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Experiences and views of a brokerage model for primary care for Aboriginal people

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Experiences and views of a brokerage model for primary care for Aboriginal people

Abstract

Objective A mixed methods study was conducted to determine the views of Aboriginal people on their experiences of a brokerage model for access to community-based health services in an urban setting. **Methods** A broad range of approaches, using surveys, semi-structured interviews and community forums with Aboriginal people were used to find out people's views and experiences of using the brokerage service. **Results** Of the 1304 people invited to participate, only 127 people provided feedback on the brokerage service model for Aboriginal people. Of these, 120 people identified as being Aboriginal. Participants said that the service helped them to navigate the system and access health care. Participants felt that the health professionals involved with the service were respectful of their needs. The service was not able to improve access to dental care. **Conclusions** The brokerage model implemented in this area appears to have been well received and is supporting urban Aboriginal people to access some of the health care needed. What is known about the topic? Aboriginal and Torres Strait Islander people often experience difficulty accessing health services. Urban brokerage models of care were funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) under the Improving Indigenous Access to Health Care Services initiative and aimed to increase access to mainstream health services. What does this paper add? The brokerage model of care in South West Sydney has been well-received by the Aboriginal people receiving the service and participants are positive about the role of the service in increasing access to mainstream health care. What are the implications for practitioners? Navigating the healthcare system is difficult for some and a brokerage service with supportive Aboriginal health workers increases access.

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Experiences and views of a brokerage model for primary care for Aboriginal people

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Abstract

Objective: A mixed methods study to determine the views of Aboriginal people on their experiences of a brokerage model for access to community based health services in an urban setting.

Methods: A broad range of approaches, using surveys, semi-structured interviews and community forums with Aboriginal people were used to find out people's views and experiences of using the brokerage service.

Results: Of the 1304 people invited to participate only 127 people provided feedback on the brokerage service model for Aboriginal people. Of these, 120 people identified themselves as being Aboriginal. Participants said that the service helped them to navigate the system and access health care. Participants felt that the health professionals involved with the service were respectful of their needs. The service was not able to improve access to dental care.

Conclusions: The brokerage model implemented in this area appears to have been well received and is supporting urban Aboriginal people to access some of the healthcare needed.

1. What is known about the topic?

Aboriginal and Torres Strait Islander people often experience difficulty accessing health services. Urban brokerage models of care were funded by OATSIH under *the Improving Indigenous Access to Health Care Services* initiative and aimed to increase access to mainstream health services.

2. What does this paper add?

The brokerage model of care in South West Sydney has been well received by the Aboriginal people receiving the service and participants are positive about the role of the service in increasing access to mainstream health care.

3. What are the implications for practitioners?

Navigating the health care system is difficult for some and a brokerage service with supportive Aboriginal Health Workers increases access.

Introduction

According to Australian Institute of Health and Welfare (AIHW) the life expectancy for Aboriginal and Torres Strait Islander people is 67.2 years for males and 72.9 years for females which is 11.5 and 9.7 years respectively less than the life expectancy of other Australians (1). Non-communicable disease was shown to contribute to 70% of the health gap between Aboriginal and Torres Strait Islanders and other Australians (2). In 2008, nearly a quarter (23%) of Aboriginal people surveyed reported problems accessing health services, with dental service access being particularly problematic. Two of the reasons given were long waiting times (13%) and cost (11%)(3).

In 2006, the Department of Health and Ageing (DoHA) Office for Aboriginal and Torres Strait Islander Health (OATSIH) launched an Improving Indigenous Access to Health Care Services initiative with funding of \$12.63 million. A feature of this initiative was to fund health brokerage services with the aim of linking Aboriginal Australians living in urban and regional areas with appropriate mainstream primary and allied health care, in order to meet their health needs. Australia wide there were five urban brokerage services funded by this scheme and one of these was Marumali in South Western Sydney. The word Marumali means “to heal” in the Aboriginal Kamilaroi language. Initially, Marumali was established under the auspices of the Macarthur Division of General Practice but subsequently moved to be under the auspices of the Gandangara Local Aboriginal Land Council. The role of Marumali was to create an opportunity for local Aboriginal people to access culturally appropriate health services. After an assessment with an Aboriginal health worker a care plan was developed and clients were assisted to access the relevant mainstream health services for their problems. Appointments were organised, costs negotiated with the providers and preference given to providers who were keen to address the health needs of Aboriginal people. Urban Aboriginal people have access to both Aboriginal Community Control Health Services (ACCHS) and mainstream services. South Western Sydney Local Health District serves an Aboriginal population of approximately 11,200 (NSW Health) and by September 2011 there were 3422 Aboriginal and Torres Strait Island people registered with the brokerage service.

There has been little published evaluation of the brokerage services established under this initiative and what happened to the other services funded is unclear. In the only paper published, researchers from the University of Melbourne conducted qualitative interviews with Aboriginal people before the brokerage services were implemented in Victoria and regional New South Wales. Participants identified potential benefits of a brokerage service model as power to ensure quality of service provision and flexibility. Perceived limitations were reliance on adequacy of existing services and lack of power to reform organisation of services. Another emergent theme was trust and included concerns that brokerage models could threaten funding of existing community controlled services (4).

In the published literature on access to health care and increasingly, in Aboriginal health research the concept of candidacy is discussed (5). The term candidacy arose from a systematic review and interpretive synthesis of access to health care by vulnerable people (6). Dixon-Woods described the concept of candidacy as the way in which the

eligibility for medical attention is negotiated between patients and the health services. Within the concept of candidacy there are sub-themes, these include navigation, permeability, appearing at services and resistance (6). Often, vulnerable people experience difficulties navigating the system and have fewer resources available to them to access the care they need. Services differ in the extent to which they are permeable; those services that are at the porous end of the spectrum are easier to negotiate whereas those that are less permeable tend to result in reduced access for vulnerable people. The importance of the role of candidacy in the context of Aboriginal Medical Services has been described (5). The success or otherwise of a brokerage service in improving access to healthcare may be related to the extent to which it can address issues around candidacy.

The aim of this project was to explore the views of Aboriginal people on their experiences of a brokerage model for access to community based mainstream health services in an urban setting in New South Wales. The extent to which the brokerage service increases access to health care is considered in relation to the concept of candidacy, in particular navigation and permeability of the services.

Methods

The views of both Aboriginal people who had used the brokerage service and those who had not were sought at a number of time points during the evaluation. The brokerage service started to enrol patients in August 2007, interviews were conducted with users of the service after 24 months (Aug-Sep 2009) and 36 months (Sep-Oct 2010) of the service being in operation. Views of non-users of the service were also elicited through mailed out surveys to the membership of two local Aboriginal Land Councils (Gandangara Aboriginal Land Council and Tharawal Aboriginal Land Council) in July 2009 and February 2010. Two community forums were held in September 2009. A number of key stakeholder interviews were conducted in 2011 with Aboriginal Elders, Aboriginal Health Workers, health professionals and staff of the brokerage service. The reference group included representatives from the AHMRC of New South Wales, the Tharawal Aboriginal Medical Service, the Aboriginal Advisory Committees of local councils in the area and the Marumali Cultural Governance Committee. During the course of the evaluation there was a concern about the low response rate to the telephone survey of service users. Following discussions with the Reference Group a number of approaches were taken in an attempt to gain the views of as many users and non-user as possible.

The details of each method used are outlined below.

1. Telephone survey

A random sample of 200 and a random sample of 400 brokerage service users were invited to take part in a telephone interview with one of the evaluators (IH) in 2009 and 2010 respectively. At the time of the random samples, the number of people registered with the brokerage service was ### and #### respectively. The Marumali manager generated address labels for all the active members and one of the administration staff who was not involved with the evaluation randomly selected the required number of labels and attached them to the letters for the mail-out. The letters, information sheet and consent forms were sent from the service and those people willing to take part in

the interviews signed the consent form and returned it to the evaluators. The interviews were semi-structured and conducted by telephone and were audio recorded if the person gave consent. This method was chosen because and a copy of the interview schedule is included as Appendix 1.

2. Surveys

In 2009 and 2010 members of the two local Aboriginal Land Councils were invited to take part in a postal survey in order to get the views of the broader Aboriginal community including people who might not have used the service. The two Land Councils were selected because they cover the catchment area of the brokerage service. The survey packages, letters, information sheet and survey (Appendix 2), were prepared by the evaluators and sent from the Aboriginal Land Councils to 650 of their members, 450 from Gandangara and 200 from Tharawal. The completed surveys were returned to the evaluators in reply paid envelopes. Members were offered the option of answering the survey questions by telephone with a member of the research team.

3. Community Forums

Given the low response rate to the surveys and request for interviews the advice of the evaluation reference group was sought about how to get broader input from the Aboriginal community. It was decided to hold two community forums to get feedback on the model of care provided by the service from both users and non-users. Local Aboriginal Health Workers in two areas of south western Sydney publicised the event among their local community. At the meetings two (IH, SD) or three (IH, SD, NZ) of the evaluators were present to discuss the services using a series of questions and prompts. Field notes were taken by one of the evaluators (SD) at the community forums

1. Stakeholder Interviews

In the final year of the evaluation, 2011, key stakeholders in the service were invited to take part in interviews with one of the evaluators (IH). The key stakeholders included Aboriginal Elders, staff from Aboriginal Health in the local area health service, Aboriginal Health Workers from the brokerage service, non-Aboriginal staff from the brokerage service, and health professionals who had provided services for Marumali members. The Aboriginal Elders were identified from Marumali, Wingecarribee Shire and the local Aboriginal Land Councils by the members of the reference group. All key stakeholders were sent a letter and information sheet inviting them to take part. Those who wished to take part completed the consent form and returned it to the evaluators. The interviews were conducted either face to face or over the telephone and they were audio recorded.

Table 1 summarises the process of obtaining the views of the Aboriginal participants on the brokerage service and the associated timing.

<Table 1 about here>

The interviews with users of the service and key stakeholders were audio recorded and transcribed verbatim. The quantitative data from the postal surveys and service user interviews were analysed using SPSS and the answers to open end questions coded and

analysed thematically (IH). The field notes from the community forums were analysed thematically (SD). The transcripts from the key stakeholder interviews were analysed thematically using NVivo 9 (QSR, Melbourne, Vic., Australia). The transcripts were coded by one of the evaluators (SD) and then discussed with the evaluators before being circulated to the reference group for further comment and discussion.

The evaluation was approved by the ethics committees from the University of New South Wales (HREC 08038), the University of Western Sydney (HREC 08/059) and the Aboriginal Health and Medical Research Council of New South Wales (HREC 646/08).

Results

Overall out of 1304 people invited 127 people provided feedback on the primary health care brokerage service model for Aboriginal people. Of the 127 people who provided feedback on the service, 120 identified themselves as being Aboriginal. The seven people interviewed who were not Aboriginal were health professionals (GP or allied health) or other staff employed by the brokerage service. Despite the efforts to obtain input from both brokerage service users and non-users the majority of respondents (89/109 (82%)) had used the brokerage service.

Telephone survey (users of the service and key stakeholders)

There were 44 Aboriginal people interviewed, average age 50.2 years (SD 16.6) and 36.4% male. All of the users of the service interviewed were registered members and most had used the service at least once. Many of the people interviewed said that prior to the service they had experienced problems trying to access health care (26/44). The most common problems faced were accessing affordable dental care, obtaining spectacles, long waiting times and the additional expense when seeing specialists.

The users were satisfied with the way in which the service organised the appointments and reminded people when appointments were due making it more likely that patients appeared at the service:

“Every time I got an appointment coming they would call and give me a reminder and asked whether I needed a transport to get there. I can’t say anything bad about them – they have been fantastic.” (ID MU110)

The costs associated with health care were considered a barrier to access and the brokerage service was able to address this by using providers that had agreed to bulk-bill for members. Where providers would not bulk bill the service was able to pay the gap fee and this meant that people could afford to see health professionals.

“...I had to have a number of things lately – a neurologist and an audiologist for hearing test. The workers at [] have so much knowledge about where to send me and payments were made before you get there. So, accessing specialist services have become easy now.” (ID MU225)

“They helped me with my dental issues. I had been suffering for 3-4 years now and could not afford to see a dentist. They organised a dentist for me and now my problem is solved.” (ID MU 202)

People surveyed valued the fact that there were Aboriginal Health Workers at the service who understood their needs and values, were able to explain about available services and resources and were able to communicate with providers on behalf of the person. This made the services more porous and facilitated access by reducing cost barriers.

".....sometimes Koori people find it hard to communicate with other people. Aboriginal Health Worker talking to the doctors or other health carers made it easier for us..." (ID MU05)

Participants responded that the service role in guiding Aboriginal people to navigate their way through the mainstream health care system resulted in people feeling empowered and better able to manage themselves.

"...getting involved with [-] has empowered me and now I know more about the health care system in this country." (ID MU03)

Participants described feeling more comfortable going to appointments that had been made for them knowing that they would be expecting an Aboriginal person and that they would be treated with greater respect.

"Before we used to go to any health service they did not treat us nicely – now when we go to any health services as a [-] client with the [Aboriginal] Health Worker, I feel they give us more importance." (ID MU202).

There were six local Aboriginal Elders surveyed during the key stakeholder interviews. The Elders felt strongly that it was valuable to have Aboriginal Health Workers in the service who understood the needs and culture of the members and that the health professionals they use are comfortable treating Aboriginal people.

"Well, they are providing people, practitioners who are sympathetic to the Aboriginal people." (Elder 4)

"..it's Aboriginal based, you are getting support from Aboriginal people, and, you know, so I can't say much more than that." (Elder, 8)

The sense that they were being "cared" for was a strong theme that emerged from the interviews with the Elders.

"Cause they look after you and they take care of everything for you" (Elder, 14).

There were 12 other key stakeholders interviewed, four were Aboriginal Health Workers at the brokerage service or with the area health service or Aboriginal people at the service, and the remaining seven were non-Aboriginal staff of the service or local health professionals. The remaining stakeholder comments were consistent with those of the Elders. They felt that one of their roles was to advocate for the patients and this was seen as an important part of their job.

"Yeah, a lot of us liaise between doctors and medical services and they, they find that when we send people there they're more at ease because we have already

spoken to them. ...they're not stressed because they, you know, I mean we ring ahead to make sure everything is going to be OK" (AHW, 3).

As well as advocating for their patients the Aboriginal Health Workers felt that another important role was navigating the health system and negotiating for the service to bulk bill their patient, thereby increasing access,

"..and because it is 3 o'clock in the afternoon they've made enough money to cover that person to bulk bill it" (AHW, 1).

There were some aspects of the model that had not worked in the way it had been anticipated. Originally local GPs were encouraged to sign up to the service and they would also take part in cultural awareness training.

"GPs, specialists didn't want to sign anything or be committed to anything" (Hub staff, 3)

This meant that the relationship between the service and local GPs and hospital specialists was less formal than was originally envisaged. Many of the local GPs and allied health professionals had already completed cultural awareness training through the Royal Australian College of General Practitioners (RACGP) or the local division of general practice and so did not need further training. Navigating the health system and negotiating to have care bulk billed were seen as important features of the brokerage service. A concern was expressed by the service staff as to how sustainable the model could be if health providers were not willing to bulk bill for Aboriginal people referred to them;

"I would like to see more that agree to bulk bill rather than utilising the funds that we've got available. We would be able to provide more services if we had more providers understanding" (Hub staff, 2).

Community forums

There were 14 Aboriginal people who attend the two community meetings and five local Aboriginal Health Workers. Overall their comments reflected the views expressed in the surveys and interviews. The participants felt that the service had helped them to access mainstream health services more easily. One of the participants said that it was easier to approach the brokerage service for guidance and support rather than try to tackle the health system and end up frustrated and overwhelmed. One of the forums was held in a rural area, people at this forum were positive about the service because where there was a need identified the health services were brought to the community by the brokerage service rather than them having to travel to the main hospital. Again, the role of the Aboriginal Health Workers in the service was seen as being valuable and providing support to the members. The role of the service in negotiating bulk billing or payment of gap fees was again an important feature of the model. For people living in the rural areas there was a sense that the service had helped to reduce perceived racism in the local hospital and this was helped by the support of a number of key local general practitioners.

Survey

A total of 46 members of the local Aboriginal Land Councils responded to the postal survey, they had a mean age of 51.6 (SD 14.4) and 37% male. Of these 15 (32.6%) were also registered with the brokerage service. Only 12/46 said that they had experienced barriers accessing local health services, however this group were better educated and this may have contributed to them experiencing fewer problems accessing health care. There were only four of the Aboriginal Land Council members who responded who thought that there was no need for such a service and two of them felt that this was already being provided by the local Aboriginal Medical Service. Another Land Council member felt that Aboriginal Medical Services could provide similar support to their members whereas another felt that Aboriginal people should be able use mainstream health services.

How could the service be improved?

All groups interviewed or surveyed discussed the problems of accessing affordable and timely dental care and the fact that the service had only partially been able to address this. Increasing awareness of the brokerage service was another suggestion because Aboriginal people felt that there were many people in the Aboriginal community in South West Sydney who remained unaware of the service. For those members living some distance from the main hub there was a need for some services to be negotiated locally where possible to reduce the need to travel in order to get access to appropriate health care.

Discussion

For those participants who had registered with Marumali and who responded to the interviews and surveys there was a general view that the brokerage service model had improved their access to health care. They felt that the strength of the model was that it was led by Aboriginal people and it was seen as being valuable by many of those that were interviewed. Being cared for was an important issue and extended to the health services that the participants were referred to for their care. They reported that they felt that the way had been paved for them to access the service and that the provider would be respectful of them and their needs. Since its inception, the staff have developed many connections with local health services and have used this to negotiate bulk billed services for their members. Where patients need extra help such as an advocate then Aboriginal Health Workers are able to accompany members to appointments and this was valued by the users. There was a sense that people were being cared for. Some Aboriginal people, who were not users of the service, felt that this sort of care and support was already being provided by the local Aboriginal Medical Service. It was disappointing that more people did not respond to the request to provide feedback on the service and this limits the generalizability of the findings.

Whilst the brokerage service does seem to have negotiated access to many health services for its members there remain some gaps such as affordable dental care and some specialist services such as orthopaedics or vascular surgery. There are also opportunities for improved communication with providers, in particular GPs. The main challenges for the brokerage service seem to be managing the patient load and ensuring that the services provided are sustainable over the long term. The government initiative

to fund brokerage services has since ceased but the service established in south western Sydney continues to provide care for its members.

The findings from these interviews and surveys highlight some of the key issues affecting Aboriginal people when accessing health care and the extent to which the brokerage service has addressed some of these. Many of these issues relate to the themes of candidacy, in particular navigation and making services more permeable (5, 6). The relationship between Aboriginal people and the staff at brokerage service is ongoing and dynamic. The service actively navigates through the health system and seeks to increase the permeability of health services to vulnerable users. Cultural safety is important (7) and this was achieved in this model by the Aboriginal Health Workers working with providers who were willing to treat Aboriginal people. Participants reported feeling that they were treated with respect when they attended the appointments. The brokerage service does seem to have increased access to health services by developing candidacy (5, 6) by supporting patients to navigate their way through the healthcare system and to identify service providers willing to treat them. Appointments are negotiated by the Aboriginal Health Workers and this has the effect of making health services more permeable for the users. The participants in this study felt comfortable “appearing” at Marumali and that they would be assessed by an Aboriginal Health Worker who would understand their needs. What this study does not tell us is how or if this model differs from that provided by community controlled Aboriginal Medical Services as they also have an important role in enhancing the candidacy of their members to access a range of health care providers (5). What we are unable to tell from this evaluation is whether candidacy of individual members who have used Marumali will have been developed and sustained or whether people will continue to need to have support from the service.

The differences in the responses in this study compared to the published findings in Victoria (4) could be because this study aimed to explore the experiences of Aboriginal people after the service had been introduced rather than their perceptions of what a service might be like before implementation. We were therefore exploring people’s actual lived experience of the service rather than asking them to comment on a proposed model. Another difference is that the brokerage service in South Western Sydney is Aboriginal owned and run and this may have resulted in a sense of trust from its members.

What this study does demonstrate is that once people have had an opportunity to try a new or novel service, and that this service does not pose a threat to existing services, then trust and acceptance can develop. Policy makers should be mindful of these perceived threats when funding new models of care for Aboriginal people.

Limitations

The main limitation of the study was the poor response rate to the surveys and interviews, particularly from those people who were not members of the service and this may have contributed to the favourable experiences of the brokerage model of care. After the poor response rates to member and community surveys a number of different strategies were tried to increase the participation in the evaluation and the reference group suggested local community forums and attendance at NAIDOC events. In spite of

these attempts we were only able to obtain the views of a small group of people and this may have

Conclusion

The brokerage model implemented in this area appears to have been well received by those responders who used the service and is supporting urban Aboriginal people to access the healthcare they need. The poor response rate means that we cannot generalise the findings to the wider urban Aboriginal population in the area.

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