Equity Focussed Health Impact Assessment of the Review of Goodooga Health Service

(to inform Greater Western Area Health Service's implementation plan concerning changes to the Goodooga Health Service)

Developed and written by the Goodooga community

We acknowledge the kind assistance of

The Centre for Health Equity Training, Research and Evaluation at the University of New South Wales.

Goodooga community's impact assessment of the proposed Goodooga Emergency Health Service review

Overview

The community of Goodooga welcomes this opportunity to positively add to the review process regarding changes to our health service in Goodooga.

As a community we have generally found positives in the Goodooga Health Service Review. An outcome that sees us retain our Emergency Service, a Registered Nurse and the vacant Nurse Practitioner position filled, is considered vastly better than the initial plan proposed to us, which was essentially to shut up shop and install a direct telephone line to Lightning Ridge to provide health services. Compared to a phone on the wall, *anything* seems to be a relief.

Although we acknowledge that the Review directs us toward a further reduction in staffing, we want GWAHS management to be aware of our feelings in response to persistent ongoing service reduction in our community, and the numerous negative impacts that this has on a small community like ours.

The manner in which the plan to remove our access to a Registered Nurse and Emergency bed was introduced and the lack of recruitment into vacant positions have inevitably ignited much mistrust between our community and GWAHS.

This report intends to outline our response to the Review and provide recommendations concerning GWHAS implementation plan. What we seek is commitment from GWAHS to ongoing consultation and investment in the health and wellbeing of our isolated community.

Introduction

This report details the Goodooga community's equity focussed health impact assessment of the Goodooga Health Service Review. The review was commissioned in late 2008 by GWAHS to inform proposed changes to the Goodooga Health Service (GHS).

Background to the equity focussed impact assessment

In August 2008, the Centre for Health Equity Training Research and Evaluation (CHETRE) at the University of New South Wales was approached by the Aboriginal Lands Council on behalf of our community to provide advice concerning the health effects of Greater Western Area Health Service's proposed changes to the Goodooga Health Service. Following a visit to Goodooga and discussion at a community working party meeting, we agreed that an equity focused health impact assessment, developed by us with support from CHETRE, would be a useful structured process to base the community's response to proposed changes to GHS. By assessing the review, the equity focussed health impact assessment would assist our community to determine potential positive and negative impacts on our health based on our own experience and evidence we have gathered to date, supported by evidence from routinely-collected local data and international literature. We would then make recommendations based on this evidence to Greater Western Area Health Service to inform decisions about proposed changes to GHS. In February 2009, the review of GHS was presented to the Goodooga community, and at this meeting GWAHS agreed the recommendations from the impact assessment would be considered with the Review team to inform the implementation plan being developed concerning GHS.

Process

Equity Focussed Impact Assessment is a structured process that follows a number of steps[1].

Screening (to determine if an impact assessment should proceed).

The Goodooga community agreed that an impact assessment of the review of GHS should proceed, led by the community and facilitated by CHETRE.

Scoping (to plan the equity focussed health impact assessment).

During several meetings (in late 2008 and February 2009) the Goodooga community agreed that an Equity Focussed Health Impact Assessment would be useful. This is because the health of the Goodooga community is at the heart of the changes to GHS. Equity was felt to be the primary focus of the health impact assessment because the health of Aboriginal people in Australia (the majority of the Goodooga community is indigenous) is an equity issue, but also because our community is made up of many different groups of people that could be impacted upon differently by the proposed changes to GHS. We also agreed that CHETRE would assist in the analysis of evidence from a number of sources to inform our appraisal of impacts. This evidence (found in the Appendix) included a community survey, community case studies developed from interviews, the international literature on provision of health care in indigenous communities, and Australian and NSW policy documents and data in relation to indigenous health. We agreed that while this evidence was important, the most important voice to inform the appraisal of potential impacts was our own.

Appraisal (assessment of potential impacts)

[1] Harris, P., Harris-Roxas, B.F., Harris, E., Kemp, L. (2007). Health Impact Assessment: A Practical Guide. Sydney: Centre for Health Equity Training, Research and Evaluation (CHETRE). Part of the UNSW Research Centre for Primary Health Care and Equity. UNSW, Sydney. www.HIAconnect.edu.au.

At the February 2009 meeting, we adapted an equity lens developed by CHETRE to undertake appraisals of the potential positive and negative health impacts that could arise due to the recommendations of the review. This enabled us to critically appraise the review and its recommendations in order to develop our own community recommendations to submit to GWAHS for consideration in GWAHS implementation plan concerning GHS.
The agreed lens was:

- Identification of issues the review highlights and makes recommendations about
- Community's interpretation of what the review recommends concerning each issue
- Points requiring clarification per issue
- Potential impacts (negative and positive)
- Population groups in Goodooga at risk of falling through the gaps for each issue
- Goodooga community's ongoing commitments in response to each issue
- Community Recommendations for GWAHS consideration for each issue

We ran a number of community workshops during March 2009 to work through the lens. We then wrote up these discussions and door dropped this to each household in Goodooga asking for their response. These responses have been collated and incorporated into this final report.

Follow-up (monitoring and evaluation of recommendations and impacts).
The community and CHETRE have agreed to evaluate whether the proposed recommendations are adopted into GWAHS implementation plan, and to develop a plan to monitor and address predicted impacts should they occur in the community. As part of this work, we will form a Community Health Council (name to be agreed) as a representative of the broader community to oversee this ongoing work and to work with GWAHS concerning both the provision of services at GHS and the development of strategies to inform community and community members to improve their health.

Potential impacts and community recommendations

Members of Goodooga Community at risk of falling through the gaps

- **The whole community**
- **Age:** (0-8) infants and primary school
  (8-18) school kids
  (18-30) young adults
  (30 – 40) middle adults
  (40- 55) older adults
  (55-70) Elderly
  (70+) Very old
- **Gender:** Male / Female
- **Education level**: (High - University/TAFE, Medium – secondary school/TAFE, Low – primary school/none)
- **Socio-economic position** (High, Medium, Low income)
- **Current health needs**: (High – ongoing chronic care, Medium - , Low need – none, preventing sickness (such as immunisation, health education etc), occasional care (in case of flu, injury etc)
- **Indigenous**
- **Non-indigenous**
- **Health staff**
- **Visitors to Goodooga** (e.g. teachers, police)
- **Businesses / activities not directly related to health** (e.g. CDEP, Department of Education)

Issue 1: Emergency Services (Bed)

Community's interpretation of what the review recommends
Emergency services remain during normal business hours. For after hours emergency care community has to use the national call-centre.

Clarification:
- What are the 'normal business hours'? According to the Review it is 9-5 Monday to Sunday. However the community had various opinions due to the sign out the front of Health Service saying 8 a.m. – 8 p.m.

Impacts:
Negative:
- Family support is missing if emergency services are provided by Lightning Ridge (LR)
- Some community members will not feel comfortable to use a call centre (e.g. those with low literacy who are not confident in their ability to communicate effectively)
- Young mothers feel disempowered in caring for sick children and seek help of Nurse for reassurance
- Concern over how to deal with complex health needs (eg mental health) outside normal business hours
- Phone access is not always available to everyone in the community
- Increase in 'self-triage' could be life threatening in Goodooga due to our isolation from major hospitals
- Might lead to delays in response to an emergency because phoning the call centre is an extra step

Positive:
- Cost cutting
- Phone centre may see a reduction in on-call events for Health Service staff, thus reduction in the burden of work and increased work satisfaction
- Greater community health awareness through training if this is provided (the nature of this training should be negotiated with community consultation)

Which groups fall through the gaps:

Age						Gender		Education			Socioec			Current health need			Indig	Non indig	Staff	Visitors	Non-health
0-8	8-18	18-30	30-40	40-55	55-70	M	F	H	M	L	H	M	L	H	M	L					
	X	**X**	**X**	**X**	**X**	**X**				**X**			**X**	**X**		**X**	**X**		**X**	**X**	

We are concerned that some community members may be uncomfortable using a call centre, especially low literacy groups, due to concerns over their ability to explain the situation. We also felt that 'self triage' may negatively impact on the health outcomes across all age groups, with the exception of young children, because people would be more strongly motivated to act on their behalf and use the call centre. Also the call centre would be more likely to refer young children onto the Health Service for medical treatment. We felt that people with serious existing medical issues would be more likely to 'self-triage' as they have often learnt a lot about their condition. This may be negative when their health situation is complicated and they do not fully understand the impact of a symptom when it occurs.

Goodooga commitment:

- To participate in and complete training when offered by GWAHS

Community Recommendations:

- As the Review deemed our 'treatment seeking behaviour' as expensive and demanding, we request GWAHS provide specific training for the whole community on:
    - what health issues should be referred to the call centre, and how these issues should best be addressed so that we can discuss them more confidently with the call centre
    - what is an emergency health issue that should be referred straight to the emergency service even if this is after hours
    - first aid training
- This training should occur regularly and indefinitely (the timing should be agreed with community), open to the whole community, and regularly updated
- GWAHS needs to put standards for practice in place for phone triage for Staff so they are protected by the choices they make when turning away patients after hours
- GWAHS must make a long term commitment to staffing, with staffing allocations made in discussion with the community, that enable an efficient and effective running of the Emergency department so we continue to have an Emergency service and quality primary health care in Goodooga!

Issue 2: Visiting Services

Community interpretation of review recommendations:

- Care plans should be developed in consultation with LR to inform multidisciplinary care at both GHS and both LR / GHS staff to take responsibility for managing day to day needs of community.

Clarifications: N/A

Impacts:

Negative

- Health Service Manager being off site is a serious concern due to sustainability! Currently the job is being filled by the Lightning Ridge Health Service Manager. Will it be included it future job descriptions or up to the discretion of the individual? Will they be allocated specific time and funding to manage Goodooga or will it blend into one?
- Services from outside Goodooga are historically very irregular. This is a constant irritation and makes managing our health care very difficult.
- Community is concerned that GHS will be run in a way that it fits LR needs rather than the needs of Goodooga.
- There are concerns that LR is unable to provide quality and accessible services.
- We have been downgraded and the proposed arrangement will only restore some of what we previously had (i.e. visiting midwife etc)
- Coordination of so many services is extremely difficult and has a risk of ongoing breakdown in communication, and no current formal system for following up care plans (ie. FERRET).

Positive

- *Real*, *REGULAR* visits to Goodooga from specialists medical/nursing.

Which groups fall through the gaps:

Age						Gender		Education			Socioec			Current health need			Indig	Non indig	Staff	Visitors	Non-health
0-8	8-18	18-30	30-40	40-55	55-70	M	F	H	M	L	H	M	L	H	M	L					
X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X			

Goodooga commitment:

- To use these much needed services
- To improve our personal health via care plan and seek necessary (visiting and local) health professionals advice and care
- To establish a Community Health Council to liaise with relevant groups including GWAHS

Community Recommendations:

- GWAHS to support the community establish a community health council
- Brewarrina be developed as an alternative service provider for those who choose to go there, as this is our local council area, in addition to LR.
- Visiting services / multidisciplinary care requires good organizing, monitoring and proactive management, including regular communication with the community, and would benefit greatly from the presence of the Health Service Manager onsite. It is possible that this position may be adequately filled full time, or possibly part time in Goodooga and LR or Brewarrina.
- LR Health Service Manager needs to meet with community or 'community health council' regularly to establish trust and understanding about community needs, particularly concerning health records, care plans, and visiting services
- GWAHS provide regular workshops on health issues for community, involving an established community health council but also broader community including the Goodooga Community Working Party members

Issue 3: Information Management

Community interpretation of review recommendations:

- Establish electronic health records linked between Goodooga and LR (and the whole of NSW) accessible to all health professionals involved.

Clarifications:

- What is the realistic timeframe to implement this system?

Impacts:

Negative

- What happens when we are without power and it is not possible to access records? This occurs often during storms when we experience 'brown outs' (a repeated turning on and off of power) or we can be without power for up to 6 hours at times
- Would take a while to implement so requires managing incrementally
- There is a lack of broadband in Goodooga, therefore the speed of access to medical records limited, might cause frustration among staff and could be dangerous in emergency situations

Positive

- Holistic health records
- Monitoring of health records possible
- Possibly more confidential than current paper work
- Transients may be at risk. Transients range from younger Indigenous families who move frequently between towns, often only staying for a few months at each place. Also, teachers and police who come to live in town often for only two years and do not find a GP due to the briefness of their stay. They will benefit from their records being accessible in each location so that health care can be followed up when needed. However, if due to their transient situation they are not included on the system they may be severely disadvantaged.

Which groups fall through the gaps:
The whole community is at risk. Transient populations in particular will be affected if they fail to be included on the system.

Goodooga commitment:
- We will accept changes from current record keeping to electronic records when this takes place

Community Recommendations:
- The electronic database needs to be confidential and only accessible to certain people with different access levels for different health staff.
- The system needs to contribute to staff's ability to proactively identify individuals health needs in order to arrange specialist visits etc.
- Develop a strict code of conduct and protocol; to be agreed on with community health council
- Tracking transients needs to be a priority

Issue 4: Staffing of GHS

Community interpretation of review recommendations:
- Acknowledge that reducing staff allocation from current number of 12 (of which only 5 are filled) to 8.
- Introduction of staff allocation to meet Goodooga's health needs:
  - 1 NP
  - 1 RN
  - 3 AIN
  - 2 AHW
  - 1 handyman (part-time)
- NP and RN will rotate with staff from Lightning Ridge to develop clinical skills.
- One AIN will be changed to senior AIN position.
- Retain current situation of Health Service Manager located in Lightning Ridge Health Service.

Clarifications:
- Although the current Lightning Ridge NM has agreed to fill the Health Services Manager position, will the succeeding ones or is this arrangement dependant on the individual?
- Currently the only male is the handyman and part-time leaves no male on site.
- Will the ambulance be driven by the Staff of GHS?
- What about transport?
- Will senior AIN be paid accordingly?

- When our NP and RN rotate with LR staff will we have similar replacements?
- What will happen if there is a shortage of staff in LR to rotate?

Impacts:

Negative

- A reduction of an already agreed upon staff.
- Given prior history, we don't trust GWAHS commitment to fill positions and reject the Reviews implication that our mistrust is unfounded. GWAHS has a history of not advertising positions and we all know it is impossible to fill positions if you don't bother advertising them.
- An offsite Nurse Manager leaves a nursing team of two; with supply difficulties in Lightning Ridge also it will mean Goodooga is faced with supplying staff to LR Health Service. We are extremely concerned that this will leave us in the situation at present where only one nurse is onsite in Goodooga when one is sick or a replacement for Lightning Ridge can't be found. Due to our desire to see Health programs and our Health Service running smoothly we do not recommend that GWAHS continues on this course of action.
- By 'outsourcing' management GWAHS would be limiting the team delivering primary health care to Goodooga.
  A number of likely detrimental events would follow the decision to locate our Manager in Lightning Ridge:
  - → Incidental events such as staff illness/personal commitments would leave Goodooga staffed by one RN or NP as Lightning Ridge could not cover all our staffing needs.
  - → This means programs would not run efficiently or continuously and risk failure.
  - → This is a common occurrence in Goodooga when projects are staffed externally due to our remoteness, isolation and limited pool of qualified personnel.
  - → An onsite Health Service Manager would ultimately enable the Service to run more efficiently and cost effectively as offsite managers are often out of touch with the day to day events of a workplace, not to mention the specific needs of the community.

Positive

- More people on the floor and more support for each other (staff) than there **currently** are
- NP skills a positive which we have missed in our community since the sad passing of our last NP several years ago, who has never been replaced. This position brings experience and expertise to Health care that has had great positive impacts on our community in the past.

Which groups fall through the gaps:

For this issue we have deemed the whole community risk of 'falling through the gaps' due to the lack of a Health Service Manager onsite in Goodooga.

Goodooga commitment:

- To support the staff to provide a quality health service in any way we can.

Community recommendations:

- We strongly recommend that GWAHS fills the vacant Health Service Manager position in Goodooga.
- We seek strong commitment from GWAHS to fill all of the vacant positions.
- To achieve points one and two, develop a new model of recruitment (for example more than the standard single round of advertising internally or through the national media), to be developed with the community health council.
- AINs must be given the opportunity and support to upgrade qualifications if they choose.

- GWAHS, to be developed in collaboration with the community health council, provide cultural awareness training for all staff specific to Goodooga's culture and needs
- Establish clear roles and responsibilities that are communicated to community so everyone knows who is doing what, and when they are doing it.
- Establish a process for complaint management.
- Protocols and procedure must be clear for community in regards to how to access and use services.
- More male staff are required to encourage access for the male population.

Issue 5: GHS building (facilities)

Community interpretation of review recommendations:
- Space audit
- 'Decommissioning' of unused space
- Visiting services to be billed for use of rooms

Clarifications:
- What exactly is meant by 'decomission' (is this removal?)
- What will happen with the dentist chair?
- If you close a room what happens if you want to use it again?
- Units are currently not being used often, but we have hopes of visiting specialists using them.

Impacts:
Negative
- Lack of clarity around key issues related to space may negatively impact on the provision of services

Positive
- A space audit will force staff to think about how to use the space.

Which groups fall through the gaps:
The whole community is impacted upon.

Goodooga commitment: N/A

Community recommendations:
- Assess opportunities for dentist or safe house use of rooms.
- Prioritize community needs, in collaboration with the community health council, when considering re-use of space.
- Use units for family to care for ailing community members.
- Staff needs to be consulted during space audit.

Issue 6: Medical supplies / Health vehicles / Units

Community interpretation of review recommendations:
- Prescription medicine can be stored on NP's discretion
- Keep 1 ambo, 1 bus and 1 other vehicle, get rid of 2 cars
- House to be maintained for RN and NP

Clarifications:

- Maintenance truck is not under GWAHS control
- Unclear concerning the three units

Impacts:
Negative
- Potential for transport to LR deteriorating
- LR transport (neighbourhood support) requires a weeks notice and costs $10
- Patient transport worse, resulting in irregular use of transport and worse health outcomes and making accessing treatment more difficult
- If one HS car out of town no-one can be transported around town

Positive
- Nil

Which groups fall through the gaps:

Age						Gender		Education			Socioec			Current health need			Indig	Non indig	Staff	Visitors	Non-health
0-8	8-18	18-30	30-40	40-55	55-70	M	F	H	M	L	H	M	L	H	M	L					
				X	**X**					**X**			**X**	**X**	**X**	**X**	**X**				

In addition, those without transport risk not having their health needs met.

Goodooga commitment:
N/A

Community recommendations:
- Develop clear rules and protocols about transport. For example whether this is a GWAHS or RN decision who can use transport.
- Consult with the community health council on these rules and protocols
- GWAHS and community health council to assess current use of vehicles and need for transport

Issue 7: Community knowledge of health services and personal health

Community interpretation of review recommendations:
- Community to improve knowledge about use of health services and health needs.
- Community to take ownership of and responsibility for their health
- CWP to take role of community health council
- GWAHS to facilitate community workshop on health priorities
- Link health records between Goodooga and LR

Clarification:
- Major concerns about community's input to review consultation – especially concerning inappropriate use of after hours care - as only a small number people were present which does not represent the community's knowledge on these issues. Review did not include reference to local realities and conditions in Goodooga.
- How regularly will the GWAHS facilitated workshops occur?
- How long will these measures be supported so that they can be sustained?
- Will GWAHS regularly attend workshops and community health council meetings?

Impacts:

Negative:

- Community has experienced a loss of traditional knowledge about health issues, and has limited adaptation to new ways. Therefore request to take care of their own health and deal with some acute issues at home is felt to be unsafe.
- Finding the time for training may be difficult
- Community members with low literacy may find it difficult to access training
- CWP not appropriate for Health, need another body (HAC) to form the community health committee

Positive

- The community acknowledges that improving knowledge is always positive!

Which groups fall through the gaps:

Age						Gender		Education			Socioec			Current health need			Indig	Non indig	Staff	Visitors	Non-health
0-8	8-18	18-30	30-40	40-55	55-70	M	F	H	M	L	H	M	L	H	M	L					
X	**X**									**X**		**X**	**X**	**X**	**X**	**X**				**X**	**X**

In particular we believe that those of low literacy risk not attending training sessions due to avoidance.

Goodooga commitment:

- To improve knowledge concerning our health
- Active recruitment of Community Health Council members across community

Community recommendations:

- Conduct quarterly workshops indefinitely
- Design training with community health council in a way that accommodates different knowledge and literacy levels, different health needs, and Goodooga's unique culture and situation
- GWAHS to provide and ensure ongoing support to the community with learning about health issues (for example primary health care; antenatal/postnatal care; childhood immunization; behavioural risk factors; chronic disease management and prevention of complications)

Issue 8: Funding of Service, financing responsibilities, and management responsibility

Community interpretation of review recommendations:

- Funding:
  - Federal: increase funding (potentially through Aboriginal Community Controlled Health Service in region)
  - GWAHS: maintain funding levels
  - Community: co-payments for medications and wound dressing/ more efficient use of after-hour services
- Management

- Aboriginal community controlled health service in form of a regional model with Walgett, Goodooga and Brewarrina

Clarification:

- Does recommendation of 'GWAHS maintaining funding' mean actual allocation or current spending?
- What will be the role of POCHE in funding services?

Impact:

Negative

- Concerns about co-payments because income levels are very low
- Will connection with LR impact the funding/services we will receive? Will LR get first choice to the detriment of Goodooga?
- From history we are concerned that cuts follow cuts until we will have nothing. The health service is a vital part of Goodooga's physical and social infrastructure, and reductions to this have serious negative impacts on the health and wellbeing of the community as a whole.
- There has already been an ongoing reduction in funding (i.e. removal of a vehicle already) without transparency.
- LR does take children under three years of age, this means they would also just pass us onto Dubbo Base Hospital.

Positive

- Possibility of small pharmacy on site to purchase medications and band-aids etc.

Which groups fall through the gaps:

The whole community is at risk of falling through the gaps, or benefitting, from changes.

Goodooga commitment:

We will support a regional model, but only if the direct service provider is Brewarrina (pending sealing of the road) rather than Walgett, which is further away.

Community recommendations:

- For funding and use of resources to be transparent
- GWAHS commit to current level of funding and categorically state that this is not part of any ongoing reduction in service levels.
- The community support regional model. However this support is based on Brewarrina as the preferred direct service partner as there are more overlaps between GHS and Brewarrina. This requires a paved road between the two, which council has been requesting this for many years, and GWAHS should support this request. The community does not recommend Walgett to be the preferred direct partner as Walgett is too far away.

Appendices

1. Identification of potential impacts

To identify current health issues in Goodooga community the following sources of information were used:

- Population profile data: ABS 2006 census, review on emergency department attendance in Goodooga, The NSW Chief Officer's Report 2008, data from the Australian Institute for Health and Welfare 2004-05.
- Interviews: telephone interviews with the registered nurse in Goodooga, community members and with a Brewarrina Council member
- Community household survey
- Literature: Academic and policy documents

Key issues that arose related to changes in Goodooga's health services across these sources of information are highlighted first, followed by an outline of issues per data source.

2.1 Main issues related to changes in Goodooga's health services:

Health needs

The Goodooga community has a higher level of risk of poor health and a resulting high need for health care, especially for chronic disease and risk of injury, than the average population in NSW. This is because Goodooga is in remote rural NSW, its population is largely Indigenous, and it is classified at a high level of socio-economic disadvantage [1]. There is on-going need for high quality primary health care for the population, and including regular health checks ongoing and regular monitoring. This needs to be supported by continuous pharmacological treatment and accessible specialist care. There is also a need for high quality preventive services – initiatives to reduce the incidence and prevalence of tobacco smoking, to support good nutrition and to increase participation in regular physical activity among other preventive health measures.

Access

Goodooga's remoteness from Lightning Ridge and the other closest towns/communities means that the 24 hr emergency service in Goodooga has served to provide accessible primary health care. This is because access to health services outside the community is both difficult and costly for the community. Specialist outreach services to Goodooga have not been integrated well with each other, nor with the emergency service. The services have been irregular and infrequent to date, constituting an additional barrier for the community to accessing appropriate and comprehensive health care. There is a single general practitioner who provides primary medical care but he is close to retirement. There is no planned replacement.

Quality

The ongoing downgrading of Goodooga's health service (fewer qualified medical staff) raised community's concerns about service quality. Health services in other locations such as Lightning Ridge are limited and do not meet all of the community's health needs (e.g. lack of endocrinologist, services limited to adults).

To ensure good quality services for Goodooga's population trained and well supported health professionals are needed, including Aboriginal Health Workers, doctors, nurses. This requires a system for recruitment and training.

Acceptability

The emergency service has proven vital to save the lives of the admittedly few people who have experienced serious emergences in or close to the community. It provides a sense of security for residents, who feel vulnerable. It is also a valued source of employment.

Sustainability

Services that are of good quality, well staffed, and culturally appropriate would ensure sustainable use of services by the community. The small size and remoteness of the community requires innovative mechanisms to address challenges in recruitment and retention, supervision and training of staff as well as integration with specialists and allied health services.

2.2 Health issues facing Goodooga per data source

2.1.1 Community specific data

Goodooga's population is relatively young, with 38% under the age of 20, 29% under age of 15 and only 4% at or over the age of 65 [1]. Goodooga's population can be classified as having a low socio-economic status with a high proportion of the population not in the labour force [1].

National data shows that low socio-economic status is closely linked to poor health [2], which puts Goodooga's population at an increased risk of poor health outcomes.

Results from a survey [9] of 33 (41%) of Goodooga households documenting the use of health services shows that the majority of the surveyed households used health services in Goodooga (70%) and Lightning Ridge (67%) at least once in the past 12 months. Medical emergencies were experienced by 8 surveyed households and required x-ray or ultrasound outside Goodooga in most cases.

Between the end of 2007and July 2008, most presentations to the health service were for routine checks and immunizations. Emergency presentations accounted for 31.6% of all presentations. About 50% of presentations to the emergency department were in the 15-54 age groups, and 29 % were in the 0-14 yrs age group [7]. Less than 1 percent of emergency presentations were classified as triage score 2, which means they medical attention is needed within 10 minutes of presentation. Most emergency presentations were classified as triage score 4 or 5, which means attention is needed within 1 to 2 hours. Overall, females used the health services more than males.

2.1.2 Other data sources

In Australia there is a recognised higher burden of disease for Aboriginal people than non-Aboriginal people. Chronic diseases, mental health and injuries account for most of this disease burden [2, 4].
Among Aboriginal people chronic health problems start on average at a younger age than among non-Aboriginal people. Complications from chronic illnesses are more common and more severe among the Aboriginal population [2, 4]. The rate of risk factors for chronic diseases, such as smoking, high risk alcohol consumption, lack of exercise and low fruit and vegetable intake, are higher in remote Indigenous communities [2]. National data also shows that depression and anxiety are major contributors to the Indigenous burden of disease [4]. Stress levels are particularly high for people living with a chronic condition [2].

For Aboriginal people the rate of avoidable death in NSW is more than double the rate for non-Aboriginal people and is even higher for Aboriginal people living in remote and very remote areas [1].The high rate of avoidable death is mainly caused by unintentional injury, coronary heart disease, neoplasms, chronic respiratory diseases (COPD), stroke, and complications from diabetes.

In NSW Aboriginal people experience higher hospitalization rates for chronic conditions, poisoning, injury and alcohol related conditions than non-Aboriginal people [10]. The infant mortality rate for Aboriginal babies in NSW is double the rate for non-Aboriginal babies, which is mainly linked to low birth weight [10].

2.1.3 Interviews

The following information was gathered from community members, council members and health providers through telephone interviews and face-to-face consultations.

Goodooga has one primary health care centre with one emergency bed; it provides service 24hrs/7days. It is staffed with one registered nurse (RN), 1 Aboriginal health worker (AHW), 3 assistants in nursing (AIN) (one part-time, two full-time) and three casual assistants [6].

Services provided at the health centre include acute care and monitoring of chronic conditions, immunizations, baby-checks, ante-natal care, as well as, outreach services such as Community Aged Care Packages, health promotion and prevention activities [6].

In addition, Goodooga has one resident GP, who is expected to retire soon due to his age [6] and is selective about the health care he provides. For instance, he does not participate in any form of ante/post natal care.

Varying flying medical services are available to the community such as podiatry, optometry, and diabetic nurse services. Endocrinologist flying services have been discontinued and there are no endocrinologist services available at Lightning Ridge either [6].

According to community members specialist services are irregular and only the most urgent cases are seen during outreach visits [21].

For obstetric services, women have to attend to Dubbo hospital. For x-rays, patients are referred to Lightning Ridge hospital, and in some cases to Dubbo. Some referrals are also made to Walgett AMS. The nearest dental service is in Lightning Ridge. Some community members use GP services in Lightning Ridge which has a waiting list of 3 weeks. Lightning Ridge's health services have 4 beds and only provide care to people over 18 years of age. The services are perceived as immature [5, 6, 21]

Pharmacy services are not available in Goodooga, this adds travel or delivery cost to medical expenses for medications. [21] Also, fresh food is not easily available in Goodooga which is an additional health risk. [21]

A decrease in number of overall consultations has been observed in Goodooga. The health provider noted this may be due to the community's better understanding of preventive health [6]. However, the community feels this is due to the ongoing downgrade of the health services, such as loss of midwifes and a nurse practitioner, which made residents seek medical attention at other locations. This means more travel for community members in order to access services they need. The community also feels that health education activities within the community have decreased. [21]

The community household survey shows that many of the surveyed households (27%) would move away from Goodooga if the Health Service loses its RN position and the emergency bed. Other concerns are the overall affect the changes will have on the community's well-being (18%) - one respondent describing the health service as the community's "life blood". Households are also concerned about increased health care costs and financial stress (18%); about 15% of the surveyed households perceive the proposed changes as life-threatening and making life unsafe. [9]

2.1.4. Research and policies related to the provision of health care in remote Indigenous Australia

Primary health care (PHC) is the first level of health care that is directly accessible for individuals and communities and plays an important role in early detection of diseases and its risk factors and preventing disease complications. In the Aboriginal context comprehensive primary health care should also include 24hr emergency care [26]. It is well documented that the Aboriginal population has reduced access to health services despite a higher need for health care. Barriers to access are geographic and social, institutional racism, and poor policy development. [25].

To be effective, primary health care delivery must address these barriers. Research studies investigating models of health care delivery for remote Aboriginal communities show that there is no "one size fits all"-approach but that community strengths and assets should be taken into account when planning for health service delivery [12]. There is evidence Aboriginal health workers (AHW) increase access and improves access and quality of healthcare for Aboriginal people [13, 14, 15, 17] and that AHWs can successfully take on responsibilities for diabetes eye checks, mental health support, and health promotion [14, 15, 16].

Essential requirements for primary health care delivery in remote communities are: workforce organization and supply; sufficient and flexible funding, clear governance and management structures and good leadership, linkages for referral services, standard treatment protocols, and appropriate infrastructure [18]. It's perceived that a minimum number of 2000-3000 people for remote communities is necessary to support an comprehensive permanent local primary health care services [20]. For smaller communities research suggests that access to and availability of services be enhanced through outreach services or telemedicine. Outreach services thereby could be followed up by health workers in the community to provide continuing care between visits [18]. Transport has to be a crucial part of remote health services to access services, referrals, ongoing care and maintain social and mental health [11].

Telemedicine, the provision of health care and related services from a distance by using communication technology, is seen as supporting local primary healthcare providers in a range of services. The range of positive outcomes of telemedicine in remote areas includes reduced demand for ambulance and less presentations to emergency departments, better access to professional advice and counselling, and faster decision making. It also is seen as a source of support and integration for local health workers [19].

The value of Aboriginal Health Workers (AHWs) has been highlighted in a couple of intervention studies that found that access and quality of care for Aboriginal people is increased by AHWs. Studies also show AHWs can successfully take on responsibility in mental health care, cardiovascular risk education and diabetes care and diabetic eye checks [13, 14, 15, 16, 17].

To have a sustainable primary health care model in any remote community supportive policies on federal and state level have to be in place. In 2008, closing the gap between Indigenous and Non- Indigenous Australians was declared a national priority in the federal budget. "The Australian Government is committed to improving the access of Aboriginal and Torres Strait Islander peoples to comprehensive primary health care services." [21, p.17]. Government targets include closing the life expectancy gap within a generation and halving the mortality of children under 5 within a decade [22].

The NSW State Health Plan towards 2010 outlines that it aims to strengthen Primary Health Care in the community through new service delivery methods. With regards to Aboriginal health the plan aims for better primary and community health services for Aboriginal people, with focus on maternal and child health, supported by a sustainable workforce with more Aboriginal people in health related roles [23].

The Aboriginal and Torres Strait Islander Health Performance Framework 2005 recognizes the need for greater investment in service development, infrastructure and workforce strategies for health services in remote areas [24]. This will, in turn, mean that small communities experiencing high levels of illness and injury, have access to the high quality health care services, including preventive services that will be needed if it is to be possible to close the gap.

The recent national review of the Australian Health Care system by the National Health and Hospital Reform Commission [27] found that both Aboriginality and remoteness resulted in significant disadvantage in relation to health care and health status. In order to close the gap, the commission recommended a number of changes to the current system, including greater investment in services to Aboriginal communities. In particular, Aboriginal Community Controlled Health Services were recommended as playing an important role in the delivery of comprehensive primary health care to maximise Aboriginal people's potential and ameliorating illness as a barrier to Aboriginal and Torres Strait Islander people's participation in family, community and workforce. However, the review notes that additional resources are required to improve service provision to enable services to be delivered in an efficient manner. The review recommended that in rural and remote areas access to quality health care requires the care to

be brought to the people or the people to be transported to the care. As a result the review recommends that primary health care services in a remote or rural context need to include the provision of emergency care, retrieval services and repatriation. At the same time, the review notes that rural and remote services can become models of innovative care practices for future practice in Australia.

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Glossary:

Aboriginal Health Worker:
An Aboriginal or Torres Strait Islander person employed in an identified position in the NSW Public Health System and provides health services or health programs directly to Aboriginal people regardless of whether the person is employed in a generalist or specialist position. It encompasses all/any areas, irrespective of the award that covers employment of the worker.
Reference: NSW Department of Health, http://www.health.nsw.gov.au/policies/

Assistant in Nursing:
A person, other than a registered nurse, trainee or enrolled nurse, who is employed in nursing/midwifery duties in a public hospital or public health organisation. It requires a Certificate III in Community Services.

Cardiovascular disease: Any abnormal condition characterized by dysfunction of the heart and blood vessels. CVD includes atherosclerosis (especially coronary heart disease which can lead to heart attacks), cerebrovascular disease (e.g., stroke), and hypertension (high blood pressure).

COPD: Chronic obstructive pulmonary diseases are a group of disorders characterised by airway inflammation and airflow limitation such as chronic bronchitis and emphysema that is not fully reversible by bronchodilator or other therapy. Many people are more familiar with the terms chronic. Smoking is the major cause of COPD.

Infant death rate: Number of deaths of children under 1 year of age per 1000 life births.

Neoplasm: A general term for any type of tumor, benign or malignant.

Nurse Practitioner
A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations.
Reference: Australian Nursing and Midwifery Council, National Competency Standards for the Nurse Practitioners.

Primary Health Care:
A definition of PHC developed in Australia to suit the needs of this country is: Primary Health Care seeks to extend the first level of the health system from sick care to the development of health. It seeks to protect and promote the health of defined communities and to address individual and population health problems at an early stage. Primary health care services involve continuity of care, health promotion and education, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology (Australian Health Ministers' Council 1988; Commonwealth Department of Health and Family Services 1988)". *Reference: Fry D, Furler J 2000. General practice, primary health care and population health interface. In: Commonwealth Department of Health and Aged Care 2000, General Practice in Australia: 2000. Canberra: Commonwealth Department of Health and Aged Care. p.388*

Registered nurse:
A person registered by the Board as a Registered Nurse and/or Registered Midwife. The registered nurse provides evidence–based nursing care to people of all ages and cultural groups, including individuals, families and communities. The role of the registered nurse includes promotion and maintenance of health and prevention of illness for individual/s with physical or mental illness, disabilities and/or rehabilitation needs, as well as alleviation of pain and suffering at the end stage of life.
Reference: Australian Nursing and Midwifery Council, National Competency Standards for the Registered Nurse.

Telemedicine: provision of health and medical services over long distance via various technologies to remote communities.

2. Personal Stories

Uncle Ronnie's Story

From personal experience I can tell you that the Goodooga Health Service needs to be left as it presently is; with an RN, Accident & Emergency Service, and Nurse Manager.

On the 4th August 2008 when I arrived home my son was slumped in a lounge chair and his speech was slurred. I asked what had happened and he said he had a terrible headache, he couldn't use his legs. He had all the symptoms of someone who was drunk, but he hadn't been drinking. He suspected he had had a stroke.

I rang for the Ambulance and AINs. Vivian (my wife) arrived and she saw the condition Ashley was in and immediately left to call out to workers next door to help get him into the Ambulance. I have little recollection of what else went on, I was focussed only on Ashley.

Within five minutes an Ambulance from the Goodooga Health Service arrived, attended by an RN and two AINs.

They took him back to the Health Service and after assessment commenced treatment and preparation to have him transported to Dubbo for further treatment.

On arrival in Dubbo it was discovered he had deteriorated and would have to be transferred to Royal Prince Alfred Hospital in Sydney where he was operated on immediately to save his life.

Goodooga Health Service and staff played a very important part in the way they prepared my son for the first step to recovery and without this we would have lost our son.

I was told by Doctors in both Dubbo and Sydney that we only had 1 hour to spare. One hour.

My son is undergoing rehabilitation in Lourdes Hospital Dubbo and is anxious to return home. We will be eternally grateful to the staff of Goodooga Health Service, Dubbo Base Hospital and The Royal Prince Alfred Hospital.

There have been numerous occasions in the past where the Service has played significant rolls in the Health and Wellbeing of community members.

We must never forget; the Health and Wellbeing of any person should be a priority in the remote areas. Without the Health Service being a link in such an important chain in the road to recovery, Health (the system) would be unacceptable.

Lorina's Story

Living in Goodooga is isolated. What it lacks is a long list.

But when I faced my first pregnancy and entered motherhood I found the Health Service supportive, close, and easy. My experience has not been life threatening or desperate. It is the day to day concerns of a mother. I felt safe to be pregnant here despite our distance from major Health Care facilities.

And that is entirely due to the midwives, nurses and support staff we had/have at our Health Service. Once, late in my pregnancy I had been on a long car journey. I hadn't felt the baby move all that day and even over night. By the next day I was worried. But the worry didn't last long. The nurse listened to my baby's heartbeat and when I heard it beating happily I felt again at ease.

When my daughter was around 5 months old she was unwell for several days. I took her to see the nurse on duty and he gave advice on how to get through general bouts of childhood illness. We weren't too worried; she was still chatty, active, alert, a little whingey and had disturbed sleep.

But on the fourth day she woke up limp. She barely moved, ate, didn't want to even open her eyes much. She stayed this way for a few hours. I had grown into a panic. Had she gotten worse? She had been sick, but not like this. What was happening?

I called the Health Service. They were there in less than two minutes. I cried instantly as the AIN walked into my home and held my daughter (her cousin). It felt so good to have help, people who look objectively and have knowledge that I don't. I was a bit of a wreck at this stage. The nurse soon calmed me, convincing me that she was probably resting after illness. They checked her over and left with assurances to call again if we were still worried.

My daughter slept for a whole day and by the next day was well. It turns out, that is her way to recover and she has done it repeatedly since.

The beauty of our Health Service is that when you walk in, or they come to you, you and your family are the most important things in the world.

And the relief at having help available is immeasurable.

Because, in Goodooga, time in receiving Health Care is crucial.

Uncle George's Story

I won't remember dates. In 2000 I had a heart attack where the Health Service had to send me from here to Orange; we were down there for 1 week. From Orange I was sent on to Sydney for two weeks. They put two stints in because I had two blockages.

Only for the Health Service that I'd be here today. It could have been a lot worse. There is no way in the world I'd have made it to The Ridge.

All I remember was a real tightening if the chest and a lot of pain. I remember after that I drove to the Health Service because I was home on my own. I couldn't ring 'cause I had no phone. I was very frightened.

I walked into the Health Service and they put me on a machine and they worked out I'd had a slight heart attack and they rang the Flying Doctors and they told me I had.

I think the Health Service rang my family then, but I don't remember them arriving.

Aunty Stacey's Story

When my son was a baby he went into convulsions, but he was good as gold. We were up at the school carnival and he felt hot with a temperature. We arrived and at the Health Service and we were there for 15 minutes and the top of his head sort sunk down and I flipped out. I just threw him to Kimmy (AIN) and Lesley (the Aboriginal Health worker) they were standing at the end of the bed and I sort of just threw him.

They put him on the bed and the two nurses put a tube down his throat and he sorta went all grey, like he as dead. Dead.

I ran outside, I remember waiting around for the Ambulance to come and they took him by road to Walgett. One of the nurses came with me all the way. When we get to the big bridge at Walgett the nurse said to me "remind him when he was 18 hit his head a brick wall and remind him how he scared us". He had stopped breathing for 15 seconds.

Another time was the Easter weekend, two years ago when Dad needed the assistance of the Health Service with blood poisoning, yeah. And the Health Service came to the house to collect him. He was like going unconscious, his organs were closing down, he was lying in bed. People from the community helped get him into the Ambulance.

I wasn't home. I'd gone to Lightning Ridge to get him medicine. My sister kept ringing to say hurry up. By the time I got back he was at the Health Service, with the drip and stuff in him and waiting for the aeroplane. When I first saw him it brought tears to my eyes. I thought he was gone. He didn't know where he was when he first arrived so they got him on a plane and flew him to Dubbo.

He'd had a sun spot cut off his leg and it had poisoned him. They reopened it and stuck a tube in and let the inside drain out and kept flushing it out with water.

So yeah, I reackon I'm pretty lucky to have a Health Service in Goodooga.

Aunty Nic's Story

Um, in 1994 my son died in an accident that happened down behind my house, in the river. He had seizure and drowned.

They called the Health Service to come and take Clem and I to the Health Service. They took us up to check us over because we were very very upset. While we were there they gave us a throughough check up and at no time were we left alone on our own.

We never had to leave the camp because they were always there for us. All those girls at the Health Service. No matter what the time. They were in the car and down to us.

They monitored us for two days at the Health Service. And when we went home they were always there asking if we needed help in any way. They made sure that Clem had plenty of tablets, his blood pressure was checked. And they not only filled their roll as Health Service workers they were like counsellors as well. If we wanted to talk they sat and listened to what we need to say.

And the same thing happened with my brother in law when he had seizure and was taken to the Health Service. They monitored him, looked after him, kept Clem and I informed of his health.

And after he had passed away they kept coming back checking on Clem and myself to see how our health was going and were eager to sit and listen.

When we had to bury my son we were broke. We had buried my mother-in-law, my brother, two sister-in-laws, my Mum, My Dad, our other son, and five uncles. We had paid about $82,000 in funeral costs. The day of my son's accident I was standing in the Post Office signing off the last payment on my Dad's funeral.

When we had nothing Pat Hickey and Jeanie Collis got a bucket and went 'round the town and collected a few bob from everyone. People were chucking in hundreds. We got a list off Aunty Pat of the names and how much they'd thrown in. When we had some money we went to Tommy Stanton to pay him back and he said to me "don't come here and offend me by giving me that money back".

Nobody in Goodooga would take the money back.

I didn't have to cook once for my family while they were home for the funeral, Tommy, Nina, Chongy, people brought bread and tucker and feed my family in our time of need and we didn't have to lift a finger.

We never argue with anyone in this town. I'll just walk away from an argument because when we needed them they were all there for us.

Clem and I give a lot of credit to the Health Service for helping us through our trouble. ln times when we really needed help.

They've helped me and my old fella a lot. Without this little town here and that Health Service I think me and Clem would have committed suicide.