PaRROT

Pathways to Rural and Remote Orientation and Training

a Primary Health Care approach to Chronic Disease

Orientation

Participant Manual

Part 4—Primary Health Care

Name _____

Community _____

Site _____

Position _____

Date Completed _____

PaRROT Orientation Handbook
Part 4

Table of Contents

Click on the relevant section for an immediate link

Unit 14 Aboriginal and Torres Strait Islander Health 1
Session 1 3
Bibliography 4
Learning Activity - Participant 13
Questions 14
Session 2 15
Bibliography 16
Quiz - Participants 17
Questions 18
BIBLIOGRAPHY 20
Unit 15 Comprehensive Primary Health 21
SESSION 1 23
Bibliography 24
Learning Activity - Participant 35
Questions 35
SESSION 2 37
Bibliography 38
Quiz - Participant 39
Questions 40
BIBLIOGRAPHY 42
Unit 16 Selective Primary Health Care 43
Session 1 45
Bibliography 46
Learning Activity - Participant 55
Question 55
Session 2 57
Bibliography 58
Quiz - Participant 59
Questions 60
BIBLIOGRAPHY 61
Unit 17 Introduction to Health Checks 63
Session 1 65
Bibliography 66
Learning Activity - Participant 73
Questions 74
Bibliography 76
Quiz - Participant 77
Questions 78
BIBLIOGRAPHY 79

PaRROT

Pathways to Rural and Remote Orientation and Training

a Primary Health Care approach to Chronic Disease

Orientation

Unit 14

Aboriginal and Torres Strait Islander Health

Session 1

According to the Australian Institute of Health and Welfare (AIHW) 2008, Aboriginal and Torres Strait Islander peoples experience significantly more ill health than other Australians and that a number of socioeconomic and health related data indicates the population is disadvantaged. Other data shows that risk behaviours associated with the development of chronic disease, including poor nutrition, smoking and alcohol consumption, overweight and obesity and physical inactivity is more common in the Aboriginal and Torres Strait Islander population [1].

A number of publications have also identified the social determinants of Aboriginal and Torres Strait Islander Health, and have reported at the length the importance of health professionals not only acknowledging these factors, but providing services that respond to the needs [2, 3].

Social factors impacting on health include

- History of the Aboriginal and Torres Strait Islander population,
- Racism,
- Poverty and social class,
- Income and social capital,
- Education,
- Employment and welfare,
- Relationship to country,
- Housing,
- Policy processes and
- Human rights issues [4]

The AIHW report on the health of Aboriginal and Torres Strait Islander Peoples 2008 identifies a trend for an earlier onset on chronic disease, and higher mortality and morbidity associated with a variety of chronic diseases[5]. Research conducted in the Northern Territory and Queensland supports the data findings [6, 7].

At Federal and State levels of government a number of strategies most notable "Close the Gap" campaign have also been implemented and strategic documents such as the Queensland Strategy for Chronic disease, identify Aboriginal and Torres Strait Islanders and people from rural and remote areas as target populations for intervention as they carry a higher burden of disease and experience other systems issues which impact on their health status [8].

This unit looks at the findings of research on Aboriginal and Torres Strait Islander health, particularly in reference to chronic disease and the development of systems to support a holistic approach to chronic disease care. These systems are currently being implemented across the state in line with increased funding and resource allocation for Aboriginal and Torres Strait Islander health care.

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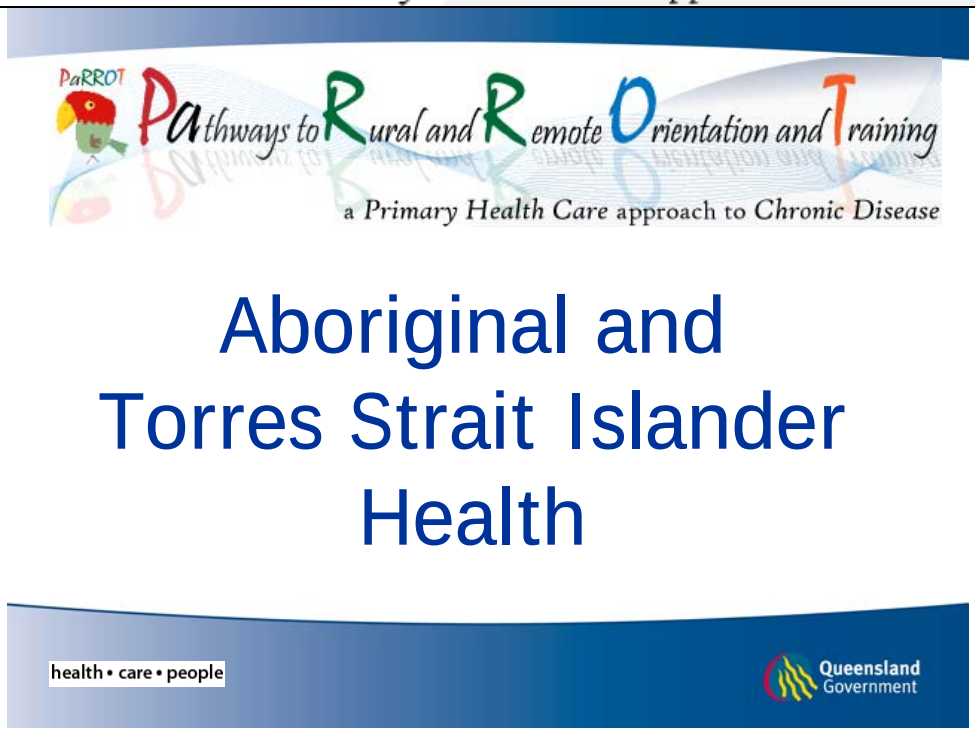
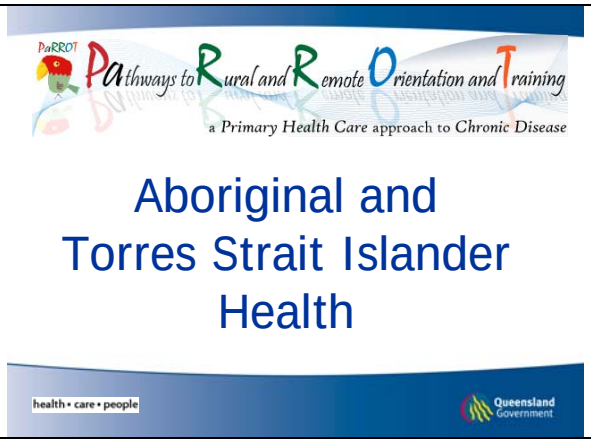
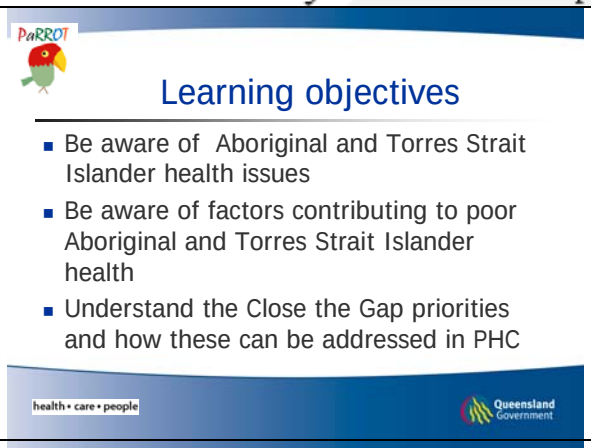
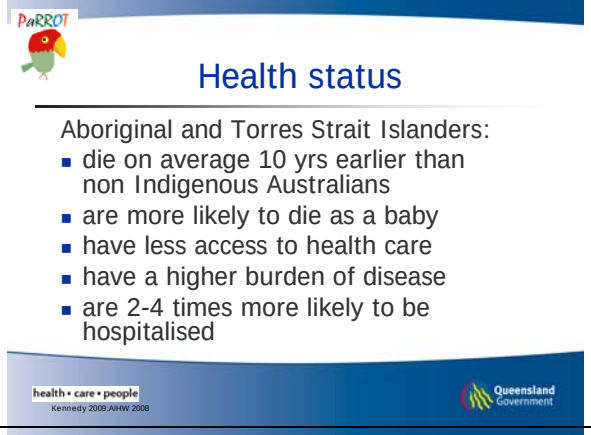
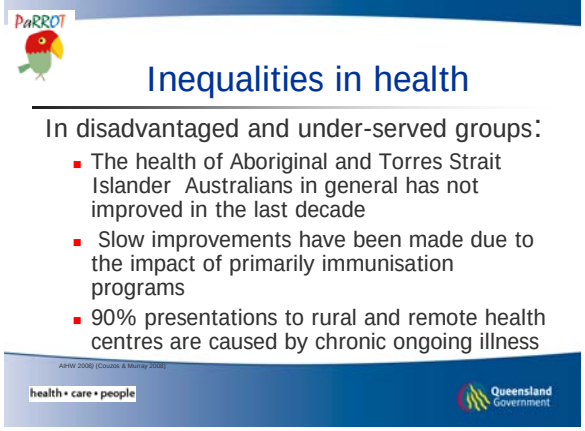
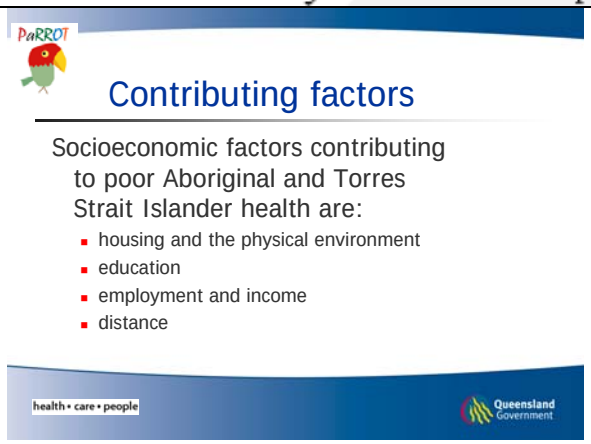
3. Smith J, *Australia's Rural and Remote Health: a social justice perspective*. 2nd ed, ed. S. J. 2007, Croydon: Tertiary Press.
4. Carson B. Dunbar T. Chenhall D and Bailie R eds, *Social Determinants of Indigenous Health*. 2007, Crows Nest: Allen and Unwin.
5. AIHW, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, A.B.o. Statistics, Editor. 2008, Australian Government.
6. D'Abbs P, et al., *Implementing a chronic disease strategy in two remote Indigenous Australian settings: A multi-method pilot evaluation.* Australian Journal of Rural and Remote Health, 2008. **16**: p. 67-74.
7. Weeramanthri et al, *The Northern Territory Preventable Chronic Disease Strategy - promoting and integrated and life course approach to chronic disease in Australia.* Australian Health Review, 2003. **26**(3): p. 31-42.
8. Queensland Health, *Queensland Strategy for Chronic Disease 2005-2015*. 2005, Queensland Health.



Slide 1 **Aboriginal and Torres Strait Islander Health**		**Notes:**

Slide 2 **Learning objectives**		**Notes:**
Slide 3 **Health status**		**Notes:** When compared to non-Indigenous Australians, Aboriginal and Torres Strait Islander Australians have a lower life expectancy and carry a greater burden of chronic disease, they also have greater difficulty accessing health care and are more likely to be hospitalised.
Slide 4 **Inequalities in health**		**Notes:** Although the burden of chronic disease in Queensland is great, Aboriginal and Torres Strait Islander people carry an even greater burden. Their life expectancy is on average 10 years less than non-Indigenous people and 90% of presentations to rural and remote health services are the related to chronic disease. A large number of Aboriginal and Torres Strait Islander Australians live in rural and remote areas. Some jurisdictions have shown slight reductions in mortality in recent years along with declines in infant mortality. While mortality rate has improved, birth weights still remain ~200g less than birth weights of babies born to non-Indigenous mothers.

Slide 5
Contributing factors



Notes:

Slightly more than 50% of Aboriginal and Torres Strait Islander people live in cities and towns, with around 25% living in areas classified as 'remote' or 'very remote'.

The poor health status of Aboriginal and Torres Strait Islander people is impacted by social, environmental and economic factors, made worse by a lack of access to health care services.

(The following is based on the 2001 Census)

Housing and physical environment

Substandard living conditions are characterised by overcrowding, inadequate water and washing facilities, poor sanitation and sewage disposal, limited food storage, and poor food preparation facilities

2. Education

Aboriginal and Torres Strait Islander people reported:

17% completed year 12 or equivalent compared to 38% of non-Indigenous

<15% had a post-secondary school qualification compared to 35% of the non-Indigenous population

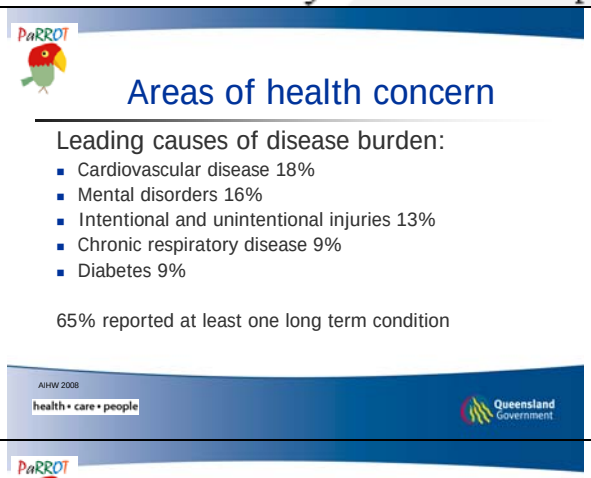
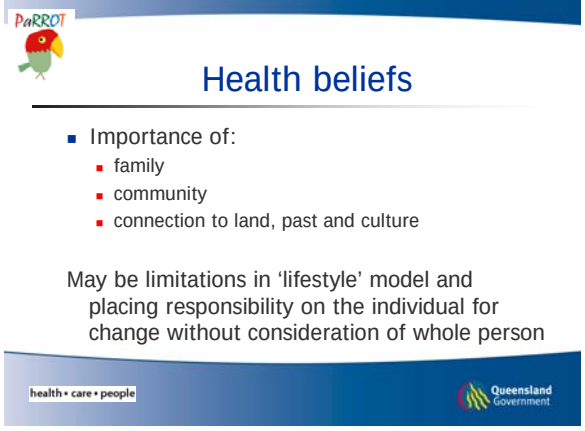
3. Employment and income

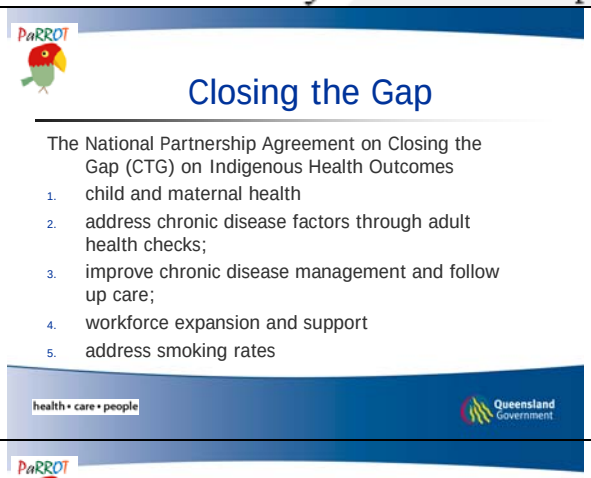
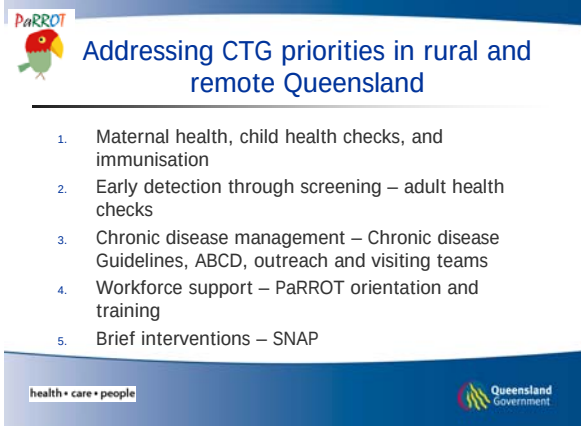
Unemployment rate for Indigenous males was 22% and for females 18%, compared to non-Indigenous rates of 7.7% and 6.5%.

Excluding those employed under Community Development Employment Program (CDEP) this rate would increase to around 34%

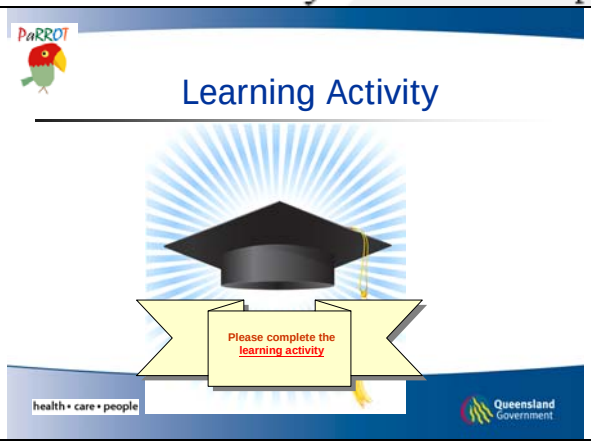
The median weekly family income for Aboriginal and Torres Strait Islanders was $630 compared to $1188 for non-Indigenous

(Couzos & Murray 2008)

Slide 6 **Areas of health concern**		**Notes:**
Slide 7 **Health beliefs**		**Notes:** Health beliefs form the basis for what we think cause ill health and the impacts ill health has on our lives. These beliefs are embedded within social and cultural contexts. Family, extended kinship, community, and connections to land, past and culture are prominent within Aboriginal and Torres Strait Islander health beliefs (Thompson and Gifford 2000). Socioeconomic disadvantage alone cannot be used as an indicator for increased risk for a chronic illness. A community in the Northern Territory that is connected to culture, family and land and that has the opportunity for self determination is able to demonstrate significantly lower risk factor prevalence, including reduced impaired glucose tolerance, smoking in men and hypercholesterolemia (Rowley, O'Dea et al 2008) Individual, family and community systems need to be considered when addressing individual risk factors, such as diet and exercise. Having an understanding of the meaning of what is being recommended is important. For example, exercise based interventions could focus on sport and everyday activity rather than individual based activities.

Slide 8 **Closing the Gap**		**Notes:**
Slide 9 **Addressing CTG priorities in rural and remote Queensland**		**Notes:** The Chronic Disease Strategy in rural and remote Queensland addresses the CTG priorities across the lifespan: Maternal health and antenatal care is an important component of a program to address the health of Aboriginal and Torres Strait Islanders. Ideally antenatal care will start in the first trimester and involve at least four visits. Child health checks are recommended at each immunisation visit and health check forms are available for each check at 1-6 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years and 5-14 years. Adult health checks provide evidence based screening and are available for 15-54 years and 55+ years. The screening tests and age for screening are based on population level risk. This with increased risk, for example a family history of diabetes, may need to be screened earlier or more frequently. The aim of primary health care is to keep people well. By identifying risk factors for chronic disease early, they can be addressed early, hopefully preventing progression or cause of a chronic disease. For example, if hyperlipidemia or high blood pressure is treated early, further progression of cardiovascular disease, or renal disease may be prevented. Once a chronic condition has been identified, the Chronic Disease Guidelines (and many other

		evidence based guidelines) provide management protocols to manage the conditions. This may involve follow up checks e.g. blood pressure, long term medication use and referral to other team members or specialists. The referral to other providers may involve visiting teams in the community, or travel to larger centres. A population register and recall system, such as Ferret, can assist in planning this care and following up on how well patients are managed. One program aimed at improving the quality of care that is provided in the PHC setting is the Audit and Best Practice for Chronic Disease (ABCD) program. This involves auditing clinical records, results interpretation and feedback, and action planning in a twelve month cycle. Workforce development requires significant investment from both the employer and the employee. The PaRROT program is an example of a workforce support program to assist in the orientation and training of those providing services in rural and remote PHC centres. This program can be used in conjunction with other online and District based orientation and clinical education and training. While CTG specifically address smoking as a major risk factor, poor nutrition, alcohol misuse and lack of physical activity are also risk factors for the development of chronic disease. These can be addressed firstly by asking the patient about them, then if required, providing a brief intervention based on the patients stage of change related to the risk factor.

Slide 10 **Learning Activity**		**Notes:**

Learning Activity - Participant

Information for Participants

This activity will be conducted as a large group activity which will be led by your facilitator. Please submit a copy of this to your facilitator who will scan and email it to parrot@health.qld.gov.au or fax it to 4033 3040 and keep a copy for your records.

Property	Setting
Total Number of Questions	2
Total Number of Questions to Ask	All

Questions

1. Patrick is an experienced remote area nurse, leading a multidisciplinary outreach team whose main role is managing clients with diagnosed chronic conditions in small Aboriginal communities in Queensland. He feels the approach of the team is not having any impact on clients' health and wants to review the service delivery model. He has spoken to the leaders and health team in one community who are happy to lead discussions and trial a different service model. What things should the team be considering in tackling the issue of poor health in the community?

Choice	
History of the Aboriginal and Torres Strait Islander population	
Racism	
Poverty and social class	
Income and social capital	
Education	
Employment and welfare	
Relationship to country	
Housing	
Policy processes	
Human rights issues	

2. How could the team change its approach to better manage the poor health of the community? *(Essay Question)*

Session 2

This unit has discussed the issues of Aboriginal and Torres Strait Islander health. It reinforces the fact that Aboriginal and Torres Strait Islander people experience inequality in health status and have a number of factors contributing to poor health including:

- Poor living conditions including overcrowding
- Lower economical status as a result of higher unemployment and lower education levels
- Social isolation
- Cultural diversity and
- Distance which impacts on their ability to access health services.

These facts, plus research evidence and the acknowledgement at government levels, that Aboriginal and Torres Strait Islanders do carry a high burden of chronic disease reinforces the need for any health service provided to Aboriginal and Torres Strait Islander communities, to provide a systems approach to service provision which is currently being implemented in some areas in Queensland [1-3]

Health practitioners working in the area need to be aware of the link between chronic disease, Aboriginal and Torres Strait Islander chronic disease and the systems approach. The next two units in this module look at comprehensive and selective primary health care which are essential elements in this approach, with the comprehensive primary health care focus on the prevention, early detection and management of chronic disease arguably the approach of choice [4-6]

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1. Queensland Health, *Queensland Strategy for Chronic Disease 2005-2015*. 2005, Queensland Health.
2. D'Abbs P, et al., *Implementing a chronic disease strategy in two remote Indigenous Australian settings: A multi-method pilot evaluation.* Australian Journal of Rural and Remote Health, 2008. **16**: p. 67-74.
3. Queensland Health and the Royal Flying Doctor Service (Queensland Section), *Chronic Disease Guidelines*. 2nd ed. 2007, Cairns.
4. McMurray A, *Community Health and Wellness, a sociological approach*. 2nd ed. 2003, Marickville: Elsevier.
5. Smith J, *Australia's Rural and Remote Health: a social justice perspective*. 2nd ed, ed. S. J. 2007, Croydon: Tertiary Press.
6. Talbot L and Verrinder G, *Promoting Health The Primary Health Care Approach*. 3rd ed. 2005, Marrickville: Elsevier.

Quiz - Participants

Information for Participants

Please complete the following quiz individually or in pairs. The scores for each question are indicated in the question. Information for your answers can be found in the session notes and or the presentation story board which are included in your participant package. Once the quiz has been completed, your facilitator will provide and answer sheet for you to self mark. The quiz should take 10 to 15 minutes to complete.

Your facilitator will scan and email the answer sheets to parrot@health.qld.gov.au or copy and fax to 40333040. They may keep a copy for themselves for their records and give the original copy to you for your records.

Property	Setting
Passing Score	60% or 15/25
Display Point Value	Yes

Questions

1. Please indicate which of the following statements are incorrect. *(Multiple Response Question, 6 points)*

Correct	Choice
	Aboriginal and Torres Strait Islanders are more likely to die as a baby
	Aboriginal and Torres Strait Islanders have the same life expectancy as non-Indigenous Australians
	Aboriginal and Torres Strait Islanders have equal access to health care as non-Indigenous Australians
	Aboriginal and Torres Strait Islander have a higher burden of disease
	Aboriginal and Torres Strait Islander are 5-7 times more likely to be hospitalised than non-Indigenous Australians

1. Social, economic and environmental factors all contribute to poor Aboriginal and Torres Strait Islander Health *(True/False Question, 1 point)*

Correct	Choice
	True
	False

3. A number of Aboriginal and Torres Strait Islander communities have poor food and water quality which impacts on their health. *(True/False Question, 1 point)*

Correct	Choice
	True
	False

4. Aboriginal and Torres Strait Islander health status is not impacted by education and income levels. *(True/False Question, 1 point)*

Correct	Choice
	True
	False

5. What are the main areas of concern identified in reviews of Aboriginal and Torres Strait Islander Health? *(Short answer Question, 10 points)*

6. What is required to provide effective health services to Aboriginal and Torres Strait Islander communities? *(Multiple Response 6 points)*

Correct	Choice
	Implement a 'whole person' approach
	Implement evidence-based medicine
	Continue to allow clinical staff to develop their own protocols
	Provide population based care
	Ensure the workforce is trained in primary health care
	Provide comprehensive primary health care
	Engage the community
	Provide medical led care

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D'Abbs P, Schmidt B, Dougherty K, & Senior K. (2008). Implementing a chronic disease strategy in two remote Indigenous Australian settings: A multi-method pilot evaluation. *Australian Journal of Rural and Remote Health, 16*, 67-74.

McMurray A. (2003). *Community Health and Wellness, a sociological approach* (2nd ed.). Marickville: Elsevier.

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World Health Organisation report, *Preventing Chronic Diseases a vital investment*. 2006

PaRROT Pathways to Rural and Remote Orientation and Training

a Primary Health Care approach to Chronic Disease

Orientation

Unit 15

Comprehensive Primary Health

SESSION 1

'Primary Health Care (PHC) is a framework to improve the world's health and is summarised in 1978 with the Declaration of Alma Ata [1], which can be found at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

'*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 health and detect 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'*(WHO 1978)

The Alma-Ata outlines the 10 fundamental principles for primary health care and was very much about the comprehensive primary health care approach, which viewed health from a holistic and social justice perspective. In Australia this translates into services that are affordable, accessible and appropriate [2, 3].

The concept of comprehensive primary health care was a reorientation from the existing medical model of care, to a model that emphasises the principles of equity, social justice, community control and working for social change in an effort to improve the health of the world population [3, 4]. It was often criticised as a utopian approach which was not achievable. Despite this, however, it is recognised that comprehensive primary health care will not only address health issues but will also address the root causes of poor health which is more affordable and sustainable in the long term.

The Ottawa charter goes one step further by clearly defining the 5 action areas required to address health issues, and includes approaches that incorporate both the comprehensive and selective models of care. The focus areas include:

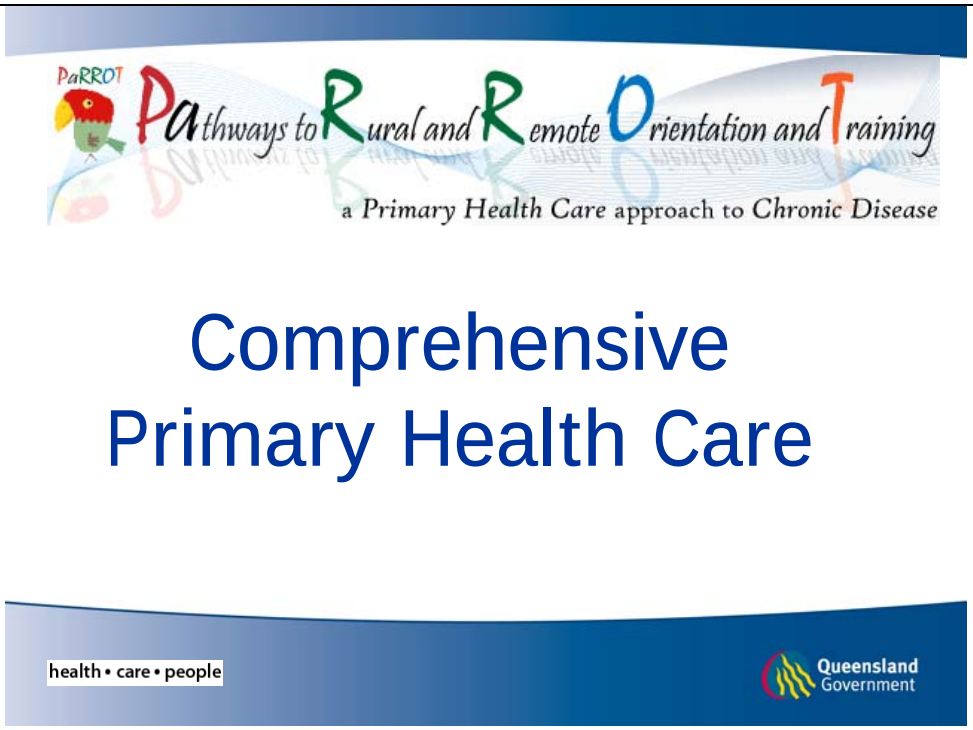
- Building healthy public policy
- Creating environments which support healthy living
- Strengthening community action
- Developing personal skills
- Reorienting health care [3, 4].

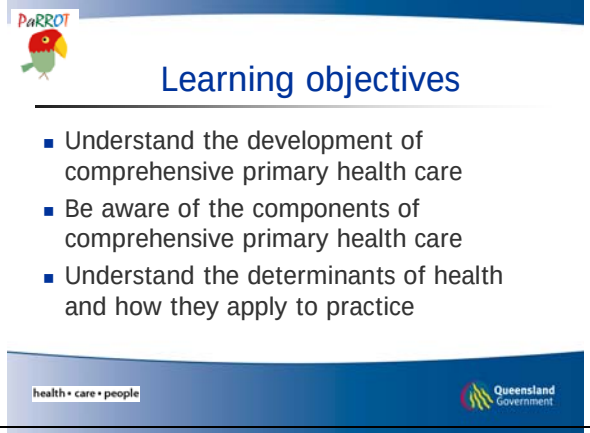
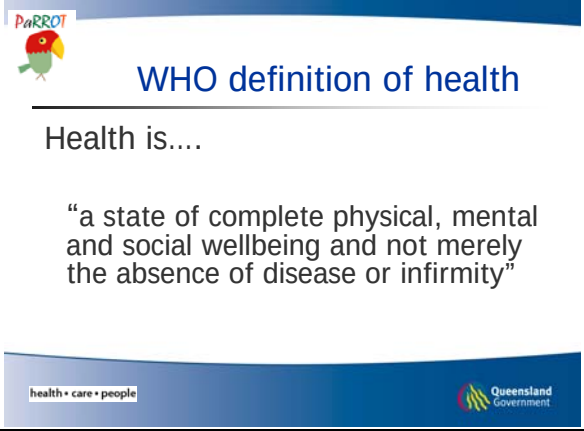
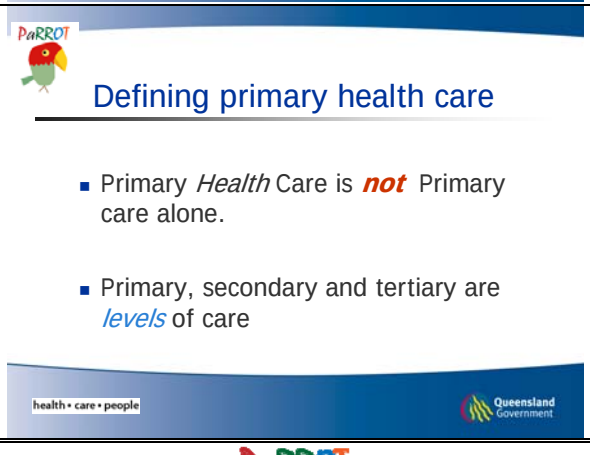
The Alma-Ata and the Ottawa charter are the bibles of primary health care, and as such will be covered in much more detail in the Induction section of the PaRROT program.

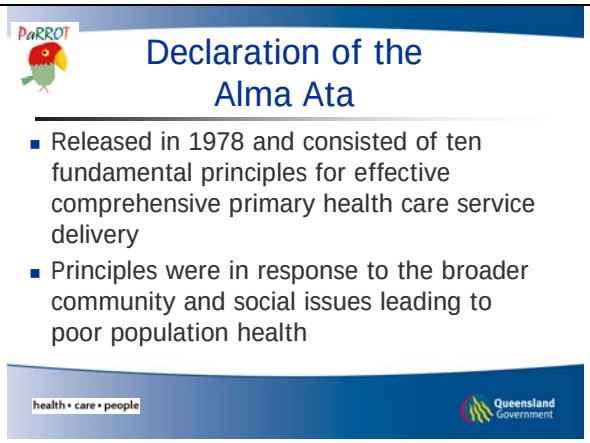
This unit will look briefly at the principles of comprehensive primary health care and will include some discussion on the social determinants of health which is the focus of the comprehensive primary health care approach.

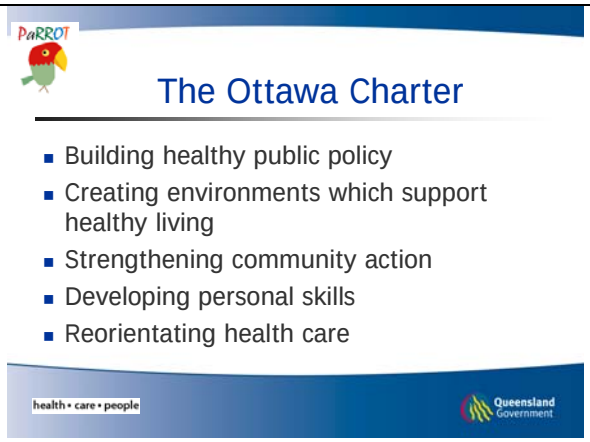
Bibliography

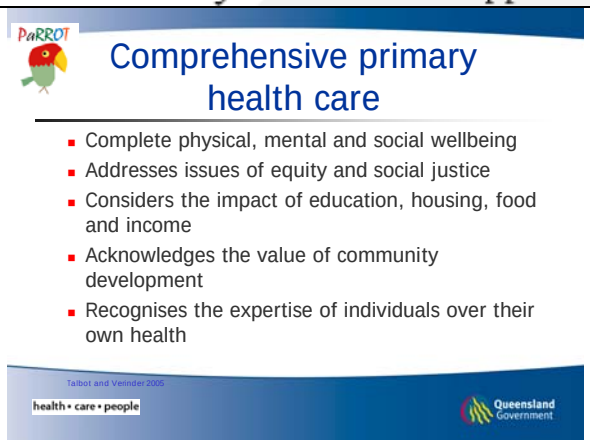
1. World Health Organisation, *Declaration of the Alma Ata*. 1978.
2. Smith J, *Australia's Rural and Remote Health: a social justice perspective*. 2nd ed, ed. S. J. 2007, Croydon: Tertiary Press.
3. McMurray A, *Community Health and Wellness, a sociological approach*. 2nd ed. 2003, Marickville: Elsevier.
4. Talbot L and Verrinder G, *Promoting Health The Primary Health Care Approach*. 3rd ed. 2005, Marrickville: Elsevier.

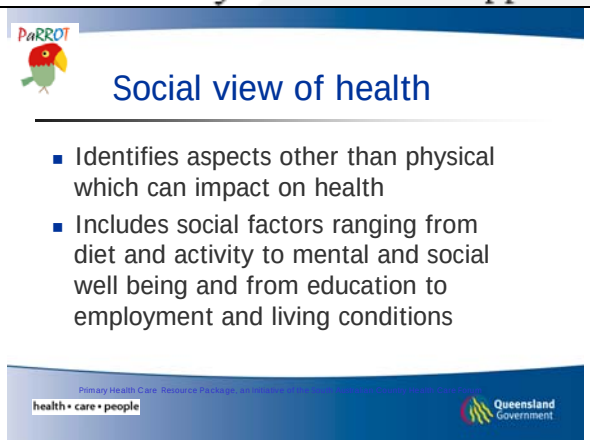

PaRROT Pathways to Rural and Remote Orientation and Training
a Primary Health Care approach to Chronic Disease
Comprehensive
Primary Health Care
health • care • people
Queensland Government

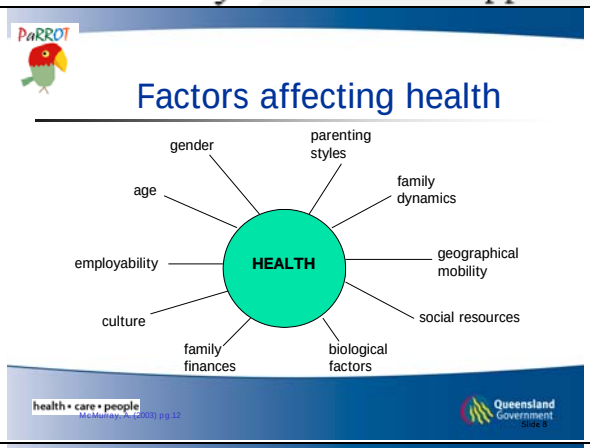
Slide 1 **Comprehensive Primary Health Care**		Notes:
Slide 2 **Learning objectives**		Notes:
Slide 3 **WHO definition of health**		Notes: In 1948 the World Health Organisation defined health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"
Slide 4 **Defining primary health care**		Notes: The terms primary health care (PHC) and primary care are often used interchangeably. While primary care may be seen as the first point of care in a community setting, PHC is the organisation of a full range of health care, from home to hospital, with prevention as equally important as cure. PHC

		should be universally available, person centred and supported by healthy public policies. Primary, secondary and tertiary care are levels of care that can be coordinated within the PHC setting: Primary care - general, on-going medical care such as seeing a GP for basic health care, check-ups, etc. Secondary health care - care provided in hospitals Tertiary health care – specialised medical services, usually in major centres In relation to PHC, the terms primary, secondary and tertiary are also used to describe prevention. For example, with heart disease, smoking cessation advice is primary prevention, treatment of high blood pressure is secondary prevention, and physical activity promotion with existing heart disease is tertiary prevention.
Slide 5 **Declaration of the Alma Ata**		Notes: In 1978 the World Health Organisation and the United Nations International Children's Emergency Fund held a conference on primary health care. The main outcome of the conference was the Declaration of Alma Ata which has ten fundamental principles of primary health care. They are: • Equity • Community participation • Use of socially accepted technology • Health promotion and disease prevention • Involvement of ALL

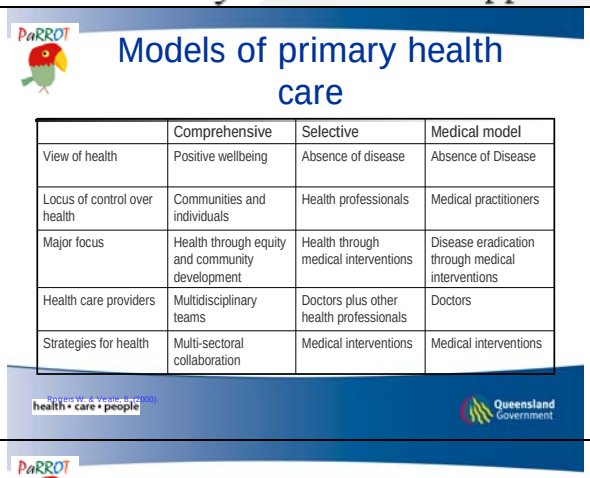
		government departments • Political action • Cooperation between countries • Redirection of funding to health • World peace. This challenged the world's nations to embrace the principles as way of overcoming health inequality and encouraged primary health care to become a main philosophy, and strategy for embracing health care.
Slide 6 **The Ottawa Charter**		Notes: The Ottawa Charter for Health Promotion was developed in 1986 at the first WHO International Conference on Health Promotion held in Ottawa, Canada. It supports the comprehensive primary health care approach and identifies 5 action areas designed to promote health. They are: • Building healthy public policy • Creating environments which support healthy living • Strengthening community action • Developing personal skills • Reorientating health care The Ottawa Charter was the defining document of the new public health movement.

Slide 7 **Comprehensive primary health care**		Notes: Comprehensive primary health care is aligned with the Declaration of Alma Ata, recognising the expertise of the individual and the importance of community or individual empowerment. Comprehensive primary health care is Complete physical, mental and social wellbeing Addresses issues of equity and social justice Considers the impact of education, housing, food and income Acknowledges the value of community development Recognises the expertise of individuals over their own health A comprehensive approach to chronic disease prevention, early intervention and management is preferable to a selective primary health care approach which is clinician controlled and usually initiated by a person presenting with a health problem.
Slide 8 **Comprehensive Primary Health Care** Duration: 00:00:29 Advance mode: Auto		Notes: Comprehensive primary health care includes identification and response to social factors which influence health which in turn impact on the key determinants of health. Some of these factors are able to be controlled and some are not. This is quite different to selective primary health care which defines health as the absence of disease and relies on treatment of conditions

Slide 9 **Social view of health**		Notes: The social view of health includes factors that can impact on health including diet, activity, housing, transport, local services, education, safety and income, support from family & community, feeling valued, and mental and social wellbeing. Access to health services, such as health professionals and hospitals is also considered within this view.
Slide 10 **Social determinants of health**		Notes: The WHO definition of comprehensive primary health care clearly identifies that the social determinants of health listed impact greatly on health. If we are to respond to ill health, we need to respond to the social determinants as well as the presenting problem. At least 90% of the health budget is spent on the provision of health services, including salaries, medication, laboratory testing, hospital care and health infrastructure. Because the social determinants are not only the responsibility of health, there is a good case for why health services need to work with other government departments, such as education and housing, and other organisations.

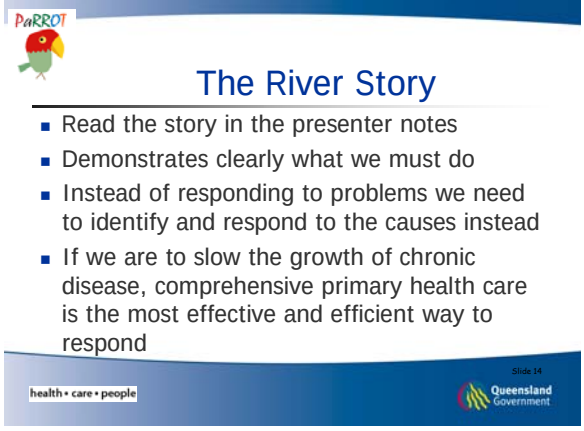
Slide 11  **Factors affecting health**		Notes: This diagram clearly summarises the determinants of health. In planning and providing comprehensive prevention, early detection and management services for chronic disease, there is a need to work with the community, other service providers and other government departments.
Slide 12  **Comprehensive primary health care**		Notes: Comprehensive Primary Health care is therefore. • An approach to health care that emphasises social justice, equity, community control and social change. • The emphasis is on identifying, intervening or managing factors that generate ill health not on intervention and treatment of health conditions. • It includes but is not limited to health promotion, education, early detection and intervention, treatment of acute episodes and ongoing management of chronic conditions. • Underpinning this is the acknowledgement and promotion of an Individual's expertise and right to manage their own health.

Slide 13
Models of primary health care

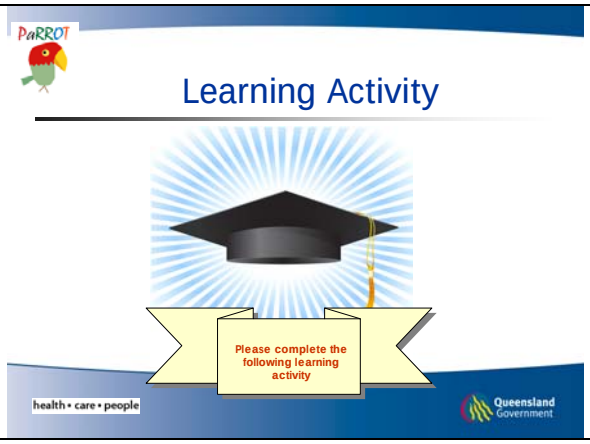


Notes:
This model shows very clearly the differences in the comprehensive and selective models of primary health care and the medical model of care which is still favoured today. The next unit on selective primary health care will explain these differences in more detail.

Slide 14
The River Story



Notes:
Once there was a fast flowing river. A person was walking past when they noticed people in the river – in trouble and drowning. The person tried to pull them out of the river, but as soon as one person was saved another person was seen to be in trouble. More people came to help people out of the water, but there seemed to be more and more people floating down the river in trouble. The rescuers were working harder and harder to save those drowning and felt they were getting nowhere. The problem was that while the rescuers were working so hard to save everyone in the river they were too busy to see why all the people were falling in!
The rescuers finally decided that it would be more useful to walk up the river and find out why people were falling in. When they got there, they saw the bridge upstream had collapsed and the unsuspecting people had fallen in.
It took a few short minutes for the rescuers to set up blockades to prevent people from reaching the bridge, therefore stopping all of those people from falling into the river and drowning!
It is important that we change

		our thinking to support this approach and that we do all we can to work with the community and other service providers to influence those making decisions about health care provision in rural and remote areas. However, unlike the use of the barricades, the outcomes of a comprehensive primary health care approach could take years to appear. In the interim we need to find innovative ways to show outcomes.
Slide 15 **Learning Activity**		Notes:

Learning Activity - Participant

Information for Participants

This activity will be conducted as a small or large group discussion. Please record the group discussion on this page and keep the original for your records. Your facilitator will copy, scan and email it to parrot@health.qld.gov.au or fax it to 4033 3040.

Quiz Settings

Property	Setting
Total Number of Questions	1
Total Number of Questions to Ask	All

Questions

1. **Please match the social determinants of health with its health benefit.**

Social Determinant	Health Benefit
Income	Ability to afford to pay for choices
Social status	Ability to get a fulfilling job
Stress	Control over life
Early childhood development	Decreases likelihood of chronic disease development
Education	Decreases stress
Employment and work conditions	Disease control
Social Support	Healthy growth and development
Physical environment	Healthy work environment
Transport	Impacts on self esteem
Diet and lifestyle choices	Increases choice

SESSION 2

This unit has introduced the concept of comprehensive primary health care and identified some components of the approach to health care from a sociological perspective.

Rogers and Veale (2000) have clearly defined the differences in selective and primary health care, which will be discussed in more detail in the next unit. Comprehensive primary health care is supported by the Alma-Ata which identifies 10 fundamental principles which can be mapped into general areas of community development, sustainability, health promotion, health education and public health. Comprehensive primary health care calls for the achievement of the highest level of health for the greatest number of people [1] and focuses very much on the individual or the community taking ownership of their health and their environment.

As health practitioners we need to aspire to this level of health care, and can begin by approaching the health care we deliver based on the principles of the Alma-Ata. We cannot ignore the influence of the selective model of care which will be covered in the next unit, but where possible we need to ensure that the community and our clients retain ownership over their health decisions.

We also need to remember that health is ***"a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity"*** – this definition needs to be firmly planted in our mind so that we can go forth and work within the comprehensive primary health care model of service delivery.

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1. McMurray A, *Community Health and Wellness, a sociological approach*. 2nd ed. 2003, Marickville: Elsevier.

Rogers W. Veale B (2000). Primary Health Care and General Practice - A scoping report. Bedford Park, Department of General Practice, Flinders University.

Quiz - Participant

Information for Participants

You will be allowed 10 to 15 minutes to complete this quiz. Information on the questions can be found in the session notes and presentation story board. Your facilitator will advise if you do the quiz individually or in pairs. Once the quiz has been completed, you will be given an answer sheet to self mark.

Your facilitator will scan and email the answer sheets to parrot@health.qld.gov.au or copy and fax to 40333040. You can choose to keep a copy for yourself and give the original to the participants for their records.

Property	Setting
Passing Score	60% or 17/28
Total Number of Questions	6
Total Number of Questions to Ask	All

Questions

1. In what year was comprehensive primary health care first defined? *(2 points)*

---

2. What was the World Health Organisation's definition of comprehensive primary health care? *(10 points,)*

---

3. The WHO definition of comprehensive primary health care clearly identifies that the social determinants of health impact greatly on health. If we are to respond to ill health, we need to respond to the social determinants not just the presenting problem - in this way we are getting to the root of the problem rather than responding to the symptoms. *(True or False 2 points,)*

	True
	False

4. The Ottawa Charter for Health promotion was developed in 1976 at the first WHO International conference on Health Promotion held in Ottawa Canada it supports the comprehensive Primary Health Care Approach and identifies 5 action areas designed to promote health *(True/False Question, 2 points,)*

	True
	False

5. Which of the following action areas designed to promote health are included in the Ottawa Charter (5 correct answers)? *(Multiple Response 10 points, 2 points each)*

Correct	Choice
	Building Healthy Public Policy
	Creating environments which support healthy living
	Developing personal skills
	Giving Medical Officers greater responsibility for health
	Increased focus on the greatest health needs
	Increased health education
	Increased spending on nutrition programs
	Increasing spending on hospitals
	Reorientating health care
	Strengthening community action

6. The social determinants of health are: (Please indicate the correct answer/s)
(Multiple Choice Question, 10 points,)

Correct	Choice
	Income and social status
	Stress - control over our life
	Early childhood development and education
	Employment and work conditions
	Social Support
	Physical environment
	Exercise and transport
	Diet and lifestyle choices
	None of the above
	All of the above

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Rogers W. Veale B (2000). Primary Health Care and General Practice - A scoping report. Bedford Park, Department of General Practice, Flinders University.

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PaRROT

Pathways to Rural and Remote Orientation and Training

a Primary Health Care approach to Chronic Disease

Orientation

Unit 16

Selective Primary Health Care

Session 1

Selective primary health care is a version of the medical model of care and is much more like the medical model than comprehensive primary health care. However, there are still some similarities between the selective and comprehensive models of care including:

- Holistic understanding and recognition of multiple determinants of health
- Equity of access
- Community participation
- Health promotion and disease prevention focus
- Accessible, affordable and acceptable
- Locally based services
- Integrated approach

[1-4].

The difference is more philosophical, comprehensive primary health care focuses on the principles of equity, social justice, community control and working for social change in order to impact positively on health status. Comprehensive primary health care is therefore very much community led where selective primary health care is led by health professionals and focuses on the identification and treatment of illness [2].

Selective primary health care was originally developed as an interim strategy between the medical model and comprehensive primary health care. Four factors were identified to guide the process and included growth monitoring, oral re-hydration therapy, breast feeding and immunisation. Other interventions around family planning, female education and food supplementation were added a few years later [5]. Although selective primary health care was only ever meant to provide interim measures, it continues to evolve and has become the model now supported by the Australian Government.

The comprehensive primary health care view of health is positive well being with the major focus being health through equity and community empowerment, the selective approach is more about the absence of disease through eradication and medical interventions [3]

Like the comprehensive primary health care approach, the selective primary health care approach has a role to play in achieving health outcomes for all. It has produced important gains in immunisation, disease control and eradication, but remains limited in its effectiveness as it does not address the social determinants of health.

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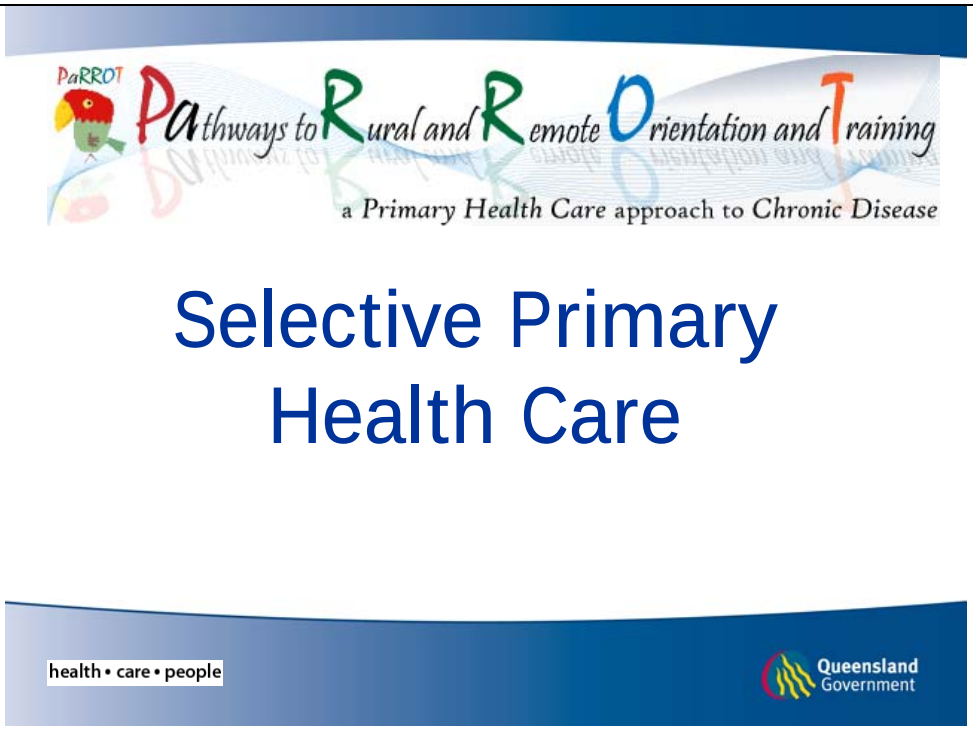
1. University of New South Wales. *PHC Connect - Defining Primary Health Care*. 2009 [cited 2009 March 2009]; Available from: http://www.phcconnect.edu.au/defining_primary_health_care.htm.

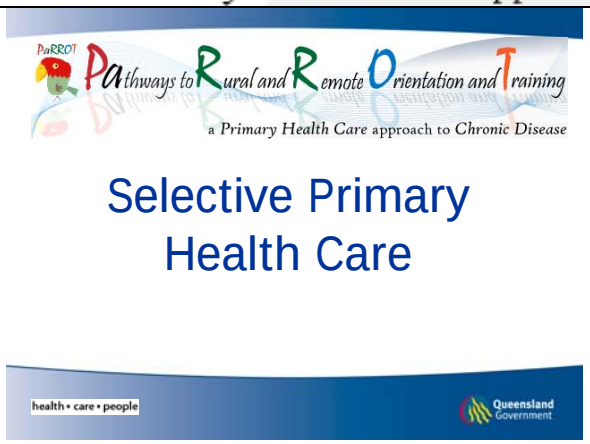
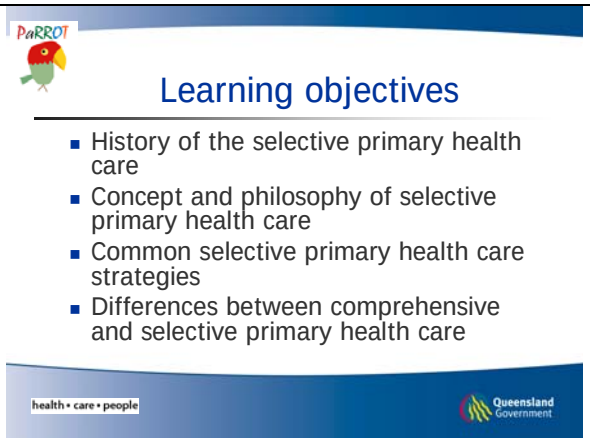
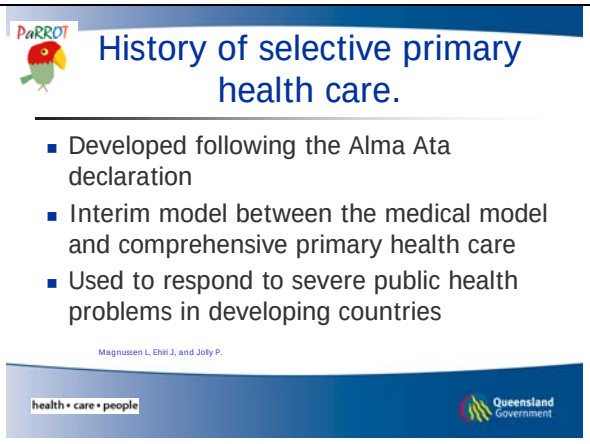
2. Talbot L and Verrinder G, *Promoting Health The Primary Health Care Approach*. 3rd ed. 2005, Marrickville: Elsevier.

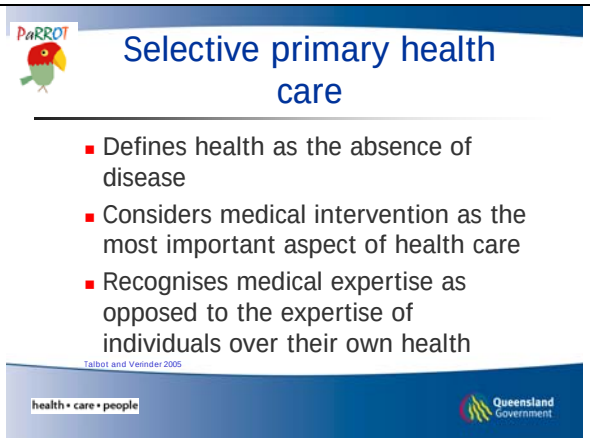
3. Primary Health Care Research & Information Services. *InfoBytes Primary Health Care*. 2009 [cited 2009; Available from: www.phcris.or.au/infobytes/about_phc.php.

4. Rogers W. Veale B, *Primary Health Care and General Practice - A scoping report*. 2000, Department of General Practice, Flinders University: Bedford Park.

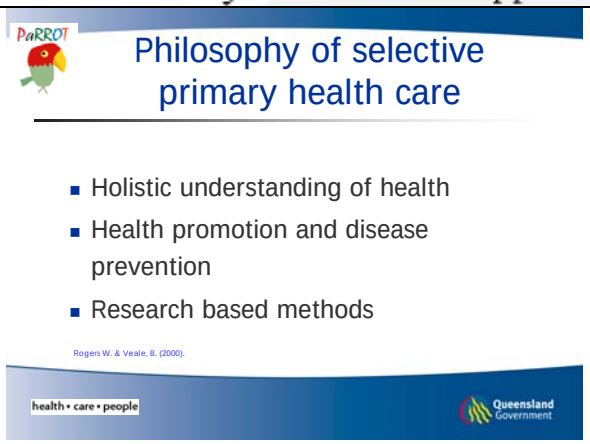
5. Magnussen L. Ehiri J. Jolly P, *Comprehensive versus selective primary health care: Lessons for global health policy.* Health Affairs. **23**(3): p. 167-176.


PaRROT Pathways to Rural and Remote Orientation and Training
a Primary Health Care approach to Chronic Disease
Selective Primary Health Care
health • care • people
Queensland Government

Slide 1 **Selective Primary Health Care**		**Notes:** Welcome to this unit on selective primary health care. My name is Mary King and I am the Manager of the Pathways to Rural and Remote Orientation and Training Program which is based in the Office of Rural and Remote Health in Cairns. The previous presentation looked at comprehensive primary health care and briefly mentioned the partner concept of selective primary health care. This unit will provide a lot more detail on what has become known as selective primary health care.
Slide 2 **Learning objectives**		**Notes:** The learning objectives of this presentation are to: Develop knowledge of the history of the selective primary health care Understand the concept and philosophy of selective primary health care Have knowledge of common selective primary health care strategies and to Understand differences between comprehensive and selective primary health care
Slide 3 **History of selective primary health care.**		**Notes:** Selective Primary Health Care was developed following the Alma Ata declaration. It was originally presented as an interim measure of health service delivery while the medical model was being phased out and the comprehensive primary health care model was being phased in. The model proposed a selective attack on the most severe public health

		problems in developing countries which included growth monitoring, use of oral re-hydration therapy, breast feeding and immunisation. A couple of years later family planning, female education and food supplementation were added.
Slide 4 **Selective primary health care**		**Notes:** Over the years, selective primary health care has further evolved, and is now a model of health care delivery in its own right. The approach was embraced by the medical services and became known as the medical model of primary health care. Selective primary health care relies much more on the expertise of health professionals, with the absence or presence of disease forming the basis of an individual's state of health. Selective Primary Health Care: Defines health as the absence of disease and relies on treatment of conditions Considers medical intervention as the most important aspect of health care Is less likely to consider what impact education, housing, income and food has on health Recognises medical expertise as opposed to the expertise of individuals over their own health

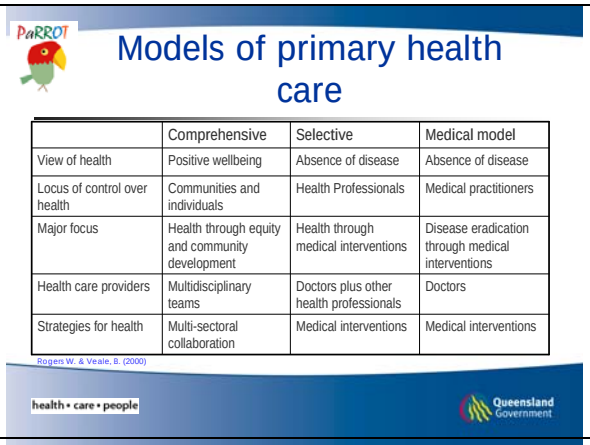
Slide 5
Philosophy of selective primary health care



Notes:
Like comprehensive primary health care, selective primary health care philosophy acknowledges a holistic understanding of health, the importance of health promotion and disease prevention and research based methods of care.

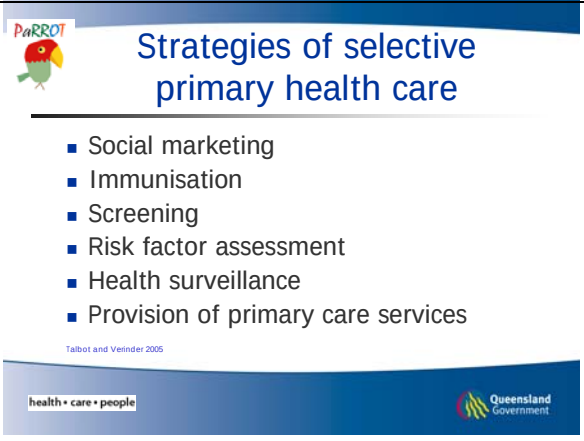
Unlike comprehensive primary health care, selective primary health care does not recognise multiple determinants of health, community control over health services, the importance of equity in health care and the need to provide accessible, acceptable and affordable services.

Slide 6
Models of primary health care



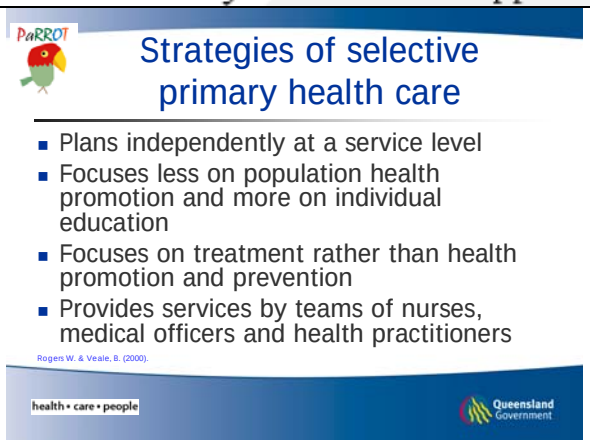
Notes:
The table on this slide, which was introduced in the comprehensive primary health care unit, clearly demonstrates the differences in approach for comprehensive and selective primary health care and the medical model of health.

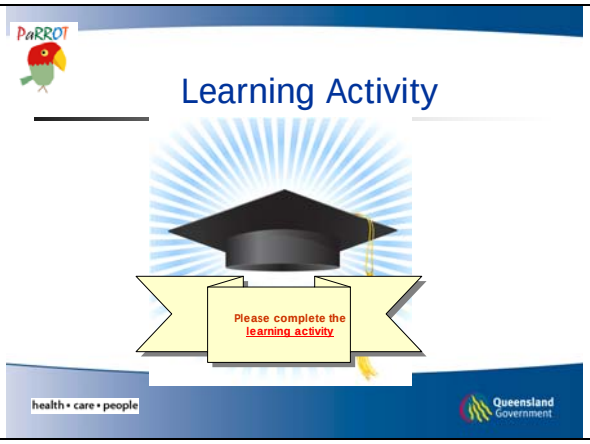
Slide 7
Strategies of selective primary health care



Notes:
There are a number of strategies associated with the provision of selective primary health care. They include
Social Marketing with a disease or condition focus as opposed to that of general focus eg national awareness programs such as the Queensland Government drink driving campaign rather than one that might look at ensuring good water supplies.
Immunisation programs

		which are universally available and developed to reduce the spread of vaccine preventable diseases across targeted populations Screening which aims to identify specific conditions in targeted groups before symptoms appear. It can include general health checks or checks specific to diseases such as bowel cancer, cervical cancer or childhood screening for hearing or vision problems Risk Factor Assessment is similar to screening but it looks at early markers or risk factors that may result in the development of chronic disease, the most common process is the well child or persons health check Health Surveillance which is the process of monitoring risks, responding to threats and improving preparedness for epidemic prone and emerging diseases. An excellent example of this is the Influenza pandemic preparation which began a couple of years ago and has now evolved into the current swine flu outbreak and world wide response. Provision of primary care services in which a client presents, usually with a health problem, and the health professionals work with the client to manage the problem.

Slide 8 **Strategies of selective primary health care**		**Notes:** Strategies underpinning the provision of selective and comprehensive primary health care differ at a number of levels. Selective primary health care is more likely to plan independently at a service level, provide individual education, focus on treatment rather than health promotion and prevention with multidisciplinary health teams consisting of medical officers, nurses and health practitioners providing health servcies. Comprehensive primary health care, on the other hand, plans collaboratively at community level, provides population based health promotion, focuses on prevention, early detection, intervention and treatment and has extended multidisciplinary multi agency teams working collaboratively with the community and other agencies to provide a wide range of related services
Slide 9 **Strategies of selective primary health care**		**Notes:** Selective primary health also differs from comprehensive primary health care in that: It does not emphasise social justice, equity, community control and social change. Rather than identify, intervene or manage factors that generate ill health, selective primary health care focuses on intervention and treatment of health conditions. Early detection, intervention and treatment of acute episodes and ongoing management of chronic conditions is the usual approach to chronic disease care. Underpinning this is belief

		that the health professional has the expertise so they manage the health of the client as opposed to the client managing their own health.
Slide 10 **Service provision**		**Notes:** Although selective and comprehensive primary health care have different philosophies and strategic approaches, at the service provision level there are many similarities. Both approaches are locally based, generally affordable and accessible, integrated and provide services from health care teams. They also provide health education, disease prevention, illness treatment and rehabilitation services. These similarities provide the basis for the confusion surrounding the two approaches to primary health care. However, they remain philosophically very different to each other, but both approaches have a role to play in the overall provision of primary health care services.
Slide 11 **Learning Activity**		**Notes:**

Learning Activity - Participant

Information for Participants

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Property	Setting
Total Number of Questions	1
Total Number of Questions to Ask	All

Question

1. Please identify the Primary Health Care Model which matches the statements outlining the intervention in the first column.

Type of intervention	Model of Primary Health Care
Respond to overcrowding	
Respond to outbreaks of infection	
Provide social marketing programs	
Respond to food supply issues	
Respond to poor water supply	
Respond to poor housing standards	
Respond to outbreaks of disease	

Session 2

This and the previous unit have briefly looked at the similarities and differences between selective and comprehensive primary health care.

Over the past 10 years a number of initiatives across the health sector have been developed in an attempt to make health care more efficient, effective and sustainable. In response a number of models of delivery fro primary health care have evolved ranging from community control to general practice [1]. The majority of the models unsurprisingly have leant towards selective primary health care, with the recently released report by the National Preventative Health Taskforce [2] reinforcing.

The ideal approach to chronic disease prevention is comprehensive primary health care, as it is more sustainable and effective in the long term, so as primary health care practitioners we need to aspire to this goal.

However, we cannot discount the value in the selective approach, which is the preferred model for governments and health practitioner groups. Funding is very much based on selective primary health care services, so in developing programs in the primary health care setting, we need to ensure we keep this in mind.

Bibliography

1. McDonald J. Cumming J. Harris MF. Powell Davies G. Burns P, *Systematic review of comprehensive models of primary health care* 2006, Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine: Canberra.
2. National Preventative Health Taskforce, *Australia the Healthiest Country by 2020*, N.P.H. Taskforce, Editor. 2009, Commonwealth of Australia.

Quiz - Participant

Information for Participants

You will be allowed 10 to 15 minutes to complete this quiz. Information on the questions can be found in the session notes and presentation story board. Your facilitator will advise if you do the quiz individually or in pairs. Once the quiz has been completed, you will be given an answer sheet to self mark.

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Property	Setting
Passing Score	60% or 24/40
Display Point Value	Yes
Total Number of Questions	4
Total Number of Questions to Ask	All

Questions

1. What was the reason for the development of the selective model of primary health care? *(Short answer question 10 points)*

2. Please match the statement with its primary health care model *(10 points)*

Statement	Primary Health Care model
Views health as the absence of disease	
Gives control to communities	
Sees health as medical interventions	
Views health as positive well being	
Gives control to health professionals	

3. Which of the following statements are true of the philosophy of selective primary health care? *(Multiple Response Question, 10 points)*

Correct	Choice
	Defines health as the absence of disease and relies on treatment of conditions
	Considers medical intervention as the most important aspect of health care
	Is less likely to consider what impact education, housing, income and food has on health
	Recognises medical expertise as opposed to the expertise of individuals over their own health
	Defines health as a state of complete well being
	Does not consider the impact of social factors on health
	Acknowledges the importance of equity in health care
	Recognises multiple determinants of health

4. Which of the following are strategies used in the provision of selective primary health care? *(Multiple Response Question, 10 points)*

Correct	Choice
	Social marketing with a disease prevention focus
	Health surveillance
	Primary care services
	Environmental health assessment
	Immunisation programs
	Water purification
	Screening programs

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PaRROT

Pathways to Rural and Remote Orientation and Training

a Primary Health Care approach to Chronic Disease

Orientation

Unit 17

Introduction to Health Checks

Session 1

Australia is currently in the grips of a chronic disease epidemic. Diabetes, cardio- respiratory, renal disease and cancer are the four major causes of morbidity and preliminary death and have been identified as the focus for initial action in Queensland [1]. Chronic disease development is usually preceded by chronic conditions like overweight or obesity, hypertension, and underlying lifestyles factors including poor nutrition an inactive lifestyle, tobacco use and alcohol misuse [1]. Mental illnesses including depression all add to the mix[2] .

Screening and early intervention for early markers of chronic disease are effective preventative strategies for the development of chronic illnesses [1, 2]. In response to this, state and commonwealth health organisations and funding bodies have begun to invest large sums of money and resources into screening programs. Example of these programs include, breast, cervical and bowel cancer screening. initiatives and the development of claimable Medicare items attached to individual health screening activities (For more information see Medicare – RRMBS unit).

Information on cancer screening programs can be found at the following sites.
Breast cancer screening
http://access.health.qld.gov.au/hid/Cancer/BreastCancer/breastCancerScreeningWhatYouShouldKnow_fs.asp
Cervical cancer
http://www.health.qld.gov.au/cervicalscreening/default.asp
Bowel cancer
http://www.health.qld.gov.au/bowelcancer/default.asp

A number of screening tools have also been developed over the past couple of years in response to this approach. The Well Child and Adult Health Checks and the supporting Chronic Disease Guidelines are two such tools, which have been developed and extensively trialled in rural and remote Queensland. These resources are evidence based and have been developed to meet the mandatory requirements of Medicare. The recommended frequency on most of the checks is annually in high risk populations and less frequently in populations with a lower risk.

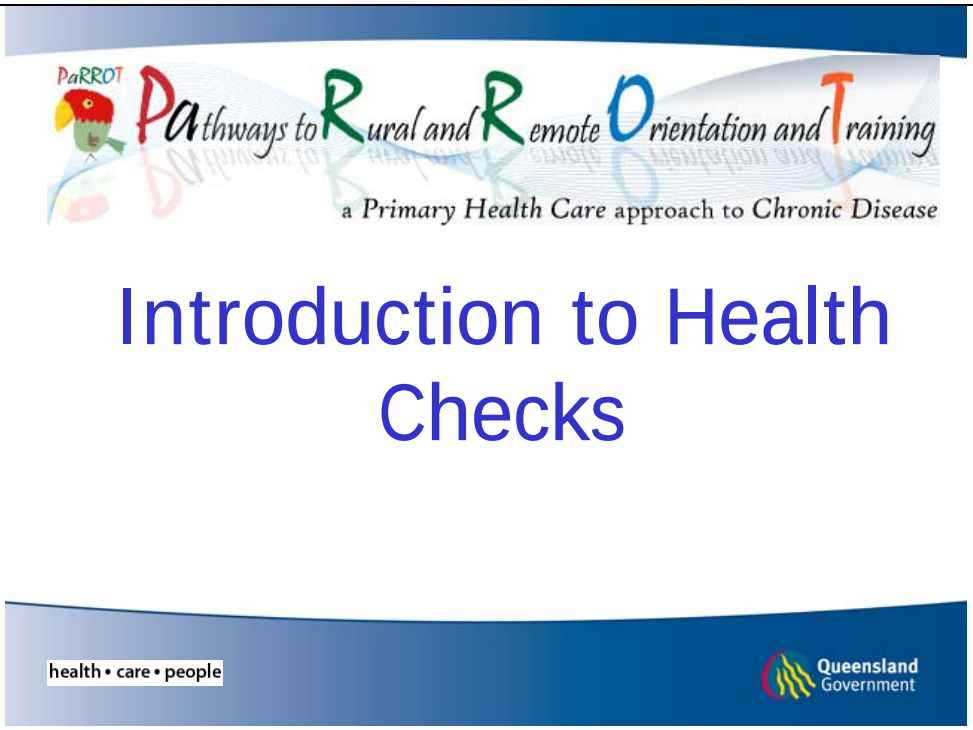
Health check tools can be found at
http://www.health.qld.gov.au/orrh/html/phc_resources.asp and
The chronic disease guidelines – health check section at
http://qheps.health.qld.gov.au/nahs/clinical/programs/docs/cd_guidelines_sec_4.pdf

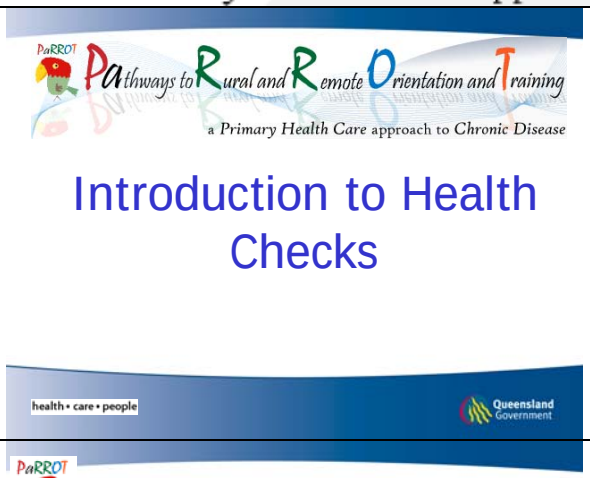
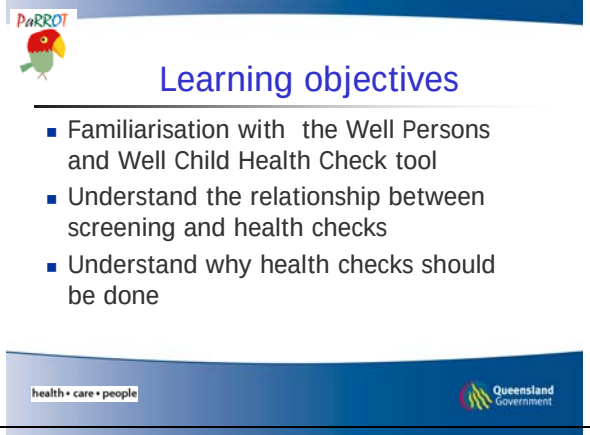
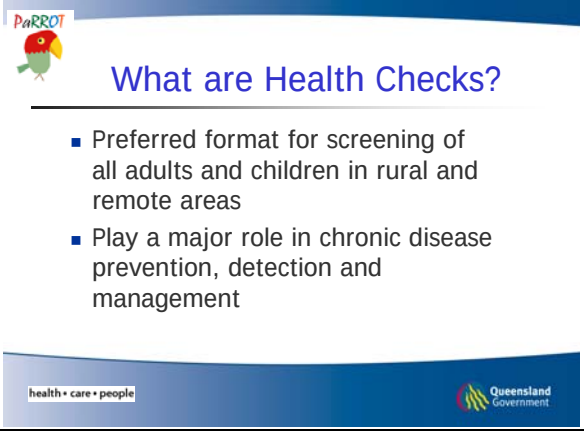
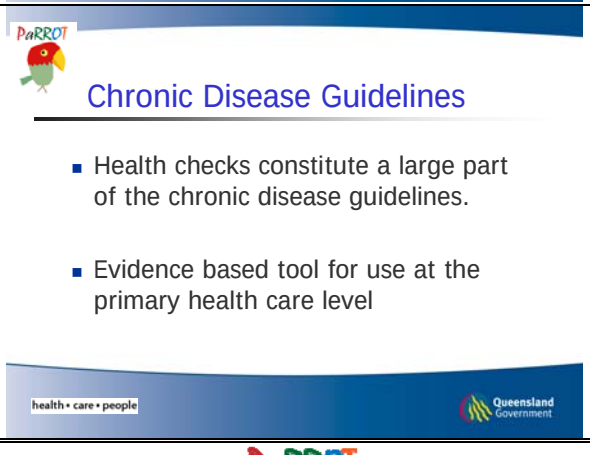
This unit introduces the concept of health checks using the well child and adult health check tools. Much more detailed units will be included in the Induction module of the PaRROT program.

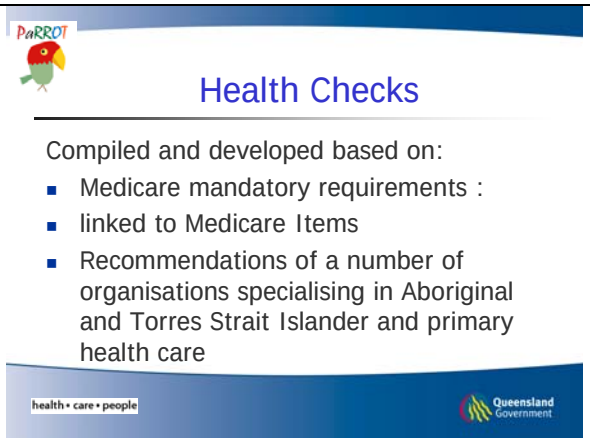
Bibliography

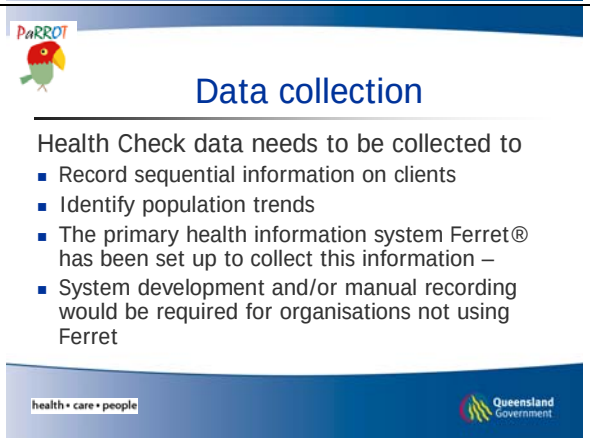
1. Queensland Health, *Queensland Strategy for Chronic Disease 2005-2015*. 2005, Queensland Health.

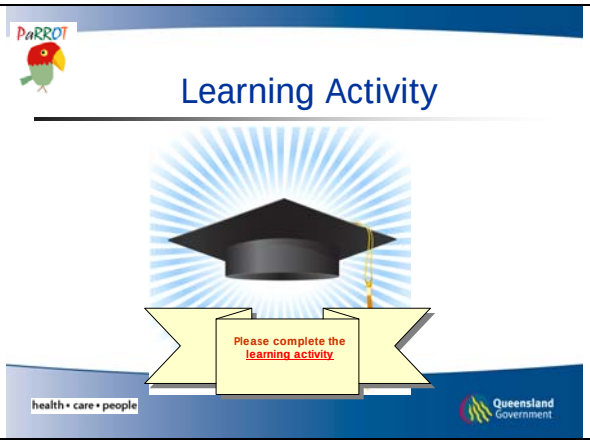
2. Queensland Health and the Royal Flying Doctor Service (Queensland Section), *Chronic Disease Guidelines*. 2nd ed. 2007, Cairns.


PaRROT Pathways to Rural and Remote Orientation and Training
a Primary Health Care approach to Chronic Disease
Introduction to Health Checks
health • care • people
Queensland Government

Slide 1 **Introduction to Health Checks**		**Notes:**
Slide 2 **Learning objectives**		**Notes:**
Slide 3 **What are Health Checks?**		**Notes:** Well persons and well child health checks are a systematic approach to screening adults and children in rural and remote areas. The aim of the checks is to identify the early markers for the development of chronic conditions which, if left untreated are likely to result in the development of chronic disease.
Slide 4 **Slide 4**		**Notes:** Health checks are included in the Chronic Disease Guidelines. It is based on current evidence and the needs of the population and is for use at Primary Health Care level. A technical reference group, clinicians and the clinical networks have input into the guidelines. The Guidelines are

		supported by: The Primary Clinical Care Manual Pathology Handbook Electronic patient information recall system (Ferret). Partnerships are also important, with current partnerships including North Queensland GP Partnership since 2003 CHIC Monitoring and evaluation is required with the ABCD Hub supporting quality improvement. ABCD is a QI program specifically designed for the population approach health care and was developed by Menzies school of population health in NT.
Slide 5 **Health Checks**		**Notes:** Health Checks were compiled and developed based on Medicare mandatory requirements and are linked to Medicare Items 708 , 709, 710, 717, 704, 706, 700 and 702. They are also based on recommendations by: Office of Aboriginal and Torres Strait Islander Health Queensland Aboriginal and Torres Strait Islander Health Council RACGP – Royal Australian College of GP's Local experts (HW's, RN's, MO's and Specialists National and international standards, research and quality evidence reviews.

Slide 6 **Why do we need to screen?**		**Notes:** We need to screen so we can Monitor a child's growth and development throughout childhood Monitor the health status of children, adolescents and adults Identify and respond to risk factors and health problems prior to the development of chronic disease. Respond to health problems early to prevent further complications in adult life.
Slide 7 **Why are they needed?**		**Notes:** The reason we need to do health checks particularly in rural and remote Australia is in response to Poor health of individuals Poor health of population Higher than average infant mortality rate Decreased life expectancy in Aboriginal and Torres Strait Islander population
Slide 8 **Data collection**		**Notes:** The Primary Health Information System Ferret® is used to collect health check data which can then be collated and analysed and used to identify individuals who are at risk, population health trends including prevalence of risk factors, chronic conditions and chronic disease in communities and populations. It is important that all health practitioners completing health checks record them on Ferret®.

		If Ferret® is not used in a community, then other systems including manual collection and collation should be developed. Registers are one effective way of doing this.
Slide 9 **Learning Activity**		**Notes:**

Learning Activity - Participant

Information for Participants

This activity will be conducted as a small or large group discussion. Please record the group discussion on this page and keep the original for your records. Your facilitator will copy, scan and email it to parrot@health.qld.gov.au or fax it to 4033 3040.

Property	Setting
Total Number of Questions	3
Total Number of Questions to Ask	All

Questions

1. **In order to ensure your primary health care client group - including children, youth, adults and the older population are screened regularly; systems need to be in place to allow this to happen.**

Correct	Choice
	True
	False

2. **How would you promote screening?**

Correct	Choice
	Newsletters, posters and pamphlets
	Fact sheets
	Multimedia
	Community activities
	Workplace
	All of the above

3. **How could you provide screening?**

Correct	Choice
	Planned program
	Incorporate into another program
	Opportunistically
	Community activity day
	Screening days
	All of the above

Session 2

The well child and adult health checks provide a means to individually screen adults and children, but when used in conjunction with Ferret®, enables a health service to collect population data which can be collated and used to identify population health issues and assist with the planning of health services.

Considerable research has been conducted on mass screening of individuals, with some finding mass screening in healthy populations is not effective or efficient, but in populations who have been identified as “high risk”, it has found to be effective[1, 2]. Clinicians working in rural and remote areas with “high risk” populations are encouraged to conduct regular screening programs.

This unit has looked briefly at health checks which one of the tools used for screening adults and children. Health checks are the preferred tool for Queensland Health in North Queensland, but there are many other tools that have been developed and used by health practitioners across Australia.

Some of those tools include the ones used for Healthy for Life, those developed by the Federal Department of Health and Aging (DOHA) to complement the Medicare item numbers, and some developed by the National Rural Health Alliance which is used by General Practice.

Although it is preferred that standard tools are used across the state to allow comparative data to be collected, the reality is that it doesn’t really matter which tool is used for screening, so long as it is evidence based and meets Medicare requirements. It is more important for health practitioners to adopt an approach to preventative health care which includes a regular screening program incorporated into every day practice.

Bibliography

1. D'Abbs P, et al., *Implementing a chronic disease strategy in two remote Indigenous Australian settings: A multi-method pilot evaluation.* Australian Journal of Rural and Remote Health, 2008. **16**: p. 67-74.

2. Queensland Health and the Royal Flying Doctor Service (Queensland Section), *Chronic Disease Guidelines*. 2nd ed. 2007, Cairns.

Quiz - Participant

Information for Participants

You will be allowed 10 to 15 minutes to complete this quiz. Information on the questions can be found in the session notes and presentation story board. Your facilitator will advise if you do the quiz individually or in pairs. Once the quiz has been completed, you will be given an answer sheet to self mark.

Your facilitator will scan and email the answer sheets to parrot@health.qld.gov.au or copy and fax to 40333040. You can choose to keep a copy for yourself and give the original to the participants for their records.

Property	Setting
Passing Score	60% or 24/40
Display Point Value	Yes
Total Number of Questions	4

Questions

1. How are the Health Checks, Medicare and Chronic disease connected?
(Short Answer Question 10 points)

2. Which of the following are ways in which screening can be provided? *(Multiple Response Question, 10 points)*

Correct	Choice
	Opportunistically
	Self initiated by a well person
	Initiated by clinicians
	Targeting a specific section of the community
	Mass screening over a short period of time

3. How often can we claim the following from Medicare? *(10 points*

Correct		Choice
1	Aboriginal baby under 18 months	Once only
2	Aboriginal child between 2 and 5	Every 9 months
3	Non-Indigenous well child between 2 and 5	Annually
4	Healthy 56 year old non-Indigenous female	Annually
5	75 year old male	Every 2 years

4. How can data collected on health checks be utilised? *(Short Answer 10 points)*

BIBLIOGRAPHY

Queensland Health (2005). *Queensland Strategy for Chronic Disease 2005-2015*. Retrieved. from http://www.health.qld.gov.au/chronicdisease/documents/strat2005to15_full.pdf.

Queensland Health and the Royal Flying Doctor Service (Queensland Section). (2007). *Chronic Disease Guidelines* (2nd ed.). Cairns.