

# Aboriginal Health Services Access to the Asthma 3+ Plan

## NACCHO Survey

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## Acknowledgements

- NACCHO Board of Directors
- ACCHSs across Australia
- University of Adelaide
- University of NSW
- National Asthma Reference Group
- Australian Government, Department of Health and Aging (asthma section)



## Objective

- To examine the uptake of the Asthma 3+ Visit Plan initiative among Aboriginal community-controlled health services (ACCHSs).
- Explore barriers and facilitators to asthma care.

## Background

- Asthma 3+ Plan initiative from the 2001-2 Federal Budget (\$48.4 million over 4 years).
- Encouraged doctors to talk to their patients about asthma management over at least three visits, incorporating diagnosis, assessment and review.

## Funding elements

- Financial incentives for GPs (through the Practice Incentive Program or PIP)
  - service incentive payment (SIP) which is triggered by a Medicare Benefits Schedule (MBS) claim (such as for item 2546), upon completion of *three* GP visits for those with moderate to severe asthma over 4 weeks to 4 months
- Division of GP infrastructure support
- National awareness campaign targeting both GPs and the general community.

## Additional funding

- Federal Budget (2001-02) *Chronic Disease Program* with Divisions of GP for national health priority areas including asthma.
- *National Asthma Council (2002)*- national education program to Divisions and GPs (A-teams held 108 workshops across Australia).
- Divisions of GP also receive annual funding with loading for the Aboriginal population (\$2.55 per head of Aboriginal population).

## ACCHSs

- Primary health care services established since 1971, as expressions of Aboriginal self-determination
- Over 120 ACCHSs provided 1.2 million episodes of health care to Aboriginal and TSI clients (2000-01)
- 70% employees are Aboriginal
- Non-appointment based
- Culturally safe environments including 'Aboriginal space'
- Provide clinical and preventative care, health promotion, screening and recall, immunisation, substance misuse programs, social and emotional well-being programs, pharmaceutical supply, community support services, etc.

## Methodology

- Questionnaire for ACCHSs (pilot tested in two ACCHSs)
  - Eligibility criteria: at least one FTE GP employed
- Focus groups with cross-section of the Aboriginal population with asthma or asthma carers (urban, rural and remote ACCHS location)
- Ethical clearance

## Results

- 50 ACCHSs met the eligibility criteria
- 60% response rate (30/50)
- 27 Aboriginal focus group participants.
- Geographical distribution of ACCHS respondents was representative of all ACCHSs ( $p > 0.05$ ).
- Included services in highly accessible areas to very remote.

## Uptake of the Plan

- 74% (22/30) reported barriers to using the Plan.
- 60% (18/30) of ACCHSs were accredited with the PIP and immediately eligible for Asthma 3+ Plan
- 7% (2/30) were preparing to be accredited
- Only 25% (5/20) of those eligible had used the Plan (with between 1-5 clients)
- Only 1 ACCHS had received payment.

## Reasons for not using:

- 'red tape' + complex
- program inflexibility
- patients not returning for the third visit
- lack of staff training and insufficient resources to understand and implement the program.

## Access to information

- 59% (10/17) of ACCHSs that were either PIP accredited or near accreditation received assistance from Divisions of GP.
- 40% (8/20) of ACCHSs could recall receiving invitations to attend National Asthma Council workshops.

## Access to spacer devices and medication

- 80% (24/28) of ACCHSs reported poor client access to spacer devices.
- 48% (13/27) reported poor client access to asthma medication.
- The majority of those reporting *no medication access problems* (8/14) were Section 100 pharmaceutical providers to Aboriginal clients.

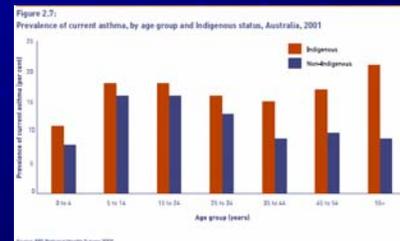
## Focus groups

- Most reported difficulties accessing medication and spacers.
- Most were using nebulisers.
- Some had been using home-made spacers using plastic coke-bottles.



## Context

- Aboriginal and TSI have higher asthma prevalence than the non-Indigenous population (2001 ABS NHS).
- There is evidence of suboptimal therapy (north Qld report).



## Key findings

- Significant barriers exist for ACCHSs to access the Asthma 3+ Plan funding initiative.
- A third of services were immediately 'locked out' of the program on the basis of PIP ineligibility.
- More than 50% of *eligible* services reported not using this initiative for reasons related to poor program design.
- ACCHSs were not recipients of education and training to the degree that other practices were.
- This seriously limits Aboriginal people's capacity to benefit.

## What did the Medicare and GP survey show?

- Health Insurance Commission data (2001-3) shows a *distinctly lower rate of asthma SIPs* generated from GP Divisional regions with a high Aboriginal and Torres Strait Islander population.
- Moreover, 50% (80/161) of GPs with asthmatic Aboriginal or Torres Strait Islander patients reported *not using* the Asthma 3+ Visit Plan with them in 2003.
- 61% (33/54) of Divisions of GP surveyed *did not* provide the local ACCHSs with assistance in the implementation of the Asthma 3+ Plan.

## Policy implications

## New Medicare items

- The new Chronic Disease Management Medicare items offer a preferable and alternative funding mechanism to the asthma SIP.

Chronic disease Management items (item 721 etc)	<ul style="list-style-type: none"> <li>National Asthma Reference Group</li> <li>Department,</li> <li>Medicare Benefits Branch,</li> <li>Health Insurance Commission</li> </ul>
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## Spacer devices

- Spacer delivery devices for asthma inhalers should be subsidised for Aboriginal and TSI peoples.

Spacer devices	<ul style="list-style-type: none"> <li>APAC</li> <li>PBS listing of spacer devices;</li> <li>Specific drugs list inclusion for Aboriginal and Torres Strait Islander population;</li> <li>Section 100 for direct access.</li> </ul>
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## Asthma communication strategy

- A national asthma communication strategy for the Aboriginal and TSI community is urgently needed.

National Aboriginal and Torres Strait Islander Asthma Communication Strategy	<ul style="list-style-type: none"> <li>National Asthma Reference Group</li> <li>Asthma Section DOHA</li> <li>2005-06 Federal Budget extension of the Asthma Management Program (\$27.6 million over 4 years)</li> <li>?relevant committees?</li> </ul>
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## Divisions of GP

- Improve Divisional responsiveness to Aboriginal and TSI Peoples.

Divisions of GP responsibilities to the Aboriginal and Torres Strait Islander population and ACCHSs	<ul style="list-style-type: none"> <li>NACCHO:ADGP Memorandum of Understanding. <i>Workplan in development.</i></li> <li>Limitations to the newly developed <i>National Objectives and Performance Indicators for Divisions.</i></li> <li>?Review funding formulae for Aboriginal weighting for Divisions due to limited accountability.</li> <li>More accountable Asthma 3+ Plan expenditure.</li> </ul>
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## Future

- Asthma 3+ Plan program is one of many that fails to be accessible to Aboriginal and Torres Strait Islander peoples.
- We know what needs to be done to improve asthma program expenditure.

“We’ve been part of all the reviews. We’ve heard all the speeches. But if you don’t have a government committed to implementing these programs and policies, you’re pissing in the wind.”

*The late Dr Puggy Hunter, HREOC Human Rights Medal*

[Sept 2000, ATSIIC News]

