Non-Government Organisations and a Collaborative Model for Rural, Remote and Indigenous Health

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INTRODUCTION

This paper explores some of the issues faced by non-government organisations working in the area of rural, remote and Indigenous health in today’s fast changing environment. The process used to gather information and develop appropriate and effective strategies is presented. To develop these strategies it has been important to consider the latest evidence and use this to direct the program. Some of this evidence and its influence on program development is explored prior to outlining the National Heart Foundation’s Rural and Remote Indigenous Program (NHF’s RRIP).

INTEGRATION OF EVIDENCE INTO PRACTICE

Some of the major issues that must be considered when developing strategies for health care are emerging from the ideas and research emanating predominantly from Europe and USA, from people such as Professors Marmot, Syme, Kaplan, Mustard and Tarlov (Dixon 1999). These researchers have come to the conclusion that as well as the known correlation between the socio-economic gradient, risk factors and health status, personal and social control also have a significant influence on health.

The introduction of personal and social control factors are generally referred to as the social determinants of health and their inclusion in the health equation significantly increases the complexity of issues that must be considered when determining health strategies, services or programs.

The traditional determinants of health, or risk factors are usually cited as:

• nutrition;
• physical activity; and
• high risk behavior such as substance abuse eg tobacco.

These determinates are considered in the context of education, employment, poverty, poor environment (including housing, transport, water supplies and sewerage disposal). Added to the traditional determinants of health and the context in which they exist, are the more recently identified social determinants of health. As the complexity of the factors that affect health emerge so it logically follows that complex problems cannot be addressed with single focus, isolated
or uncoordinated strategies. The natural progression is to increase co-
ordination, collaboration and a strategic approach from government health and
other related departments (ie education, employment, sport and recreation,
primary industries and local government etc), academic institutions, non-
government organisations and community groups. Much of the current change is
being driven by the public health sector. A major initiative of the Commonwealth
Department of Health and Aged Care is the National Public Health Partnership
(NPHP) which draws together Commonwealth/ State/ Territory government
officials and public health experts to develop co-operative public health
strategies.

In addition to NPHP, local initiatives are emerging that advocate a multifocal
collaborative process. For example, Weeramanthri (1998) states:

The [non-communicable] diseases and their risk factors are ...inextricably
linked with the broader socio-economic determinants of health and quality of
life, particularly education and employment. Therefore an integrated,
intersectoral and whole of life approach is needed.

Weeramanthri continues by identifying the need for an “Intersectoral Taskforce
on Primary Prevention” or “Intersectoral Taskforce to Promote Wellness and
Healthy Living” to promote healthy lifestyles, particularly in Aboriginal
communities. He suggests that to be effective, the taskforce would need to
include:

• Northern Territory (NT) government departments;
• relevant Commonwealth departments (including Aboriginal and Torres Strait
  Islander Commission (ATSIC) and the Office of Aboriginal and Torres Strait
  Islander Health Services (OATSIHS));
• local government;
• NT Aboriginal organisations e.g. Aboriginal health services; and
• non-government organisations (e.g. National Heart Foundation (NHF) and
  Diabetes Australia).

Weeramanthri’s work is moving towards turning theory into practice by
combining the results of the recent research with his own experience and
developing strategies for health service intervention. He states that because of
the complexity of the origins of ill health collaboration between organisations
together with strategic co-ordination and a multidisciplinary approach must be
used to find appropriate interventions and, eventually, solutions. The need for an
integrated approach to risk factors and their context is also a feature of his work.
The model outlined by Weeramanthri is equally applicable to all Australian
States and Territories.

The NHF’s RRIP must be congruent with this approach if it is to be effective in
achieving its aim which is to:

• reduce the prevalence of cardiovascular disease (CVD) and risk factors in
  rural remote and Indigenous population, and
ensure that the focus populations have access to appropriate information and services relating to primary and secondary prevention, primary health care and rehabilitation in relation to CVD (NHF, 1998).

COLLABORATION – YESTERDAY, TODAY AND TOMORROW

The reality is that the terms inter and intra sectoral collaboration have been identified as a priority in Aboriginal health circles since the National Aboriginal Health Strategy (1989) and the Royal Commission into Aboriginal Deaths in Custody (1991). Both these documents state the need for collaboration. However, there has only been patchy evidence of change in this direction. Now that the terms are being applied to mainstream services we may see a real shift towards multidisciplinary co-operation that should result from good collaboration.

My involvement in Aboriginal health has resulted in a strong conviction that collaboration and a multidisciplinary team approach are essential components of effective health promotion and health service delivery. As a consequence the NHF’s RRIP is based on these principles.

The multidisciplinary team approach is integral to a collaborative approach and underpins the Singapore Declaration (1998) as an essential component of prevention and treatment of CVD and all health care services. The multidisciplinary team approach is particularly important to rural and remote areas because the number of health professionals decreases as the distance from metropolitan areas increases, resulting in health professionals needing to cover a broad range of issues. Their effectiveness is greatly enhanced by working co-operatively.

ESTABLISHING COLLABORATIVE NETWORKS

To establish networks for the NHF’s RRIP, I traveled extensively and met with health service providers, officials from Commonwealth and State/ Territory health services, academics and educators. During these meetings I gathered as much information as possible, asked for suggestions and briefed the individuals and groups about my role and program in the NHF. I emphasised the importance of a collaborative multidisciplinary approach. It is essential for the NHF to work in this way in order to maximise our effectiveness in rural, remote and Indigenous areas. I was open in asking for direction and ideas. As well as face to face meetings I distributed a discussion paper via professional newsletters and networks.

As a new staff member to the NHF, it was also necessary to develop collaborative working relationships within the NHF. I approached this in a similar way and broached the need for a broader view of health promotion by combining strategies for addressing CVD risk factors (poor nutrition, obesity, hypertension, inadequate physical activity, tobacco and excessive alcohol). Discussions addressing the needs of lower socioeconomic groups and people from non-English speaking backgrounds were also initiated.
Initially the NHFs RRIP was separated into rural and remote and Indigenous. Dr Chris Burns, Executive Director NT Division of the NHF led the Indigenous program although both were very much interconnected. Chris has worked very closely with me and provided valuable assistance in developing the current program which has now been amalgamated. He continues to be closely involved and provides extensive support and advice particularly in the area of Indigenous Health.

On the whole the response that I received was very good internally and externally. Within the NHF I found that there was a high degree of interest in the RRIP and some Divisions had already developed sound programs. These included:

- an Aboriginal Health Worker (AHW) Training Program on CVD developed by the NHF Western Australia (WA) Division and Perth Aboriginal Medical Service;
- a Promoting Heart Health Manual developed by the Queensland Division and Queensland University of Technology; and
- extensive collaborative outreach programs that focussed on tobacco and rehabilitation underway in the NT, North Queensland and Victorian Divisions.

Generally the response from government officials was polite, but suspicious. There seemed to be uncertainty about my “real agenda”. Several government officials stated that they were not able to fund programs. I had not suggested this. At times government personnel were very helpful and gave me a great deal of assistance to make more contacts. Recently I have had a high degree of support and enthusiasm from the Public Health Division of the Commonwealth Department of Health and Aged Care. This Division is developing collaborative strategies and staff are keen to work with non-government organisations and other government sectors from a wholistic primary prevention perspective (Sindall, 1999, personal communication).

I was greatly assisted in the process of developing networks by Professor Andrew Tonkin, NHF Director of Medical and Scientific Affairs. He nominated me for a working group to consider rural remote and Indigenous issues for the National Health Priority Area (NHPA) Report to the Minister on CVD. This gave me an opportunity to be part of a strategic collaboration of academics, researchers, health professionals, and Commonwealth officials. To maximise interaction of key stakeholders I successfully nominated the National Rural Health Alliance (NRHA) and the National Aboriginal Community Control Health Organisation (NACCHO) to be part of the working group. I undertook much of the co-ordination and documentation for this process. The group worked well and the process was of great assistance to me in establishing good working relationships with key people working in rural, remote and Indigenous health.
NHF’S RRIP STRATEGIES

As a result of the consultation and discussions and with reference to the recent literature the RRIP has focused on priorities for developing strategies that facilitate and support:

- a collaborative approach to improving the continuum of care;
- demonstration projects to develop, implement and evaluate innovative programs producing models for health promotion and health care services;
- improved professional education and support;
- the collection and dissemination of information; and
- appropriate research.

Part of the program development process included the convening of the NHF Rural, Remote and Indigenous Advisory Group (RRIAG) to provide expert comment and advice for the RRIP. This group is comprised of several members of the NHPA working group together with other professionals who have expertise in rural, remote and Indigenous health. This group has a strong public health focus, with one clinical cardiologist who has a strong interest in public health. It includes representatives of NRHA, NACCHO, as well as Aboriginal health worker, medical, allied health and nursing professionals. The mix is practical and academic. At the first RRIAG meeting in October 1998 the group ratified the RRIP priorities and identified specific activities and directions within these priorities. These are:

- review current research in CVD and determine priorities for the future;
- increasing NHF funded research in rural, remote and Indigenous populations and specific targeted areas of need in these areas. This should include public health, sociological, behavioral and qualitative research;
- developing a strategic framework for service delivery, education and training; and
- a review of best practice guidelines and determine appropriate guidelines for rural, remote and Indigenous populations.

In addition to these initiatives and within the programs priorities the NHF’s RRIP has either initiated or is involved in the following projects:

1. A collaborative project with the Public Health Unit of NSW Health, Southern Area Health Service and the South East NSW Division of GPs. The project will consider inter and intrasectoral collaboration in health service and risk management.
2. A diabetes education project in conjunction with Territory Health Services and Menzies School of Health Research in Central Australia. This project aims to provide clients, health staff and community members in a remote area with diabetes education, management and risk minimisation.
3. Developing and producing a professional education and support a satellite video broadcast “Primary Prevention Non-Communicable Disease: New Information on Health Determinants and Risk Factors” with the Rural Health
Education Foundation. The Anti Cancer Council of Victoria, Diabetes Australia and the Commonwealth Department of Health and Aged Care are also involved in the development of this program.

4. Audiographic CD ROM for Aboriginal Health Worker (AHW) Training. The North Queensland Rural Health Training Unit and the North Queensland Regional Office of the NHF are developing this program. The content of the course will be based on the AHW course developed in WA. Funding is still to be identified for this project.

5. A coalition comprising James Cook University, the National Heart Foundation (NHF), the National Rural Health Alliance and the National Aboriginal Community Controlled Health Organisation has been formed. This group will develop a strategic framework for service delivery, education and training for CVD in rural, remote and Indigenous populations. A national workshop is planned later this year as part of this process.

6. A collaboration with the University Centre for Remote Health in Alice Springs, is to consider current research in CVD in rural remote and Indigenous populations in order to identify future research priorities.

All strategies and projects have a collaborative, multidisciplinary approach with consideration of social determinants and contextual factors as well as more traditional risk factors.

From these beginnings a comprehensive and strategic approach to CVD in rural remote and Indigenous populations is being developed. It is important to realise that significant sustainable improvement in any disease cannot be successfully achieved in isolation. Broad collaboration and a multidisciplinary approach are essential. Working in this way non-government organisations have an important role as facilitators and collaborators, as well as providing specific expertise in technical aspects of the disease, prevention and treatment.

REFERENCES


Weeramanthri, T 1998. *Finding the right balance – a “preventable disease” strategy for the NT*. Discussion paper, Territory Health Services, Darwin, NT.