance with attending out-of-town specialists, and that there was a pressing need for a gynaecologist to visit Moree on a regular basis.

Owing to the infrequency and brevity of specialist visits, as well as the lack of some specialist services entirely (eg gynaecologist), many patients are referred to specialists in Inverell, Tamworth, Brisbane or Sydney.

Ancillary Services

The town has a pathology collection service, operated by a nurse from one of the town's medical centres. The pathology service bulk-bills pension and health care card holders as a standard, as well as those accounts the referring doctor marks 'bulk-bill please'.

In addition, there are two optometrists and two dentists in town.

Aboriginal children may be referred to the Crippled Society (Tamworth), Stuart House or Far West (Sydney) for respite care or rehabilitation. Banksia House in Tamworth is the closest psychiatric facility which provides an after hours service and accommodation for those with alcohol and other drug dependencies or psychiatric illness.

Medicare Office

Moree has a Medicare Office employing four staff and operates Monday to Friday 9:00am to 4:30pm. A Moree HIC staff member reported that perhaps 5% of face-to-face transactions were with Aboriginal people. This equated to about ten Aboriginal clients per day on average. It was reported that most of these presented because they had lost their Medicare Card or needed to enrol a baby. Few over-the-counter claims from Aboriginal people were encountered.

Aboriginal Health Service

In addition, the town has a small Aboriginal Health Service, funded by the NSW Department of Health. This service employs a co-ordinator for Aboriginal Health Services, an Aboriginal Health Worker and two Aboriginal Health Education Officers. The service conducts a diabetes screening program, immunisation program co-ordination, and promotes a healthy lifestyle to the community through exercise classes and football team sponsorship.

Other Health Services

The director of one of the town's medical centres believed more general practitioner specialists were needed in Moree, as well as more ancillary health services: namely drug and alcohol; mental health; aged care and rehabilitation services.

Two of Moree's doctors observed that a particularly at-risk group was Aboriginal adolescents (male and female), because they were unlikely to seek help in relation to sexual problems, pregnancy counselling, antenatal care and alcohol and other drug issues. This group was reported to include a large proportion of early school leavers and functionally illiterate individuals, especially amongst males.

Aboriginal people themselves reported that no-one uses traditional healers in Moree, but some of those interviewed reported that their mother or father used bush medicines. The consumption of live green ants was reported as useful for common ailments; cooked flying fox for bad asthma; cold tea or breast milk for sore eyes and urine was reported to be used at times. A non-Aboriginal

nurse reported bush medicines were used mainly for boils and carbuncles. Such remedies were reported to sometimes be used as a first line of treatment if available.

■ **Issues relating to Medicare**

Enrolment

All health care providers reported that there were currently no problems in Moree with Aboriginal adults having never been enrolled in Medicare. A staff member at the Medicare office reported that two years previously Medicare staff visited outlying Aboriginal communities such as Toomelah mission and 'sorted out' a number of enrolment problems by enrolling or re-enrolling a number of people 'on the spot'.

This Medicare officer in fact reported that Aboriginal people now believed they could not see the doctor unless they were enrolled.

However, the most common medical problem identified for Moree Aboriginal clients by health providers was the high likelihood of parents not enrolling babies on their Medicare card. While such babies were reported always to be treated by the doctors if required, this posed a problem for the doctors concerned as they were unlikely to receive payment from Medicare in such cases. However, this situation was equally likely to arise amongst the non-Aboriginal community.

One medical practitioner reported that he saw one baby each week which was not registered with Medicare.

Hospital staff, general practitioners and Medicare and AMS staff all reported that this was a significant problem which existed in the community. The chief reason for this problem was thought to be that it was a low priority for new mothers. It was reported to be a procedure many did not think of until their baby became ill.

The majority of them don't think about enrolling the baby until the baby's sick.

One community health nurse working with the Aboriginal community believed that hospital

midwives and nurses needed to assist new mothers with this procedure -

They're not being told clearly enough at hospital what they have to do.

More recently it has been standard practice for Moree Hospital nursing staff to distribute Medicare forms to mothers for enrolment of their baby. These Medicare forms are distributed with a range of other information and application forms to mothers. There was the opportunity to lodge completed forms with nursing staff who in turn would send them to Medicare. However maternity nursing staff explained that as there were only two nursing staff in this unit, mothers were not followed up to fill out the forms. Thus in many cases, enrolment of babies was overlooked.

Health care providers and administrative staff recommended that this problem might be overcome by setting up a procedure to ensure babies are enrolled in Medicare before they leave the hospital at birth. Medicare forms could be provided to mothers at this time by including them with the hospital discharge papers.

Aboriginal people interviewed believed it was a parent's (particularly a mother's) responsibility to enrol a child in Medicare. The majority said they were familiar with the process and had no difficulties with it.

It was also reported that hospital staff however did not believe it was their responsibility to ensure this took place, or to chase up patients. A lack of maternity staff resources was a key issue.

A hospital officer reported that there was a general resistance amongst nursing staff to filling out forms. Nurses did not believe this was a core responsibility in their work, and even basic patient records were difficult to keep up-to-date as a result.

Medical administrative staff confirmed that their most recurrent difficulty with patients (both Indigenous and others) is expired Medicare cards. This was seen as a major difficulty which disrupted medical surgery billing procedures.

Administrative staff reported that it was normal practice for patients to present their Medicare card to their attending doctor. Doctors would often

omit to check expiry dates however. Administrative and HIC staff believed there was generally a poor understanding within the community of the fact that Medicare cards could expire and thus be invalid.

They think that the government will automatically send them a card (GP)

They don't understand the expiry date (GP)

A lot don't realise they have to go in to apply for a new card (clerk)

Even administrative staff showed confusion as to whether cards expired at the beginning or end of the month shown on each card.

It was suggested by a few professionals that it might be better to automatically send people a new card in the mail rather than rely on them to apply for one themselves.

An AMS worker however did not believe Aboriginal people had any difficulties with the actual procedure of re-enrolling -

I think it's very simple - it's very quick and easy.

A number of health care providers did not believe many Aboriginal patients were very motivated to bother going to the Medicare officer to re-enrol. As these people already received Medical care, this seemed an inconsequential procedure.

Identification procedures for Medicare enrolment were reported by both health care providers and Aboriginal people to be fairly easy and user-friendly. Medicare staff reported that if a client had insufficient identification to enrol, they would suggest the person goes to the Social Security office or the Aboriginal Legal Service to obtain a letter confirming their identity. Such identification was also necessary if a person was registered with Medicare, but had no identification on their person.

Medicare and AMS staff reported that Aboriginal people do not consistently give babies the father's surname - often the mother's name may be used. In the cases where different surnames are used, Medicare's requirement of a birth registration form was reported to often cause long delays in registering children.

Often Aboriginal parents had not filled out and returned a birth registration form to the appropriate government registry as they did not understand the need to do so.

This has been a bit of a problem because often they don't send it away - and it can take 6-10 weeks to process.

The issue of multiple cards was noted as a problem when a person had lost their card, applied for and received a new card (with a new number) and then perhaps found their old card and used it again without understanding that it was no longer valid. Health care providers suggested that better education of consumers was needed to guard against this situation. A number of health care providers were unclear as to how duplicate Medicare cards worked.

Amongst Aboriginal people interviewed, problems with duplicate cards were not raised.

The majority of health care providers believed that their Aboriginal clients had few problems with filling out the necessary paperwork. Health care providers tended to say that Medicare office staff were very helpful in assisting clients. The ACCHS reported they sometimes helped patients in filling out Medicare forms.

Aboriginal people interviewed did not report problems with Medicare forms either.

Claiming

The majority of Aboriginal people interviewed stated that they made sure they used a doctor who bulk-billed for consultations.

HIC staff at Moree's Medicare office reported that often Aboriginal clients might not have their Medicare card with them when coming in to make a claim. However the majority of Aboriginal people interviewed said they kept their Medicare card in their wallet.

In such cases, a person would be asked to produce suitable identification so that staff could obtain their Medicare number from the computer. For Aboriginal clients, the most common alternative form of identification was a Health Care Concession Card. A Pension Card, Student Card

or letter from a government department would also suffice.

Administrative staff interviewed also confirmed that many of their Aboriginal patients were bulk-billed owing to their mobility or unwillingness to pay for their consultation and subsequently claim the Medicare benefit. Thus bulk-billing was seen as an important strategy to offer to this community.

We tend to bulk-bill the vast majority of them

The vast majority don't/can't pay or are unwilling to pay (for a consultation).

It was standard policy for both major medical practices in Moree *not* to bulk-bill. However one of these practices was prepared to make exceptions depending on the patient's ability to pay. As a result this practice saw 60 - 100 Aboriginal patients per day on average. The other major medical practice did not bulk-bill any patients and thus saw very few Aboriginal patients.

The medical practices which did bulk-bill reported that they would send a patient to the town's Medicare office if their card was out of date. If a patient had forgotten their card, they were asked to ring the surgery or come by with their card number.

Many health service providers said they were often unable to obtain Medicare numbers for patients by using the Medicare Hotline. This was owing to HIC policy that the date of birth and address given by the service provider match those in HIC records. It was reported that the address given by an Aboriginal patient was often more recent than the one initially provided to Medicare. As missing Medicare numbers were not dealt with until the patient had left the surgery, it was often impossible for the surgery to clarify their old address until they visited the surgery again.

It was common for Medicare claims to be rejected by the HIC owing to cards being out-of-date. One Moree general medical practice reported that an average of 2% of their Medicare claims were rejected, usually due to the card number having expired. Another medical practice confirmed that out-of-date cards were the most common reason claims were rejected. This could be remedied by

contacting patients and asking them to apply for or provide a current Medicare number. This process was reported to be relatively simple.

Difficulties were more likely to arise with Aboriginal patients, as they were less likely to be contactable by the surgery. When patients had been treated by doctors at the AMS, patient details were often not available. Many of these patients were reported not to have telephones connected, in which case one surgery reported they would write a letter to the patient, asking them to provide a valid Medicare number. The other (smaller) surgery contacted reported they would not bother to chase up difficult-to-find patients. Some reported resentment at the time it took to chase claims and Medicare numbers. In cases where a patient was too difficult to contact, rejected claims were often written off by a practice as unrecoverable debt. (Both doctors and their clerks who were interviewed did not believe they should have to spend time chasing up patients for correct Medicare numbers).

That's not really our responsibility.

Administrative staff complained that it would be more efficient if Medicare directly notified them by telephone of wrong or expired Medicare numbers, rather than having to mail claims back and forth.

All of the nurses and health workers interviewed were salaried staff and thus had no motivation to claim monies from Medicare. Even the community nurses and health workers at the Moree AMS were paid from grant monies, so that Medicare claims were not an issue for them.

As mentioned earlier, invalid cards/ incorrect details was reported as a common problem. Health care providers commented that there was poor understanding amongst Aboriginal clients of the need to use a card with the correct number on it. When patients had both a new and an old Medicare Card, many believed these were interchangeable.

They don't realise they have to destroy the old one.

Expired cards have already been noted as a problem for health care providers when it came to rejected claims. This was reported as much easier

to sort out (ie obtain the correct or new card number) when clients were contactable by telephone. However it was estimated that some 50 - 60% of Aboriginal clients did not have telephone numbers. Often health care providers decided to write off rejected claims in these cases where patients were difficult to chase up.

Some Aboriginal clients were reported to believe they would not need identification when presenting at the Medicare office. There was a general belief that 'everything's on the computer'. It seemed that some based their conceptions on what they had experienced at other government offices such as Social Security.

For the majority of Aboriginal clients however, providers believed they were well aware of how the Medicare system worked.

The director of one of the large medical practices in Moree reported that there was resentment amongst the whole population about having to pay a \$13 to \$16 gap-benefit for a medical consultation, when other towns did offer bulk-billing facilities.

A number of health care professionals reported that it was very important to offer an Aboriginal Medical Service as Pius X did, as Aboriginal people were more likely to attend such a service. The free nature of this service was thought to be an important motivator for many for whom medical care was not a high personal priority.

The propensity of many specialists who visited Moree to bulk-bill was also thought to increase the chances of referral to such specialists. A paediatrician who regularly visited Moree reported that patients never went untreated because they had not been enrolled in Medicare.

A psychiatrist who held regular clinics in Moree reported he was paid on a sessional basis by the Department of Health and thus did not require patients to provide a Medicare card. This system was found to work very well for both doctor and patients.

Referrals

A more difficult problem related to organising some Aboriginal patients to visit specialists outside of

town. General practitioners needed to keep in mind their patient's motivations to travel to see specialists and their access to transport. These considerations affected whether some patients were referred to outside specialists, and whether AMS staff were involved.

Pius X staff reported that they were in need of a transport driver to take patients to specialists in Tamworth and Inverell. At present many Aboriginal patients will not attend such referrals owing to transport difficulties.

One of Moree's optometrists also reported that he often made referrals to Tamworth or Inverell eye specialists. He believed a transport driver would be very useful to prevent about 20% of his clients failing to show at these appointments.

Sometimes general practitioners avoided out-of-town specialist referrals, if they knew the patient had a poor past attendance record.

It was reported that the majority of specialists who visited Moree did bulk-bill for their services if the patient had a health care or pensioner card.

Use of Medicare Card in Hospitals

Moree hospital staff reported that they required each patient's Medicare number for administrative purposes (although not as a prerequisite to providing treatment). The hospital's Aboriginal Liaison Officer reported numerous instances where patients did not bring a Medicare card on presentation to hospital. If they had a card at home, this proved easy to obtain, however if they had lost their card or needed to be enrolled /re-enrolled, hospital staff reported that this could be quite difficult to arrange. The chief barrier identified was the need for the patient themselves to fill out the necessary forms at the Medicare office.

Administrative staff at the hospital reported that often nursing staff neglected or were unable to obtain Medicare numbers for patients. In these cases, the admissions officer and staff were responsible for locating Medicare numbers.

■ Issues Relating to PBS

Staff members at both the town's pharmacies were interviewed. Approximately 75% of prescriptions at both pharmacies were prescribed to concession card holders. It was estimated that Aboriginal people made up 20% of the clients at one pharmacy and 40-50% of the clients at the other.

It was reported by some health care providers that a proportion of Aboriginal patients did not see expenditure on their own or their families' health as a high priority, compared to activities such as gambling and drinking. It was reported that Aboriginal patients sometimes failed to pick up their prescriptions from the pharmacy, and this was put down to the placement of low priority on health concerns. However, this was reported to now occur much less frequently than in the past (say once every three weeks).

As a result, one of the main problems reported with Aboriginal patients' access to medications was a tendency to get a prescription filled only if they felt sick. Both AMS staff and medical doctors in town reported that they spent time trying to impress upon patients the importance of taking their medication and completing the whole course.

However it was reported that most of those Aboriginal patients on regular medications would put money aside to pay for these out of their fortnightly payments.

One pharmacist reported that often Aboriginal clients presented to his pharmacy to fill a prescription without their concession card. In such cases, both pharmacies reported that if the client was known to them or could present other identification and had previously filled a prescription at the pharmacy, they could look up the patient's concession card number on the pharmacy computer. If listed on the computer, the pharmacist could also check whether the card had expired.

When the pharmacy had no record of the patients number, or the card was found to have expired, clients were given three options.

If it was within office hours, the client could go to the town's Social Security office and request a letter which gave the client's pension number and its expiry date.

Alternatively, the client could return home to get their card or as a third option, pay the full price for the medicine. In this last case the pharmacy would fill in a NHS claim receipt which could be taken to Medicare to obtain a refund by the client.

The pharmacy assistant reported that it was uncommon that customers would say they were eligible for the concession price, but did not have a concession card (either on their person or elsewhere). One pharmacy reported that a customer was unable to produce a concession number approximately once per week.

It was reported that about once per fortnight, an Aboriginal client would use the concession card of another family member - that is, the prescription would be filled in using their name, but the concession card number would be that of another person.

Pharmacy staff reported that as health concession cards were valid for only three to six months at a time, it was common for clients not to have renewed their card when using it. The pharmacy computer could usually detect this.

Pharmacy staff did not report any problems with children not being listed on guardians' concession cards.

Pharmacy staff and AMS staff reported that it was not uncommon for Aboriginal clients to fail to have a prescription filled because they did not have sufficient spare cash even for the co-payment. This was reported to be of particular concern when parents/guardians failed to fill a prescription for a child in their care owing to a lack of money.

Both pharmacy staff and the AMS nurse recommended that the town's prescribing doctors become more aware of the cost saving benefits to patients of prescribing generic name brands of medications rather than more costly brands. It was reported that the co-payment for generic brands could be \$3.20 for concession card holders compared to \$5.40 for the more expensive brands. This price difference was thought to be significant for some clients.

When medical practitioners were asked whether they took generic brand price differences into account when prescribing, a number said they did not. Pharmacy staff recommended that doctors

could be more co-operative in prescribing the cheaper generic brands to Aboriginal patients. This might mean raising prescribers' awareness of the price differentials in gap-benefits for various pharmaceuticals.

Pharmacy staff also admitted that they were allowed to offer a client a cheaper brand of a prescribed drug, if this was thought to encourage the client to comply with treatment. One pharmacy assistant felt that this responsibility did lie partly with pharmacies.

The doctors interviewed were aware that Aboriginal patients often might not have enough money available to afford the co-payment.

They tend to not have money available to pay for a script - that's common.

Some Aboriginal people themselves confirmed that if they had no money they would wait a few days until money was available. A few others reported that the pharmacist would give them the medication on credit (although this was denied by Moree pharmacies).

There were varying opinions amongst doctors about how likely Aboriginal patients were to admit to the doctor that they could not afford a medication. When patients did not have money available, doctors reported that other arrangements could usually be made. Often, the patient might wait until s/he received his/her next pension payment, and perhaps be provided with a starter pack from the prescribing doctor.

One Moree doctor believed that if a body such as ATSIC could cover the \$3.20 (average) co-payment, this would significantly increase the proportion of Aboriginal patients who filled their prescriptions.

A main benefit for Aboriginal clients who attended Pius X AMS was reported to be the provision of free basic medications, without the need for a co-payment. This was reported to ensure that this population at least started on a particular medication when necessary. However, compliance with medications was not thought to be significantly worse for Aboriginal people as compared to non-Aboriginal patients.

Pharmacists, doctors and AMS nursing staff all agreed that there were a number of medications commonly prescribed to the Aboriginal community in Moree which were not listed or had been removed from the PBS list. These include:

- Fefol (iron replacement)
- Hydrofoam, Canesten (anti-fungal creams)
- Lyclear cream (for scabies)

The expense of these unsubsidised medications was thought to be a real deterrent to low income Aboriginal and non-Aboriginal patients buying such medications. While some of these non-PBS medications could be substituted with PBS listed treatments, these alternative medications were reported to be less than ideal by doctors as they did not work as well or as quickly.

One Aboriginal woman reported having difficulties with a pharmacist in Moree a year ago who used to charge \$70 for prescriptions. This pharmacist was apprehended apparently, and no longer works in Moree.

No problems were identified with the practice of doctors needing to get HIC authority to prescribe certain drugs.

AMS staff reported that Aboriginal clients were not very aware of the Safety Net entitlements. One nurse believed Aboriginal people would need their doctor to make them aware of this potential saving.

Owing to both local pharmacies being in the same street in Moree and not within easy walking distance of two of the medical surgeries or Pius X (which see the majority of Aboriginal patients between them), it was reported by some health care workers that less 'motivated' patients who did not have vehicles might need to be taken to the pharmacy to ensure they went at all.

A Pius X AMS staff member was usually available to transport patients from the clinic, and staff were very aware of patients who had transport difficulties. However patients seen in private surgeries were not offered such a service.

Doctors interviewed did not report that their Aboriginal patients had any need for more repeat scripts than was allowed by law.

Medical and nursing staff reported that patients were only given starter packs of medicine when discharged from hospital.

Pius X AMS staff reported that they were only allowed to stock S1, S2, S3 and some S4 pharmaceuticals. The S4 drugs which were stocked (and dispensed under a doctor's supervision) were Maxolone, Stematil, four commonly prescribed antibiotics and courses of immunisation. Stronger painkillers such as Panadeine Forte for example were not available at the Pius X dispensary.

AMS staff were happy with this range of drugs as it ensured that for common conditions and immunisations, patients could be assured of immediate access to pharmaceuticals.

■ Levels of misinformation

Aboriginal clients reported they were given enough information about their medication from both doctors and pharmacists. Older Aboriginal people suggested that instructions on medicines be printed larger and use simple text which is easy to comprehend. Aboriginal clients reported they felt confident asking questions of both doctors and pharmacists if unsure about a prescription.

Aboriginal people interviewed reported that it was helpful if any information was presented in bright colours. Aboriginal colours (red, yellow and black) were suggested by a number of people as effective in grabbing people's attention.

Most people reported that they had access to all the information they needed. The town's medical centres were reported to be good sources of information by Aboriginal people. Television was also mentioned as an important medium used to obtain health information by Aboriginal people.

Staff who are easy to understand and fact sheets in comic form were also mentioned as important.

■ Satisfaction with the HIC

There were complaints from doctors about the amount of time it took for Medicare cards to be sent out to customers. Most health care providers however believed that HIC staff in Moree did a

very good job, and were adept at dealing with Aboriginal clients.

Providers suggested , as mentioned earlier, that the system might work more smoothly if clients were automatically sent out their Medicare card when the old one expired, or at least sent a reminder letter by Medicare. (This is, in fact, the process adhered to. However, the system breaks down when an up-to-date address is now known.)

Information provided by the Health Insurance Commission was reportedly sufficient. Service providers said that HIC staff were culturally sensitive and Aboriginal clients did not report any problems or feelings of alienation by Medicare staff.

Current forms were seen as very user-friendly for Aboriginal people by health care providers. No specific problems were reported in regard to filling out these forms.

PORT AUGUSTA, SOUTH AUSTRALIA - RURAL

■ Background

Port Augusta is about 300 kilometres north-west of Adelaide. Known as 'the crossroads', it is at the intersection of the highways heading west to Perth and north to Alice Springs. It is a regional centre providing health and other services to many towns and communities in the region, such as Quorn and Hawker. It also services a number of remote communities in the north of the State such as Leigh Creek and Copley (380 km), Marree (496 km), Nepabunna (460 km), Oodnadatta (770 km) and to some extent Cook, Tarcoola and Yalata on the Nullarbor.

The population of Port Augusta is around 15,000. The Aboriginal population is around 3000, though this can double around Christmas time, at ceremonial times and during NAIDOC week. The Aboriginal population lives in the town and at the Davenport community five kilometres from the centre of town.

Quorn, 41 kilometres away, has a population of around 1,500 (7% Aboriginal) and is virtually considered a suburb of Port Augusta. Hawker is just over 100 kilometres away and has a population of around 350 (50% Aboriginal). Leigh Creek and the satellite town of Copley are about 380 kilometres away and have a permanent population of about 1000. Aside from the train line which runs through Quorn, transport is limited to private vehicles. The area has a traditional mining background and today most employment in the area is with the ETSA Corporation (Electricity Trust of South Australia), which operates a power station on the outskirts of Port Augusta.

■ Range of Health Services

Pika Wiya Health Service

Pika Wiya has operated continuously for around a quarter of a century. *The Aboriginal Medical Service* was established in the early 1970s with funding from the World Council of Churches. It

became incorporated in the Health Commission of South Australia in 1984 and remains Aboriginal Community Controlled. Funding responsibility for Pika Wiya lies more or less equally with the State, through the Health Commission of South Australia, and the Commonwealth, through the Department of Health and Family Services (OATSIHS).

There are two arms of the service. The community health centre in the middle of town operates by appointment only. They see around 200 patients each week, half of whom would be seen by a doctor and the other half would be seen by a nurse or health worker. The majority of the patients are Aboriginal. The Davenport clinic services the Aboriginal community at the former reservation. It is a drop-in clinic and around 200 patients are seen each week, 50% by a doctor and 50% by a nurse or health worker. Both services are open five days a week, 8.30am to 5.00pm. It also operates outreach services to Copley, Lyndhurst, Marree and Nepabunna.

Pika Wiya has been bulk-billing for four years following advice from the Department under the previous Federal Government. Until the Minister's announcement last year they felt uneasy about the Medicare arrangements and kept their bulk-billing income in a separate account, *'in case the Government wanted the money back'*. There was some concern expressed about becoming reliant on Medicare in case there was pressure to push patients through to maximise Medicare rebates and become a mainstream service. The current arrangements take into account adequate time for consultation and other duties, for example doctors have a day off consulting each week to go over case notes, liaise with health workers, specialists and so on.

The service currently employs around 50 staff, including four doctors working on a rotational basis, 12 health workers and two registered nurses/health educators. The service sees both Aboriginal and non-Aboriginal patients, though the clientele is primarily Aboriginal.

Reasons given for some Aboriginal people not using the service include confidentiality issues (it was said that a few patients felt personal information had been or could be disclosed to third

parties) and personal preference for another doctor.

Private surgeries/medical centres

There are three private medical surgeries in Port Augusta. One is a medical centre with five doctors (not all full time), with a clientele of about 150 per day, of which only a few per cent are Aboriginal. The centre does not generally bulk-bill, but does for Health Care Card holders. The other two practices are sole practitioners. One bulk-bills all patients, the other does not, and both estimate their Aboriginal clientele to be around 30%.

The non bulk-billing services charged a fee above the Medicare schedule for a variety of reasons. It was claimed that Medicare alone doesn't cover the costs of providing health services and that they were only able to provide extra services (eg audiometry and ECG) because they charged a fee. One surgery outside the town claimed it was difficult to recoup costs through Medicare in a surgery outside urban or regional centres because of the diminished volume of patients.

One doctor was told by his bulk-billing predecessor that he wouldn't get the Aboriginal patients to pay. However the doctor disagreed: *'I don't think that's right for Aboriginal people, treat everyone the same'*. The doctor felt that a lot of people don't pay because they don't understand the system and that his patients *'appreciate being treated the same'*.

However some Aboriginal people strongly supported bulk-billing. Two women said they are always bulk-billed when they see the doctor, otherwise they wouldn't be able to go.

Port Augusta Hospital

The public hospital is located in town and offers a broad range of services. It is the main hospital in the region, providing medication and emergency services for many of the outlying towns. There are two resident paediatricians and other specialist services are provided through the hospital by doctors from Adelaide. These include a general surgeon, an anaesthetist, an ear/nose/throat

specialist, a plastic surgeon, an ophthalmologist and an obstetrician.

Royal Flying Doctor Service

The RFDS base at Port Augusta services a large part of remote South Australia, reaching communities such as Oodnadatta, Yalata and Marree. The RFDS receives grant funding and does not use Medicare when visiting the communities. When not on duty in Port Augusta, the doctors have the right to private practice, operating out of the hospital or relieving other GPs in town.

Pharmacies

There are four chemists in Port Augusta. The chemist closest to Pika Wiya holds the service's account while another does a lot of postal orders for remote communities.

Outlying areas

Quorn, Hawker and Leigh Creek are each serviced by a GP and a small acute care public hospital. The GPs in each town are able dispense medication under Section 92 of the National Health Act.

Pika Wiya also operates clinics staffed by health workers at Copley, Marree and Nepubunna. A Pika Wiya doctor visits each community once a week, as does an RFDS doctor. It was commented that to some extent these communities (Copley in particular) were overserviced and that there was the risk of contradictory diagnoses and doubling-up on medication, which could result in patients overdosing.

Medicare

The Medicare office is located next door to the Pika Wiya town clinic. Both ACCHS and Medicare staff say they have a very good working relationship. However at the time of the study there were rumours that the office could close as part of a restructure intended to give greater access to remote areas.

■ Issues relating to Medicare

The ACCHS reported they did not experience too many problems with Medicare:

Medicare is running not too badly.

We don't really have any problems with Medicare

Enrolment

Only a small percentage of Aboriginal people are not enrolled in Medicare, though about half come through without their Medicare card. The staff say that enrolment is not a problem at the town clinic because the Medicare office is located next door. Whenever someone isn't enrolled, they are sent next door and the Medicare staff help them to fill out the enrolment form or complete it for them.

At the Davenport clinic patients are enrolled on the spot. Medicare enrolment forms are kept at reception and regularly sent to Adelaide. It was suggested that the HIC go to communities and enrol people as the Electoral Commission does. However it's not often that someone isn't enrolled - they usually just don't know their number.

Medicare enrolment and claim forms were seen by a few staff members as user-unfriendly. It was said that many patients have literacy problems and can't read them. *'Some of the things they ask for are too technical.'* Pika Wiya staff help patients to fill out the forms but often don't have the time.

Staff at both clinics reported a high level of non-enrolment of newborn babies and young children.

Until they come and use the service they don't enrol their baby.

Mums are given a load of forms at the hospital and they're too ashamed to admit they can't read. It would be good if someone was employed at the hospital to help them.

One staff member reported they had been told that only the *mother* could enrol a child. This causes a problem if the child is in the care someone other than the parents. The case of an unenrolled baby

born in Oodnadatta was related. The mother did not have any documents to prove the child was hers and eventually (four weeks later) a letter from the hospital was obtained.

Other health services in town also reported very few problems with Medicare enrolment. Generally reception staff enrol babies under six months old via the Medicare Claim form. They say problems arise when the child is over six months of age as Medicare requires them to provide a birth certificate. It was said that parents often can't read the forms and can't afford the \$23 fee, resulting in the child remaining unenrolled. It was reported that children were more often not enrolled than adults.

Almost all health care providers reported re-enrolment after the Medicare card had expired as being a problem. No-one was really sure whether Medicare cards were automatically re-issued or whether the patient had to re-apply. One doctor reported that claims had been rejected because of expired cards 15-20 times over the past six months.

One doctor saw quite a few patients from remote communities and said they didn't carry Medicare cards and frequently were not enrolled. He always sees them and tells them to get themselves enrolled, but he thought that usually they don't bother. Other occasional problems included removing one member of the family from a card (ID was required but was often unavailable) and difficulties caused when one family member moved away and there was only one Medicare card. One Aboriginal woman said when she sent her child to Sydney for treatment she had to send the card along with her, leaving the rest of the family without a Medicare card. When she or her husband needs to travel, only one of them has the card. *'It took me ages to get two cards'*. She thought Medicare should ask clients upon enrolment whether a second card is required. She said when young people turn 16, they can visit the doctor by themselves and should have their own cards.

In Quorn, Hawker and Leigh Creek enrolment problems were occasional. Principal problems concerned identity requirements, enrolment of babies and re-enrolment after card expiry.

One Aboriginal man said he had applied to Medicare about four times in 13 years but has never received a card. He applied for three cards in South Australia and one in Queensland. He didn't know why he had never received his card because he always had mail redirected. He added that a lot of people north of Port Augusta would not know what Medicare is. Other Aboriginal people said enrolling was easy, for both themselves and their children. *'Just fill out the form when a child is born...it's just part of the paperwork, it's no drama, just have to fill out the form along with everything else'*.

The Medicare staff don't see a lot of people wanting to enrol; most people come in to find out their Medicare numbers. They said when some Aboriginal people come in, they appear to be confused by all the forms and pamphlets and too shy to ask. They often pick out a claim form and start to fill it in, so generally the staff ask if they would like some help.

The Medicare staff ask to see a birth certificate or other form of ID (eg driver's licence, bank account, health care card). If none of these is available, they will accept a letter from a health worker at Pika Wiya or the school principal stating that the person is known to them. The office staff have never known of a letter such as this being rejected as a form of ID. They reported that enrolling infants over six months old is a much harder task. *'The hardest problem is ID'*.

Medicare numbers

When people come to Pika Wiya town clinic they are asked for their Medicare number. Staff estimated that about half of all patients don't have their card with them. Generally if they don't have their Medicare card and the number is not on file, they are sent next door to Medicare and usually come back with their number on a slip of paper. In acute cases, they don't worry about chasing up someone's Medicare number. All patients are seen whether or not they have a Medicare card.

At the Davenport clinic, they ring the Medicare office in town to get people's numbers. If the person is from a remote area, they ring the patient's community and the health clinic usually

has the number on file. *'It would be quite rare that we don't find a Medicare number somewhere.'* A few patients leave their Medicare card with the clinic.

Pika Wiya is not reliant on Medicare income, so where they can get Medicare numbers without considerable investment in staff time and discomfort to the patient, they will. *'The last few per cent we don't chase'*.

When they first started bulk-billing they were given the Medicare Hotline number to call if they needed to get a number. However many patients don't know or have changed one or more of their personal details. Many older patients' dates of birth are recorded as 1 January because they don't know when they were born. Some transient people do not remember where they registered and they may have changed their names one or more times since enrolling. Because of frequent failure to get numbers, it was reported that both clinics avoid ringing the Hotline and go through the local Medicare office.

All other health service providers used the Medicare Hotline when a Medicare card could not be presented or the surgery did not have the number on file, but said that it was much easier when they could ring up the local Medicare office. They felt the staff at the local office understood the problems they regularly experienced and were more skilled at finding a way around the problems.

When ringing the Hotline, other service providers reported similar difficulties to Pika Wiya. Some Hotline staff were reported to be more helpful and patient than others: the best ones would allow the service provider to try a few variations and might hint at the correct one. Because the service provider generally rings the Hotline after the consultation (for convenience) the patient is usually no longer there to consult if a detail is incorrect.

'Too much relies on having the date of birth and the names'.

Some surgeries reported problems trying to get a number for a child in the care of an aunt or other relative. It is often not known which name the child is enrolled under nor the child's date of birth. One

surgery reported this occurred three to six times a year. Another reported *'getting nowhere'* with the Hotline when a woman from Oodnadatta came in to the surgery, so they sent her around to the Medicare office and she returned a short time later with her number. Despite the difficulties, they were generally able to get the number from the Hotline. One provider said that when they do not know the patient's number, they write in all the details they do know and lodge the claim, and it is usually processed.

Though services had to ring the Hotline to get the numbers for both Aboriginal and non-Aboriginal patients, they phoned more often for Aboriginal patients. For example, one medical practice phoned once a week with about six Medicare number inquiries, half of which would be for Aboriginal patients.

The surgeries outside Port Augusta reported fewer problems in getting patients' Medicare numbers. Most patients were said to bring their Medicare cards, or they had the numbers on file. Generally patients are locals, so local knowledge usually resolves any problems of identity/ change of name/ address. One surgery said tourists in car accidents were a much greater source of lost income.

An Aboriginal man who didn't have a Medicare card said he used to show his social security card when he needed medical or dental treatment, but he hadn't been sick for a while.

Rejected/ unlodged claims

Pika Wiya gets *'quite a few'* rejected claims - *'a couple a week... but we don't lose much sleep over them'*. One staff member estimated at least ten claims per week are rejected or not lodged.

'If it's easy and we have the time to look up the details we will, but a lot of times we just tear them up and put them in the bin.'

Claims have been rejected because the Medicare number is incorrect or invalid (eg they still see several of the original green and yellow cards) or the name is incorrect. Claims are also rejected because of clerical errors, eg the receptionist has forgotten to tick the patient's name if on a family card, fill in the date or write in the consultation fee.

They have also had claims sent back because the patient has signed with a 'X' because they are illiterate. It was said that if the patient's name is printed by the staff below the 'X' they are usually processed by Medicare.

Other health care providers reported that 'once in a while' patients bring in old cards to one surgery. One surgery reported sending in Medicare claims with the old number, and receiving a remittance with the new numbers written on it. The provider assumed this only happened when the patient had already applied for a new card.

The main reasons reported for claim rejections were clerical errors made by reception staff or the GP or scanning errors made at the HIC. One service provider said these scanning errors were happening more often now than they used to while another said that electronic claiming had minimised these errors. Most mistakes were said to be easily rectified but some service providers invested a lot of time and effort doing this. Most clinics reported having to throw at least some claims out. One surgery reported having to shred about 20 claims a year, 70-80 % of them for Aboriginal patients. Another surgery with a much smaller Aboriginal clientele throws out 'just a couple'.

Non-claimable work

Much of the clinical work is performed by nurses and health workers. The nurse sees patients who don't have an appointment at the town clinic (eg after fights). She fixes them up and if necessary gets the doctor to check them. Quite a lot of people walk in without an appointment and have to be attended to by the nurse. It was regretted by some staff that this work did not attract Medicare rebates.

On some days a doctor is not in attendance at one or other of the clinics, so the nurses see the patients and may do a phone consultation with the doctor in the other Pika Wiya clinic. Neither the nurse's work nor the doctor's telephone consultations are billable.

■ Issues Relating to the PBS

Pika Wiya's pharmaceutical budget incorporates a considerable imprest stock of medication approved by the Health Commission of South Australia. Although the imprest stock is quite expensive to maintain, it gives medical staff the option of providing the patient directly with their medication where it is considered necessary, eg when they believe the patient won't go to the chemist to fill a script or they don't have any money.

Pika Wiya also has an account with a local chemist, which covers concession-priced medication bearing a special orange sticker from the ACCHS. It is cheaper to put drugs on the account than to give out imprest stock, as they always pay full price for the latter. The doctors tend to send patients needing medication for chronic illnesses to the chemist, but tend to take medication for acute illnesses straight from the imprest stock (eg antibiotics, pain killers). They say that patients often present at a late or acute stage of their illness when their pain is great and it would be too risky to send them away without medication in their hands.

Entitlement numbers

Staff estimate that 60-70% of Pika Wiya patients have concession entitlement cards. Pika Wiya keeps patients' concession card numbers on file when they get them. Their chemist account is limited to concession card holders only and they generally won't put an orange sticker on a prescription unless they know the patient has a concession card. It was reported that sometimes patients don't have their concession cards, in which case they are sent to the chemist anyway, in the hope that the pharmacist has a record of the number. If the pharmacist doesn't have the number, he rings Pika Wiya and responsibility shifts back to the health service. It was said that this used to happen a lot, but is now a rarity.

Most health care providers and pharmacists reported the refusal by Department of Social Security (DSS) to release entitlement card numbers to third parties was a problem. A few service providers have tried to get through to DSS

on the telephone while the patient is at the clinic, but they reported waiting up to an hour to get through to an operator.

I rang DSS and was on the phone for half an hour and I finally gave up. It was easier to pay the difference.

We tried it one day and it was three-quarters of an hour.

It was said that the automated phone system at DSS was not user-friendly for Aboriginal people. The problem was of greater concern to the dispensing GPs outside Port Augusta, where up to 99% of Aboriginal people were in receipt of benefits. One GP said missing entitlement numbers was 'a big problem', happening two or three times a month. The GP sometimes threatens to charge the full \$20.00 if they don't bring in the card, at other times gives the patient the medication on credit, or if it's for a child, just gives it to them for \$3.20 or free. At the time of the visit there were ten prescriptions in the drawer with no concession number on them (some were multiple scripts for the same client). It was said that older and transient people tend to be less reliable with their numbers.

Another GP charges \$20.00 and tells the patient they can get a refund if they bring in their concession card. *'They usually come back a while later with the card'*.

The pharmacy with the Pika Wiya account phones the ACCHS about once a week and would have one or two prescriptions a month that he couldn't get a number for. Another pharmacist said it wasn't such a problem because his pharmacy is very close to DSS and clients can go and get their numbers. However it was reported that waiting time at DSS offices can be very long as well:

Some patients say 'I'd rather pay the full amount than wait half a day at Social Security.'

The pharmacists agreed that not having concession cards was a greater problem with the non-Aboriginal clientele: *'Of ten people coming in who don't have cards, two would be Aboriginal.'*

A pharmacist who does postal orders to remote areas said getting concession numbers is 'a big problem'. Though some 90% of Oodnadatta clients are regulars for whom he has the numbers on computer, he is still unable to locate some numbers. He generally fills the script at full price and tells the nurse in Oodnadatta (who gives out the medication and takes the money) to ask for the full \$20.00 or get the patient to find a concession card. This pharmacist believed the problem is more common with Aboriginal clients than with non-Aboriginal clients.

Lack of money

Patients not having money was the second major barrier to getting medication consistently raised by service providers. Some service providers said this problem was by no means limited to Aboriginal patients.

Pika Wiya has addressed what they consider to be a major impediment by allowing patients who can't afford medicine to put it on their account or by supplying them with medication directly. Other service providers did not generally send patients without money to Pika Wiya to get free medication, though some did 'occasionally'.

In town, one medical practice reported that a patient who needed a Modicate injection to treat schizophrenia said she had no money - 'I'll have to wait 'til next week'. The practice manager phoned the pharmacy and asked the pharmacist to put the medication on account for the patient.

At the surgeries outside Port Augusta, the dispensing GPs and office staff generally made allowances for children. One said that when the medication was for an adult, they would be told to go and get the money, but when it was for a child, the medicine would be supplied and the patient asked to pay later (they usually did pay when they got some money). The surgery reportedly writes off around \$500 a year in unpaid scripts, but this included both Aboriginal and non-Aboriginal clients. Another GP commented that everything in town is put on credit so they expect the same with medical care and pharmaceuticals.

The pharmacists reported that clients often say they haven't got any money. Three of the four

pharmacies have 'casual accounts' for people they trust. One pharmacist said that his Port Augusta clients don't get credit, but some Oodnadatta clients do. *'Sometimes they don't bring the money back and we don't get paid - it's a bad debt'*. With certain clients he gives them enough to go on with and tells them to come back and pay for the rest: they usually come back. He sometimes goes to the solicitor about unpaid clients, but none of these has ever been for an Aboriginal client.

It was reported that sometimes patients go to Adelaide to have specialist treatment and are started on medication provided by the hospital. They come back to Port Augusta with a small discharge supply (up to a week's worth) and a prescription only to find the medication they need is non-PBS and very expensive. Either they don't take it or come to the hospital to try to get free medication. It was thought by local GPs that specialists ought to be more aware of medication cost when prescribing. *'City specialists start this cycle of expensive drug giving and then we can't continue it. We don't have a budget for it.'*

An Aboriginal woman living in one of the towns some distance from Port Augusta reported that although Pika Wiya include her town in its health statistics, they will not supply pharmaceuticals to the residents. *'They say we should be getting our drugs from (our GP), but we have to pay for them here. They're free at Pika Wiya'*. She generally has drugs put on account, and when the bill gets to \$10 she pays it. She talked about the shame and humiliation of not being able to pay for medication.

If they didn't bulk-bill and put things on account, I wouldn't take the kids to the doctor. It gets expensive buying Dymadon, Drixine and asthma stuff. We used to say, 'We'll have to sit this one through'.

Scheduling of PBS medication

Many medications are classified as 'comfort drugs' and are not subject to the PBS subsidy, making them quite expensive. It was said that if patients on low incomes - and most Aboriginal people fall into this category - are given a script for an expensive non-PBS medicine, they won't get it or will go to another doctor for something cheaper. It

was reported that doctors are forced to prescribe something on the PBS which may not be wholly appropriate, eg steroids instead of antihistamines.

The Safety Net

The pharmacists said they keep a record of regular clients' spending on computer. However it was thought that most Aboriginal people don't know how the Safety Net works. This is a problem for transient people and even local people who move about. The Record Form is their only alternative, but it was thought that many people wouldn't know to ask for it nor know how to use it.

It was reported that some Aboriginal people had been told by pharmacists in other cities they couldn't use their Safety Net card interstate. One woman said she had read about the Safety Net in the newspaper, but was told it hadn't started yet.

Delays in medication supply

One pharmacy fills most of the prescriptions brought in by the Flying Doctors from remote areas. It was reported that the turnaround averages about three to four days, and can be up to five days, which is sometimes too long. It was reported that local hospitals in remote areas often have to supply medication to outpatients because they are unable to wait, but it was felt to be burden for the hospitals because there is no way to restock supplies.

Use of hospital pharmacy

After 12.30pm on Saturday, there is no pharmacy open in Port Augusta until Monday morning. Some patients present at the hospital because they have run out of medication. The hospital usually gives them starter packs to tide them over. There is the problem then of patients taking only the starter pack and not following up with their prescription, and they frequently re-present with the illness.

■ Other Health Delivery Issues

Shortage of doctors

Like much of rural Australia, the Port Augusta region finds it difficult to attract health personnel. Until Pika Wiya recently employed one, there was only one other female doctor in town. One nurse said she has to drive to Port Pirie (110 km away) to do Pap smears because there was no female doctor there.

Specialist services

No-one reported hearing about specialists charging over the Medicare fee, though some patients had returned from Adelaide saying they had been charged more. It was said that there is a preference for city specialists - many patients believe that *'Adelaide specialists are better'*.

One health care provider said that when patients without Medicare numbers are referred to a radiologist, the radiologist will do the x-rays but won't release them until they've been paid for. It was reported that the doctor sometimes phones the radiologist and gets the report, which in most cases is enough to make a diagnosis.

Medication compliance

'Compliance is as big a problem as access to medication' (pharmacist).

Pika Wiya is well aware of the problems associated with compliance, which is one of the main reasons they supply a lot of medication directly to patients. It was said that education about the use of medicines on an independent basis was needed.

Bush medicine

Pika Wiya staff did not know whether or not patients used bush medicine. One GP outside Port Augusta said a few people still use bush medicine for arthritis and diabetes.

An Aboriginal woman said she often uses bush medicine for cuts, sometimes in combination with western medicine, eg use of ventolin and bush medicine (inhaling steam from boiling water poured on leaves). The bush medicines are usually medicines that go *on* rather than *in*.

■ **Satisfaction with the HIC**

Most service providers had little contact with the HIC other than through using the Medicare Hotline. Some complained that the Hotline operators were too rigid and failed to understand that certain cultural differences made some bureaucratic procedures unworkable.

A number of service providers said the Medicare staff in Port Augusta were very helpful and understanding.

A couple of service providers complained of *'being given the run around'* when they contacted the HIC about specific cases. One wanted to find out whether it was possible to get a concessional diabetic patient on a glucometer machine more cheaply through the PBS: *'I got shoved from department to department and it took 3 days to get an answer'* (no). Another rang the HIC about not being able to administer necessary drugs and spoke to someone who was *'no help'* and kept being told he couldn't use or dispense the drug.

One GP said the statistics sent out quarterly or half-yearly were useful for billing. A few said they would like more information about the Safety Net.

Cultural sensitivity

Pika Wiya staff were pleased with the way staff at the Medicare office handle their patients.

Overall the only criticisms relating to cultural sensitivity related to the Hotline and DSS phone service. One service provider said it was important to explain to Aboriginal people why they should enrol in Medicare and what the benefits are.

Most people have an understanding of Medicare cards etc, but not necessarily how the system works. Information needs to be provided in big print and simply - at least ten per cent of the population has literacy problems.

PERTH, WESTERN AUSTRALIA - URBAN

Perth has a population of over 1.2 million people, of which about 3% are Aboriginal and Torres Strait Islander. While there are small numbers of Aboriginal people in most suburbs and a number of people still live reasonably close to the city, there are a number of areas with larger Aboriginal populations located some distance from the city centre. For example in the north (Nollamara, Balga, Girrawheen, Koondoola and Mirrabooka), east (Lockridge, Midland and surrounding suburbs), south-east (Gosnells, Armadale, Westfield) and south (Kwinana-Medina area and Coolbellup area). Research for this study incorporated the areas of Lockridge, Midland and the inner city area.

■ Range of Health Services

Perth Aboriginal Medical Service (PAMS)

Perth AMS (PAMS) is centrally located and is the only Aboriginal Community-Controlled Health Service in the city. Most Aboriginal people live a long way from PAMS and transport is a major problem. PAMS is reasonably close to a train station but for people who are ill, elderly or have limited mobility, public transport presents considerable difficulties. To help overcome some of these difficulties the service employs drivers who provide transport for patients throughout the metropolitan area, including transport to hospital and specialist appointments as well as transport to and from the AMS itself. Drivers also pick up and deliver medical supplies to PAMS patients. The service is concerned about the impact of poor transport on health standards and has been funded to establish a satellite service in the Midland area, with other satellite services to follow. PAMS also provides a range of outreach services to people in the community to help overcome transport difficulties. The majority of PAMS clients are regular patients, though there are a number of patients who are in Perth from remote areas for specialist treatment who have their primary care needs addressed by PAMS while they are in the city. Other transient patients wind up at PAMS

because of death or illness in families or because they are working or looking for work in Perth.

PAMS is funded from several sources which adds to the accounting burden on the service. Core funding is provided by OATSIHS, with additional Commonwealth funds coming from Medicare billing, while State Health funding supports a range of projects on a contract basis (Home and Community Care in conjunction with the Commonwealth, various health promotion projects etc.) and these are funded through several different branches.

Around 12,500 patients a year are seen by the medical staff at PAMS, between the equivalent of four full time doctors (one of whom is Indigenous), an average of about 60-65 patients per full time doctor, per week. The service employs five Indigenous registered nurses and a large number of Aboriginal Health Workers who work in a range of capacities from administration to community work to health promotion to primary medical care in the clinic. Apart from patients attending the medical clinic there are a large number of patients who use other services and do not necessarily see a doctor. These include patients of the dental clinic, the podiatrist, the optometrist (a commercial arrangement at no cost to PAMS), visiting specialists (currently only a psychiatrist once a week but there have been a range of other specialist services provided at different times), people with welfare issues (such as housing, access to other services, funerals, Social Security, juvenile justice, literacy and numeracy), and large numbers of people who are seen in the community (eg Home and Community Care program for the elderly and disabled). Three community nurses do follow-ups, an Aboriginal interpreter service is provided for hospital patients, and a range of health promotion activities take place, including a needle exchange program, heart health, women's health, men's health, youth programs and health promotion in prisons.

PAMS provides various services that cannot be claimed from Medicare, therefore the real cost of providing health services cannot be estimated nor met by Medicare income. Given the generally poorer health status of Aboriginal people, PAMS aims to address the causes of chronic ill health in

a holistic manner, by incorporating issues such as land, housing, racism, employment, education and incarceration through health promotion and early intervention programs. An emphasis is placed on meeting immediate living needs of patients rather than just addressing their medical needs, keeping in mind that many Aboriginal people live in circumstances that make accessing health services difficult.

Despite being an urban service where housing should be less of a problem, accommodation is a major issue for many clients and evictions from Homeswest housing is a major problem, both for the evicted families and for their extended families who have to provide emergency accommodation, leading to overcrowding and more evictions. With such urgent day to day difficulties it is often difficult to focus on chronic medical problems.

Medical records are maintained manually and staff are concerned that paper based records make efficient recall and follow up a problem. A limited computerised record keeping system is in place and new hardware which will allow better use of this system is due to be installed in June 1997.

PAMS have access to most of the bulk-billing specialists they need. However, for conditions requiring surgery they have to send people to major teaching hospitals and often extraordinarily long waiting periods are experienced. Without the provision of PAMS transport it is likely many of the people would not make it through the maze of appointments leading to essential treatment.

PAMS feel it is perceived by many as a 'fix it' organisation for all Aboriginal issues by mainstream health services (eg hospitals). There is no remuneration for many of the services they provide which they feel should properly be provided by other organisations. For example, Perth Hospital reportedly picks up remote patients from the airport but they do not offer a return journey.

Other Health Services

Bulk billing GP services are widely available in most, but not all, of the areas previously mentioned. The majority of these services are readily available in the northern suburbs whereas

in the southern districts patients without health care cards need to shop around for bulk-billing medical services. There are continual reports of Aboriginal people not attending surgeries because of the lack of bulk-billing services. It was also reported that many Aboriginal people feel uncomfortable when visiting mainstream health services because of a perceived lack of cultural sensitivity and the experience of racism. Mainstream practices in Perth tend to have a very small minority of Aboriginal clients.

Two mainstream medical practices interviewed to the east of the city centre that see a number of Aboriginal and Torres Strait Islander peoples were included in the study. The Lockridge Medical Practice reports having approximately 5% Aboriginal clientele. The Swan Medical Group located in Midland estimated perhaps a 2% Aboriginal clientele.

PAMS has continuously used the same chemist for 11 years and patients are able to put PBS medication on the PAMS account. The community pharmacy interviewed did not have a large proportion of Aboriginal clients and did not make any special arrangements for them, apart from reporting an occasional act of charity with medication for children.

■ Issues Relating To Medicare

PAMS began to use Medicare two years ago. Prior to its implementation, Medicare was resisted because staff feared it would over emphasise the role of doctors in a comprehensive health service and would encourage the service to become more like mainstream health care agencies. It was feared that a culturally appropriate health care service would no longer be delivered and that financially it may not be an advantage. However because accessing Medicare was the only way to obtain any additional funding PAMS felt compelled to accept Medicare.

The Medicare income for this service in the 95-96 budget was about \$250 000. Approximately 1-2% of Medicare claims are not lodged by the service and up to a further 2-5% of forms are rejected because forms are not properly signed either by

patients or by the doctor. Procedures with Medicare forms have been improving but staff at PAMS still felt it was not financially viable to chase up many of the claims that were rejected as the cost of staff time would be greater than the amount of money obtained.

Across all the health services there were major concerns in relation to current Medicare procedures. Clients frequently do not have Medicare numbers and a number of these may never have been enrolled. Often cards have expired, and because many patients do not have stable addresses, they do not receive notification that they need to apply for a new card. The bulk of transient clients are thought to use the service several times a year and usually do not have a Medicare card. PAMS does not refuse service because a patient does not have a Medicare card. Adding new babies was reported to be a problem: if this is not done at the hospital patient does not see an immediate need for the baby to be enrolled. Some complained of the long delays in having a new cards sent out to patients.

PAMS and the other medical practices reported continual problems with making claims from Medicare. Patients often do not bring their Medicare cards with them, and if the service does not have the number on record, it proves difficult to find one. PAMS records patients' numbers on their files, but if the card has expired then a claim will be rejected. Phoning the Hotline frequently involves difficulties, as many of the patient's details may not be known, eg date of birth (it was pointed out that Aboriginal people were not counted as human beings until 30 years ago and consequently the birth dates of many, especially those from remote areas were not recorded - a common date of birth is July 1), incorrect spelling of names, unknown addresses etc. There are also problems when members of the extended family look after children: often the children do not have a Medicare card, do not know their personal details and the parents are often out of contact so it is difficult to verify the child's identity.

Approximately four calls per day are made in relation to Medicare patient numbers. PAMS staff estimate that inquiries to the Hotline often take

over 20 minutes which includes significant waiting time before the Hotline answers.

The majority of Aboriginal people attending the services interviewed in Perth have limited literacy and numeracy skills and often have problems communicating verbally. Some clients do not speak English well. Both urban and remote people can have severe problems, not only in completing the required documentation, but also in speaking to HIC staff over the telephone. The majority of services where interviews took place said that they telephoned the Hotline while the patient was standing in the waiting room. Often the Hotline operator asks to speak to the client, but it was reported that the patient frequently does not understand or doesn't know the answers to the questions they are being asked. The patient was therefore shamed in front of several people in the waiting room.

Locum doctors and Family Medicine Program Trainees only stay at PAMS for limited periods and chasing up these doctors can be difficult, leading to loss of Medicare income. For example, if doctors do not write the correct item number in the designated space, or the date is not entered, the form is returned unpaid. If the doctor is a locum, s/he may not be there when the form returns and so the claim cannot be resubmitted. PAMS estimate a loss of about \$5,000 a year, totalling 2% of income, for these reasons. It was estimated that about two claims per day are rejected by the HIC. A staff member is required to work continually on follow-up calls to the HIC in relation to numbers etc. This works out as approximately three to four days per month (not including normal Medicare procedures) due to the length of time required to locate unidentified numbers etc. The cost to the service of this extra workload is estimated at about \$15,000 per year. They would like funding for the employment of a full-time person to work exclusively on Medicare claims.

Some staff believe that a majority of forms are returned to the health service for the simple reason it's an Aboriginal health service. They felt they were perceived to be unimportant and that PAMS does not receive the respect it deserves from HIC staff members. HIC practices were thought to be inconsistent, HIC staff varied from

being cooperative to being extremely unhelpful, and that the attitudes of the latter required change. PAMS staff regretted that they are entirely dependent on HIC staff for information. The WA head office of the HIC reported that there are special processes for dealing with Aboriginal and Torres Strait Islander clients, but that these processes can vary and break down with turnover of staff at either the HIC or at PAMS. The State Manager for the HIC understood and supported the necessity of cultural awareness training for staff employed within the HIC.

A large number of PAMS patients have complex medical and social problems which require consultations lasting up to one and a half hours. Doctors rarely see someone who has a straight-forward problem such as cold or flu, blood pressure checkup etc. (While it was recognised that this was likely to be a common problem for urban services, it was felt that it was likely to be worse in Perth than elsewhere in Australia because the service is located inconveniently for the vast majority of the Aboriginal population.) As a result, they do not operate on a 5-15 minute rota like most mainstream practices. The service foregoes much needed payments for longer consultations. Furthermore, doctors said there was some concern about possibly being investigated by the HIC for over servicing and so sometimes under-claimed (Level C instead of D or Level B instead of C).

Another concern was that because much of the clinical and non-clinical work is performed by staff other than doctors (nurses, health workers) there is no remuneration in the form of Medicare rebates. It was considered unfair that the additional work created by the administration of Medicare was not paid for by Medicare.

■ Pharmaceutical Benefits Scheme

Arrangements at PAMS

It was commented that PBS is probably a bigger problem in terms of access to timely care than Medicare. Whereas it was thought that there were enough doctors around who will bulk-bill or accept not being paid for an occasional consultation, it

was felt that few pharmacists were prepared to provide medication without payment.

It is not uncommon for patients to present to PAMS because they have been given a prescription at another service and cannot afford it.

Clients may not have an entitlement number (because they have lost/can't find their card, don't know they are eligible etc) and cannot afford the full \$20.00 PBS copayment, or may have an entitlement card but still can't pay the concessional copayment of \$3.20. It was pointed out that if several medications are required it is often a significant expense for a person on Social Security benefits.

Where workable, PAMS use sample drugs for clients to try to decrease the cost of medication to both patients and the service. PAMS also has an account with a nearby chemist which may be used by selected patients who can't afford the copayment. Nearly all of these are Health Care Card holders and the bill used to come to about \$1500 per month, though now it is thought to be about one third of that (primarily because PAMS staff are now devoting considerable time to tracking down entitlement numbers for patients).

In the majority of cases the patient is required to walk the distance to the chemist to have the script filled unless sickness or the distance limits the patient's mobility. Where no number is presented, the chemist will contact the AMS for the appropriate entitlement number. If PAMS do not know the entitlement number, the chemist will dispense the medication on the AMS account and PAMS will chase up the entitlement number. Concerns were raised in relation the cost of medication and other medical supplies not on the PBS (which in many cases improve compliance because they are easier to administer/take). These include topical medication for skin conditions which are common in many Aboriginal communities, eg clotrimazole, other topical treatments such as emollients as well as dressings etc. PAMS would prefer to dispense medication themselves as it would decrease the cost and ensure that medication was supplied in an interested, culturally appropriate way. They feel that AMSs are the most effective organisations in

addressing the health concerns of Aboriginal people by ensuring that complete access to medical care and pharmaceuticals is provided. It was believed that unless medicine is supplied to patients at the time of the visit, there is a greater chance that patient will never get the medication they need.

PAMS has a working relationship with the Aboriginal Liaison Officers at DSS. They help to sort out any problems with entitlement cards. Some people complained that the cards themselves disintegrated easily and the number rubbed off to the point of illegibility.

PBS and non-PAMS clients

While the majority of clients not attending PAMS did not have a problem with cost, concerns were raised in relation to constant script supply. Chronically ill patients find it difficult to pay for multiple scripts and repeats if they are on low incomes. In some cases people were unable to have their scripts filled when required because they did not have enough money. It was reported that in such cases, the patient's illness invariably worsened.

It was reported that a chemist was more likely to dispense medication for a child than for an adult, and in some cases the chemist refused to dispense until the medication was paid for. If a patient was well know to the chemist or a long term patient the chemist may dispense on credit. However, it was pointed out that this relied heavily on the charity of the pharmacists.

WESTERN SYDNEY, NEW SOUTH WALES - URBAN

■ Background

Western Sydney describes the large urban area in which the greater part of Sydney resides. A large portion of the population both Aboriginal and non-Aboriginal are former inner city and rural residents who were resettled under the State Government's public housing programs. Many families are from the west and south of the State from towns such as Brewarrina and Cowra.

Mount Druitt is a large suburb in Western Sydney with a significant Aboriginal and Torres Strait Islander population. The ethnic mix of the suburb includes a significant number of people born in the Asian region, Pacific Islands, Iran, the former Yugoslavia and Greece. Many residents are in a lower socio-economic group and unemployment is fairly high. The Aboriginal population includes those who permanently reside there and a significant number of people who are visiting relatives or are transient.

■ Range of Services

Daruk Aboriginal Medical Service

Daruk Aboriginal Medical Service was established in 1988 to provide health care to the people within the area defined by Mount Victoria to the west, Colo Heights to the north, Silverwater Road to the east and Elizabeth Drive to the south, an area of some 4000 square kilometres. While Daruk's charter defines the region they are responsible for, the service is used by many people who live well beyond those borders. The service itself is located in the area to the south of the railway line, about fifteen minutes walk from the town centre.

The salaries of one doctor and one health worker were initially paid by the Aboriginal Medical Service, Redfern, until ATSIC agreed to take over funding responsibility. Within twelve months, two more doctors were taken on, both of whom bulk-billed. Currently there are three full time doctor positions, which are filled by six part-time medical staff. The service also employs a social worker, a

drug and alcohol worker, three mental health workers, a sexual health worker, a psychiatrist, two public health workers, a midwife and ante-natal worker, three health workers, a clinic nurse, a part time chiropractor, a dentist and a dental assistant as well as administration staff. An obstetric staff specialist and a liaison mid-wife attend the weekly ante-natal clinic. The AMS provides home nursing transport as needed.

The AMS currently has files for over 6000 patients, though some of these are known to be country patients who visit only occasionally. They estimate that 20-40 new patients come to the service each month. While some non-Aboriginal people use the service (mainly spouses and partners), the majority of patients are Aboriginal. Because of the high demand and cost, the dental service is restricted to Aboriginal and Torres Strait Islander peoples. Dental staff determine patients' eligibility to use the dental program through family linkages and informal networks, and in most cases they are able to verify this.

Public hospitals

Mount Druitt Hospital, Blacktown Hospital, Nepean Hospital and Westmead Hospital are the main public hospitals in the area. However, given its proximity to Sydney city (direct train link) patients may be referred to other major city hospitals. Western Sydney Area Health Service employs Aboriginal Liaison Officers who act as go-betweens for Aboriginal patients and medical staff.

Medical Practitioners and Allied Health Services

In the Mount Druitt area there are a large number of general practitioners, though few reported having many Aboriginal or Torres Strait Islander patients.

In addition, a full range of allied health services is provided by private organisations (eg Douglas Hanly Moir Pathology, Castlereagh Radiology) or through the public hospitals.

Pharmacies

There are four chemists located in Mount Druitt centre, two of them located inside the Marketown

shopping complex, which is also close to the Department of Social Security office (DSS). Daruk AMS has held an account with both a chemist a few doors away and one of the chemists in the Marketown complex. The chemist nearby says Aboriginal people would constitute about 5% of his clientele. The chemist in the shopping centre reports that Daruk patients have not had their scripts filled there for some months, and that currently he would see no more than ten people per week, representing less than 1% of his clientele.

Medicare

The Medicare Customer Service Centre is located in the Marketown shopping complex. Staff report they see few Aboriginal clients - perhaps three per week. These contacts usually concern lost Medicare cards and rarely involve new enrolments.

■ **Issues Relating to Medicare**

Enrolment

In early 1997 Daruk AMS began using *Ferret*, a computerised health management system which has enabled staff to (among other things) accurately keep track of patients' Medicare status. At the time of the study, about 1700 patients had been entered into the system. Just over 17% of these did not have Medicare numbers. (This would include those who may be enrolled but whose Medicare number was not available.)

It was reported that enrolment levels were lower for children than for adults and that the requirement of a birth certificate had prevented many from enrolling children. It was said that Medicare will only accept a birth certificate for children over a certain age, although the process of obtaining one is prohibitively expensive and bureaucratically complex (eg one patient reported that if there is no father on the birth registration form, a Justice of the Peace must witness the mother's signature).

Staff commented that the distance of the AMS (about a 15 minute walk) from the Medicare office

sometimes deters patients, and, as they or their children have usually been seen by the doctor already, there is little incentive to walk to the Medicare office. Some also thought the Medicare office was intimidating for people who are shy or illiterate.

It was reported that Nepean Hospital has recently begun to enrol babies in Medicare before they are discharged and the AMS staff expected this would impact on the number of unenrolled children in the future.

Adult non-enrolment was largely accounted for by transient and rural/ remote patients. Sometimes the Medicare number or card given by a patient has expired. Older people in particular were reported to have difficulties producing identification for re-enrolment and making alterations to their Medicare enrolment.

The AMS provides identification letters for patients to use at DSS, confirming that a person is a patient at the AMS and their details are correct. These letters are reportedly not accepted by Medicare, however. Staff felt it would be far simpler to enrol people on the spot:

Why can't we send in the enrolment forms?

You have to get rid of the need for birth certificates. It's just too hard.

Locating Medicare numbers

A large number of patients do not bring their Medicare cards when they come to the AMS. If the Medicare number is on file and is correct, there isn't a problem. However, as mentioned previously, a significant proportion of patients do not have or do not know their Medicare numbers. When the AMS needs to find out someone's Medicare number, they usually ring the Hotline. However it was felt that the Hotline operators could be rigid and would not give out information unless the details given were 100% correct.

The AMS does not spend too much energy searching for Medicare numbers and ends up absorbing the cost of many consultations. When the clinic is busy, as often it is, staff do not have

time to chase up Medicare numbers. It was said the AMS does not generally try to lodge claims for which there is no Medicare number, and frequently does not resubmit rejected claims. They have a number of bulk-billing vouchers 'in the drawer' for which they do not have Medicare numbers. Because they rely on the patient returning to the clinic with their Medicare details, which may not happen for twelve months or more, they frequently have to throw out the vouchers because they pass the six-month time limit on lodging claims.

Generally the AMS writes the patient's Medicare number on referrals, and this is acceptable to most of the bulk-billing specialists who see Daruk patients. However, it was reported that some radiologists will no longer accept a number without sighting a Medicare card. It was thought this was because rejected claims had resulted from some incorrect or expired numbers.

Medicare staff reported a particular difficulty locating numbers for teenagers and young people in their early twenties. Frequently they do not know their date of birth, which name they were enrolled under or their last address. This was reported to be a problem experienced almost wholly with Aboriginal clients. While apparently anomalous, some of this may be explained by children who have grown up in foster care and may not know the details surrounding their birth.

Rebate issues

The point was made that Medicare rebates alone would not cover the doctors' salaries. Daruk's holistic approach to health care often necessitates longer consultations: patients (particularly if they are making their once a year visit to the doctor) often have multiple health problems, it often takes much longer to get a case history and organising follow-up or secondary treatment can take some time. The maximum consultation time recognised by Medicare is 40 minutes, however in reality, consultations can take up to 1.5 hours in reality. The longer consultations mean a smaller turnover of patients with less return. Doctors estimate that around 50% of their consultations last 30-40 minutes. Because one position is fully funded they are able to use that doctor's Medicare rebates to top up any shortfall in income.

The doctors commented that the necessity to keep the Medicare rebates flowing by seeing patients sometimes prevented them from doing other work which they see as important to their role, for example case conferencing, sorting out problems at the hospital, training health workers and community health work. Some concern was expressed over pushing ACCHSs to operate like mainstream medical centres, which could see these non-clinical roles diminished.

Gap payments for specialist services

The AMS doctors try where they can to refer patients to bulk-billing specialists or those in the hospital system. However they are finding it increasingly difficult to find specialists who are willing to bulk-bill their patients. For example, they say they are unable to find any orthopaedic, plastic surgery or ENT specialists either in the hospitals or in private practice who will bulk-bill. Furthermore, there is often a long waiting period (sometimes months) before a patient is able to get an appointment with a specialist at the hospital, and this is felt by the medical staff to be problematic because their patients are less likely to comply if they have to wait.

You can't wait for the waiting lists to diminish.

The result is that sometimes doctors have to refer to non bulk-billing specialists where a fee higher than the Medicare schedule is charged (usually at the time of the consultation). It was reported that generally if patients have to pay for their consultation they won't go. A large proportion of Daruk patients receive Social Security benefits and find it difficult to find the money to pay the up-front fee (even if some of it is refundable from Medicare) or the gap payment, which can be as much as \$80. Some specialists, who may treat a patient in hospital, refuse to bulk-bill the patient's follow-up consultations, with the usual result that the patient does not go. Doctors reported having to ring specialists and 'beg' them to bulk-bill or rely on professional contacts for favours.

■ Issues Relating to the PBS

Inability to pay

The majority of Daruk AMS patients receive Social Security benefits or have low incomes and frequently say they cannot afford medication. While the AMS keeps a small stock of medication, it is unable to supply whole courses of medication. The AMS has accounts with two chemists in the local area, which are used to pay for the medication of patients who can't afford even the concession copayment. The AMS puts a stamp on the scripts to indicate that either the \$3.20 or full \$20.00 patient contribution is to go on Daruk's account.

One of the pharmacies reported that most account items are concession-priced medicines, though sometimes it covers the full cost. However the AMS says it is unable to subsidise some people because their funding is limited.

I'm sure a lot of people don't get their scripts filled.

Another problem arises when carers, looking after children who are not their own and are not included on the Health Care Card, need to pay for the children's medicines. The carers are generally required to pay the full amount, which many can't afford, particularly if there is more than one child in their care. This was reported to be a frequent problem.

Entitlement numbers

One of the chemists reported that Aboriginal clients generally don't have their Health Care Card with them or the card has expired, when they have scripts filled. He generally directs them to DSS, which is nearby, to get an interim number. However he reported that they frequently do not return to have their script filled.

Another reported that most have their Health Care Card with them, or if they don't he rings Daruk for the number. In cases when clients do not have their Health Care Card they must pay the full amount and the pharmacist reported this was usually not a problem. He says he offers to refund them the difference if they bring in their Health

Care Card, but few return. If the medication is put on the AMS account, the AMS is billed the full cost of the medication.

Medication use

Staff were not aware of any patients using bush medicine.

If anything, they're too dependent on medication... they keep coming back for more scripts.

The staff at Daruk AMS take a hands-on role in the management of medication for some patients. A community nurse takes medicines to the homes of the elderly and mentally disabled patients. When patients are discharged from hospital they generally come to the AMS to sort out their ongoing treatment and medication. The medical staff say they make sure the patients know what they have to do, what medicine to take and when they next have to see a doctor.

■ Satisfaction with the HIC

Other than problems with the Hotline and rejected claims, few comments were made in relation to the AMS's relationship with the HIC.

Some staff felt there was a need for Aboriginal-specific promotional materials.

Koori posters for Medicare, not just showing white people.

It was also thought that the employment of Aboriginal staff at Medicare would make the process less intimidating.

There needs to be Koori workers, so they don't feel ashamed because they can't read the forms.

You feel comfortable when you walk into a place and there's a Koori working there.

APPENDIX 1

**PROCEDURES FOR NON
FACE-TO-FACE FIELDWORK**

APPENDIX 2

INTERVIEW SCHEDULES

APPENDIX 3

ACCHSs CONSULTED

WESTERN AUSTRALIA

Broome Aboriginal Medical Service
Carnarvon Aboriginal Medical Service
East Kimberley Aboriginal Medical Service
Geraldton Regional Aboriginal Medical Service
Kalgoorlie Aboriginal Medical Service
Kimberley Aboriginal Medical Service
Mawarnkarra Health Service
Perth Aboriginal Medical Service
Yura Yungi Aboriginal Medical Service

NORTHERN TERRITORY

Anyinginyi Congress
Central Australian Aboriginal Congress
Danila Dilba Aboriginal Health Service
Miwatj Aboriginal Health Service
Wurli Wurlinjang Health Service

QUEENSLAND

Aboriginal and Islander Community Health - Brisbane
Aboriginal and Islander Community Health - Ipswich
Dunwich Aboriginal and Islander Health Service
Goondir Health Service
Mackay Aboriginal Health Service
Mamu Aboriginal Medical Service
Mulungu Aboriginal Medical Service
Rockhampton Aboriginal Health Service
Townsville Aboriginal and Islander Health Service
Wu Chopperen Aboriginal Medical Service

NEW SOUTH WALES

Aboriginal Medical Service Co-Op Ltd
Armidale and District Services Inc
Awabakal Aboriginal Medical Service
Biripi/Taree (Purfleet) Aboriginal Medical Service
Bulgar Ngaru Medical Service
Daruk Aboriginal Medical Service
Durri Aboriginal Medical Service
Illawarra Aboriginal Medical Service
Tharawal Aboriginal Co-Op
Thubbo Aboriginal Medical Service
Walgett Aboriginal Medical Service

TASMANIA

Tasmania Aboriginal Medical Service

AUSTRALIAN CAPITAL TERRITORY

Canberra AMS - Winnunga Nimmityjah

VICTORIA

Central Gippsland Aboriginal Health
Gippsland and East Gippsland Aboriginal Medical Centre
Rumbalara Aboriginal Co-Operation
Lake Tyers Aboriginal Trust

SOUTH AUSTRALIA

Ceduna/Koonibba Aboriginal Health Service
Nunkuwarrin Yunti Health
Pika Wiya Health Service

APPENDIX 4

POSTAL SURVEYS

APPENDIX 5

**PROOF OF IDENTITY -
VERIFICATION**

BIBLIOGRAPHY

