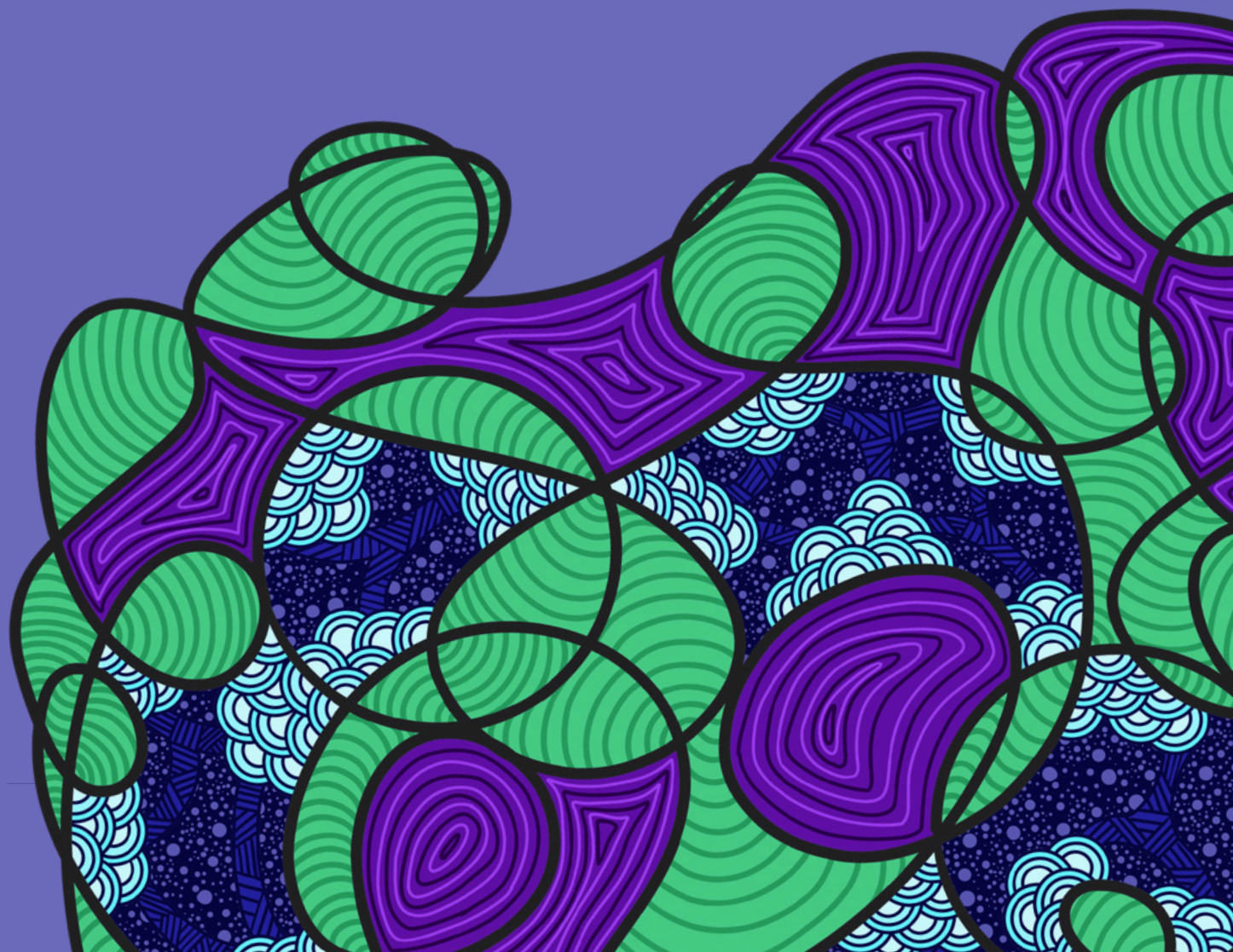
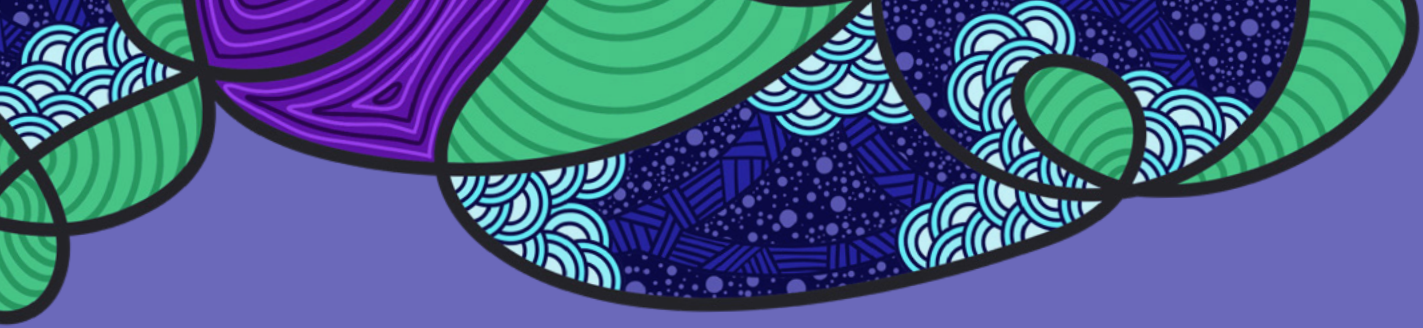


Aboriginal Community
Controlled Health Services

A Handbook for Clinicians

Last updated April 2026





The Aboriginal Health Council of Western Australia acknowledges the traditional custodians of the land we are located on, the Whadjuk people of the Noongar nation, and their continuing connection to the land, waters and community.

We pay our respects to all Aboriginal and Torres Strait Islander communities and their cultures; and to Elders past, present and emerging.

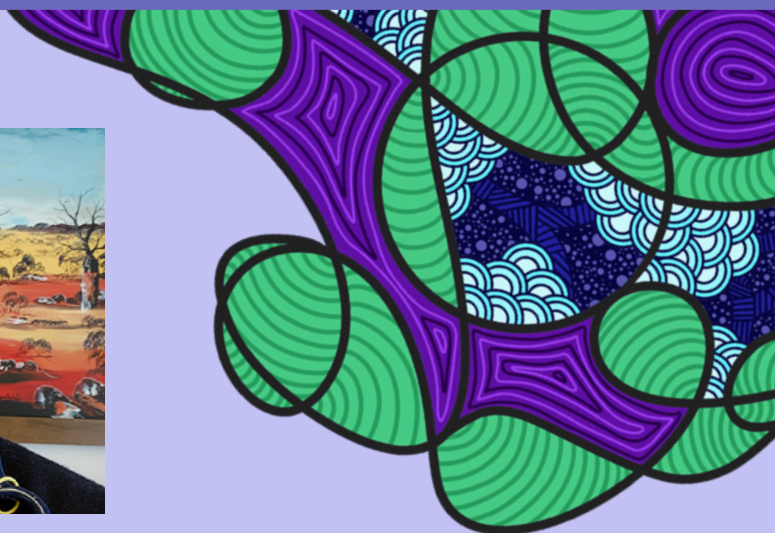


Wandjoo Bidi (Welcome Pathways) 2026 by Ashley Spratt, Whadjuk & Yuet Noongar

Wandjoo Bidi means Welcome Pathways. It is an invitation to enter with respect, listen carefully, and walk gently on Country.

This artwork represents welcome and movement across Country. There are different shapes making up the different pathways and shows the many journeys' people take coming together, separating, and meeting again. No path is straight, and no one walks alone.

The blue path, the darker blue with the lighter dots are memory and story, the blue half circles are the many communities with pathways between them. The purple path, are the meeting places of yarning, rest, and connection where people are seen, heard, and welcomed. The green pathway represents healing, care, and support, lines showing how people can move through services at their own pace.



Dr Daniel Hunt, Jaru & Indjibarndi

AHCWA Medical Advisor and Contributing Author

Working at Derbarl Yerrigan Health Service on Whadjuk Noongar Boodjar for almost a decade has been one of the greatest privileges of my career. Over the years I've had the opportunity to serve in many roles - Dentist, GP registrar, Deputy Medical Director and Acting Chief Executive Officer - and I'm grateful to have completed my entire GP training within one organisation that is so deeply connected to community.

The ACCHS Sector offers a clinical experience like no other. You're not only providing complex, holistic care; you're also part of community events, public health initiatives, advocacy work, and the broader movement for better outcomes for Aboriginal and Torres Strait Islander peoples. It's a place where clinical practice and community responsibility naturally intersect.

As an Aboriginal GP, the privilege runs even deeper. Derbarl was my first GP clinic as a patient, and years later I found myself caring for Elders who once held me as a baby, and working alongside staff who used to babysit me. That sense of community is something unique to the ACCHS Sector.

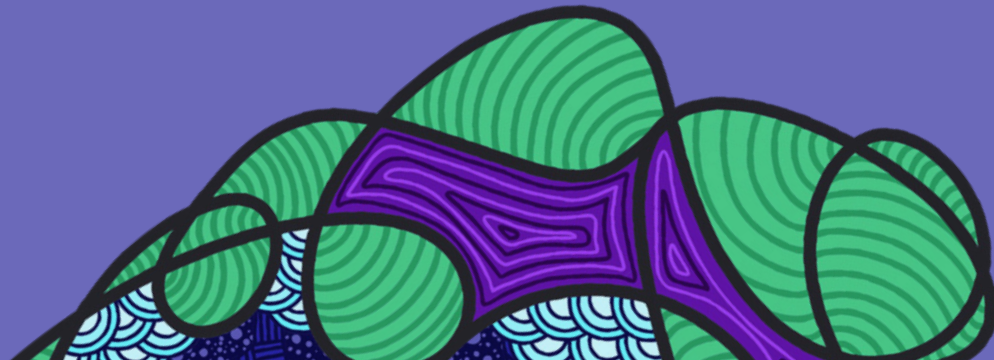
Working in an ACCHS is something unique; it's a genuine act of service. I would encourage any GP to consider it. The professional growth, the community connection, and the privilege of being trusted in this space are unlike anything else in medicine.



Using this Handbook

Text shaded in grey is information specific to WA. This information should be updated by other jurisdictions where this Handbook is adapted by NACCHO affiliates from other Australian states or territories.

The WA-specific version of this Handbook will be reviewed annually for any required updates to content and hyperlinks. Please be aware that as the health system landscape changes, some information may become out of date – use hyperlinks or ask a trusted colleague to check for new information or changes.



Contents

Welcome	1
Acronyms	4
Chapter 1 Aboriginal Community Controlled Health Services	9
Chapter 2 Cultural Security	15
Chapter 3 Australian Health System	21
Chapter 4 Referrals	27
Chapter 5 Funding	33
Chapter 6 Medicare Benefits Schedule	39
Chapter 7 Medicines	47
Chapter 8 Continuous Quality Improvement	54
Chapter 9 Digital Health	58
Chapter 10 Public Health	64
Chapter 11 Regulatory Processes	69
Chapter 12 Medical Training, Teaching and Research	75
Chapter 13 Special Conditions	79
Chapter 14 Self-Care	87
Appendix Getting Ready to Start: A Checklist for GPs	90

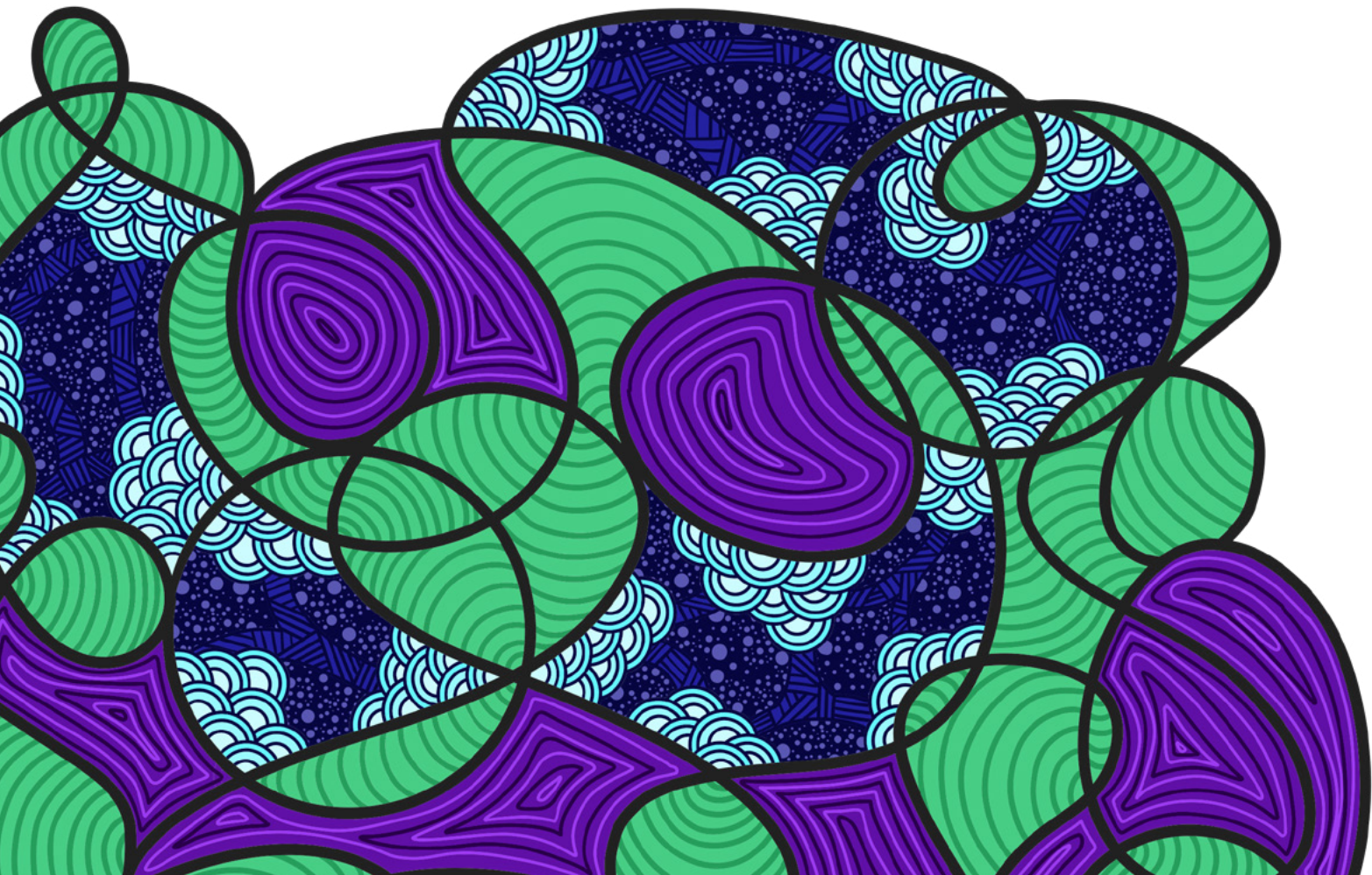
Welcome



The Aboriginal Community Controlled Health Service (ACCHS) Sector is a great place to work. In fact, the Royal Australian College of General Practitioners (RACGP) [Health of the Nation Report](#) found that General Practitioners (GPs) working in Aboriginal and Torres Strait Islander health settings (including ACCHS) are the most satisfied GPs in Australia.

There is much to look forward to when starting work in an ACCHS for the first time, including the opportunity to contribute to true team-based care, where health needs can be addressed comprehensively, often in one place, by spending quality time with patients, their families and the wider community.

Clinicians in ACCHS are also uniquely positioned to learn from their patients and colleagues, particularly about the richness and diversity of Aboriginal and Torres Strait Islander culture, and to grow in providing culturally safe care. In ACCHS, the clinician's role is much broader than caring directly for patients alone – teaching, research, advocacy, health promotion and continuous quality improvement are other aspects of primary health care that many clinicians have the opportunity to become involved in.



Purpose

This Handbook has been written for GPs joining the ACCHS Sector in Australia – including International Medical Graduates (IMGs) navigating the Australian health system for the first time.

There is a lot to learn about when starting work in an ACCHS, particularly for IMGs where the whole health system may be new. This Handbook serves as an introduction to key clinical, administrative and cultural aspects of working in an ACCHS, and aims to support (not replace) local onboarding and orientation processes. Much of the content will also be relevant for other ACCHS clinicians.

While it might seem overwhelming at the start, please remember that as a new clinician you are not expected to know everything at the

beginning. There is always someone to ask and support is available. All new clinicians should identify trusted colleagues they can reach out to within their workplace early on when starting work. Additionally, there are many online resources to turn to for specific questions, of which many are linked within this Handbook.

Importantly, this Handbook aims to demonstrate how Aboriginal and Torres Strait Islander Community Control works in practice in our Sector. Each ACCHS is unique in how it implements the Model of Care shared by all ACCHS – with the local community controlling how healthcare is designed and delivered to their community. Clinicians play an important role in contributing their skills and knowledge to their local ACCHS Model of Care.



Disclaimer

While every effort has been made to provide up-to-date and accurate information, this Handbook is provided as guidance only. The ACCHS Sector is diverse.

In Western Australia (WA) alone, there are 24 unique services,

each governed by their local community to meet specific needs. Clinicians must take care to understand how the information presented here applies to their local context and should always check for updates to clinical guidelines, government programs and state or territory specific legislation. Where they are uncertain, clinicians are strongly encouraged to seek advice from an experienced ACCHS clinician or practice manager.

Terminology

In alignment with best practice, this Handbook uses the term Aboriginal and Torres Strait Islander people.

The term Aboriginal person is also respectfully used, when relevant, to acknowledge Aboriginal people as the original inhabitants and custodians of WA.

The term First Nations is used respectfully to refer to the First Peoples of Australia, particularly when this term is used regarding government programs. The term Indigenous is used only where it has been used by government as part of a program or service name, or in referring to non-Indigenous people.

The terms ACCHS and ACCHOs are often used interchangeably.

ACCHS is the preferred term for member organisations of the Aboriginal Health Council of Western Australia (AHCWA).

The National Aboriginal Community Controlled Health Organisation (NACCHO) refer to their sector members as Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ACCHOs).

The broader term Aboriginal Medical Service (AMS) is also sometimes used to refer to ACCHS (and some ACCHS include AMS in their name), however AMS may also refer to Aboriginal-specific services that are not controlled by the community. Other (non-health) community-controlled organisations are referred to as Aboriginal Community Controlled Organisations (ACCOs). Please note that different terms may be used by different states and territories.

Appreciation

We gratefully acknowledge and appreciate the contributions of both Aboriginal and non-Indigenous GPs with extensive experience in the ACCHS Sector who contributed to the writing and review of this Handbook.

We also recognise the vital role of the broader ACCHS workforce, including Aboriginal and Torres Strait Islander Health Workers (AHWs), Aboriginal and Torres Strait Islander Health Practitioners (AHPs) and other Aboriginal staff whose cultural and clinical expertise is a critical enabler of the ACCHS Model of Care.

Finally, we acknowledge the Boards of NACCHO and AHCWA, and the communities they represent, who supported the writing of this Handbook and whose commitment to self-determination and Community Control makes this holistic model possible.

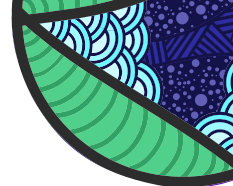


Acronyms



Acronym / Term	Definition and Context
ACCHS / ACCHO	Aboriginal Community Controlled Health Services / Organisations; community-led primary health services addressing health inequities.
ACR	Albumin-Creatinine Ratio; a urine test used to screen for and monitor Chronic Kidney Disease.
ACRRM	Australian College of Rural and Remote Medicine; a specialist college for medical practitioners.
AFB	Acid-Fast Bacilli; used in the context of sputum collection and initial investigation of Tuberculosis.
AHD	Advance Health Directive; a legally-binding document outlining future treatment decisions.
AHCWA	Aboriginal Health Council of Western Australia; the peak body for Aboriginal health in WA and the state NACCHO affiliate organisation in WA.
AHP	Aboriginal and Torres Strait Islander Health Practitioner; a nationally regulated, culturally based clinical workforce role.
AHW	Aboriginal and Torres Strait Islander Health Worker; a culturally based workforce role delivering clinical and non-clinical care.
Ahpra	Australian Health Practitioner Regulation Agency; the authority responsible for regulating health professions in Australia.
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies; provides a map representing Indigenous language and social groups.
AIHW	Australian Institute of Health and Welfare; produces reports using aggregated health data.
AIR	Australian Immunisation Register; the national whole-of-life immunisation register.
AMC	Australian Medical Council; accredits Australian medical programs and assesses International Medical Graduates seeking registration to practise in Australia.
AOD	Alcohol and Other Drug; an abbreviation often used when referring to services that support people with substance use disorders.
APSGN	Acute Post-Streptococcal Glomerulonephritis; an acute kidney condition following a Group A Streptococcal infection.
ARF	Acute Rheumatic Fever; an abnormal immune response to Group A Streptococcal infection of the throat or skin.
ASL	Active Script List; a digital list of a patient's active prescriptions.
BBi	Bulk Billing Incentive; an additional MBS payment for services that are bulk billed.
BBV	Blood-borne Virus; infections transmitted through blood, such as HIV and Hepatitis B or C.
CCMP	Chronic Condition Management Plan; a structured approach to managing chronic conditions (MBS Item 965).

CKD	Chronic Kidney Disease ; common in Aboriginal and Torres Strait Islander communities, often secondary to diabetes or hypertension.
COPD	Chronic Obstructive Pulmonary Disease ; a progressive, treatable but irreversible lung disease causing restricted airflow.
CPD	Continuous Professional Development ; annual learning requirements for registered health practitioners.
CQI	Continuous Quality Improvement ; the process of using data to analyse and improve the quality of patient care.
CRS	Central Referral Service ; the system used in WA to allocate public specialist referrals.
CSOM	Chronic Suppurative Otitis Media ; a severe form of ear infection that can lead to permanent hearing loss.
CTG	Closing the Gap ; an agreement to achieve health equity; also refers to a PBS co-payment program for medicines.
DAA	Dose Administration Aid ; devices like blister packs used to organise medicine doses (e.g. Webster-Pak).
DSP	Disability Support Pension ; financial support for people with permanent conditions that prevent them from working.
ECG	Electrocardiogram ; a diagnostic test often as part of point-of-care testing.
ED	Emergency Department ; a hospital's 24/7 unit for immediate care of severe injuries, illnesses and life-threatening conditions (also known as Accident and Emergency).
EPG	Enduring Power of Guardianship ; a legal document nominating a guardian to make personal and treatment decisions.
GAS	Group A Streptococcus ; the bacteria responsible for infections that can lead to ARF and APSGN.
GP	General Practitioner or General Practice ; the medical specialist and setting providing acute and chronic primary care services in Australia.
HbA1c	Glycated Haemoglobin ; a blood test used for the screening and management of Type 2 Diabetes.
HMR	Home Medicines Review ; a clinical process where a pharmacist reviews a patient's medications at home.
HPOS	Health Professional Online Service ; a portal for practitioners to interact with Services Australia.
HSP	Health Service Provider ; the geographically-based organisations (Local Hospital Networks) that manage public hospitals in WA.
HTLV-1	Human T-Lymphotropic Virus Type 1 ; a retrovirus with high prevalence in some central Australian communities.



IAHP	Indigenous Australians' Health Programme ; the primary Australian Government program for funding ACCHS.
IDAA	Indigenous Dose Administration Aids ; a program that allows eligible patients to access medicine organisers (like Webster-Paks) for free through community pharmacies.
iFOBT	Immunochemical Faecal Occult Blood Test ; the home-based test kit used for the National Bowel Cancer Screening Program.
IMG	International Medical Graduate ; medical practitioners trained outside of Australia who are a vital part of the rural workforce and often subject to the 10-year moratorium.
ITC	Integrated Team Care ; a program providing care coordination and funding for medical aids for chronic disease patients.
KICA	Kimberley Indigenous Cognitive Assessment ; a validated, culturally appropriate screening tool for cognitive impairment.
KMMS	Kimberley Mums Mood Scale ; a culturally appropriate perinatal depression and anxiety screening tool.
KRT	Kidney Replacement Therapy ; relevant to the high rates of end-stage kidney disease and the need for dialysis or transplantation.
LDCT	Low Dose Computed Tomography ; the specific imaging used in the National Lung Cancer Screening Program.
MBS	Medicare Benefits Schedule ; the list of health services subsidised by the Australian Government.
MDO	Medical Defence Organisation ; provides professional indemnity insurance for medical practitioners.
MHR	My Health Record ; Australia's voluntary and patient-accessible national secure online summary of key patient health information.
MHTP	Mental Health Treatment Plan ; a specific MBS-subsidised plan that allows patients to access up to 10 appointments with a mental health professional.
MM	Modified Monash Model ; a classification system (1–7) used to define how rural or remote a location is.
MPH	Master of Public Health ; a qualification required to start Advance Public Health Medicine training.
NACCHO	National Aboriginal Community Controlled Health Organisation ; the national peak body for the ACCHS Sector.
NDIA	National Disability Insurance Agency ; the government agency that manages the NDIS.
NDIS	National Disability Insurance Scheme ; Australia's major program for disability support for those aged 9 to 65.
NIP	National Immunisation Program ; provides a series of free vaccines across the life course to eligible people.

nKPIs	National Key Performance Indicators ; data indicators used to track health progress in IAHP-funded services.
NP	Nurse Practitioner ; Registered Nurse with the experience, expertise and authority to diagnose and treat people of all ages with a variety of acute and chronic health conditions as endorsed by the Nursing and Midwifery Board of Australia.
OSR	Online Services Report ; an annual report on health service characteristics and staffing.
PATS	Patient Assisted Travel Scheme ; financial assistance for travel and accommodation for regional patients.
PBB	Protracted Bacterial Bronchitis ; a precursor to bronchiectasis in children, identified by a chronic wet cough.
PBS	Pharmaceutical Benefits Scheme ; the government program that subsidises the cost of essential medicines.
PCR	Polymerase Chain Reaction ; used for point-of-care testing of STIs and respiratory viruses.
PHN	Primary Health Network ; Australian Government-funded organisations that commission local health services and support primary care.
PIMS	Patient Information Management System ; the clinical software used to manage patient records, billing and nKPI reporting in ACCHS, such as Communicare or MMEx.
PIP	Practice Incentives Program ; Australian Government payments to support quality care and practice capacity.
POCT	Point-of-Care Testing ; diagnostic tests performed on-site at the clinic rather than in a distant laboratory.
PRODA	Provider Digital Access ; an online identity verification and authentication system for government services.
QAAMS	Quality Assurance in Aboriginal and Torres Strait Islander Medical Services ; the program that enables point-of-care testing for HbA1c and urine ACR in many ACCHS.
QUM	Quality Use of Medicines ; a policy pillar focused on using medicines safely and effectively.
RAAHS	Remote Area Aboriginal Health Service ; the S100 program providing free PBS medicines in remote areas through Aboriginal Health Services.
RACGP	Royal Australian College of General Practitioners ; sets accreditation standards for general practices, trains GPs and is the largest professional organisation for GPs in Australia.
RCS	Rural Clinical School ; university-affiliated rural training programs for medical students, which aim to assist with the shortage of medical practitioners in rural Australia.
RFDS	Royal Flying Doctor Service ; provides aeromedical retrieval and GP services in remote parts of Australia.

RHD	Rheumatic Heart Disease ; permanent damage to heart valves caused by episodes of Acute Rheumatic Fever.
RTO	Registered Training Organisation ; delivers nationally recognised training in the Vocational Education and Training sector.
RTPM	Real-Time Prescribing Monitoring ; digital systems used to track the prescribing of high-risk monitored medicines.
RWA	Rural Workforce Agency ; organisations that support the rural health workforce.
SASA	Structured Administration and Supply Arrangement ; authorises non-prescribers to supply or administer medicines in WA.
SEWB	Social and Emotional Wellbeing ; a holistic term used by Aboriginal and Torres Strait Islander people and communities to describe the social, emotional, spiritual, and cultural wellbeing of a person.
SMO	Senior Medical Officer ; a Fellowed GP who holds clinical leadership and governance responsibilities within an ACCHS.
STI	Sexually Transmitted Infection ; includes conditions like chlamydia, gonorrhoea, and syphilis.
VAD	Voluntary Assisted Dying ; a lawful process in WA and other states for eligible patients.
WACHS	WA Country Health Service ; the Health Service Provider covering all of WA outside metropolitan Perth.
WAPHA	WA Primary Health Alliance ; the Primary Health Network in WA.
WIP	Workforce Incentive Program ; payments to support multidisciplinary teams and rural practitioners.
WWC	Working with Children ; a compulsory screening check for people working with children.

Chapter 1 Aboriginal Community Controlled Health Services

Aboriginal Community Controlled Health Services (ACCHS) are community-built and led [primary health](#) services, which play a major role in addressing health inequities and improving health outcomes for Aboriginal and Torres Strait Islander people in Australia.

Health practitioners new to Australia may be unfamiliar with the historical, political and social factors that have contributed to inequality in health and socioeconomic

outcomes experienced by many Aboriginal and Torres Strait Islander people today. While these are explored further in Chapter 2, this chapter will address how the ACCHS Sector works differently to mainstream health services to holistically support the health and wellbeing of Aboriginal and Torres Strait Islander people in Australia, beyond the biomedical model of healthcare.

Aboriginal and Torres Strait Islander People

Aboriginal and Torres Strait Islander people are the First Peoples of Australia and have continued to practice their culture here for more than 60,000 years. Aboriginal people originate from mainland Australia, including Tasmania and other islands, while Torres Strait Islander people come from a region between the tip of Cape York and Papua New Guinea made up of more than 2,000 islands. Aboriginal and Torres Strait Islander people represent around 4 per cent of the Australian population, with the majority living in cities and regional areas, although the proportion of Aboriginal

people and/or Torres Strait Islander people within the broader population is greater in remote areas¹.

There is great diversity in Aboriginal culture across Australia. Prior to European colonisation more than 250 languages and 800 dialects were spoken and approximately 120 languages are still spoken today. The [AIATSIS Map of Indigenous Australia](#) is an important resource which visually represents the language, social or nation groups of Aboriginal Australia.

Respectful terminology

- Using 'Aboriginal and Torres Strait Islander people' or 'Aboriginal person' or 'Torres Strait Islander person' are most often considered best practice. These terms should never be abbreviated.
- The term 'First Nations' is also often used to respectfully refer to Aboriginal and Torres Strait Islander people as the First Peoples of Australia.

¹[AIHW: Indigenous Australians](#)



Identifying as Aboriginal and /or Torres Strait Islander

Aboriginal people may identify themselves by language group, traditional Country (relating to specific lands or place)², ways that relate to their Country, or by their regional identity. Cultural identity remains tied to a person's cultural and ancestral homelands, which may not be where the person is currently living. Torres Strait Islander people may identify themselves by specific islands, tribes, family groups and/or sea country³.

For example, the [Yawuru people are the traditional custodians of the lands and waters in and around Rubibi \(Broome\)](#) in the Kimberley region of Western Australia (WA). [The Noongar people are the original inhabitants of the south-west of WA](#), and are made up of 14 different language groups.

The Royal Australian College of General Practitioners (RACGP) in its position statement on [Identification of Aboriginal and Torres Strait Islander people in Australian general practice](#) outlines that 'effective identification of Aboriginal and Torres Strait Islander people is a crucial first step in providing high-quality, culturally responsive healthcare'. Self-reporting is the most accurate means of identifying an individual's Aboriginal and/or Torres Strait Islander status and it is best practice for general practices to ask all patients a standard question 'Are you of Aboriginal or Torres Strait Islander origin?' and record this within the clinical record.

At ACCHS, confirmation of Aboriginal and/or Torres Strait Islander identity is usually guided by organisational policies and is typically completed during the registration process by administrative staff.

Practice tip: Aboriginal and/or Torres Strait Islander identity is personal to the individual and self-identification should be respected by all clinicians. More formal identification processes may be used by some government and non-government programs to determine eligibility for Aboriginal and Torres Strait Islander-specific services, but the oversight of these processes sit with Aboriginal communities (not non-Indigenous staff or clinicians).

Aboriginal and Torres Strait Islander Health

The Aboriginal and Torres Strait Islander definition of good health, is not only the absence of disease or illness, but includes the physical, social, emotional, cultural, spiritual and ecological wellbeing of individuals and the whole community. It emphasises the connectedness between these factors, and recognises the impact that social and cultural determinants have on health⁴.

Aboriginal and Torres Strait Islander people experience burden of disease at more than twice the rate of non-Indigenous people in Australia. Major contributors to this

disproportionate burden include mental health and substance use disorders, injuries, cardiovascular disease, cancer and respiratory disease⁵. Many chronic conditions are more common among Aboriginal and Torres Strait Islander people, and often occur at a younger age, including type 2 diabetes mellitus, chronic kidney disease and chronic obstructive pulmonary disease (COPD). Children are disproportionately impacted by conditions such as chronic otitis media, which contributes to hearing loss at a young age. There continues to be a gap in life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous people in Australia – this is greater than 8 years on average across

²Country is not just a physical location but an interconnected entity encompassing cultural, spiritual and ancestral identity.

³[AIATSIS Map](#)

⁴[Healthinfonet: Aboriginal and Torres Strait Islander Concept of Health](#)

⁵[AIHW: Indigenous Health and Wellbeing](#)

Australia, with some variation between states and territories⁶. The historical, political and social factors and determinants that contribute to this health gap are explored further in Chapter 2.

Aboriginal Community Controlled Health Services (ACCHS)

ACCHS provide primary health care services specifically for Aboriginal and Torres Strait Islander people in Australia. ACCHS are non-government, independent organisations that are built and led by local Aboriginal and/or Torres Strait Islander people from the community they serve. ACCHS provide a Model of Care that puts culture and community at the centre, in keeping with the Aboriginal and Torres Strait Islander definition of good health.

The first ACCHS was established in Sydney in 1971 (the [Aboriginal Medical Service Redfern](#)) and ACCHS in other states and territories were established around the same time. A major driver of this was the racism experienced by Aboriginal communities when accessing mainstream health services. More than 50 years later, there are now more than 140 ACCHS across Australia, with clinic services at more than 450 locations, providing comprehensive primary healthcare to more than 500,000 Aboriginal and Torres Strait Islander people (more than half of the Aboriginal and Torres Strait Islander population of Australia)⁷.

In WA, there are 24 ACCHS (see map opposite).



Figure 1. WA Aboriginal Community Controlled Health Services (2026)

⁶ABS: Aboriginal and Torres Strait Islander Life Expectancy

⁷AIHW: OSR and NKPIs

The ACCHS Model of Care

ACCCHS deliver Models of Care that aim to be timely, accessible, affordable, acceptable and culturally appropriate for Aboriginal and Torres Strait Islander people. The model of

care for Aboriginal and Torres Strait Islander Community Controlled health services is articulated in the National Aboriginal Community Controlled Health Organisation's (NACCHO) [Core Services and Outcomes Framework](#) (see Figure 2).

Some of the principles of the model include:

- **Community control** – ACCCHS are governed by elected members of the local Aboriginal or Torres Strait Islander community, who are involved in the planning, development and management of service delivery.
- **Self-determination and governance** – centred around the community being able to make decisions about matters that affect their lives.
- **Cultural safety** – provision of services that are free from racism and discrimination, and where an individual's cultural identity is respected and they feel safe.
- **Focus on the social determinants of health** – the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness.

The model exemplifies the 1978 Declaration of Alma-Ata, which states that people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

In WA, the Model of Care is conceptualised in Figure 3, with eight pillars – Community, Family, Culture, Spiritual, Language, Physical, Country and Emotional.

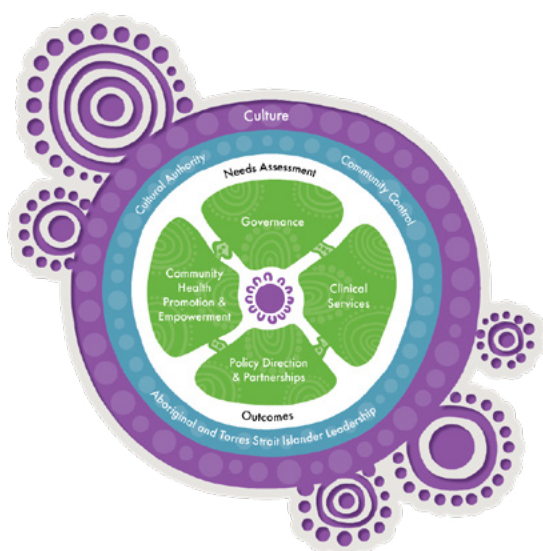


Figure 2. NACCHO's Model of needs-based community controlled comprehensive primary health care⁸



Figure 3. The WA ACCCHS Model of Care

⁸[NACCHO Core Services and Outcomes Framework](#)

This may be the first time working within a culturally-based health service for many clinicians new to the ACCHS Sector. On a day-to-day basis, the ACCHS Model of Care typically supports longer consultations, greater involvement of families in care decisions and stronger team-based care, where all team members contributions are valued and respected regardless of position. The Model of Care supports clinicians to better understand a patient's priorities, which are often shaped by culture (rather than a typical western cultural worldview).

See the ACCHS Model of Care in action [here](#).

Advocacy and Support for ACCHS

[NACCHO](#) is the national peak body representing all ACCHS in Australia, providing national advocacy and a range of support services and programs for ACCHS. NACCHO works closely with [eight affiliate organisations](#), located in each of the states and territories. Affiliates support ACCHS in their state or territory through advocacy, advice, guidance and facilitating knowledge-sharing forums across all aspects of ACCHS governance and service delivery. ACCHS are members of their state or territory affiliate, and NACCHO.

In WA, the NACCHO affiliate and peak body for Aboriginal health is the Aboriginal Health Council of Western Australia (AHCWA).

The National Agreement on Closing the Gap

[The National Agreement on Closing the Gap](#) (signed in July 2020) is an important agreement between all Australian governments (Commonwealth, states and territories) and peak Aboriginal Community Controlled Organisations (including NACCHO) to work together to overcome the inequity experienced by Aboriginal and Torres Strait Islander

people, and achieve life outcomes equal to all Australians. There are four Priority Reforms which aim to change the way governments work with Aboriginal and Torres Strait Islander people and communities. There are 19 associated socio-economic targets, and progress against the targets is monitored by the Productivity Commission. Target 1 is that 'Everyone enjoys long and healthy lives (Close the Gap in life expectancy within a generation, by 2031)'.

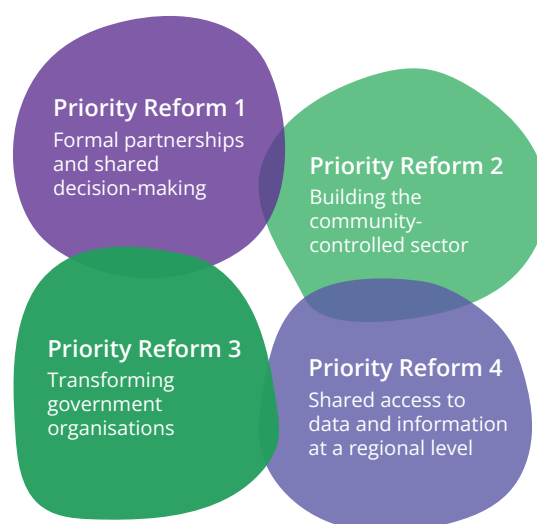


Figure 4. The National Agreement on Closing the Gap Priority Reforms⁹

⁹National Indigenous Australians Agency: [National Agreement on Closing the Gap](#)



The Aboriginal and Torres Strait Islander Workforce

Aboriginal and Torres Strait Islander communities are intimately involved in leading the Model of Care within each ACCHS, with service delivery guided by the needs and priorities of the local community. The Aboriginal and Torres Strait Islander workforce is a critical enabler at every level of an ACCHS, including by ensuring that health care delivered is culturally safe, and the organisation is culturally secure (see Chapter 2).

Most ACCHS will employ both Aboriginal and Torres Strait Islander people, and non-Indigenous people across the various roles within the organisation. There are several workforce roles, however, that can only be performed by an Aboriginal and/or Torres Strait Islander person. These roles include:

- Aboriginal and Torres Strait Islander Health Workers (A&TSIHWs or AHWs)
- Aboriginal and Torres Strait Islander Health Practitioners (A&TSIHPs or AHPs)

AHWs and AHPs are the world's only culturally based workforce underpinned by national regulation and training¹⁰. They play a unique role in Australia's health system, acting as a vital and reliable community resource in the

delivery of culturally safe, responsive clinical and non-clinical health care. AHWs and AHPs play a key role in bridging cultural and linguistic gaps, fostering trust and improving health outcomes.

AHWs and AHPs have a wide range of clinical and non-clinical skills, usually having completed qualifications in Aboriginal and/or Torres Strait Islander Primary Health Care ranging from a certificate II to an advanced diploma (through Aboriginal Community Controlled Registered Training Organisations (RTOs)). AHPs must have completed at least a certificate IV, and can be registered with the Australian Health Practitioner Regulation Agency (Ahpra). The AHW and AHP scope of practice can vary across states and territories and new ACCHS clinicians should check with AHWs and AHPs, or their practice manager, regarding the scopes of practice of AHWs and AHPs within their ACCHS.

In WA, AHWs and AHPs have a scope of practice that can include assessment and management of patients, administering and supplying some medications, performing diagnostic testing including point-of-care testing (e.g. molecular testing, ECGs, spirometry, phlebotomy) and administering vaccinations.

Practice tip: AHWs and AHPs are central clinical team members who are essential to helping bridge the gap between non-Indigenous clinicians and Aboriginal and/or Torres Strait Islander patients.



¹⁰NAATSIHWP: Achieving greater national consistency for the Aboriginal and/or Torres Strait Islander Health Worker and Health Practitioner Professions

Chapter 2 Cultural Security

As a clinician entering the ACCHS Sector, growing in your ability to provide culturally safe care is essential. Experiences of racism and discrimination within mainstream health services were major drivers behind the establishment of the first ACCHS in the 1970s. Even today, the cumulative effects of colonisation and various past government policies have contributed to entrenched disadvantage, and the ongoing experience of systemic racism, including within the health system. The ACCHS Model of Care is specifically designed to overcome barriers to accessing primary health care for Aboriginal and Torres Strait Islander people and to address inequities.

For ACCHS to succeed in delivering its Model of Care, they work to sustain a culturally secure organisation. An important element of this cultural security is providing culturally

safe services, which requires clinicians to practise in culturally safe ways. Culturally safe practice involves ongoing critical reflection on a practitioner's own 'knowledge, skills, attitudes, practising behaviours and power differentials' to ensure that healthcare delivery is safe, accessible and responsive, and free from racism¹¹.

This chapter provides a framework for understanding the historical, political and social determinants of Aboriginal and Torres Strait Islander health in Australia, and the practical application of cultural safety in your daily practice. This chapter does not replace the need for in-person cultural awareness and safety training, which should be arranged by an employing ACCHS on commencement, and an ongoing commitment to growth in cultural safety as a clinician.

Practice tip: International Medical Graduates (IMGs) may have limited understanding of the historical context of Aboriginal and Torres Strait Islander health and wellbeing, and are encouraged to utilise online or print resources to increase their understanding of this context before commencing and through the course of their work.



¹¹[Ahpra: Definition of cultural safety for the National Scheme](#)



Defining Cultural Awareness, Safety and Security

While the terms cultural awareness, cultural safety and cultural security are often used interchangeably, they represent distinct levels of practice and organisational commitment.

- **Cultural awareness** involves recognising and understanding cultural differences, including learning about traditions, customs and practices of different cultural groups. While awareness is a necessary starting point, it cannot be relied upon in isolation as it does not address systemic issues or power imbalances within the health system.
- **Cultural safety** goes beyond awareness and is essential for providing an environment where individuals feel

respected and free from racism, discrimination and bias. Cultural safety is determined by the Aboriginal and Torres Strait Islander person or community receiving the care, not by the practitioner. It requires clinicians to actively reflect on their behaviours and the power differentials present in the clinical encounter. Cultural safety is essential for clinical safety. The Australian Health Practitioner Regulation Agency (Ahpra) has developed a definition of cultural safety in Australia [available online](#).

- **Cultural security** is the systemic, organisational commitment to policies and practices that actively support cultural rights and wellbeing, address existing inequities and promote community self-determination¹².



¹²[Reconciliation WA: Cultural Safety and Security](#)

Determinants of Aboriginal and Torres Strait Islander Health

The disproportionate burden of disease experienced by Aboriginal and Torres Strait Islander people is shaped by complex historical, political, and social determinants. [Ahpra outlines](#) that the first step to ensure

culturally safe and respectful practice is for health practitioners to “acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health”.

Colonisation and its impacts

The impacts of European colonisation have resulted in profound intergenerational trauma, grief, and a loss of connection to family and Country for many Aboriginal and Torres Strait Islander people and communities across Australia.

From the time the First Fleet arrived in 1788, the British government used the legal concept of Terra Nullius – that the land belonged to no one – to justify settlement in Australia. This was overturned in 1992 in the Mabo High Court case in Queensland, which ruled that the lands of the continent were not Terra Nullius at the time of settlement and set a precedent in Australian law that has seen many Aboriginal and Torres Strait Islander groups regain rights over their traditional lands.

Following colonisation there were many massacres of Aboriginal and Torres Strait Islander people across Australia. People were also exposed, for the first time, to many infectious diseases for which they had no immunity, including smallpox, influenza and measles. Massacres and epidemics resulted in significant mortality, contributing to a profound loss of traditional knowledges, cultural practices and languages, which is still felt today.

When Australia was federated in 1901, there was a policy to secure a ‘White Australia’ (ending only in 1966). In the Australian constitution, Aboriginal and Torres Strait Islander people were excluded from having laws made about them, leaving each state and territory to determine how Aboriginal and Torres Strait Islander people were managed.

In WA, under these laws, Aboriginal people were confined to reserves, used as free or indentured labour, moved from traditional homelands to pastoral stations and missions where they relied on rations (such as tea, milk and flour) rather than traditional foods and practices, excluded from social security schemes and had their lives controlled by the government, including controlling where a person could travel, who they could marry and where they could be employed.

In 1967, Australians overwhelmingly supported a referendum to change the constitution to allow the Australian Government to make laws for Indigenous people and be included in the census.

Under the government policy of Assimilation, children were forcibly removed from their families. The policy held that Indigenous people of mixed descent should be absorbed or assimilated into the wider population. During this time between 1910 and the 1970s, now known as the Stolen Generations, it is estimated that this practice affected between one in 10 and one in three Aboriginal children. Around one in three Aboriginal adults today are estimated to be descendants of the Stolen Generations. This policy has resulted in a profound source of intergenerational trauma and loss of family, culture and kinship structures. The [Bringing them home report](#) presented the findings of the national inquiry into the Stolen Generations conducted in the 1990s.

On 13 February 2008 Prime Minister Kevin Rudd made a formal apology to Aboriginal and Torres Strait Islander peoples, particularly the Stolen Generations.

Social Determinants of Health

The impacts of colonisation have a direct influence on the social determinants of health for Aboriginal and Torres Strait Islander people today, including income, employment, housing, and education¹³.

It is important to understand that addressing the social determinants of health (the conditions in which people are born, grow, live, work and age) are integral to the approach of ACCHS.



Figure 5. Based on the Dahlgren & Whitehead (1991) model of health determinants¹⁴

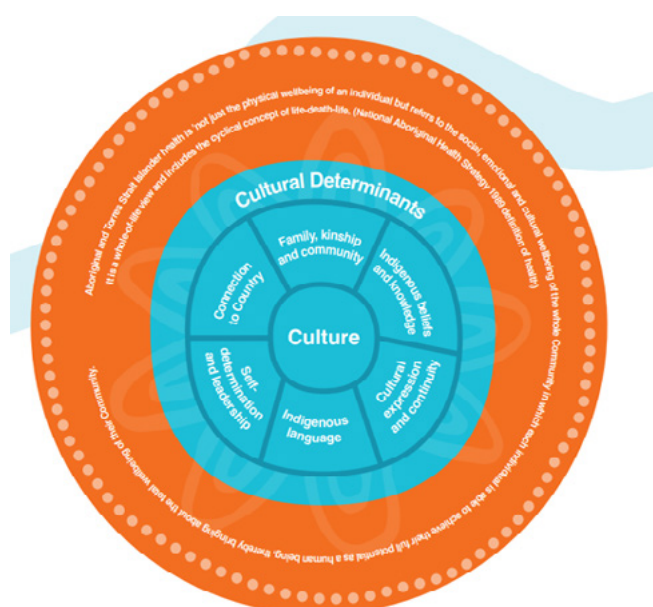


Figure 6. Cultural Determinants of Health¹⁶

Cultural Awareness and Safety Training

ACCHS will arrange location-specific cultural awareness and/or safety training for staff, usually incorporating education on the cultural protocols of the local community. Training typically assists individuals to explore their own attitudes and values, which can influence their behaviour. Training supports staff to practise in culturally safe ways.

Cultural Determinants of Health

There is evidence that cultural factors – such as connection to Country, Indigenous beliefs and knowledges, Indigenous language, self-determination, family, kinship and community, and cultural expression and continuity – can be protective and positive influences on health and wellbeing. A conceptual framework based on Indigenous knowledge that maps the elements that form cultural identity and act as protective factors of health and wellbeing has been developed¹⁵. ACCHS prioritise holistic and culturally safe care for individuals and communities, and in so doing support expression of the cultural determinants of health.

Some online resources to begin learning about the history of Australia since European colonisation and the impacts of past government policies and institutional practices on health today include:

- [The journey of health and wellbeing \(WA Health\)](#)
- [Cultural Wealth, Community Health \(Rural Health West\)](#)

¹³[Australian Indigenous HealthInfoNet: Determinants of Health](#)

¹⁴[AIHW: Determinants of Health](#)

¹⁵Cultural determinants domains identified by the Mayi Kuwayu study (see [Lowitja Institute – Culture is Key](#))

¹⁶Cultural domains identified by the Mayi Kuwayu study and figure from [Culture is Key \(Lowitja Institute\)](#)



Cultural Protocols

It is important for clinicians to recognise the diversity among Aboriginal and Torres Strait Islander communities.

There are around 70 distinct [language groups in WA](#).

Each distinct language group may have their own cultural protocols and practices. Because every community is different, it is very important for new clinicians to take the time to learn about local communities and their cultural protocols through training, discussion with local Aboriginal and/or Torres Strait Islander staff, and where appropriate, Elders. It is not expected that you will understand all local cultural protocols when you first start, but ensuring your approach is patient, kind and respectful will enable you to practise appropriately as you learn about the culture in your location.

Some common cultural protocols that are likely to be shared by many Aboriginal and/or Torres Strait Islander language or cultural groups include:

- **Acknowledgement of Country:** a respectful practice given by anyone to recognise the Traditional Owners' enduring connection to the land, at the beginning of meetings, events and other engagements¹⁷.
- **Elder Respect:** Elders¹⁸ carry significant cultural authority and decision-making power within their community, and are highly respected.
- **Sorry Business:** refers to mourning practices and protocols following a death. These can include familial responsibilities and obligations, which can require extended time away from home and work. There may be protocols around not using the name of the deceased following death in some communities, and for not conducting some activities within communities during Sorry Business. Protocols will vary by community.
- **Men's and Women's Business:** discussion of certain cultural and health topics are gender-specific and should be discussed and managed with sensitivity to the patient's preference (e.g. some patients may prefer care provided by a clinician of the same gender). It may be inappropriate for a person of the opposite gender to discuss certain gender-specific cultural practices or obligations.
- **Kinship and Decision-making:** clinical decisions may often involve the extended family rather than just the individual patient. Where this occurs, this should be managed with care and respect for the patient's preferences and confidentiality.
- **Lore:** Lore refers to the stories, customs, beliefs and spirituality of Aboriginal people, that was given to Aboriginal people from the Dreaming¹⁹.

Practice tip: AHWs and AHPs can provide vital cultural context regarding local protocols and kinship structures, and how these influence health and healthcare.

Practice tip: Cultural awareness and/or safety training arranged by your ACCHS in your region will assist with understanding local cultural protocols and practices, how to be respectful of these, and how to build your skills in providing culturally safe care.

¹⁷A Welcome to Country is a ceremony that can only be performed by Traditional Owners of the relevant Country.

¹⁸Elders are the custodians of cultural knowledge, tradition and law.

¹⁹[Deadly Story: Life and Lore](#)



Traditional Healing and Medicine

Many Aboriginal and Torres Strait Islander people view health through a lens deeply rooted in spirituality and connection to their lands (Country). Traditional healers bring to life holistic worldviews that address the collective social, emotional, cultural, and spiritual aspects of a person's health through different practices and traditions. Some ACCHS may incorporate traditional healers within their service delivery model, working in parallel with the ACCHS teams (delivering comprehensive primary healthcare through GPs, nurses, AHWs and AHPs). Traditional healers are able to interpret symptoms and may provide traditional healing

treatments including bush medicines (often derived from plants)²⁰.

While traditional health practices have been disrupted by colonisation, in many places these practices remain strong. It is important for clinicians to understand that even where traditional healers do not provide services from an ACCHS, that patients may be accessing traditional healers and bush medicines in the community, alongside accessing medical services from an ACCHS.

Local Aboriginal and/or Torres Strait Islander staff and community Elders can provide local guidance on traditional healers and the use of bush medicine, and how these ancient wisdoms are honoured in your location.



²⁰[Australian Indigenous Health/InfoNet: Traditional healing and medicine](#)

Chapter 3 Australian Health System

The Australian health system is a hybrid public-private model, where the public system is underpinned by Medicare – the Australian government's universal health benefits system which provides free hospital care and subsidised GP, private specialist and some allied health visits. Essential medicines and diagnostic testing are also subsidised by Medicare (see Chapters 6 on the Medicare Benefits Schedule (MBS) and 7 on Medicines).

Around 60 per cent of the general Australian population have some form of private health insurance, which can provide faster access to private hospital care and/or some ancillary services (such as dental, optical and ambulance)²¹, however the private health insurance coverage among Aboriginal and/or Torres Strait Islander people is significantly lower²². Both those with, and those without, private health insurance can access the publicly-funded Medicare system for healthcare.

Australia has a federated system of government, whereby there is a federal government (referred to as the Commonwealth or Australian Government) and a government in each of the six states and two territories. The responsibility for the public health system is shared by both levels of government. In simple terms, the state and territory governments are responsible for managing the provision of free public hospital care and some community health services. The Australian Government, through Medicare, is primarily responsible for subsidising out of hospital care including visits to general practice and ACCHS. Aged care and disability

services are also mostly a responsibility of the Australian Government.

In addition to public hospitals, most large population centres have private hospitals for privately insured (or fee-paying) patients; and philanthropic organisations help to support a range of not-for-profit health services²³.

Out-of-pocket expenses are common for many health services in Australia and the Commonwealth concession card scheme provides higher subsidies to reduce health expenses for people on low incomes. Information on types of concession cards and their benefits are available through [Services Australia](#) (the Australian Government agency that delivers services and programs including Medicare and [Centrelink](#)²⁴).

Both levels of government also recognise the challenges of providing healthcare in remote locations and extra support is available. Many government programs utilise the [Modified Monash Model](#) to define whether a location is metropolitan, rural, remote or very remote. It is common to see a location referenced by its 'MM', which is a number from 1 (major city) to 7 (very remote).

The Australian health system is complex, and this chapter aims to provide an overview. New clinicians to Australia, and the ACCHS Sector, will not be expected to understand or recall details of the system immediately. Local ACCHS orientation processes, and ongoing practice support, including from managers and senior clinicians, will help to guide new clinicians with their day-to-day work.

²¹As well as some non-medical health services not covered by Medicare if a person has 'extras' cover (e.g. some dental, optical and allied health services).

²²[AIHW: Access to Services Compared with Need](#)

²³[AIHW: Health System Overview](#)

²⁴Centrelink is the Australian Government program that delivers social security payments and services to Australians and is operated by Services Australia. This includes payments for older Australians, job seekers, students and trainees, families, carers, parents and people with disabilities.



General Practice

General Practice (which includes the ACCHS Sector) is the cornerstone of the Australian health system and the pathway to many other essential services²⁵. Although diverse (in size, location and focus), most general practices offer both acute and chronic disease care across the life course. National [accreditation standards](#) are set by the RACGP (see Chapter 8).

Most mainstream general practices are private businesses – owned by individual GPs, partnerships or large corporate groups. Income is generated through Medicare Benefits Schedule (MBS) subsidies (see Chapter 6), with some practices also charging a ‘gap’ fee directly to the patient (in addition to the MBS rebate). Practices that do not charge a ‘gap’ fee, but accept the MBS rebate for services directly from Medicare, are known as ‘bulk-billing’ practices (more information in Chapter 5). Most ACCHS are fully bulk billing practices.

Patients are free to choose their own GP and can move freely between GPs and practices. Patients can choose to formalise a relationship with a specific practice (and GP) through MyMedicare registration (see Chapter 6 for more details).

Patients can only access public specialist outpatient services, and private MBS-subsidised specialist services through a referral from their GP (or Nurse Practitioner (NP)²⁶). Pathology and radiology services also require a referral.

In more remote parts of regional WA, where there is no ACCHS or private general practice, GP services are often provided by salaried medical officers in small hospitals or by the Royal Flying Doctor Service (RFDS). No fees are charged for these services.

Public Hospitals

Free public hospital care, including emergency, inpatient and outpatient specialist care is provided by state and territory governments through [state and territory health departments](#), and is jointly funded by the Australian government. Most states will have secondary, tertiary and quaternary level services, although for smaller states and territories some specialised services (e.g. coronary angiography, transplant medicine, and other highly specialist services) may be accessed inter-state.

Each state and territory has Local Hospital Networks (LHNs) which are organisations that manage local public hospital (and some public community-based) services within a defined geographical area (different terms are used for these in some states and territories)²⁷. Some LHNs may be tasked to provide specific highly-specialised state (or territory) wide services, and may also be tertiary referral centres (usually based in metropolitan centres).

In WA, the WA Department of Health oversees the public healthcare system (referred to as [WA Health](#)). There are five LHNs in WA (termed Health Service Providers (HSPs)) – four in metropolitan Perth (North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS), East Metropolitan Health Service (EMHS), Child and Adolescent Health Service (CAHS)) and one covering the remainder (non-metropolitan) of the state (WA Country Health Service (WACHS))²⁸.

Each of the metropolitan HSPs has a local catchment with a network of secondary and tertiary hospitals and community-based services.

²⁵[RACGP: Achieving a stronger healthcare system](#)

²⁶A [Nurse Practitioner \(NP\)](#) is a Registered Nurse with the experience, expertise and authority to diagnose and treat people of all ages with a variety of acute and chronic health conditions (including prescribing). NPs have completed additional university study at Master's degree level and are endorsed by the Nursing and Midwifery Board of Australia. NPs form an important part of the ACCHS team in many settings.

²⁷[AMA: Australia's public hospital system explained](#)

²⁸[WA Department of Health: Our Hospitals](#)

Tertiary Hospitals in WA include:

- Perth Children's Hospital (CAHS) – specialist paediatric hospital and trauma centre (up to 16 years)
- King Edward Memorial Hospital (NMHS) – obstetric, gynaecology, perinatal mental health and neonatal hospital
- Royal Perth Hospital (EMHS) – adult tertiary hospital, including state trauma centre
- Sir Charles Gairdner Hospital (NMHS) – adult tertiary hospital, including state neurointerventional and advanced neuroimaging service
- Fiona Stanley Hospital (SMHS) – adult tertiary hospital, including the state rehabilitation centre and state burns service
- Graylands Hospital (NMHS) – psychiatric hospital

The [WACHS](#) catchment covers [the whole of WA outside the Perth metropolitan area](#).

It provides a network of smaller hospitals (regional and district), community health clinics and Remote Area Nursing (RAN) posts across seven regions. Specialist care for people living in regional WA is largely provided by hospitals based in larger regional towns (e.g. general physicians, paediatricians, psychiatrists, obstetricians and gynaecologists) and specialists based in Perth (through telehealth, visiting outreach services and patients travelling to Perth).

Urgent Care

Urgent care clinics have been established in metropolitan and some regional areas, and provide walk-in treatment for urgent but non-life-threatening conditions. [Medicare urgent care clinics](#) are funded by the Australian Government, are free to the patient, and aim to relieve pressure on public hospital emergency departments. Privately operated urgent care clinics also exist, that charge a fee to the patient.

Private Providers

A vast array of private community-based health providers operate in Australia, including community pharmacies (see Chapter 7), radiology and pathology companies, non-GP specialist practices and allied health. Most of these services are subsidised through the MBS, the Pharmaceutical Benefits Scheme (PBS) and other government programs. Many require GP (or NP) referral.

Many ACCHS build relationships with local private providers, and in some cases have developed local arrangements to reduce the financial burden for their patients to access these services.

Practice tip: Community pharmacists dispense prescription medicine, provide advice to patients and administer vaccines. Independent prescribing by pharmacists is limited, and varies by state and territory.



Maternity Care

Australia has a range of maternity services and models of care – including public, private, midwife-led and obstetrician-led. GPs typically provide pre-conception care and the first antenatal visit. Many GPs participate in a shared care model and in some locations (particularly regional and rural) trained GP-obstetricians also provide intra-partum care²⁹.

There is a growing number of initiatives to improve maternity care for Aboriginal and Torres Strait Islander families through Birthing on Country models of care³⁰. This culturally safe approach returns control of maternity services to Aboriginal and Torres Strait Islander communities through service redesign, greater investment in the Aboriginal and Torres Strait Islander workforce, and greater continuity of midwifery care. Many ACCHS have endorsed the [RISE framework](#) from the Molly Wardaguga Institute³¹.

Child Health

Australia has a free universal program of child health and development checks with each state and territory determining its own specific schedule. Checks are typically completed at state or territory-run community health clinics by specialised child health nurses. Where concerns are identified, the nurse may notify the GP, or refer a child directly to a specialist service for further assessment. In some remote areas, the service may be contracted to the local ACCHS. Elsewhere, ACCHS may proactively provide checks as part of their comprehensive model of care. Child health checks are voluntary, however the completion of a check prior to school entry is necessary for [some family tax deductions](#).

In WA, there are [five recommended child health checks](#) from a few days after birth to 3 years. These checks are recorded in a parent-held 'purple book' (personal health record book). A further check is offered at [school entry](#).

Dental Care

Most dental care is provided by private dentists on a fee-for-service basis, with limited rebates available through some private health insurance plans. Public dentistry is provided by state or territory governments for children and people on low incomes, but eligibility rules, geographic availability and cost vary; and wait times can be long. The Australian Government provides a means-tested (and capped) [Child Dental Benefits Schedule \(CDBS\)](#) for children under 18 years. Some ACCHS may employ their own dentist, or host visiting dental services (arrangements will vary by location).

Disability Care

The [National Disability Insurance Scheme \(NDIS\)](#) is Australia's major disability program³². The scheme funds 'reasonable and necessary' supports for people aged 9 to 65 years with a permanent and significant disability. The scheme aims to give people greater independence, more time with family and friends, new skills and improved quality of life. Participants choose the services they want, the providers they use and how support is delivered. Support is also available in early childhood for children with developmental delay. Adults over 65 years are not eligible for the NDIS and can apply for support through the aged care system.

The NDIS allows for a wide range of services including allied health, support workers and care coordinators. Some ACCHS are registered NDIS providers. ACCHS, including GPs, play an important role in identifying, assessing and supporting patients who might benefit from the scheme (see Chapter 4 for more information).

²⁹[Healthdirect: Maternity care in Australia](#)

³⁰[AIHW: Maternity models of care in Australia](#)

³¹[Molly Wardaguga: Birthing on Country](#)

³²[NDIS: What is the NDIS?](#)



Practice tip: Other support services may be available for patients who do not meet the eligibility criteria for the NDIS. Aboriginal and/or Torres Strait Islander people with a chronic disease may also access some support services and products through the Integrated Team Care (ITC) Program (see below). Income support may be available through the Disability Support Pension (DSP) (see Chapter 11).

Aged Care

The Australian Government has the primary responsibility for the aged care system in Australia. It provides support to older people (also known as Elders in Aboriginal and Torres Strait Islander communities) to receive [government-subsidised aged care services](#), either in their own home, or in residential care facilities. Eligibility is based on need and age - Aboriginal and Torres Strait Islander people must be 50 years or older, while the rest of the population may be eligible from 65 years. See Chapter 4 for further information.

Initiatives to increase access to and improve the cultural safety of aged care services include the [National Aboriginal and Torres Strait Islander Flexible Aged Care Program \(NATSIFACP\)](#) and the [Elder Care Support Program](#).

Mental Health

There are many different providers of mental health services in different settings (including online) across Australia. This includes publicly-funded hospital inpatient and outpatient services, private hospital inpatient and private specialist outpatient services, not-for-profit community-based services and fee-for-service community-based services. Some ACCHS may directly employ mental health service providers. Service provision varies significantly by location, particularly in rural and remote areas, and culturally appropriate options may often be limited.

Referral information for WA is available in Chapter 4.

Social and Emotional Wellbeing

Many ACCHS have dedicated [Social and Emotional Wellbeing \(SEWB\)](#) programs. SEWB 'is a term that has been utilised to broadly represent culturally grounded, holistic, and relational aspects of Aboriginal and Torres Strait Islander health'³³. SEWB teams within ACCHS can provide a range of services which can include (but are not limited to) counselling, social work, youth support, perinatal support, and group programs. The [Culture Care Connect program](#) is another key ACCHS-led program which focuses on suicide prevention and holistic aftercare.

NACCHO has a [useful list of resources](#) for Aboriginal communities.

Alcohol and Other Drug (AOD) Services

Services for people needing help with drug and/or alcohol use include telephone services, outpatient services, sobering up shelters and residential rehabilitation centres. Some services are provided by Aboriginal Community Controlled Organisations. Service availability is location dependent. ACCHS may support harm minimisation strategies, including providing Needle Syringe Programs (NSPs).

WA NSP locations are available [here](#).

The Mental Health Commission's (MHC) [MyServices Directory](#) provides information on mental health, alcohol and drug services in WA.

The [Drug and Alcohol Clinical Advisory Service \(DACAS\)](#) (08 6553 0520) is a specialist telephone consultancy service that provides clinical advice to health professionals on all issues relating to patient management of AOD use.

³³Lowitja: SEWB – a review

Aeromedical Retrieval Services

Aeromedical retrieval services provide emergency and non-emergency medical transport using helicopters and planes to transport patients particularly from regional and remote areas, to higher levels of care. Major providers include the [Royal Flying Doctor Service \(RFDS\)](#) and [CareFlight](#).

The RFDS provides free aeromedical retrieval services across WA. Clinicians working in remote locations (where there is no nearby hospital) should ensure they understand local retrieval policies and procedures. Where a local hospital is accessible, but a patient needs a higher level of care, hospital staff will stabilise the patient and arrange inter-hospital transfer as required.

Ambulance Services

Ambulance services are not covered by Medicare and [each state and territory has its own provider and own system of payment](#). **Emergency ambulances can be accessed by calling 000.**

In WA, St John Ambulance is the state-contracted provider for ambulance services and fees are often up to \$1,200 per trip for the patient. Fees may be covered for those with private health insurance that includes ambulance cover. Concessional rates (50 per cent) are available for those 65 years and over. For seniors with a Commonwealth Concession Card, emergency ambulances are free. [A trial is currently underway in WA](#) to lower the age of access to concessional rates to 50 years for Aboriginal and Torres Strait Islander people³⁴.

Other Services

Other Government Services

Many government programs exist both for the general population, and specifically for Aboriginal and Torres Strait Islander people, to improve access and quality of healthcare. Of particular importance is the [Integrated Team Care \(ITC\) program](#) - an Australian Government program for Aboriginal and Torres Strait Islander people with complex chronic disease needs. The program has two main components - Care Coordination and Supplementary Services. Care coordinators assist patients to manage their care (e.g. attendance at hospital specialist and allied health appointments). Supplementary services provides a pool of funding for medical aids, such as CPAP machines, and for out-of-pocket fees (e.g. appointment fees) when no other funding is available. Access to ITC requires both a GP referral and a chronic disease care plan that outlines needs to be addressed.

[Primary Health Networks \(PHNs\)](#) are Australian Government-funded geographically-based organisations whose purpose is supporting primary care, including by commissioning local health services to address unmet needs. Further information is available in Chapter 5.

Other Non-Government Services

There are a range of non-government and/or not-for-profit organisations providing care and support for families and/or education for health professionals. These can include organisations focused on a single condition (e.g. Diabetes WA), or specialised services (e.g. RFDS).

Practice tip: With such a complex health system, patients often find navigating the system challenging. GPs, especially within the ACCHS Sector, often play an important role in helping patients navigate the system, including as an advocate.

³⁴Currently to 30 June 2026, check [the AHCWA website](#) for up-to-date information.

Chapter 4 Referrals

This chapter provides information on important referral processes for referrers (usually GPs and NPs). While state and territory referral systems can be complex and administratively burdensome, new clinicians are not expected to manage these processes independently. Local administrative and clinical staff will help new clinicians to navigate the referral system, which will vary by location (even within a state or territory).

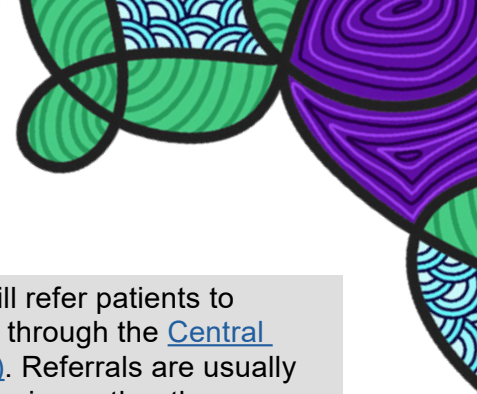
It is important to note that referrals are typically written (typed) by GPs (or NPs) themselves (rather than by administrative support staff). Artificial Intelligence (AI) scribes are being used more frequently including for writing referrals, but should be utilised within an ACCHS organisational policy (see Chapter 9).

Emergency Care

Ambulances can be accessed by calling 000. Most public hospitals have emergency departments (EDs) that provide free 24-hour, 7 day per week emergency treatment. Patients can self-refer or be referred by a primary care provider. Where referred by a primary care provider, a detailed referral letter should be sent with the patient. It is expected the hospital will provide a discharge letter to the GP after their patient has been treated. Some private hospitals may also have emergency departments, but treatment usually incurs a fee (often even with private health insurance).

In remote areas without a hospital, Remote Area Nursing (RAN) posts or remote ACCHS





often provide emergency care. They may be assisted through telephone support from referral hospitals, specialised emergency telehealth services which link the patient (and clinician) with an emergency physician, or other clinical telephone support services (such as through the RFDS).

Patients can access non-emergency urgent care through their GP (including ACCHS) or through an urgent care clinic (no referral required). Telephone health advice can be sought by patients through [1800MEDICARE](#) - an Australian government, nurse-led, telephone health advice service.

Inpatient Care

Admission to public hospitals can be for acute or urgent care (through the ED), for booked elective treatment (particularly non-acute surgery) or for recurrent day treatment (e.g. haemodialysis, oncology treatment). If a GP assesses that a patient requires urgent hospital admission, the usual process is to refer the patient to ED and contact the relevant specialist (or registrar) if appropriate. Admission is at the discretion of the admitting hospital doctor.

Outpatient Care

A written referral is usually required from a GP or NP for a patient to access non-emergency, non-admitted, non-GP specialist outpatient care. See below for details.

Public Outpatient Referrals

Referral systems to public specialists will vary across states and territories, with some jurisdictions having centralised referral systems, and others having local arrangements with nearby hospitals.

In WA, most regions will refer patients to public specialist clinics through the [Central Referral Service \(CRS\)](#). Referrals are usually made to a specialist service, rather than a named specialist. The CRS is responsible for allocating referrals to the appropriate hospital, based on clinical need and geographical catchment. Referral letters must be completed in a standard template, available in clinical software. [Referral access criteria](#) are available for some specialties to guide referrers to provide the information required to accept the referral. Referrals can be rejected if the content of the referral does not contain sufficient information, particularly where criteria for information required has been set. Urgent referrals where a patient needs to be seen within seven days, obstetric referrals and mental health referrals are out-of-scope for the CRS. For urgent referrals, referrers should speak to the appropriate hospital clinician directly to arrange referral, and obstetrics and mental health referrals should be sent directly to the relevant hospital/clinic.

The [Manage My Care](#) app allows patients to see their specialist outpatient appointment details and request a change in appointment time.

Rural Health Outreach Specialist Services

The Australian Government funds state or territory-based Rural Workforce Agencies (RWAs) to support specialists to visit regional and remote areas to provide specialist services that would otherwise not be accessible locally. Specialist providers may be funded directly to provide services, or ACCHS can apply for funding directly to fund specialists to provide outreach services from their clinic. Check local referral processes for rural health outreach specialist services. Further information is available in Chapter 5.

In WA, Rural Health West (RHW) approve outreach specialist services and list approved services on their [website](#).

Private Specialists

Referrers can refer patients directly to private specialists. Patients will usually be required to pay a gap fee for appointments, which can often be quite costly. Some ACCHS may have local arrangements with private specialists to waive gap fees, or access to reduced rates for their patients. In some cases, the [Integrated Team Care \(ITC\)](#) program may be able to cover payment of gap fees for private specialists, where access to a public hospital or outreach specialist is not possible within a clinically-acceptable timeframe, and no bulk billing private specialist is available. Private specialists may utilise telehealth, particularly for follow-up appointments after an initial in-person appointment (see Chapter 9). Additionally for patients with chronic conditions, it is common for GPs to be asked to provide an updated referral to the specialist after 12 months.

Aged Care

Primary healthcare services, including ACCHS, play an important role in helping to link eligible patients with the Aged Care System. GPs and other ACCHS staff provide information and support for patients to access services. This includes by referring eligible patients for an Aged Care Assessment. An assessor will contact the patient to arrange an assessment in their home. Sometimes these assessments can be conducted during a hospital admission. The assessment determines which government-funded services a patient may be eligible for.

Referrals are made to [myagedcare](#) either by e-referral through your clinical software, through an [online form](#), or by phone. Some ACCHS have specifically funded staff roles to engage and support Elders to access Aged Care Services (a program called [Elder Care Support](#)). These workers may have direct access to the myagedcare portal where they can help to facilitate referrals as well.



Practice tip: Although myagedcare is the principal system for accessing aged care services, GPs can still refer to geriatricians or general physicians through standard referral processes for advice and management support. Additionally, a culturally appropriate cognitive assessment tool is available – the [Kimberley Indigenous Cognitive Assessment \(KICA\)](#) (see Chapter 13).



Disability Care

Health practitioners are often involved in supporting a patient when applying to become an NDIS participant. The patient or the National Disability Insurance Agency (NDIA)³⁵ (with patient consent) may ask health providers to provide evidence of a patient's disability and its functional impact by completing:

- The NDIS supporting evidence section of the Access Request form
- Assessments or reports outlining the extent of the functional impact of their disability.

ACCHS also play an important role in identifying patients who may benefit from access to the NDIS and supporting them in the access process. Some ACCHS (particularly in remote areas) may have specific staff available to assist with identifying people who may be eligible (Remote Community Connectors) or to help the patient gather evidence for their Access Request Form. In other ACCHS, clinical staff including GPs, AHPs, nurses and/or allied health staff may provide patients with this support.

Once a patient has been granted access to the NDIS by the NDIA, the NDIA will develop a plan with the patient to determine what services and supports they would like to access, and through which providers. Patients can consent to family, friends or sometimes ACCHS staff to support them through this process. NDIS funding can only be used for items listed as NDIS supports by the NDIA. Details on supports funded by the NDIS are available at [their website](#).

NDIS support is available for children younger than 9 years through [the early childhood approach](#). This approach helps children younger than 6 with development delay or children younger than 9 with a disability. Currently, children younger than 6 do not need a diagnosis to get support where there are concerns about their development.

The Australian government is currently in the process of [implementing a number of reforms to the NDIS](#). It is important to check any updates to NDIS processes at the NDIS website.

Allied Health

Access to affordable [allied health services](#) in Australia can be challenging. Local arrangements for allied health vary widely and clinicians should ensure they understand which services are available in their area and how these are accessed.

Direct referrals to allied health providers in public hospitals are often restricted, with access often only available after a patient has been assessed by a hospital specialist. The MBS does subsidise up to 10 non-hospital allied health visits per year for Aboriginal and/or Torres Strait Islander people with a Chronic Condition Management Plan or Annual Health Assessment (see Chapter 6). Private allied health providers will most often charge a gap fee to the patient. Some ACCHS may directly employ allied health providers within their service, and claim the MBS-rebates for services provided. Patients on the NDIS may include allied health services within their funded plan. In some locations, a range of funding mechanisms may fill gaps in allied health services, particularly for diabetes care (e.g. diabetes educators, podiatrists, dietitians etc).

Mental Health

Clinicians should ensure they understand local mental health and alcohol and drug service availability and referral processes. Telephone, telehealth and online options play important roles in many areas where services are limited.

Some [key services providers across Australia](#) include:

- Public hospital inpatient and outpatient services (can be accessed through EDs)
- Private hospital inpatient and outpatient services

³⁵The NDIA is the Australian government agency that administers the NDIS.

- Not-for-profit organisations: check local arrangements for counselling and other services
- [Headspace](#): for people aged 12 to 25 years
- Online treatment programs: for example -
 - [MindSpot](#)
 - [This Way Up](#)
- Telephone lines:
 - [13 YARN](#): 13 92 76 – for Aboriginal and/or Torres Strait Islander people in crisis
 - [Lifeline](#): 13 11 14 – for anyone in crisis
 - [Beyond Blue](#): 1300 22 4636
 - State or territory based mental health telephone triage services:

[Mental Health Emergency Response Line in WA](#)

GPs can complete a [Mental Health Treatment Plan \(MHTP\)](#) for patients which provides up to 10 appointments with a mental health professional (usually a clinical psychologist) subsidised by the MBS. A gap fee is often still charged.

Each state and territory has its own legislation for involuntary assessment or treatment where a person is at risk of harming themselves or others³⁶.

In WA, the Mental Health Act 2014 requires clinicians to use forms approved by the Chief Psychiatrist. Form 1A may be used by a medical practitioner in primary care to refer a person for examination by a psychiatrist when certain conditions are met. Further information is available from the [Office of the Chief Psychiatrist's Information for Referring Practitioners](#)³⁷.

Justice Health

Healthcare in correctional facilities (including prisons) is provided by state and territory governments. Incarcerated individuals lose their access to Australian Government subsidy programs including the MBS and PBS. Healthcare delivery models vary by state and territory.

In WA, healthcare is provided by the WA Department of Justice. Aboriginal people are disproportionately represented within WA prisons (approximately 40 per cent across WA, and up to 90 per cent in some regional prisons). There is no systematic mechanism of communication between prisons and ACCHS to facilitate follow-up after release, which is a major challenge for patients and clinicians alike. Clinicians can request the medical records of prisoners after their release by phoning [1800 077 735](#).

Practice tip: ACCHS play an important and ongoing advocacy role to ensure the health and wellbeing of Aboriginal and/or Torres Strait Islander people within the justice system.

See AHCWA's position statement on youth justice and health [here](#).

³⁶AIHW: [involuntary treatment in mental health care](#)

³⁷Further information is available from the [Office of the Chief Psychiatrist](#)

Travel Subsidies

Many patients living in regional and remote areas are still required to travel long distances to access inpatient and outpatient healthcare, where outreach or telehealth services are not available or appropriate. State and territory travel subsidy programs are available in each jurisdiction, although these often do not fully cover the costs incurred when travelling for healthcare.

In WA, the [Patient Assisted Travel Scheme \(PATS\)](#) (through WACHS) provides patients and eligible escorts with financial assistance to offset the transport and accommodation costs associated with care. There are specific eligibility rules to access PATS subsidies. ACCHS staff may assist patients to complete PATS forms and liaise with local PATS offices to arrange subsidies and transport bookings. If clinicians feel their patient is not receiving the support they need, they can request a review through the 'exceptional management process' (contact PATS). The [Country PatHS](#) program can provide journey coordination and support for vulnerable people from the Kimberley, Pilbara, Midwest and Goldfields regions, with a referral form available online. GPs often advocate for their patients, including by contacting PATS or writing letters of support to assist patients and their families to access travel subsidies.

Pathology

Laboratory pathology testing requires a GP, NP or eligible midwife referral. Most tests are bulk billed through the MBS. Results are sent electronically to the requesting clinician through practice software, and copies are sent to the patient's My Health Record (unless the patient requests they are not). In mainstream general practice, patients typically attend a pathology laboratory collection site for phlebotomy (with their referral form). In many ACCHS, phlebotomy is provided on site at the time of appointment by a nurse or AHP and sent to the laboratory. In remote clinics, bloods may need to be centrifuged on site before being transported to a laboratory.

In WA, the public pathology service is PathWest (also provides WA's reference laboratory). Additionally there are several private pathology providers (including Clinipath, Western Diagnostics and Australian Clinical Labs). PathWest processes specialised tests on behalf of the private laboratories, and is the state's genomic testing and neonatal screening facility.

Point-of-Care Testing

In addition to referring patients for laboratory tests, most ACCHS are able to complete a range of point-of-care (POC) tests. These can include: HbA1c, urinary albumin-creatinine ratio (ACR), INR, haemoglobin, syphilis antibody testing, and PCR for chlamydia, gonorrhoea, trichomoniasis and respiratory viruses. Remote clinics also maintain portable blood analysers (such as the i-STAT device) which can provide POC blood gases, electrolytes, chemistry (including troponin) and haematology for emergency management. These are funded via a variety of mechanisms, and MBS rebates are available for some tests (see Chapter 6). Each device requires quality assurance programs and policies. See the [RACGP Standards for point-of-care](#) testing for more information.

Radiology

Radiology services are a mix of private and public, with private services dominating in large towns and cities. In some regional and rural areas, public hospital radiology services may be the only available. Referrals are required, and for most imaging (except plain x-rays) bookings are essential. Gap fees are often charged by private providers, but ACCHS may have local arrangements for their patients to be bulk billed.

Access to CT and MRI imaging is limited in many rural and remote parts of Australia. It is important that clinicians are aware of local and regional availability, including interventional radiology outreach service schedules. It should be noted that GPs cannot refer directly for most Medicare-subsidised MRIs. MRIs typically must be requested by a specialist.

Chapter 5 Funding

Most ACCHS have a blended funding model – accessing MBS rebates through Australia’s universal health insurance system (Medicare), direct funding from the Australian and state or territory governments, and program-specific funding. These funding mechanisms aim to support the distinctive ACCHS Model of Care (see Chapter 1), which aims to provide holistic, culturally responsive and continuity-based care. Effective stewardship of funding sources is critical to the sustainability of an ACCHS, workforce stability and improved health outcomes.

This chapter gives an overview of the various funding sources for an ACCHS. New clinicians are not expected to have a detailed working understanding of funding sources, but this context may be helpful in understanding how ACCHS can provide a Model of Care that is different to mainstream general practice in Australia. The information in this chapter may be especially useful for clinicians who assume leadership roles, such as a Medical Director or Senior Medical Officer (SMO).

How ACCHS Funding Differs to Mainstream General Practice

The funding model for ACCHS contrasts with mainstream general practice which operates within a private, fee-for-service system where MBS rebates are available for services provided by GPs (see Chapter 6 for more information on the MBS). Practices may choose to bulk bill (accept the MBS rebate directly from Medicare for the service provided), privately bill (the patient pays the general practice directly, and then claims the MBS rebate from Medicare which only covers

part of the cost they paid), or apply mixed billing (where some patients are bulk billed (e.g. children and concession card holders), while others are privately billed).

While there have been [welcome reforms over recent years](#), the MBS funding model still means that mainstream general practices are better remunerated for high patient throughput via short, time-limited consultations with private billing (requiring out-of-pocket cost to the patient).

ACCHS usually provide free (bulk-billed) care, reflecting a deliberate equity approach in response to the disproportionate burden of disease experienced by Aboriginal and Torres Strait Islander peoples. By contrast, reliance on patient fees and gap payments in private general practice can be a barrier to access for many people, particularly populations experiencing socioeconomic disadvantage and high burdens of disease.

Expenditure in Aboriginal and Torres Strait Islander Health in Australia

Health expenditure for Aboriginal and Torres Strait Islander people is higher on a per-person basis than for non-Indigenous Australians; however, it remains below the level required to account for the higher burden of disease and associated service need. In 2022–23, average health spending was approximately \$12,100 per Aboriginal and Torres Strait Islander person compared with \$8,900 per non-Indigenous Australian, a ratio of around 1.4:1. During the same period, Aboriginal and Torres Strait Islander

people experienced more than twice the disease burden of non-Indigenous Australians, indicating a continuing gap between expenditure and need³⁸.

Analysis by NACCHO, in partnership with Equity Economics, identified a persistent shortfall in health expenditure relative to need. In 2022–23, total health expenditure for Aboriginal and Torres Strait Islander people was approximately \$12.3 billion. Of this, 55 per cent was allocated to hospital services, while 7 per cent was directed to ACCHS and other First Nations–specific health programs under the Indigenous Australians’ Health Programme (IAHP). A further 6 per cent was spent on Medicare services and 5.6 per cent on PBS medicines, with the remaining 27 per cent attributed to other recurrent health expenditure, including community health services³⁹.

Evidence indicates that investment in primary healthcare is associated with reduced hospital utilisation and improved health outcomes. Studies of remote Aboriginal and Torres Strait Islander communities have found that higher levels of primary care use are associated with lower rates of avoidable hospitalisations, mortality, and years of life lost, as well as net reductions in hospital costs. These findings highlight the role of primary healthcare, including services delivered by ACCHS, in meeting health need alongside hospital-based care.

MBS Funding in ACCHS

MBS funding is a critical component of ACCHS revenue and is covered in detail in Chapter 6. MBS funding in ACCHS is enabled by an exemption to Section 19(2) of the Health Insurance Act 1973. While MBS benefits are ordinarily not payable for services delivered by government-funded providers, the section 19(2) exemption allows approved ACCHS to claim MBS benefits alongside receiving Australian and state or territory government funding. This enables the blended funding

model of ACCHS, recognising the unique role they hold in delivering comprehensive primary healthcare to populations with high and complex needs. The list of ACCHS with 19(2) exemptions is available [online](#)⁴⁰.

MBS funding alone is insufficient to support the ACCHS Model of Care, which includes multidisciplinary teams, outreach, population health activities, transport support and culturally specific programs. ACCHS routinely manage complex multimorbidity, intergenerational trauma, social disadvantage, low health literacy, and systemic barriers to access. As a result, consultations are longer, care is more resource-intensive, and essential non-billable activities—such as care coordination, advocacy, and community engagement—are integral to service delivery. In most ACCHS this comprehensive integrated approach is only possible by supplementing MBS funding with grant funding and supplementary programs.

Other Funding for ACCHS

The majority of ACCHS funding originates from government grants, primarily through Australian government programs such as the IAHP. These grants typically account for more than 70 to 90 per cent of total revenue, and include both operational funding and specific project or capital funding. MBS funding typically makes up 10 to 15 per cent of the revenue for large ACCHS. Optimal utilisation of MBS benefits through careful and accurate MBS billing, particularly by GPs, is a key mechanism for sustainability of ACCHS funding to enable comprehensive and culturally safe service delivery (see Chapter 6).

ACCHS may also apply for and receive grants from state or territory governments and Primary Health Networks (PHNs), and may have other funding sources including from patient fees or charges, the NDIS (as registered providers) and other sources (including philanthropic), but these sources tend to be much smaller.

³⁸ AIHW: *Aboriginal and Torres Strait Islander Health Performance Framework – Health expenditure*

³⁹ NACCHO and Equity Economics: *Measuring the gap in health expenditure*

⁴⁰ The legal Direction granting the exemption is available on the Federal Register of Legislation. At the time of writing, the most recent Direction is [Health Insurance \(Medicare Benefits Payable in Respect of Professional Services – Aboriginal Community Controlled Health Services\) Direction \(No. 3\) 2024](#)

Table 1. Examples of Australian ACCHS income streams from publicly available Annual Reports (2024-25).

ACCHS	Grant Income	MBS Income	Other Income	Total Revenue
City-based ACCHS in Northern Australia ⁴¹	\$ 36,137,859 (83%)	\$ 5,847,080 (14.4%)	\$1,085,165 (2.6%)	\$ 40,741,824 (100%)
Regional and remote ACCHS in Northern Australia ⁴²	\$ 83,924,833 (83%)	\$ 11,404, 513 (11%)	\$ 5,232,226 (5.2%)	\$ 100,714, 489 (100%)
Remote ACCHS in Northern Australia ⁴³	\$ 34,370,345 (94%)	\$ 1,820,936 (5%)	\$ 162 ,118 (1%)	\$ 36,312,111 (100%)
City-based ACCHS in Southern Australia ⁴⁴	\$ 21,814,018 (74%)	\$ 5,785,867 (20%)	\$ 849,050 (6%)	\$ 28,562,982 (100%)

Australian Government Funding in ACCHS

Indigenous Australians' Health Programme (IAHP)

The [IAHP](#) is the Australian Government's main program for funding Aboriginal and Torres Strait Islander health services, particularly ACCHS. It provides grant funding to support culturally safe, comprehensive primary healthcare, delivered through ACCHS. This includes clinical care, prevention and early intervention, chronic disease management, SEWB services, and support for workforce, governance, and service coordination. The IAHP began on 1 July 2014, bringing earlier Indigenous health funding programs into a single national program.

From 2024–25, ACCHS delivering comprehensive primary healthcare under IAHP are funded through four-year rolling agreements. Funding is confirmed for the first two years and reviewed every two years using the Funding Distribution Model, with agreements extended for a further two years to ensure continuity. IAHP funding is provided as grant funding and is reported through standard Australian Government grant acquittal processes, including financial and performance reporting against agreed service activities and outcomes⁴⁵.

IAHP funding is delivered through multiple funding streams and administrative arrangements. For example, funding may be provided through specific grants such as Strengthening Aboriginal Health initiatives and Aboriginal Primary Health Care grants. While the funding originates from the Australian government, administration can be delegated to different organisations or jurisdictions.

In Western Australia, some IAHP-related grants are administered by the WA Country Health Service (WACHS).

The [Health Data Portal](#) (see Chapters 8 and 9) enables standardised reporting to demonstrate delivery of IAHP-funded comprehensive primary healthcare, meet routine reporting and acquittal requirements, and support funding reviews under the Funding Distribution Model. Aggregated data support service planning and performance monitoring while maintaining data confidentiality and data sovereignty.

Primary Health Networks (PHNs)

[PHNs](#) are Australian Government-funded geographically-based mainstream organisations whose purpose is supporting primary care, including by commissioning local health services to address unmet needs (particularly mental health and Aboriginal and Torres Strait Islander Health, population health, health workforce, eHealth and aged

⁴¹[Danila Dilba Health Service Annual Report 2024-25](#)

⁴²[Central Australian Aboriginal Congress Annual Report 2024-25](#)

⁴³[Apunipima Cape York Health Council Annual Report 2024-25](#)

⁴⁴[Derbarl Yerrigan Health Service Annual Report 2024-25](#)

⁴⁵[IAHP Primary Health Care Funding Distribution Model – Technical Factsheet](#)

⁴⁶[Available funding sources and resources for the ACCHS Sector](#)



care)⁴⁶. PHNs work directly with GPs, other primary healthcare providers and the broader community to ensure improved outcomes for patients. Current PHN programs include the Integrated Team Care program (see Chapter 3) and the Aboriginal and Torres Strait Islander Mental Health program.

In WA, there are three PHNs – Perth North, Perth South and Country WA, which are all operated by the [WA Primary Health Alliance \(WAPHA\)](#). In addition to commissioning services, WAPHA supports [Clinician Assist WA](#), which is a secure online clinical decision support tool for GPs, which provides clear, locally agreed upon assessment, management and referral advice on key patient presentations.

Rural Workforce Agencies (RWAs)

The Australian Government funds a [RWA](#) in each state and the Northern Territory to support the local rural health workforce and to improve access to essential healthcare in rural areas. RWAs are mainstream organisations, which play a major role in contracting outreach services, including medical specialists, GPs, nurses, allied health practitioners including optometrists, under five funding streams. There are three Aboriginal and Torres Strait Islander-specific programs under this funding: Medical Outreach Indigenous Chronic Disease Program (MOICDP), Healthy Ears Better Hearing Better Listening (HEBHBL) and Eye and Ear Surgical Support (EESS); and two



programs for the whole population: Rural Health Outreach Fund (RHOF) and Visiting Optometrists Scheme (VOS).

RHOF focuses on improving access to specialist services in areas with limited local workforce capacity. It supports specialist outreach by funding travel, accommodation, coordination, administration, and professional support costs for visiting health professionals.

MOICDP complements RHOF by targeting the specific needs of Aboriginal and Torres Strait Islander people with chronic conditions. It supports culturally safe outreach services delivered by multidisciplinary teams, including specialists, GPs, Aboriginal and Torres Strait Islander Health Workers, and allied health professionals. It also funds cultural safety training, workforce upskilling, and team coordination.

Together, the programs reduce the cost barriers of outreach delivery while ensuring services are both clinically appropriate and culturally safe. This combined approach helps ensure Aboriginal and Torres Strait Islander people with chronic disease can access consistent, high-quality care closer to home, regardless of where they live.

Rural Health West is the RWA in WA. In addition to [commissioning outreach services](#), RHW also provides education support for rural clinicians and runs annual statewide rural health and Aboriginal health conferences. ACCHS clinicians are encouraged to join the [RHW mailing list](#).

The Workforce Incentive Program

The [Workforce Incentive Program \(WIP\)](#) is a mainstream program (ACCHS are eligible) with three incentive streams:

- Practice Stream – provides payments to practices to support multidisciplinary, team-based care by engaging a broader range of health professionals.

- Doctor Stream – provides payments directly to doctors delivering primary care in Modified Monash (MM) 3–7 locations.
- Rural Advanced Skills Payment – provides additional payments to doctors in MM 3–7 locations who deliver primary care alongside emergency and/or other advanced clinical skills.

The WIP – Doctor Stream aims to encourage doctors to practise in regional, rural and remote communities and promotes careers in rural medicine by providing financial incentives. GPs working in MM 3 to 7 locations are eligible, and should ensure they understand [doctor stream guidelines](#) to ensure they are accessing relevant incentives. Doctors should ensure their bank details are up-to-date in the Health Professional Online Services (HPOS) platform for the WIP (see chapter 9).

Other Australian Government Funding

To support access to funding sources offered by the Australian Government, [Grant Connect](#) provides centralised publication of forecast and current grant opportunities, and grants awarded. It is a primary mechanism of the government to communicate funding opportunities.

State and Territory Government Funding

State and territory governments provide supplementary funding to ACCHS to support services that sit alongside Australian Government-funded primary care. This commonly includes community health initiatives, mental health and SEWB services, alcohol and other drug programs, and hospital avoidance and integration activities.

Funding is often delivered through dedicated programs aligned with the National Agreement on Closing the Gap. For example, Queensland's Making Tracks investment



strategy focuses on improving access to culturally appropriate health services by strengthening the Aboriginal and Torres Strait Islander community-controlled health sector as a frontline entry point to the health system. Similarly, Victoria's Supporting Self-Determination policy prioritises Aboriginal-specific funding to Aboriginal organisations, with the aim of supporting self-determination and improving health, wellbeing and safety outcomes for Aboriginal communities.

However, state and territory investment is inconsistent across areas. Some governments continue to regard Aboriginal primary healthcare as predominantly an Australian Government responsibility, particularly where services are funded under the IAHP. This results in variability in service capacity and integration, contributing to inequities between regions, organisations, and population groups.

Program-Specific Funding

In addition to recurrent funding, ACCHS commonly access [program-specific grants](#) to address priority health needs, including through programs commissioned by NACCHO, as well as other non-government organisations. These include funding for family and domestic violence programs, maternal and child health, sexual health, aged care, workforce development, infrastructure, environmental health and disease-specific initiatives such as eye health, ear health and rheumatic heart disease prevention. While these grants can enhance service reach and innovation, they are often time-limited and administratively intensive. Without careful integration into core service delivery, program funding can increase fragmentation and reporting burden⁴⁷. Clinicians should familiarise themselves with the local programs available for their patients.

Maximising Income Ethically and Effectively

Effective grant applications clearly articulate community need using local evidence, align proposed activities with funder priorities, and demonstrate strong organisational capability and governance. Applications should be written with strong community engagement, Board support and in line with current community needs and priorities. High-quality applications set out a clear program logic, define measurable outcomes, present a realistic and transparent budget, and show how the proposed activities integrate with existing services. Applications are strengthened by demonstrating sustainability beyond the funding period and alignment with broader policy frameworks, such as the National Agreement on Closing the Gap.

A successful grant proposal takes a strategic approach, clearly and persuasively communicating the organisation's purpose, priorities and intended impact.

Maximising funding in an ACCHS context means ensuring that legitimate clinical activity is accurately captured, funding streams are aligned with evidence-based models of care, and systems are efficient and compliant. It does not involve over-servicing or prioritising revenue over patient outcomes. High-performing ACCHS align clinical and funding models, monitor performance regularly, invest in workforce capability and maintain strong clinical governance. Funding is treated as an enabler of comprehensive, culturally safe care rather than an end in itself.

⁴⁷[NACCHO – sector grants](#)

Chapter 6 Medicare Benefits Schedule

Medicare is Australia's universal health benefits system funded by the Australian Government. Australian citizens, permanent visa holders and New Zealand citizens residing in Australia are generally eligible for Medicare⁴⁸. When someone is enrolled in Medicare, the Government pays some (or all) of their healthcare costs. This includes for non-hospital services (such as GP visits), hospital services, medicines, diagnostic services and other non-GP specialist services. To enable this, there are several different programs within Medicare. The MBS is the main government funding mechanism for general practices in Australia and will be the focus of this chapter. For an overview of the whole Medicare system, please refer to the Australian Government's [Understanding Medicare – Provider Handbook](#).

The MBS is complex, and can be very challenging to understand for new GPs and

seasoned GPs alike. It is however the central funding source for general practice in Australia, and a vital funding source for ACCHS. Good and responsible MBS billing practices by GPs facilitates continuity of care, and quality service provision. While complex, knowing a few key principles and some integral MBS item numbers will assist new GPs to Australia (and GP registrars) when they first start practising.

There are many resources available to assist people to understand the MBS, and local practice staff will help to guide new staff as they commence work. This chapter will focus on outlining a few key rules and principles for MBS claiming that will assist ACCHS clinicians to utilise the MBS well.

For an overview of MBS Item Numbers please see [AHCWA MBS Quick Guides](#) (by Modified Monash regions).

Practice tip: Funding from billing MBS items supports the provision of appropriate clinical care (not the other way around) – clinicians should never provide services solely for billing purposes.



⁴⁸[Services Australia: Enrolling in Medicare](#)



The MBS

The MBS lists health services covered by Medicare. Each MBS item has an item number, item descriptor, Schedule fee and benefit rate, which are all available on the [MBS Online database](#). The item number is used when claiming a benefit for a service. The MBS is divided into eight categories. The most important category for ACCHS is category 1- Professional attendances. ACCHS will typically also claim items from categories 2- Diagnostic procedures, 6- Pathology services and 8- Miscellaneous services. [MBS Online](#) provides item numbers for both GPs and 'Prescribed medical practitioners' (a medical practitioner who is not a GP, specialist or consultant physician – for example, a non-vocationally registered medical practitioner providing GP services).

Time-tiered

In the general practice setting, the MBS is structured to enable GPs to bill for the time they spend directly with their patient. 'Time-tiered professional (general) attendance items' which range from Level A to E (Level A being <5 min and Level E being 60+ minutes) are the basis of MBS claiming in general practice. There are different Level A to E time-tiered MBS items for face-to-face consultations (i.e. 3, 23, 36, 44, 123), after-hours consultations, residential aged care facility consultations and telehealth consultations (both for video and phone).

Bulk Billing

Most ACCHS are known as 'bulk billing' health services. This means that there is no out-of-pocket cost to the patient when they see their GP and other members of the health team at the ACCHS. Bulk billing is not 'lower value care', but supports better access to care for patients.

When you bulk bill services for a patient, you can claim an additional MBS item known as a Bulk Billing Incentive (BBI). This is available for all Medicare-eligible patients. The value of the MBS BBI depends on the service provided and the location you are practising in (based on the [Modified Monash Model](#)).

Explanatory Notes

Explanatory notes are available on the MBS Online database and provide information about Medicare rules as well as specific guidance relevant to MBS items. They are important notes to help ensure you are utilising MBS items appropriately. Notes can be found at the beginning of each schedule, category and following the description of an MBS item.

MBS in ACCHS

While time-tiered MBS claiming is essential in general practice, there are several key MBS items that are designed to promote good quality primary healthcare, through a preventive approach both to the development of disease, and the progression of disease. These include Health Assessment, Chronic Condition Management Plan (CCMP) and Mental Health Treatment Plan (MHTP) items.

MBS health assessments and CCMPs (with their follow-up and referral items) are designed to enable team-based, multi-disciplinary care. GPs have a responsibility to refer and bill appropriately so that ACCHS have sufficient MBS revenue to employ the necessary teams - both clinical (e.g. AHWs, AHPs, nurses) and support (e.g. transport officers, program coordinators, other support staff).

Effective billing can also help to fund health promotion, prevention and treatment programs, such as exercise classes, which can benefit the whole community. In ACCHS, practice nurses, AHWs and AHPs will often assist with the preparation of a Health Assessment, CCMP, or CCMP Review, but the GP is responsible for the content, and must see the patient as part of the service.

Time-tiered MBS items are still used within an ACCHS, but these should generally be utilised for acute presentations. It is important to note that there are rules around 'co-claiming' of MBS items. For example, time-tiered 'general attendance' items cannot be co-claimed by the same practitioner on the same day for the same patient as a CCMP. Co-claiming restrictions are outlined in the Associated Notes for an MBS item on MBS Online.

Some key MBS Items in ACCHS

Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item Number 715)

- A health assessment available to all Aboriginal and/or Torres Strait Islander people from birth.
- Can be performed every 9 months, but is usually performed annually.
- Claimed using MBS item 715 (MBS item 92004 is used if the assessment is performed via video telehealth, rather than face-to-face).
- Must include history, examination, appropriate investigations, assessment, recommending appropriate interventions, providing advice and information to the patient, and keeping a record of the health assessment which is also offered to the patient or carer.
- Specific inclusions for different age groups (children less than 15 years, adults aged 15 to 54 years and older people aged 55 years) are often templated within clinical software.
- Once an assessment is completed, any follow-up service consistent with the needs identified can be provided by a practice nurse or AHP, on behalf of a medical practitioner, using the [MBS item 10987](#) to a maximum of 10 services per patient in a calendar year.
- After completing a Health Assessment a patient can be referred for up to 10 MBS-eligible allied health services per calendar year.

Practice tip: The 715 MBS item is claimed on completion of a health assessment, but elements of the history and examination can be done over several visits. Templates within clinical software facilitate this by highlighting which elements still need to be completed.

Chronic Condition Management Plan (MBS Item Number 965)

- Patients are eligible for a CCMP if they have at least one medical or mental health condition that has been (or is likely to be) present for at least 6 months, or is terminal.
- Plans are intended for patients that would benefit from a structured approach to managing their chronic condition(s).
- Plans can be prepared no more than once every 12 months, and can be reviewed (MBS item 967) no more than once every 3 months.
- A CCMP is claimed using MBS item 965 (or MBS item 92029 if completed via video telehealth). CCMP Reviews are claimed using MBS item 967.
- Patients with a CCMP can access MBS-eligible allied health services to assist with the management of their chronic condition(s). Aboriginal and Torres Strait Islander patients can be referred for up to 10 such services per calendar year.
- The GP must write a referral to the allied health provider or AHP (it is helpful to include the number of services the patient would like to use with that provider). The allied health provider or AHP must provide a written report back to the referring medical practitioner after the first and last service⁴⁹. This also applies to allied health referrals following a Health Assessment (715).
- Additionally, a practice nurse and/or AHP can provide 5 follow-up services for a patient with a CCMP (using MBS item 10997).

⁴⁹Services Australia: Referrals for GP CCMP

Practice tip: Follow-up item 10987 has a higher monetary value than 10997. A patient who has had an annual health assessment and CCMP completed is eligible for 10 x 10987 and 5 x 10997 within a 12-month period. Item 10997 can be claimed in conjunction with 10987, as long as the conditions of both items are satisfied. AHPs, AHWs and nurses can assist the GP with information gathering to prepare health assessments and CCMPs but this time cannot be claimed for using a follow-up item.

Practice tip: Medical practitioners can refer Aboriginal and/or Torres Strait Islander patients for up to 10 individual MBS eligible allied health services per calendar year if the patient has a CCMP or has had a Health Assessment. Referrals can be made to MBS-billing ACCHS-employed AHPs/AHWs/Allied Health providers or to external private providers.

MBS Services Provided on Behalf of a Medical Practitioner

The Health Assessment follow-up item 10987, CCMP follow-up item 10997 and Immunisation by an AHP item 10988 (among others) are MBS items claimed by a GP for services performed, on their behalf, by a practice nurse or AHP. The GP retains responsibility for the patient's care including their health, safety and clinical outcomes. Follow-up care on behalf of the GP can be done in the clinic, by video, phone or home visit. See [AHCWA MBS Quick Guides](#) and refer to [MBS Online](#). The GP does not have to see the patient for a claim to be made.

MBS Services Provided by an AHP or AHW with a Medicare Provider Number

[GPs can refer patients](#) who have completed a Health Assessment or CCMP to an AHP or AHW for [health and wellbeing services in keeping with plans formulated](#). AHP/AHWs with a Medicare Provider Number can then bill for their services directly. Under these circumstances AHP/AHWs are working in the role of an allied health provider and those rules apply.

Diagnostic, Pathology and Procedural MBS Items

Various MBS Items can be claimed, along with a BBI, for diagnostic, pathology and procedural items. For example, there are MBS items for 12 Lead ECGs, spirometry, diabetic retinopathy

assessment, urine pregnancy test, point-of-care tests including HbA1c, and Long-Acting Reversible Contraception (LARC) insertion and removal. Please see [AHCWA MBS Quick Guides](#) for more information.

Practice Incentives Programs

The Australian Government's Practice Incentives Program (PIP) works alongside the MBS to support general practices to provide quality care and enhance capacity of services. The program is administered by Services Australia, and pays practices or GPs directly for providing a specific type of service or reaching a designated level of care.

There are a number of PIP programs in place, including the eHealth incentive, Quality Improvement incentive and Teaching incentive. Rural loading is automatically applied to PIP payments of practices in rural and remote areas. Practice managers and Senior Medical Officers should ensure they keep up to date with PIP guidelines, and ensure their service is registered for relevant PIPs through their organisational HPOS (see Chapter 9). See further information from [Services Australia](#), including on PIP eligibility.

One of the most important PIPs for ACCHS is the Indigenous Health Incentive (PIP IHI).

PIP - Indigenous Health Incentive



- The PIP IHI supports practices (through additional payments) to provide better healthcare for Aboriginal and/or Torres Strait Islander patients, with a focus on best practice management of chronic conditions and mental disorders.
- Practices must apply and be approved for the PIP IHI in order to participate.
- Once approved, they can register individual patients for the PIP IHI by verbally explaining the program, and then registering them [using a form](#) which can be submitted to Services Australia, or retained by the practice who can register the patient in HPOS.
- Patients of any age can be registered if they:
 - Identify as being Aboriginal and/or Torres Strait Islander
 - Have a chronic condition or a mental disorder
 - Have had or been offered a Health Assessment for Aboriginal and/or Torres Strait Islander people
 - Have a current Medicare card
 - Have nominated your practice as their 'usual care provider' and provided informed consent to be registered for the PIP IHI.
- Registration for patients is lifelong (except for children, where they must be re-registered at 15 years with their own consent). The patient can withdraw their consent or be withdrawn if they are no longer eligible.
- Payments are made to the practice for initial practice registration (\$1,000 once off) and thereafter, annually, for each registered patient who has received a required level of care (outcome payments, based on MBS items billed for a patient).
- Outcome payments:
 - Tier 1: an initial \$100 is paid to the practice per registered patient, when they have received two eligible 'Tier 1' MBS services within the patient's 12-month assessment period with that practice. Tier 1 MBS services include CCMP preparation (965) and review (967) items, and GP Mental Health Treatment Plan items.
 - Tier 2: a further \$300 is paid to the practice per registered patient, when they have received a minimum of five eligible MBS services within the patient's 12-month assessment period with that practice. This includes the two Tier 1 services.
- For example, a patient with Type 2 Diabetes should be registered for the PIP IHI with their consent.
 - Once a CCMP has been prepared (965), and reviewed (967) after 3 months the practice receives \$100 in the next quarterly PIP payment cycle (Tier 1 outcome payment).
 - Within the same 12-months since registration, they have a further CCMP review (967), have their Annual Health Assessment (715) and are seen for an acute issue one further time (time-tiered item – 23). The practice receives a further \$300 (Tier 2 outcome payment).
 - An example of total revenue available through MBS items including BBIs and PIPs for a patient with type 2 diabetes is available at the end of this chapter.

PIP payments are made quarterly. To ensure correct PIP payments, it is vital that when a medical practitioner joins, leaves or extends their provider number at a location, that the service adds or updates their provider number on their practice profile using HPOS (including locums)⁵⁰.

Optimal utilisation of PIP programs in ACCHS is a key enabler to delivering comprehensive primary healthcare through a multidisciplinary team. PIP income can be used by ACCHS to support employment of key team members, such as transport officers to assist patients to get to and from appointments, receptionists, nurses, AHWs and AHPs and other program staff.

⁵⁰For practice managers: Medical practitioners should remain on the practice profile until the end of the relevant payment quarter to ensure correct payments are received.

MyMedicare

In Australia, a patient can seek services from any GP or practice they choose. There is currently no requirement to be registered with a specific practice. MyMedicare, introduced by the Australian Government in 2023, is a voluntary patient registration model aiming to formalise the relationship between patients and their GP / primary care team and to encourage continuity of care.

For patients who are MyMedicare registered, GPs can be funded (through MBS) to provide longer telehealth consultations, and can claim a higher value BBI ('triple BBI') for some telehealth MBS items. Additionally, MyMedicare registered patients must have their CCMP completed by their registered practice (whereas non-registered patients can have their CCMP with their 'usual provider'). [AHCWA MBS Quick Guides](#) provide information on which MBS items are only available for MyMedicare registered patients.

Practice Incentives are also available through the MyMedicare program – including the GP Aged Care Incentive and the Bulk Billing Practice Incentive Program (BB PIP). The GP Aged Care Incentive is paid directly to the GP (or the bank account they nominate – this can be negotiated by ACCHS in their GP contracts) while the BB PIP is split between the practice (50 per cent) and the GP (50 per cent) (again, this split can be negotiated by ACCHS in their GP contracts – as most ACCHS pay GPs a salary, the ACCHS and GP can agree to redirect the GP BB PIP portion to the ACCHS). Registration for these MyMedicare Practice Incentives is also completed through HPOS.

Medicare Cards

Those [enrolled in Medicare](#) receive a Medicare card. Families may have a single Medicare card which shows family members' names and individual reference numbers under a single Medicare number.

Aboriginal and Torres Strait Islander people may face several barriers to accessing Medicare benefits, even when they are enrolled in Medicare. These could be related to:

- Multiple names, whereby Aboriginal and/or Torres Strait Islander people may change their name for cultural reasons. In some regions it is disrespectful to use the name of someone who has passed away, and so others with the same name may change their name.



Figure 7. Medicare card⁵¹

⁵¹[How does medicare work](#)

- Lost cards (not having a physical card and not knowing their Medicare number; patients may have a photo or screen shot of their card, so it is good to ask).
- No physical address for receiving replacement cards.
- Limited digital access and literacy impacting navigation of online systems like MyGov.
- Historical issues with registrations of birth that may mean a person has several different dates of birth registered.
- Duplication, whereby a child (or adult) could be listed on more than one family card.
- Limited access to birth certificate or other formal identification to enrol (noting some people may have never been enrolled).

Where these issues occur it can mean that MBS claims from a practice are not paid by Services Australia, as well as limiting the patient's access to other Medicare benefits for example pathology and referred services. Additionally, it impacts health services ability to access My Health Record, national registers and other programs (see Chapter 9).

ACCHS often play an important role in supporting patients to navigate the Services Australia system so that a patient can access Medicare benefits. The Services Australia Indigenous Access Line can be used by both patients and health staff to help resolve these barriers (1800 556 955).

Patient details (including Medicare number) can be searched through HPOS (see Chapter 9), but this may not always yield a result.



MBS Billing Example – patient with Type 2 Diabetes over 12 months (MM3)⁵²

MBS Item	Payment (\$)	Bulk Billing Incentive	Payment (\$)	PIP IHI	Payment (\$)	Other team care incl. on behalf of GP	Payment (\$)	BBI	Payment (\$)	Grand Total
965	\$156.55	75855	\$11.70			715 follow-up with practice nurse/AHP: 10987 x5	\$139.75	75855 x5	\$58.50	
967 x2	\$313.10	75855 x2	\$23.40	Tier 1	\$100.00	ECG: 11707	\$18.25	75855	\$11.70	
715	\$247.65	75855	\$11.70			Diabetic retinopathy assessment: 12325	\$49.55	75855	\$11.70	
23	\$43.90	75853	\$35.30	Tier 2	\$300.00	POC HbA1c x4: 73840	\$57.80	75861 x4	\$46.00	
						POC Urine ACR: 73844	\$17.30	75861	\$11.50	
						Home Medicines Review: 900	\$180.65	75855	\$11.70	
						CCMP follow-up with practice nurse/ AHP: 10997x5	\$70.00	75855	\$58.50	
Total	\$761.20		\$82.10		\$400.00		\$533.30		\$209.60	\$1,986.20

Key MBS Resources

- Services Australia Indigenous Access Line (for patient and health staff) - for help with a Medicare service or payment: 1800 556 955
- [AHCWA MBS Quick Guides](#)
- [NACCHO Online Learning: MBS Optimisation courses](#)
- [Services Australia: Indigenous Health Services - Infographics](#)
- [Services Australia: Indigenous Health Services - eLearning](#)
- [Services Australia: Indigenous Health Services - Your guide to Medicare for Indigenous Health Services](#)
- [Services Australia: Incentive Programs](#)
- [Services Australia: MyMedicare](#)
- [Services Australia: Organisation Register](#)
- [Services Australia: PRODA](#)
- [MBS Online](#)
- [Australian Government: Understanding Medicare Provider Handbook](#)

⁵²Calculated December 2025

Chapter 7 Medicines

Several agencies, policies and programs work together in Australia to enable affordable access to, and the correct usage of, safe and quality essential medicines⁵³.

The Pharmaceutical Benefits Scheme (PBS) is an Australian Government Medicare program that reduces the cost of most essential medicines for Australian residents who hold a Medicare card. PBS-subsidised medicines are prescribed by doctors (and in some cases other health professionals⁵⁴), and patients pay a capped [co-payment](#), with the Australian Government paying the remaining cost. People with a concession card pay a smaller co-payment than other (general) patients and additional subsidies are available for Aboriginal and Torres Strait Islander people registered for the [Closing the Gap \(CTG\) PBS Co-payment program](#) (described below). The [Repatriation PBS \(RPBS\)](#) offers broader coverage of medicines and associated products for eligible veterans, war widows/widowers, and their dependents.

Many ACCHS will have partnerships with local community pharmacies to facilitate supply of medicines to their patients, with special additional arrangements in remote locations.

Prescribing in Australia is guided by Australian guidelines, such as the [Therapeutic Guidelines](#). Prescribers must also understand PBS-prescribing rules (explained below and available at [pbs.gov.au](#)), as many medicines are only subsidised for certain clinical indications. Additionally, there are often state (or territory), regional or local guidelines that should guide prescribing (e.g. antibiotic prescribing based on local resistance patterns).

New clinicians will be provided with support and guidance from local ACCHS clinicians, and should feel comfortable to ask senior clinicians for prescribing advice particularly when they begin work.

Prescribing Medicines

Prescriptions

Prescriptions (scripts) can be handwritten, computer-generated and printed, or electronic. There are several 'do's and don'ts' regarding preparing prescriptions, including specific rules for more restrictive authority scripts. Full information from the PBS is available on their [website](#)⁵⁵. Personalised script pads for handwritten scripts can be ordered through your Health Professional Online Services (HPOS) account (see Chapter 9), however prescriptions written within clinical software (digitally) are preferred as they provide an electronic record and reduce medication errors.

There are additional state or territory requirements for prescribing drugs of addiction (Schedule 8 medicines).

In WA, in addition to the standard requirements for a prescription, when prescribing Schedule 8 medicines, authorised prescribers must include a minimum repeat dispensing interval and the patient's verified date of birth. See [Requirements for prescriptions in WA](#). Medicine scheduling is described below.

PBS Items

Most⁵⁶ PBS-subsidised medicines must be [prescribed](#), but the PBS doesn't subsidise all prescription medicines (it covers about 80 per cent). All PBS items can be browsed at [pbs.gov.au](#). New Australian prescribers should be aware that some medicines commonly used in their country of origin may not be PBS-subsidised in Australia – always check [pbs.gov.au](#).

When choosing a prescription medicine in clinical software, prescribers must choose the correct PBS item for the clinical indication the medicine is being prescribed for (for most medicines, there are multiple options to choose

⁵³[National Medicines Policy 2022](#)

⁵⁴Dentists, optometrists, midwives and nurse practitioners who are approved to prescribe PBS medicines under the *National Health Act 1953*

⁵⁵[Prescribing Medicines – Information for PBS prescribers](#)

⁵⁶There are some over-the-counter scheduled medicines that are PBS-subsidised e.g. Ventolin.

from depending on PBS-subsidised clinical indication).

PBS items fall into three broad categories:

- Unrestricted benefits – no restrictions on therapeutic use.
- Restricted benefits – can only be prescribed for specific therapeutic uses.
- Authority required benefits – require either Streamlined, online, phone or written approval from Services Australia or the Department of Veteran's Affairs (for the RPBS).

Practice tip: Authority Scripts

Prescribers must choose the correct PBS item for the clinical indication the medicine is being prescribed for when selecting medicines within clinical software. Where an Authority Required medicine is chosen, an authority code, must be included in the prescription.

For example, when amoxicillin is looked up on the PBS there is an unrestricted PBS item which enables 20 capsules to be prescribed. There is also an Authority item available for certain clinical criteria. A [streamlined authority code](#) is available for 40 capsules to be prescribed so the patient can complete a full antibiotic course for the relevant infection listed.

To prescribe a medicine requiring authority approval (where a Streamlined authority code is not available), the prescriber must apply for PBS authority either online through HPOS (see Chapter 9) or by calling Services Australia. This can be done efficiently during the patient consultation. Services Australia will provide an authority approval number which must be recorded on the authority prescription form.

Further information is available from [Services Australia](#).

PBS Safety Net

A [PBS Safety Net](#) exists to assist patients and families who require a large number of medicines. When a patient meets or exceeds the safety net threshold within a calendar year, they qualify to receive PBS or RPBS items at a lower charge or for free for the rest of that calendar year. This is predominantly managed through community pharmacies.

Non-PBS Items

Prescription medicines that are not PBS-subsidised can be prescribed using a 'private prescription' (a non-PBS script). For these medicines, the cost can vary between pharmacies and the patient pays the full price for the medicine. For example, GLP-1

agonists are only PBS-subsidised for specific indications in Australia. Where patients do not qualify for PBS-subsidised medicines, they may be prescribed as a private prescription (noting, this should usually still be in keeping with clinical guidelines)⁵⁷.

Non-Prescription Medicines

Non-prescription medicines are often referred to as 'over-the-counter' (OTC) medicines and do not require a doctor's prescription. Some OTC medicines, however, may be cheaper for a patient if prescribed. Some ACCHS may keep non-PBS non-prescription medicines in their clinic imprest – this is usually at the expense of the ACCHS, with medicines provided to patients as required.

⁵⁷These medicines are not covered by the CTG PBS Co-Payment Program.



Practice tip: ACCHS clinicians should be aware that some patients may access bush medicines in addition to seeking medical care through the clinic (see Chapter 2). Consider asking your patients about any traditional or bush medicines they may be taking when taking a medication history.

Closing the Gap PBS Co-Payment Program

The [CTG PBS co-payment program](#) reduces or removes the PBS co-payments for eligible Aboriginal and/or Torres Strait Islander people, supporting equity in healthcare. Registration is required once and is lifelong. If registered, patients who would normally pay the full general PBS co-payment receive medicines at the concessional rate. Those who would normally pay the concessional rate receive PBS medicines for free. The program applies to all PBS medicines in all geographical areas.

Registration is completed through HPOS by any PBS prescriber or Medicare-registered AHP. Registration can also be delegated to other ACCHS employees (e.g. reception staff). A patient is eligible if they self-identify as an Aboriginal and/or Torres Strait Islander person; will have setbacks in preventing or managing their condition if they don't take their medicine; they are unlikely to keep up treatment without help with the cost; and they are enrolled in Medicare.

Although PBS prescribers are not legally required to write or electronically print "CTG" on eligible PBS scripts, annotation of a PBS script will help pharmacists when dispensing medicines to know that the patient is registered and eligible.

Listings on the PBS for Aboriginal and Torres Strait Islander People

There are a [number of medicines](#) that are PBS-listed specifically to assist the health needs of Aboriginal and Torres Strait Islander people. Many of these are over-the-counter medicines, for example chloramphenicol

eye drops, ferrous fumarate, ivermectin and paracetamol. Listings are brand-specific (e.g. the only oral iron tablets available are ferrous fumarate 200mg Ferro-tab). This list is sometimes confused with the CTG PBS Program, however CTG applies to all PBS medicines, including this list.

Electronic Prescribing

Electronic prescribing (e-prescribing) allows prescriptions to be created, sent, and dispensed digitally – replacing the need for paper prescriptions entirely. In ACCHS, e-prescriptions can be generated using clinical software (i.e. Communicare, MMEx and Best Practice). Once an e-prescription is created, a token is generated. This token is either sent to the patient via SMS or email, or printed as a paper token. The token is a QR code or barcode that contains a secure link to the legal prescription. Pharmacists scan the token to access and dispense the prescribed medicine.

There are many benefits to e-prescribing, both for the patient and the prescriber. For example, e-scripts reduce transcription errors and remove the need to handle or store paper documents. Some patients may still prefer to receive paper scripts. Safe digital access to a personal device and digital literacy should also be considered when discussing preferred script method with patients.

Active Script Lists (ASLs) are also available for those on multiple medications. Further information is available from the [Australian Digital Health Agency \(ADHA\)](#).

Regulation 49

Under the PBS a maximum quantity and number of repeats is allowed for each item. In some situations (e.g. for patients in remote areas where access to PBS supplied is limited) original and repeat supplies of PBS medicines



can be supplied at one time if the prescriber is satisfied that certain conditions apply. This can be indicated to the pharmacist by writing the words 'Regulation 49' or 'one supply' on the script. See [PBS information on Regulation 49](#) for more information.

Generic Medicines

All brands of the same medicine authorised for supply in Australia, regardless of price, have the same active ingredient (as assessed and approved by the Therapeutic Goods Administration (TGA))⁵⁸. Where 'generic' prescription medicines are available, they may be more affordable than the original 'brand name' medicine, which may incur an additional charge to the patient known as a 'brand premium'. This is important to keep in mind, particularly where affordability is important for patients.

Dispensing and Supplying Medicines

Medicine Scheduling System including Drugs of Addiction

Medicines in Australia are classified by the TGA under a scheduling system that determines how and where they can be accessed. These schedules are outlined in the Poisons Standard⁵⁹.

- Unscheduled medicines are not included in the Poisons Standard and can be purchased freely (e.g. at supermarkets).
- Schedule 2 and 3 medicines are available only from pharmacies and are often referred to as 'over-the-counter' medicines.
- Schedule 4 medicines require a prescription, and include most items listed on the PBS.
- Schedule 8 medicines are classified as drugs of dependence or addiction and are subject to additional restrictions, which vary between states and territories.

In WA, the [Monitored Medicines Prescribing Code](#) governs the prescribing of Schedule 8 and other high-risk medicines. The code outlines situations where prescribers do not require prior authorisation from the CEO of the WA Department of Health to prescribe Schedule 8 medicines. In all other situations, authorisation is required.

Schedule 8 medications include:

- Opioids (e.g. morphine, oxycodone, tapentadol, fentanyl, methadone and buprenorphine)
- Ketamine
- Stimulants e.g. dexamphetamine, methylphenidate
- Medicinal cannabis products
- Esketamine, MDMA, psilocybin
- Benzodiazepines – flunitrazepam, alprazolam

Some Schedule 4 medicines are also classified as Monitored Medicines, including:

- Benzodiazepines (e.g. diazepam)
- Codeine-based preparations
- Pregabalin

These medicines are tracked using [ScriptCheckWA](#), WA's Real-Time Prescribing Monitoring (RTPM) system. Prescribers and pharmacists must register and complete identity verification to access patient records.

The Monitored Medicines Prescribing Code in WA is explained [here](#).

Community Pharmacies

Most Australians will access over-the-counter and prescription medicines through a local community pharmacy (both PBS and non-PBS medicines). Pharmacists are the main profession with the legislative ability to dispense prescription medicines. Community pharmacists often offer other services, such as blood pressure checks, vaccination and Home Medicines Review (HMR). Independent prescribing by pharmacists is limited, and varies by state and territory.

⁵⁸TGA: [Generic prescription medicines: Fact sheet](#)

⁵⁹[Scheduling basics of medicines and chemicals in Australia](#)

Remote Area Aboriginal Health Service (RAAHS) Program

This program provides free PBS medicines to patients of Aboriginal and Torres Strait Islander health services in remote areas. It operates under section 100 of the National Health Act 1953 and so is often referred to as the S100 RAAHS program. Many remote ACCHS (particularly where no pharmacy is available locally) utilise the program to enable access to medicines for remote patients without using a standard PBS prescription. Some remote town-based ACCHS with a pharmacy nearby may also utilise the program to improve access to medicines for their patients.

Under the program, eligible Aboriginal and Torres Strait Islander health services (including ACCHS and remote services run by state and territory governments) can order PBS medicines from approved suppliers (usually community pharmacies). The service can then provide these medicines directly to their patients for free. To get reimbursed, the suppliers submit a payment claim to Services Australia, meaning the health service does not

need to pay the supplier for PBS medicines under the program. Eligibility is restricted to [Rural, Remote and Metropolitan Area \(RRMA\) classifications](#) 6 and 7. Full eligibility criteria are available from [Services Australia](#).

Where prescription medicines are not dispensed by a community pharmacist, they can be supplied by a prescriber. The medicine must have a label outlining the patient's name, date of birth, date, name of drug, dose, quantity and directions.

Some ACCHS have specific roles to assist prescribers with dispensing medicines (e.g. in the Kimberley, many ACCHS have an Aboriginal Medication Support Officer (AMSO)).

Medicines and Poisons Regulations

While states and territories adopt the national schedules as detailed in the [National Poisons Standards](#), each state and territory has its own laws regarding the handling of medicines and poisons. It is important that ACCHS management and prescribers understand how relevant state or territory legislation relates to their work.



In WA, the Medicines and Poisons Act 2014 and Medicines and Poisons Regulations 2016 govern how medicines and poisons are handled within the state. Specific WA rules include the requirement for healthcare facilities to have a permit if they want to hold an imprest of medicines outside of an individual [medical practitioner's doctor's bag supplies](#), or store medicines dispensed by a community pharmacist and awaiting collection by the patient. This is relevant for most ACCHS in WA with many maintaining an imprest of essential medicines on site. This is relevant for most ACCHS in WA and vital for remote services using the RAAHS program. Further information on applying or renewing a permit in WA is available from [WA Health](#).

Administering Medicines

In Australia, pharmacists are the main profession with the legislative ability to dispense prescription medicines, however, a range of health professionals can supply and administer medicines under different

circumstances and in different settings. Rules around supply and administration of medicines are state or territory specific.

[In the community setting](#), medicines must usually be ordered by an authorised prescriber, dispensed by a pharmacist (unless it is prescribed and supplied by a prescriber), and administered by a qualified health professional (e.g. an AHP or registered nurse). Exceptions to this include, for example, nurse-initiated medicines, which are then administered according to an approved protocol as per state or territory legislative requirements and the health service's organisational policy. This process is sometimes referred to as a 'standing order'.

AHPs are a vital healthcare professional within an ACCHS team. Some states and territories have legislative provisions in place for AHPs to administer some medicines, such as vaccines and antibiotics. It is important for clinicians to understand their local legislative and health service requirements for medicine administration.

SASAs in WA

In WA, [Structured Administration and Supply Arrangements \(SASAs\)](#) can be used to authorise an eligible non-prescribing health practitioner to supply or administer a medicine without a direct patient-specific order from a prescriber. SASAs can be issued by the CEO of WA Health that can apply to specific authorised provider groups across the state; or SASAs can be used at the hospital or health service level and apply to practitioners employed by the organisation. Important [CEO of WA Health SASAs](#) include those that enable AHPs and registered nurses to treat Sexually Transmitted Infections (STIs) and provide immunisations. There is also a SASA for registered nurses at remote area nursing services, which enables the administration or supply of approved medicines for the treatment of approved acute medical conditions. Many ACCHS have also developed their own organisational SASAs for specific health conditions.





Dose Administration Aids (DAAs)

A Dose Administration Aid (DAA) is a well-sealed, tamper-evident device that allows individual medicine doses to be organised according to the prescribed dose schedule. Types of DAAs include compartmentalised plastic boxes (e.g. Dosette), blister or bubble packs (e.g. Webster-Pak) and sachet systems. DAAs are provided with the aim of assisting people with the management and timing of their medicines.

An [Indigenous Dose Administration Aids \(IDAA\) Program](#) is available for Aboriginal and/or Torres Strait Islander patients. This enables eligible patients to access DAAs for free through their community pharmacy, and the program is well utilised by ACCHS. Eligibility and further information is available from [NACCHO](#).

Quality Use of Medicines

The Quality Use of Medicines (QUM) is one of the central pillars of Australia's National Medicines Policy. NACCHO supports QUM in ACCHS, particularly by creating [resources to support clinicians](#)⁶⁰. NACCHO's [Indigenous Health Services Pharmacy Support Program](#) aims to improve QUM by providing funding to ACCHS to purchase a range of QUM support activities. Important QUM services include HMRs and the role of non-dispensing pharmacists.

Home Medicines Review (HMR)

A HMR is a clinical process that considers a patient's medicines and health to enhance QUM and reduce the number of adverse medicines events. A doctor (GP, sometimes specialist) generates a HMR referral to a credentialed pharmacist (often their usual

community pharmacist, but the patient can choose). The pharmacist conducts a home visit to review current medicines, answer questions, and identify any issues. They then provide a report to the referring doctor with suggested medication management strategies. The GP can claim MBS item 900 for a completed HMR. A current GP CCMP is required to access the HMR.

Non-Dispensing Pharmacists

Some ACCHS may have non-dispensing pharmacists as part of their healthcare team. Non-dispensing pharmacists help to improve medicine adherence, enhance clinical outcomes (particularly for chronic disease) and improve prescribing safety and quality⁶¹. NACCHO provides support to ACCHS to recruit and support the non-dispensing pharmacist workforce.

Other

Some other key QUM initiatives include promoting [antimicrobial stewardship](#), [monitoring medication shortages](#), prescribing from appropriately developed standard drug lists (e.g. the [Kimberley Standard Drug List](#)), clinical governance and quality improvement systems to support medication safety, and, of course, prescribing in accordance with best practice guidelines.

Key medicines guidelines in Australia include the [Australian Medicines Handbook](#) and the [Therapeutic Guidelines](#) (both of which require subscriptions, which some ACCHS may purchase on behalf of staff).

⁶⁰For example, through NACCHOs [Good Medicine Better Health](#) Program

⁶¹[Integrating pharmacists within ACCHS to improve chronic disease management project \(IPAC\)](#)

Chapter 8 Continuous Quality Improvement

“From the beginning, ACCHOs were established to address an un-met need for culturally safe and comprehensive primary health care for Aboriginal and Torres Strait Islander communities. To this day, ACCHOs continually review their programs and services to improve the way they respond to changing community priorities and needs”

[Aboriginal Community Controlled Health Organisations in practice: Sharing ways of working from the ACCHO sector.](#)

Continuous Quality Improvement (CQI) is the process of using information and analysis at the health service (or practice) level to understand the quality of care that patients are receiving, working to improve those elements that are not working well, and measuring the change⁶².

Aboriginal and Torres Strait Islander people have the right to high quality and comprehensive primary healthcare, and CQI is a mechanism that enables ACCHS to provide culturally responsive and safe health services to meet the needs of the local community.

The [National Framework for CQI in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023](#) provides practical support for ACCHS to embed CQI into their health service. Additionally, a detailed

description of CQI in ACCHS, including examples, is included in [Aboriginal Community Controlled Health Organisations in practice](#)⁶³.

The majority of CQI work is carried out through organisation quality processes, led by the organisation’s executive (leadership) teams. However, clinicians play important roles within CQI processes in their ACCHS, for example, ensuring clear, accurate and timely documentation of clinical encounters, using appropriate clinical codes and supporting or leading clinical audits. Where clinicians contribute to CQI work outside of their usual patient duties, this is supported by the ACCHS, often with time allocation and guidance.

This chapter will give a brief overview of key elements of CQI in ACCHS for clinicians.

⁶²[Lowitja: Recommendations for a National CQI Framework for Aboriginal and Torres Strait Islander Primary Health Care](#)

⁶³[The Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange: ACCHOs in practice](#)

CQI Principles for ACCHS Clinicians

- CQI should be embedded within ACCHS at every level as part of the core business of providing healthcare. Clinicians are most involved in CQI related to the Clinical Governance of an ACCHS.
- ACCHS service delivery is driven by community priorities and needs – CQI is a vital mechanism to achieving this.
- CQI mechanisms are key to ensuring ACCHS meet accreditation standards, national Key Performance Indicators (nKPIs) and funding requirements, while at the same time driving high quality and culturally safe care.
- Most ACCHS will have a Quality Management System (QMS) and may have a dedicated staff member to coordinate CQI activities (although often CQI activities will be embedded within roles across the organisation).
- A QMS provides a mechanism to store and update policies, procedures and other key documents including staff professional registrations and certificates.
- State or territory affiliate organisations (which are the peak bodies for ACCHS in each jurisdiction) have expertise and resources to support CQI activities in ACCHS.
- A common model used for CQI in healthcare is the Plan-Do-Study-Act (PDSA) cycle⁶⁴. This model can be used by clinicians conducting clinical audits.

Governance

All ACCHS are governed by a Board of Directors, most of whom are usually local Aboriginal and/or Torres Strait Islander community members. Boards are responsible for the high-level governance and strategic oversight of the organisation. Each ACCHS will have a CEO, often assisted by an executive team, who is responsible for the operation of the organisation and reports to the Board. Cultural Governance is typically provided through the Board, Aboriginal and/or Torres Strait Islander staff, and community input.

External accountability occurs through mechanisms such as the [Office of the Registrar of Indigenous Corporations \(ORIC\)](#), which supports and regulates corporations incorporated under the Corporations (Aboriginal and Torres Strait Islander) Act 2006 (CATSI Act).

The organisation structure of each ACCHS will vary, but often there are multiple teams consisting of human resources, administrative, programmatic, support, clinical and other staff. Each member of the team supports Clinical Governance by implementing policies, fostering a culture of quality improvement, and ensuring compliance with legislation and accreditation requirements. Many ACCHS have a Medical Director or Senior Medical Officer (SMO), who is often a GP, and alongside provision of GP-services, holds other non-clinical responsibilities including managing other medical staff, providing leadership for clinical services, and supporting Clinical Governance processes within the ACCHS.

⁶⁴Many templates for the PDSA cycle are available online. [WA Primary Health Alliance \(WAPHA\)](#)

Clinical Governance

Clinical Governance refers to the systematic monitoring and quality improvement processes undertaken to promote safe and quality patient care in the delivery of ACCHS programs and services⁶⁵. Clinical Governance, as with all governance mechanisms in an ACCHS, should be accountable to the community. In an ACCHS it is inextricably linked with Cultural Governance, with community input and cultural responsiveness being key concepts that ensure services are tailored to the cultural needs of the community.

Clinical Governance processes must be in place to meet accreditation standards against the [RACGP Standards for General Practice](#). Key components of effective Clinical Governance fit within five areas⁶⁶:

1. **Quality assurance and improvement** – ensures systems in place to monitor, evaluate and enhance quality care.
2. **Risk management** – supports identifying, assessing, and mitigating risks to patients, staff and the practice.
3. **Education and training** – promoted continuous professional development for clinical and non-clinical staff.
4. **Performance and accountability** – sets benchmarks and holds the team accountable for maintaining high standards.
5. **Engaging with patients and stakeholders** – encourages feedback and fostering a culture of transparency and partnership.

Accreditation

Accreditation is the process where external auditors determine whether a service meets agreed national standards of quality care and safety, namely the [RACGP Standards for General Practice](#). Accreditation is voluntary for general practices in Australia and takes place every three years. However, practices must be accredited to access some funding mechanisms, including the Practice Incentive

Program (PIP) and Workforce Incentive Program (WIP), among others. ACCHS recognise the value of accreditation in promoting and demonstrating high quality and safe care. The Australian Commission for Safety and Quality Health Care has a list of accreditation agencies approved to operate within the [National General Practice Accreditation Scheme](#). ACCHS must engage an approved accrediting agency to conduct their practice's accreditation assessment.

Most WA ACCHS use Australian General Practice Accreditation Limited (AGPAL).

National Key Performance Indicators (nKPIs)

The [national Key Performance Indicators \(nKPIs\)](#) are a set of indicators reported by organisations receiving funding under the Australian Government's Indigenous Australians' Health Programme (IAHP) (see Chapter 5), which includes most ACCHS.

There are 21 indicators that track and evaluate how progress is being made towards the goals of the [National Aboriginal and Torres Strait Islander Health Plan](#) and the [National Agreement on Closing the Gap](#) health outcomes and Priority Reforms, through primary healthcare services funded under the IAHP. The nKPIs are made up of both 'process of care' and 'outcome' indicators covering three major themes:

- Maternal and child health: e.g. PI02: proportion of Indigenous babies born within the previous 12 months whose birthweight results were recorded as low, normal or high on more than one visit.
- Preventative health: e.g. PI14: proportion of regular clients who are Indigenous, aged 6 months and over and who are immunised against influenza.
- Chronic disease management: e.g. PI19: Number and proportion of Indigenous regular clients with a selected chronic disease whose kidney function tests in the past 12 months indicate normal, low, moderate or high risk.

⁶⁵The Centre of Research Excellence in Aboriginal Chronic Disease Knowledge Translation and Exchange: ACCHOs in practice

⁶⁶AGPAL: Clinical Governance – Insights into the RACGP Standards 6th edition

Services are required to report on the nKPIs every six months, and also provide an Online Services Report (OSR) every 12 months which provides information on the characteristics of health services, including data on staffing, types of services being provided, total number of clients seen, organisation governance and accreditation and episodes of care.

The nKPIs and OSR reports are provided back to the Australian Government, who use it to:

- Identify key issue affecting IAHP-funded primary health services and gaps in service delivery, and inform policy.
- Support CQI processes in health services.
- Produce relevant reports through the [Australian Institute of Health and Welfare \(AIHW\)](#) with aggregate level nKPI data for public use.

The [Health Data Portal](#) allows health staff to exchange data and other files with authenticated individuals, businesses, and other government agencies through a web site. It is used by ACCHS to extract and report de-identified service activity and performance

data required under IAHP funding agreements (see Chapter 5). Data are uploaded from clinical and practice management systems (e.g. Communicare, MMEx) and validated through automated quality checks prior to submission. This includes nKPI and OSR data.

Health services can continue to access their nKPI and OSR data over time through the Health Data Portal, and can use the portal for CQI activities. If the service consents, this data is also shared with their state or territory affiliate organisation and NACCHO, which then enables these peak bodies to advocate for the needs of ACCHS, and support CQI activities within ACCHS.

IAHP-funded ACCHS qualify for the [Practice Incentive Program \(PIP\) Quality Improvement Incentive](#) by providing nKPI data under their arrangement with the Australian Government's Department of Health.

Chapter 9 Digital Health

Digital health refers to the use of technology to support the delivery, management, and improvement of healthcare. It includes electronic health and information systems, telehealth, mobile applications, Information and Communications Technology (ICT) infrastructure, and the secure collection, storage, sharing and use of health information⁶⁷.

Digital Health in ACCHS

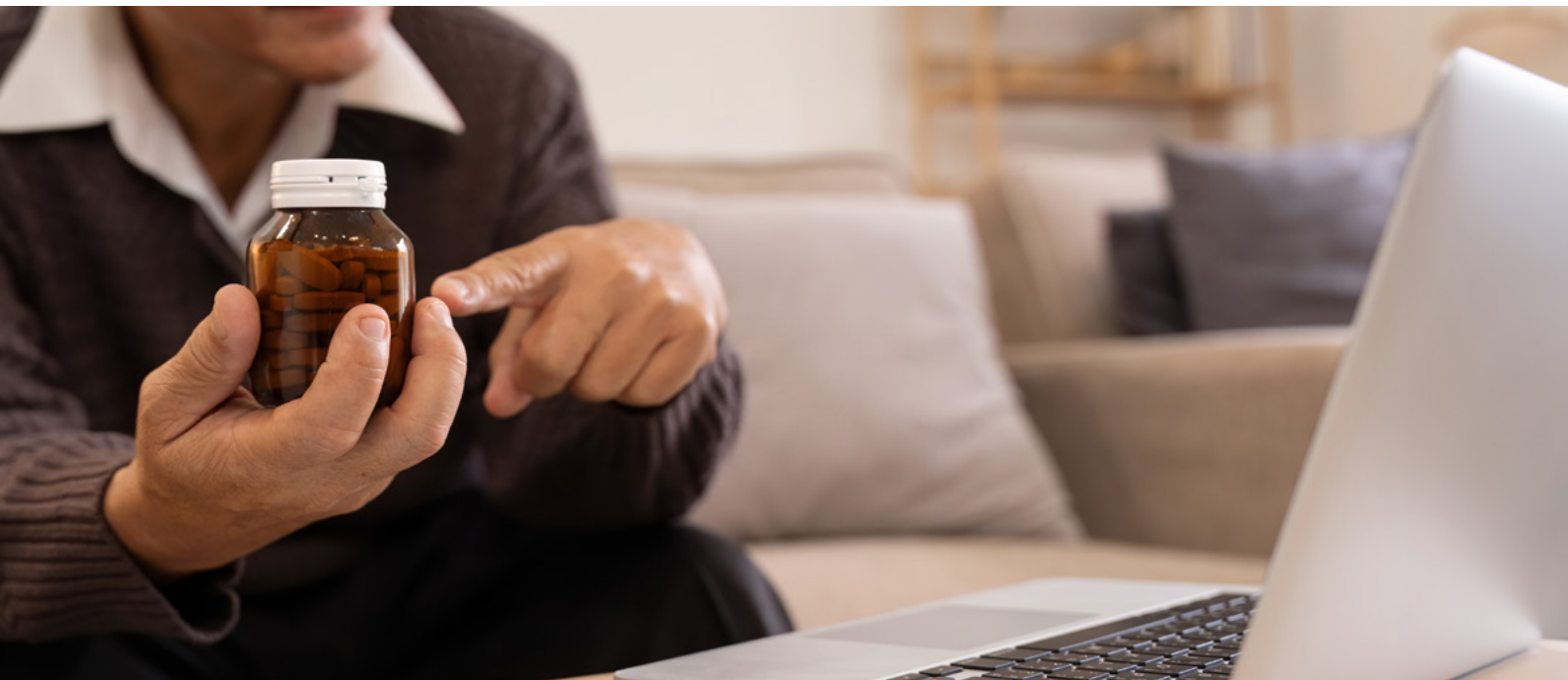
In ACCHS, digital systems are designed to support the delivery of the ACCHS Model of Care by enabling:

- Consumers, carers and families to access their health information and receive guidance that supports informed, culturally appropriate health decisions.
- Clinicians to securely access the information they need to deliver safe, high-quality and coordinated care.

- Health system planning, research and innovation through high-quality data that supports service improvement, reporting, funding accountability, national digital health integration and strong governance, including Indigenous Data Sovereignty⁶⁸.

Digital inclusion encompasses access to affordable connectivity, devices, digital skills and culturally safe digital services. Many Aboriginal and Torres Strait Islander people are at risk of digital exclusion, particularly in rural and remote communities where digital and telecommunications (including phone and internet) services and infrastructure can be limited. Other barriers to digital access can include affordability and digital ability (or digital literacy).

NACCHO, affiliates and ACCHS continue to advocate for government programs and plans to translate into measurable actions to ensure Aboriginal and Torres Strait Islander communities have equitable access to digital health tools, education and resources⁶⁹.



⁶⁷[Digitalhealth.gov.au – Healthcare providers](https://digitalhealth.gov.au/Healthcare-providers)

⁶⁸[Australian Digital Health Agency – Your health. Your Say Discussion Paper](#)

⁶⁹[NACCHO: Indigenous Digital Inclusion Plan – Discussion Paper](#)

Patient Information Management Systems (PIMS)

Patient Information Management Systems (PIMS) (clinical software systems used in primary care) are the core clinical and administrative systems used in ACCHS.

PIMS hold a single longitudinal patient record and support coordinated, team-based care. PIMS are used to document clinical care, manage recalls and reminders, support chronic disease and preventive health activities, enable MBS billing, meet IAHP reporting requirements, and support audit and CQI activities. Effective use relies on accurate and timely documentation, use of structured fields and clinical coding, protection of confidentiality, and culturally appropriate handling of patient information. Training, arranged by the employing ACCHS, should begin early to ensure staff understand how to use the specific system in place at their ACCHS.

[Communicare](#) (Telstra Health) and [MMEx](#) (ISA Healthcare) are two of the most commonly used PIMS in ACCHS in WA.

Each was purpose-built for use in ACCHS, supporting multidisciplinary practice, cultural safety, funding accountability and reporting. Both systems have built-in mechanisms for reporting to the IAHP. Best Practice and Medical Director programs are more commonly used in mainstream general practice, and require external tools to report to the IAHP when utilised by ACCHS.

Clinical Coding in PIMS

The use of standard clinical codes in PIMS in key fields, rather than using 'free-text' is a standard practice in many ACCHS that supports accurate clinical documentation, high-quality data analysis for CQI, and sustainable funding by translating clinical care into standardised codes.

In Communicare, clinical coding is captured through the use of 'Clinical Items', which allow structured recording of diagnoses, conditions, procedures and preventive activities at the point-of-care. In MMEx, the equivalent function is primarily achieved through 'presenting complaint' and 'diagnosis' fields, problem lists and coded templates, where conditions are recorded using standard classifications and then linked to encounters, recalls, reporting and funding requirements.

It is important that clinicians understand the vital role that accurate clinical coding has within ACCHS, particularly as it supports funding and governance systems. Health information entered into coded fields are extracted to the Health Portal for reporting against nKPIs for IAHP-funded Aboriginal and Torres Strait Islander health services (see Chapter 8)⁷⁰.

Telehealth

Telehealth consultations use technology as an alternative to in-person care between a patient and clinician. Consultations can be conducted by video, telephone, app or secure internet platform, and may include the electronic transmission of clinical data and images, and the transmission of referrals and e-prescriptions. Telehealth may be used for triage, diagnosis, treatment, follow-up and preventive healthcare, and plays a particularly significant role in improving access for people in rural and remote areas, during emergencies, or where travel or mobility is difficult.

While telehealth expands access and continuity of care, it is not suitable for every clinical situation and should not be viewed as a routine replacement for face-to-face consultations, particularly where physical examination or complex assessment is required. When practical, video consultations are preferred over telephone, and telehealth is most effective when used alongside in-person care with an ongoing clinical relationship.

⁷⁰[Australian Government: Introduction to the Health Data Portal for Health Service Users](#)





To use telehealth legally and professionally in Australia, doctors must meet the same standard of care for in-person consultations and comply with guidance from the Medical Board of Australia. Practitioners must be appropriately registered, use secure and clinically fit technology, protect privacy and confidentiality, obtain informed consent (including financial consent for billing), and ensure consultations are culturally safe and clinically appropriate.

A patient's identity should be confirmed, the consultation must be accurately documented, and arrangements made for follow-up or in-person review where required. Prescribing without any real-time consultation (e.g. based solely on online questionnaires or asynchronous messages) is not considered good practice, except in limited circumstances involving an existing relationship and access to the patient's record. Practitioners must familiarise themselves with the [Medical Board of Australia's guidelines for telehealth consultations](#) with patients.

Both video and phone MBS telehealth items are available for time-tiered consultations and follow-up by a practice nurse or AHP in keeping with an annual Health Assessment or CCMP. Video MBS items are available for some other items, including the preparation of CCMPs and Health Assessments. Additionally, there is a 'patient-end' MBS item that enables an AHW or AHP to support a patient during a telehealth appointment with a specialist who is also billing the MBS (note, most public specialist outpatient appointments will not bill the MBS). Clinicians should ensure they understand [MBS rules governing telehealth billing items](#).

Telehealth models that help to increase access to health services particularly in rural and remote areas include:

- Use of Clinical Virtual Care Video Conference Systems: [some ACCHS](#) utilise specific telehealth devices and software, particularly to enhance medical practitioner support to remote nurse or AHP-led clinics. These systems allow the GP or specialist

to both see and examine the patient – for example, listening to heart sounds through an AHP or nurse-held electronic stethoscope.

- Specialist outpatient appointments: some regions have worked closely with referral hospitals (often located many thousands of kilometres away) to convert in-person specialist appointments to telehealth appointments conducted from the ACCHS site, where clinically appropriate. This enables an AHW, AHP, nurse or doctor to support a patient at the specialist appointment, and often alleviates the need for the patient to travel to be seen.
- [Emergency Telehealth Services \(ETS\)](#) in WA: ETS supports WA country doctors and nurses by providing 24/7 access to specialist emergency clinicians by videoconference to more than 90 small hospitals, nursing posts, and selected remote ACCHS clinics across the state.

Government Systems

My Health Record

[My Health Record \(MHR\)](#) is a secure online summary of key patient health information including immunisations, pathology and diagnostic imaging reports, prescription and dispensing information, hospital discharge summaries, and shared summaries (uploaded by a patient's primary care provider).

A person's MHR can be accessed by that person, as well as by eligible healthcare providers for the purpose of providing healthcare and in accordance with any access controls set by the person. In ACCHS, MHR helps to support continuity of care, particularly for patients who live or move between different cities, towns or remote communities. It can also assist with clinical safety during transitions of care (e.g. after discharge from hospital).

MHR is typically integrated into an ACCHS clinical software (PIMS), and ACCHS must operate in [accordance with relevant legislation and comply with a number of obligations](#) when using MHR. MHR use

should reflect patient choice, privacy and cultural considerations, and clinicians should upload relevant summaries and review records as clinically appropriate.

Patients can use the [1800MEDICARE app](#) to view key health information stored in their MHR, as well as access to electronic prescriptions and active script lists (see Chapter 7).

myGov, myID

MyGov is a central account that allows people to link and manage Australian Government services such as Centrelink, Medicare, MHR and the Australian Tax Office. MyID is the Australian Government's Digital ID app, which allows people to securely prove who they are when accessing government online services, often removing the need to attend a service centre in person.

Aboriginal and Torres Strait Islander people often face barriers when accessing online services such as these, being around twice as likely to experience digital exclusion particularly in remote communities⁷¹. Alongside challenges such as limited internet access, affordability and digital literacy, some people face difficulties meeting standard identity requirements, especially older people who may not have documents such as a birth certificate. To support equitable access, culturally safe, hands-on assistance can be provided through trusted services, including ACCHS, with support to set up accounts, use alternative identity processes⁷², and ongoing help to establish and maintain a confirmed digital identity.

Individual Healthcare Identifier (IHI)

An [IHI](#) is a national, unique number used to identify an individual for healthcare purposes. All people enrolled in Medicare (see Chapter 6) will have an IHI. The IHI system enables the secure and accurate exchange of health information between national digital health systems such as MHR and [electronic prescribing](#) (see Chapter 7). It should be noted that each state and territory health system have their own patient identification numbers associated with their public hospital system, which is different to the IHI.

In WA, WA Health assigns each patient a Unique Medical Record Number (UMRN) which is displayed on public hospital discharge summaries, outpatient letters and public pathology (PathWest) results.

National Registers

The [National Cancer Screening Register \(NCSR\)](#) provides a single electronic record for each person in Australia participating in bowel, cervical and lung cancer screening, while the [Australian Immunisation Register \(AIR\)](#) records all immunisations given to people in Australia including those delivered through the National Immunisation Program (NIP), school-based programs, private vaccinations and travel vaccinations (more information in Chapter 10).

Together, these registers support preventive healthcare and population-level monitoring. When integrated with PIMS, they enable timely care, recalls and follow-up. Accurate entry of demographic and clinical information is essential to ensure data is reliable, clinically useful and supports quality care.

PRODA and HPOS

For Australian health practitioners, [PRODA \(Provider Digital Access\)](#) and [HPOS \(Health Professional Online Services\)](#) work together to provide secure access to government online health services.

PRODA is an individual practitioner's secure digital identity. It functions as a personal digital key and is required to access HPOS. Every eligible health practitioner must have their own PRODA account.

Once logged into PRODA, health practitioners can enter HPOS, the online portal used to manage professional, organisational, and practice-related interactions with Services Australia.

In HPOS, practitioners can:

- Apply for and manage provider numbers (see Chapter 11)
- Enter and update banking details for MBS, My Medicare (see Chapter 6) and WIP payments

⁷¹RMIT: [First Nations Australians twice as likely to be digitally excluded](#)

⁷²Including the [Confirmation of Identity – Verification for Aboriginal and Torres Strait Islander People form](#)

- Register and check patient eligibility for CTG PBS Co-payment (see Chapter 7)
- Access programs, including the AIR and NCSR
- Nominate individuals as delegates to perform tasks in HPOS on your behalf (e.g. practice managers)
- Submit MBS claims (although in most ACCHS claims will be submitted on your behalf by a responsible staff member, such as an MBS officer).

All ACCHS should be [registered on the organisation register](#) in PRODA by the organisation's administrator. The administrator will usually add senior clinical managers (such as the Medical Director or Senior Medical Officer) as a member of the organisation to

provide them with access to organisational HPOS functions. Some key functions include:

- Managing PIP details, including adding providers (e.g. all GPs) as providers so that incentive payments are calculated correctly by Services Australia. Locum GPs should be added and remain as a provider until the end of the quarter they worked to ensure incentive payments are correct (see Chapter 6).
- Managing My Medicare Program details, including adding providers (e.g. all GPs) as providers (including locum GPs as for the PIP).

For ACCHS, PRODA and HPOS are essential to day-to-day service delivery and funding integrity.

Practice tip: All clinicians working within an ACCHS must hold an active PRODA account and ensure their personal details are current. New clinicians should ensure their personal account has been set up and their details are correct.

Managers are responsible for ensuring the organisation is correctly registered in HPOS, that all GPs are linked to the practice for both the PIP and My Medicare programs, and that provider information is kept up-to-date to enable accurate MBS claiming, PIPs, and participation in national digital health systems.

Interoperability

State and territory public hospitals operate with different electronic medical record systems to ACCHS. In general, ACCHS cannot access public hospital systems, although local arrangements may sometimes be in place to access limited systems, such as radiology imaging viewers directly. This lack of interoperability can create risks during care transitions.

Discharge Summaries

Timely, comprehensive and accurate hospital discharge summaries following inpatient admission or emergency attendance, and specialist outpatient correspondence are critical to safe ongoing care. Although many public hospitals have closely monitored Key Performance Indicators (KPIs) for the timeliness of discharge summaries, issues with electronic transmission sometimes occur. To reduce clinical risks, ACCHS clinicians work to actively obtain hospital discharge information, and can use MHR to bridge information gaps where available. Additionally, ACCHS can report concerns to senior hospital managers, as feedback is often welcome and can prompt system improvement. While MHR is an important tool to access discharge information, because it is only checked when a patient presents to the ACCHS, it is no substitute for timely discharge summaries sent directly to the GP.

Secure Messaging

Historically, the Australian Health System has relied heavily on post, fax, and more recently email to share patient and clinical information, which present clinical and confidentiality risks. Most states and territories are moving to safer, digital information sharing. [Secure messaging](#) is a core foundational capability required to enable interoperability and safe, seamless, secure, and confidential information sharing across all healthcare providers. All ACCHS will use secure messaging in some way, often to send and receive referrals, specialist reports, pathology results, radiology results, hospital discharge summaries and allied health consultation reports. There may be some local systems that have not yet transitioned to secure messaging, and clinicians should ensure they keep up-to-date with referral pathways and other changes as systems continue to shift to secure messaging over post, fax and email.

Artificial Intelligence

Artificial Intelligence (AI) is increasingly being used across healthcare for both clinical and administrative purposes, including diagnostics, decision-support and tools such as AI medical scribes.

In Australia, some AI software used in healthcare is regulated by the TGA when it has therapeutic purpose and meets the definition of a medical device; while many general-purpose and generative AI tools used for documentation and workflow support are not – including AI scribes.

AI Scribes

AI scribes offer several potential benefits for GPs, including reduced administrative burden and greater ability to focus on the patient during a consultation. There are also several risks. The use of AI in healthcare does not replace the need for human oversight and professional responsibility. Health practitioners remain responsible for the accuracy, safety and

quality of care and documentation, including checking and validating any AI-generated outputs and in Australia must be familiar with the [professional obligations when using AI as outlined by Ahpra](#).

Effective use of AI requires an understanding of a tool's intended use, limitations, data handling practices and potential for bias. Transparency with patients, informed consent where personal data is used or recorded, protection of privacy and confidentiality, culturally safe use for Aboriginal and Torres Strait Islander people, and compliance with legal, regulatory, and organisational governance requirements are all essential components of responsible AI use in healthcare⁷³.

Patient consent is required to use an AI scribe to record and transcribe a consultation.

In WA it is a criminal offence to record conversations without consent⁷⁴. Therefore, consent must be obtained each time before using an AI scribe.

Medical Defence Organisations (MDOs) can provide advice on consent and other considerations for AI scribe use.

In ACCHS, decisions regarding use of AI scribes by clinicians (including which scribes are permitted) are usually made at the organisation level by executive staff and/or the Board, with advice from clinical and other relevant staff. AI scribe use should be guided by an organisational policy, which includes information on data handling, patient consent processes, validation of scribe output and compliance with relevant state or territory legislation (including privacy laws). Other considerations include how Indigenous Data Sovereignty principles are upheld, training for users, and how the risk of inherent biases within AI tools can be managed.

⁷³RACGP: AI scribes fact sheet

⁷⁴MIPS: AI Scribes – medico-legal issues

Chapter 10 Public Health

Activities such as disease notification, immunisation, and screening (cancer, chronic disease and sexually transmitted infections) are core public (also known as population) health functions of general practice in Australia. ACCHS clinicians are well positioned to undertake work that extends this population health role further, and are often involved in an array of public health activities. These may include complex contact tracing activities (including direct follow-up of contacts, particularly in sexual health); CQI activities at the whole-of-service level (see Chapter 8); community-wide health promotion; leadership and advocacy for equitable health systems; climate adaptation strategies; and teaching, mentoring and research.

The foundation for this practical whole-of-population focus is the ACCHS Model of Care (Chapter 1) which centres an Aboriginal definition of health in delivering comprehensive primary healthcare through community control. This approach also embeds the social determinants of health. A key activity of ACCHS that exemplifies this focus on primordial disease prevention is referral to and/or delivery of environmental health services by many ACCHS, which is likely to be a new referral pathway for new ACCHS clinicians. This chapter will focus on some of the key public and preventive health activities ACCHS clinicians are involved in.

In WA, [local public health units](#) can be contacted for advice and support.



Immunisation

The [National Immunisation Program \(NIP\)](#) provides a series of free immunisations across the life course to all Medicare-eligible people, based on recommendations by the Australian Technical Advisory Group on Immunisation (ATAGI). States and territories may also fund some additional vaccines, with state specific schedules available [online](#).

In [WA](#), there is both a [WA Immunisation Schedule](#) and a [WA Aboriginal Immunisation Schedule](#).

Importantly, in addition to recommendations for the whole Australian population, some additional vaccines are recommended for Aboriginal and/or Torres Strait Islander people (or recommended to be given at a younger age).

Of these, some are:

- Free to the patient through inclusion on the NIP – e.g. influenza vaccine for all Aboriginal and/or Torres Strait Islander people ≥6 months
- Free to the patient through state or territory funding (location dependent) – e.g.

Hepatitis B for non-immune adults in WA

- Recommended, but must be paid for by the patient (or health service) – e.g. some risk-based pneumococcal vaccination recommendations. The [PneumoSmart Vaccination Tool](#) assists immunisers to vaccinate for pneumococcal according to national recommendations.

It is important that clinicians are aware of recommendations in the [Australian Immunisation Handbook](#), as well as understanding their relevant state or territory immunisation schedule. Vaccines are ordered through state or territory processes

(in WA see [WA Health's vaccine ordering page](#)),

except COVID-19 vaccines which are available for free through the [Australian Government](#). The Australian Immunisation Handbook includes a National Immunisation Catch-Up Calculator tool to assist with planning a catch-up-schedule for those who are not up-to-date.

It is compulsory to record immunisations given in the [Australian Immunisations Register \(AIR\)](#) – Australia's national whole-of-life immunisation register. Failure to record childhood immunisations accurately may result in families losing their financial and/or childcare entitlements. ACCHS clinical software is typically integrated with the AIR, or AIR records can be accessed through HPOS using PRODA (see Chapter 9). Patients can access their records through myGov or MHR.

Each ACCHS will have their own model for immunisations. For example, many ACCHS employ a child health nurse or AHP who has completed training to immunise independently, and may coordinate immunisations for the ACCHS. Other ACCHS may require GPs to prescribe immunisations, which can then be given by a practice nurse or AHP under GP supervision.

Key Tips:

- Increasing immunisation coverage, and ensuring timely immunisation (as per the schedule) will help to reduce the greater burden of disease experienced by Aboriginal and/or Torres Strait Islander people. This is a priority for all ACCHS.
- Check vaccination status on the AIR and assess whether a person is recommended for immunisation based on age, risk conditions or other factors as part of the annual Aboriginal and/or Torres Strait Islander health check.
- It is imperative to ensure your ACCHS reports to the AIR using its [organisation PRODA account](#) (rather than by individual vaccine providers within the organisation). This enables vaccines recorded to be categorised as given by an Aboriginal Health Service, which is important for reporting immunisation coverage. Further information is available from [Services Australia](#).
- An MBS item (10988) is available for immunisation by an AHP on behalf of a GP (under supervising GP's provider number).
- In WA, [local public health units](#) can be contacted for advice on the immunisation schedule or catch-up vaccination.

Disease Notification

Medical and nurse practitioners have a legal obligation to report suspected or confirmed [notifiable infectious diseases](#) or related conditions to their state or territory health department. While some diseases are notifiable in every state and territory (nationally notifiable), there may be differences in which diseases are notifiable between states and territories. Notification is important for both jurisdictional and national surveillance, and disease control through public health follow-up (for example, through the testing and treatment of contacts).

In WA, notifiable infectious diseases and related conditions are notifiable under the Public Health Act 2016 and the Public Health Regulations 2017. Pathology laboratories also have a legal obligation to report notifiable diseases to the Department of Health (noting the medical or nurse practitioner attending the patient still has a responsibility to notify as well). Notification can be made using an [online form](#) or by faxing or posting a [paper form](#). Some diseases should also be urgently notified by telephone call, as per the form.

Both Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) are notifiable in WA. Further information on notification to the [WA RHD Register](#) is available in Chapter 13.

Disease Surveillance, Outbreak Management and Contact Tracing

ACCHS play a key role in disease surveillance in their community. Clinicians may notice trends or patterns in infectious diseases, and may discuss these with their local public health unit.

Further to this, ACCHS often play key roles in outbreak management. ACCHS staff may be asked to sit on state health department led outbreak management teams (OMTs) or other committees. ACCHS are well-placed within such arrangements as they are trusted by their communities, have expertise in both clinical and public health, and have avenues to communicate broadly with the community to provide evidence-based public health advice and health promotion messages. ACCHS are also often asked to assist state health services or public health units in locating a patient

known to their service (who may be a known case or contact of an infectious disease) to assist with access to healthcare, including information, testing and/or treatment.

Contact Tracing

ACCHS commonly play key roles in contact tracing, particularly in the management of Sexually Transmitted Infections (STIs) and Blood-borne Viruses (BBVs). Contact tracing is an essential part of the clinical management of patients diagnosed with STIs and BBVs in ACCHS, and healthcare providers have a professional responsibility to ensure contact tracing takes place. In some situations, ACCHS may also be asked to assist with contact tracing where a diagnosis has been made in another setting (for example, in a hospital emergency department or through a public health unit).

In basic terms, contact tracing may be patient-led or provider-led. Patient-led partner notification may include utilising free online and anonymous notification services such as: <https://letthemknow.org.au/>. Provider-led notification involves the healthcare provider directly advising contacts, or contacts being advised through public health – you can speak to your public health unit for advice on what happens in your local region. For example, in some areas, public health units may assist with contact tracing in high-risk diseases such as cases of infectious syphilis, particularly in pregnant women. For comprehensive guidance in contact tracing, please refer to resources such as the [Australian Contact Tracing Guidelines](#).

Screening

Cancer Screening

Australia has four national cancer screening programs. There are lower participation rates in cancer screening programs among Aboriginal and Torres Strait Islander people. ACCHS play an important role in overcoming access issues to facilitate culturally safe cancer screening for their patients.

- BreastScreen Australia: women 50 to 74 years are invited to be screened every

two years through their state or territory BreastScreen service (free screening mammograms are available from 40 and above 74 years, however women will not be actively invited).

In WA, the [BreastScreen WA](#) mobile service visits almost 100 rural towns every two years with appointment times available for booking approximately a month before the van arrives. ACCHS play a key role in reminding patients and/or facilitating appointments at BreastScreen, with vans sometimes being co-located at the ACCHS. In WA, eligible women are sent personalised letters inviting them to participate.

- [National Cervical Screening Program](#): women 25 to 74 years are invited to have a Cervical Screening Test (CST) to detect Human Papilloma Virus (HPV) every five years through their healthcare provider. Patients may choose to self-collect a vaginal sample or have a clinician-collected sample from the cervix using a speculum. [NACCHO resources](#) for self-collection are available.
- [National Bowel Cancer Screening Program](#): people 45 to 74 years are eligible to complete a home bowel cancer screening test (iFOBT) every two years. Those aged 45 to 49 years must request their first kit online or by phone. Those 50 to 74 receive a kit in the post every two years. An [alternative access model](#) exists to support ACCHS to offer kits directly to their patients. Kits must be ordered through the National Cancer Screening Register (NCSR) Healthcare Provider Portal, and kits handed out must be registered within the NCSR portal. [NACCHO resources](#) are available.
- [National Lung Cancer Screening Program](#): healthcare providers offer high-risk individuals referral for low-dose CT (LDCT). Eligibility includes asymptomatic people between 50 and 70 years who currently smoke or have quit in the past 10 years, and have at least a 30-pack year history of tobacco cigarette smoking. Healthcare providers must register participants in the NCSR. [NACCHO resources](#) are available.



The NCSR provides a single electronic record for each Australian taking part in bowel, cervical and lung cancer screening programs, and invites and reminds eligible people to screen. It can be accessed by healthcare providers through HPOS (see Chapter 9).

Chronic Disease Screening

Chronic disease screening can include offering HbA1c tests for type 2 diabetes screening and urine albumin/creatinine ratios for chronic kidney disease (CKD) screening according to guidelines for Aboriginal and/or Torres Strait Islander people (see Chapter 13). Both of these are available as point-of-care (POC) tests in many ACCHS through the [QAAMS program](#). The [Australian Cardiovascular Risk Calculator](#) is an important tool for cardiovascular risk assessment.

Sexually Transmitted Infection (STI) and Blood-Borne Virus (BBV) Screening

Asymptomatic STI screening should be offered opportunistically, and as part of the Annual Aboriginal and Torres Strait Islander Health Assessment from age 15 years (usually up to 30 or 34 years depending on local guidelines). Many ACCHS have access to STI point-of-care testing for chlamydia, gonorrhoea, trichomoniasis and/or syphilis antibody. See Chapter 13 for further information.

Environmental Health

The circumstances in which people live contribute to a range of preventable disease risks. For example, living in crowded conditions with limited access to washing facilities contributes to increased risk of Group A Streptococcal infections, ARF and RHD. Environmental conditions can contribute to

high burdens of other conditions, such as otitis media, trachoma, parasitic infections, asthma and mental illness. Historical experiences and the ongoing impacts of colonisation have had a significant impact on housing situations and conditions for Aboriginal and Torres Strait Islander people⁷⁵.

Environmental health services may be available in some areas, and may be provided directly by an ACCHS, another Aboriginal Community Controlled Organisation (ACCO), or the local government. Some ACCHS will have pathways to refer patients to Environmental Health Services for 'Healthy Home Assessments' which can include checking home health hardware (such as plumbing), assessing environmental home hazards, provision of cleaning and hygiene packs, and health promotion (including on the nine [Healthy Living Practices](#)).

Clinicians should understand local access to Environmental Health Services and referrals. ACCHS clinicians play an important role in advocating for addressing barriers to appropriate and affordable housing for Aboriginal and Torres Strait Islander people, and this is reflected in Outcome 9 (and targets 9a and 9b) of the National Agreement on Closing the Gap⁷⁶. NACCHO have published [A Roadmap to establish a permanent, highly skilled and nationally credentialed Aboriginal and Torres Strait Islander Environmental Health Workforce](#).

⁷⁵[Australian Institute of Health and Welfare: Indigenous housing](#)

⁷⁶Outcome 9: people can secure appropriate, affordable housing that is aligned with their priorities and needs.

Chapter 11 Regulatory Processes

General practice in Australia (including in ACCHS) involves a substantial amount of paperwork. Much of this administrative work can be complex, important (for patient and practitioner), and at times involve the use of ethical principles. This chapter provides advice on some of the key regulatory and administrative processes encountered when working in an ACCHS, but is not exhaustive. This is guidance only, and where practitioners are uncertain, they should seek support from an experienced clinician and/or their Medical Defence Organisation (MDO).

New clinicians should be reassured that while many systems and environments can be complex to navigate, regulatory bodies are available to support clinicians through these processes. Additionally, ACCHS have strong clinical governance systems, supervision arrangements and incident management processes to support clinicians and address concerns in a timely and effective way.

Requirements to Practice

Australian Health Practitioner Regulation Agency (Ahpra)

Ahpra is the Australian statutory authority responsible for regulating 16 health professions with profession-specific National Boards (e.g. Medical Board, Nursing and Midwifery Board, Aboriginal and Torres Strait Islander Health Practice Board etc). To work as a health practitioner in Australia, a person must first be [registered with Ahpra](#). Ahpra also manages complaints and concerns raised about health practitioners (except in New South Wales and Queensland), and ensures practitioners are complying with Board requirements.

Provider and Prescriber Numbers

A [Provider number](#) is required to claim under the MBS, and to refer to or request other Medicare services for patients. [Eligible health professionals](#) must first be Ahpra registered to apply for a provider number. Provider numbers are location-specific, which means a practitioner requires a unique provider number for each location they practice in (e.g. if an ACCHS has multiple locations or outreach clinics, a practitioner is required to have a provider number for each clinic location). A [prescriber number](#) is a 7-digit number that uniquely identifies a prescriber is eligible to prescribe medication under the PBS. A prescriber number is not location specific.

Provider and prescriber numbers are [applied for through Services Australia](#). Practitioners may be eligible to apply online through their PRODA account and HPOS (see Chapter 9). Those ineligible to apply online, may need to complete a paper form.

Rural Workforce Agencies

(such as Rural Health West in WA)

can assist IMGs to apply for their provider and prescriber numbers. Specialist training colleges (such as the RACGP and ACRRM) can assist GP registrars.

Working with Children

The Working with Children (WWC) check is a compulsory screening strategy for people engaging in child-related work in Australia. Checks are conducted by a screening unit in [each state and territory](#). ACCHS employers may require a WWC check prior to commencing work, which should be renewed every three years.

Professional Indemnity Insurance

All Ahpra registered practitioners who provide healthcare or opinion about the physical or mental health of any person in Australia are required to have [professional indemnity insurance arrangements](#) that meet their National Board's registration standards. Several MDOs provide medical practitioner indemnity insurance in Australia.

Continuous Professional Development (CPD)

Ahpra registered health practitioners are required to complete [annual CPD requirements](#). CPD requirements of each National Board are detailed in the Registration Standards for each profession. [Medical practitioners](#) are required to have an Australian Medical Council (AMC) accredited CPD Home, an annual professional development plan, and complete 50 hours of CPD each year split across a range of activities. Both the RACGP and ACRRM provide approved CPD Homes for their members.

Other Organisational Memberships

Health practitioners may choose to be a member of relevant professional associations, unions and/or other organisations, such as

specialist colleges for medical practitioners (ACRRM and/or RACGP for GPs in Australia). GPs may also choose to be a member of the [Australian Medical Association \(AMA\)](#) in their state or territory (the peak professional body for doctors in Australia).

Mandatory Reporting

Child Abuse

All Australian states and territories have legislation that requires medical practitioners to report cases of child abuse to the appropriate child protective service.

In WA, it is a legal requirement for doctors, nurses, midwives, and a range of other professionals⁷⁷ to report all reasonable beliefs of child sexual abuse to the Department of Communities. Reports can be made online, by email, phone, fax or post. An oral report must be followed by a written report as soon as practicable (ideally within 24 hours). Training is available [online](#), and should be completed as part of onboarding processes. Further information, training and the Mandatory Reporting Online Form is available from the [WA Government](#).

Practice tip: Where new clinicians are navigating complex issues, including concerns regarding child abuse, they are strongly encouraged to seek advice from experienced clinicians within their ACCHS for guidance and support.

Health Practitioners

All registered health practitioners have a legal obligation to report any other health practitioner who has behaved in a manner that constitutes notifiable conduct⁷⁸. Further information and advice can be sought from your MDO, including on what constitutes notifiable conduct.

In WA, practitioners are not required to make a mandatory notification when their reasonable belief about misconduct or impairment is formed in the course of providing health services to a health practitioner or student (but this is not the same in all Australian states and territories).

⁷⁷Including teachers, police officers, youth justice workers, psychologists, school counsellors, boarding supervisors, ministers of religion, out-of-home care workers, early childhood workers and departmental officers of the Department of Communities.

⁷⁸[MDA: Mandatory Reporting of Health Practitioners](#)

Disability Support Pension (DSP)

The [DSP](#) provides income support for people who can't work due to a permanent disability. This financial support is provided through [Centrelink](#) for those with a permanent physical, intellectual or psychiatric condition that stops them from working at least 15 hours a week over at least the next two years⁷⁹.

To be eligible for the DSP, people must meet certain conditions set out by Centrelink. These include both non-medical and medical rules. Health professionals are often asked to assist patients to gather the [medical evidence they require to support their DSP claim](#)⁸⁰. Evidence must be provided for each condition that significantly affects a person's ability to work. Centrelink uses this medical evidence to assess the functional impact of each condition on a person's ability to work. Centrelink may require a patient to attend further assessments by their own assessors, and/or contact the patient's doctor (with patient consent) for further information to complete their assessment of DSP medical eligibility.

It is important for GPs to have a clear understanding of what medical evidence is required to support a patient's DSP claim. The best place to find this information is in [Centrelink's DSP Medical Evidence Checklist for treating health professionals form \(SA478\)](#). This checklist outlines the medical rules for DSP eligibility, including the manifest medical eligibility criteria and the general eligibility criteria.

If a patient is not manifestly medically eligible based on the medical evidence (for example, people who are permanently blind or have a terminal illness with a life expectancy of less than two years), Centrelink will use the medical evidence provided by the patient to assess their condition(s) under the [Disability Support Pension Impairment Tables](#) – a set of 15 tables which cover a range of functions. The possible numerical ratings under individual tables range

from zero points (no functional impairment) to 30 points (extreme functional impairment). A person is not eligible for the DSP if available medical evidence shows their conditions do not attract a rating of at least 20 points under the impairment tables. A condition must be diagnosed, reasonably treated and stabilised to be eligible for the DSP, and this information should be provided as part of the medical evidence.

For a full description of what medical evidence should be provided to a patient to support their DSP claim please read [Centrelink's DSP Medical Evidence Checklist for treating health professionals form \(SA478\)](#).

Care Planning and Decision-Making

Advance Care Planning

[Advance care planning](#) is a voluntary process of planning for future health and personal care whereby a person's values, beliefs and preferences are made known to guide decision-making at a future time when that person cannot make or communicate their decisions. It is important to note that terminology regarding advance care planning varies across jurisdictions. The [National Framework for Advance Care Planning Documents](#) is a good starting point to understand what happens in your jurisdiction.

In WA, an individual can make a legally-binding Advance Health Directive (AHD) which outlines their decisions about treatment(s) they do or do not want to receive if they become unwell or injured in the future. Some people may choose to outline their values and preferences to share with their family, friends and/or health providers, rather than making a legally-binding AHD as part of advance care planning. The Advance Health Directive form used in WA is available from [WA Health](#). Further information, including a Values and Preferences form, is also [available](#).

⁷⁹The DSP is a completely separate program to the NDIS. The NDIS (see Chapter 3) is a national insurance scheme that funds specific disability-related supports to build a person's independence (it does not provide an income).

⁸⁰If a medical practitioner assists with gathering medical evidence and it forms part of a clinical consultation where examination of the patient is required, the usual Medicare consultation fee can be applied.



An individual may also choose to complete an [Enduring Power of Guardianship](#), which is a legal document in which a person nominates an enduring guardian to make personal, lifestyle and treatment decisions on their behalf in the event that they are unable to make reasonable judgements about these matters in the future.

Some ACCHS have developed their own advance care planning tools and resources. It is good practice to consider discussing advance care planning with your patient when they are well, for example during an older person Annual Aboriginal and Torres Strait Islander Health Assessment. With your patient's consent, these can be uploaded to MHR. It is also good practice to review advance care plans at least annually.

Guardianship

Where a medical practitioner is concerned regarding a patient's capacity to make decisions it is important for them to understand the relevant legislation within the state or territory in which they practice⁸¹. Where a patient doesn't have a suitable substitute decision-maker (in keeping with state or territory legislation) and there is no Enduring Power of Guardianship, an application may be made to the relevant Guardianship Tribunal for the appointment of a guardian where appropriate⁸².

In WA, this is the [State Administrative Tribunal](#).

Occupational Health

In Australia, [Occupational and Environmental Medicine](#) is a separate medical speciality. However, where occupational physicians are limited and/or where a culturally secure service is required, ACCHS GPs may be involved in occupational medicine, including performing pre-employment medicals.

In WA this is increasingly the case for Aboriginal workers in the mining industry.

ACCHS GPs may also be required to assess and manage patients who have become injured or sick as a result of their work, which often involves Workers' Compensation.

Workers' Compensation

Workers' Compensation is an insurance scheme that ensures workers who suffer a work-related injury or illness are compensated for lost earnings, medical expenses, and other associated costs, and assists injured workers to achieve a safe and sustained return to work. Each Australian jurisdiction has their own scheme, which required employers to have insurance to cover workers in the case of work-related injury or illness.

In WA, [WorkCover WA](#) is the government agency responsible for regulating and administering the workers compensation scheme.

Medical practitioners play an important role in diagnosing injuries, assessing work capacity (which is recorded in a 'Certificate of Capacity'), and participating in return-to-work assessments and processes. A Certificate of Capacity⁸³ is an official document required to be completed by a medical professional, which outlines a worker's injury, illness, capacity to work and limitations or restrictions on regular work tasks. An initial certificate of capacity is required to submit a claim to the work injury scheme. Subsequent certificates may be required through the claims process.

Patient billing is different under Workers' Compensation claims. RACGP advise that when a patient first presents following a work-related injury, and until the patient's claim is accepted, consultations should be billed as per usual practices (i.e. bulk billing in ACCHS). Once a claim has been accepted by the insurer, all costs relating to the management of the patient (including GP care) are paid by the insurer and therefore they should not be billed under the MBS. Please read the [RACGP's Supporting patients affected by workplace injury](#) for an overview of Workers' Compensation in Australia relevant to GPs. Other key guidelines and resources are listed below.

- [RACGP: Clinical guideline for the diagnosis and management of work-related mental health conditions in general practice](#)

⁸¹[newsGP: test for medical capacity – what GPs need to know](#)

⁸²[Legal Aid WA: Guardianship and administration](#)

⁸³[RACGP: Supporting patients affected by workplace injury](#)

- [RACGP: Principles on the role of the GP in supporting work participation](#)
- [The Clinical Framework for the Delivery of Health Services](#)
- [Workers Compensation and Injury Management: A Guide for Treating Medical Practitioners \(WorkCoverWA\)](#)
- [WorkCoverWA Treating Medical Practitioners Hub](#)

Pre-Employment Medicals

GPs may be requested to complete a 'pre-employment medical' for patients, often prior to starting in a new job or role⁸⁴. This is particularly common in the mining industry and some ACCHS may have special arrangements with particular companies to complete these medicals. Where an employer has requested a pre-employment medical, this is not usually eligible to be billed to the MBS, and the employer is usually responsible for payment. It is important to understand your ACCHS policy regarding pre-employment medicals, including how they should be billed.

Medical Certificates

In Australia, attendance to a GP for 'medical certificate' is a common presentation. Patients may often require a medical certificate for their employer to allow them to access personal or sick leave while they are unwell – these can often be written as a simple letter, ensuring they are dated on the day you write the certificate (not backdated). Other more complicated certificates may need to be completed, for example for Centrelink if the patient can't meet the requirements for their payments due to

sickness or injury. If there is uncertainty in how to complete a medical certificate, it is good practice to check with an experienced clinician. Some useful resources include: [Medical certificates: More than just paperwork \(AJGP\)](#); [Tips for writing medical certificates \(MDA\)](#); and [Medical certificates \(Centrelink\)](#).

Driving

Each state and territory has a [jurisdictional Driver Licensing Authority](#), which may request a GP make an assessment of a patient with a condition that may impact their fitness to drive. Some patients may also require medical examination to obtain or renew a commercial driving licence. GPs should refer to the Australian Guideline [Assessing Fitness to Drive for commercial and private vehicle drivers \(medical standards for licensing and clinical management guidelines\)](#) when assessing fitness to drive. It may be appropriate in some cases to refer a patient for a practical driver assessment or assessment by a medical specialist.

All states and territories have laws about reporting health conditions and disabilities that may affect a patient's ability to drive safely. The law requires the person to report any permanent or long-term illness that is likely to affect their ability to drive safely to the driver licensing authority. Health professionals play an important role in providing advice to patients on whether or not they should report a condition. In some jurisdiction it is mandatory for certain health professionals to report those unfit to drive – refer to [Assessing Fitness to Drive](#) for more information.

Box: Practice tip: New GPs to Australia (and GP registrars) are encouraged to take some time to familiarise themselves with the [Assessing Fitness to Drive Guideline](#) to assist them when patients attend for a driving medical.

⁸⁴[The pre-employment medical: nuisance or great opportunity?](#)

While medical examinations required to obtain or renew a licence to drive a private motor vehicle can be billed through the MBS, medical examinations to obtain flying, commercial driving or other licences must be privately billed⁸⁵.

In WA, drivers with an occupational licence or a medical condition, must show they are fit to drive before they can get or renew their driver's licence. Further information and relevant forms are available from the [WA Department of Transport website](#).

Abortion

Abortion is legal in all states and territories of Australia, but the laws on abortion timing differ from state to territory. It is important to ensure you understand the relevant abortion legislation in your jurisdiction.

In WA, resources for health professionals regarding abortion are [available from WA Health](#).

Voluntary Assisted Dying

Voluntary Assisted Dying (VAD) is lawful in all Australian States and the Australian Capital Territory (ACT)⁸⁶. There are restrictions on when VAD can be discussed, and which health professionals can do this. There are also restrictions on providing information about VAD. Health professionals can conscientiously object to participating in VAD, but in some jurisdictions, they still have a legal obligation to ensure patients and residents can access VAD⁸⁷. It is important to ensure you understand your legal obligations as a health practitioner relevant to your profession, and the state or territory in which you practice.

In WA, resources for health professionals regarding VAD are available from [WA Health](#).

⁸⁵[Medicare Benefits Schedule – Note GN.13.33](#)

⁸⁶As of September 2025, it is not lawful in the Northern Territory.

⁸⁷[End of Life Directions for Aged Care: Overview of Voluntary Assisted Dying](#)

Chapter 12 Medical Training, Teaching and Research

As the Australian health system faces a projected shortfall of approximately 7,700 GPs by 2033⁸⁸, investing in training young medical professionals within ACCHS is vital. ACCHS offer a rich and rewarding training environment for medical students, junior doctors, specialist trainees and other health professionals.

Providing good training experiences is a key mechanism to promote long careers in the ACCHS Sector, and increase the cultural safety of clinicians working across the Australian health system.

This chapter will focus on opportunities for medical training within ACCHS, which may assist clinicians involved in supervising students, registrars and some IMGs who require initial supervision. Other clinicians may find this chapter useful information to explore teaching opportunities where this is an interest.

It should be noted that opportunities exist for a variety of health professionals and students to train in ACCHS, including AHWs and AHPs (see Chapter 1).

Medical Students

Early exposure is a key driver for long-term recruitment. Opportunities for students include:

- Rural Clinical Schools: students can undertake year-long penultimate or final year clinical placements in regional and remote areas in many parts of Australia, including placements in ACCHS.

In WA, the [Rural Clinical School of Western Australia](#) oversees these placements.

- GP clinical placements: supported by the [PIP – Teaching Payment](#), which encourages practices to provide sessions to undergraduate and graduate medical students.
- Electives and audits: students are encouraged to organise electives or useful audit projects within ACCHS, supported by their home universities.
- Support for Aboriginal and Torres Strait Islander students: the [Australian Indigenous Doctors' Association \(AIDA\)](#) and programs such as the [Ngalla Bidi Bursary Fund](#) provide essential mentoring and professional development for Aboriginal and Torres Strait Islander medical students.

Prevocational Doctors

ACCHS have many opportunities to engage junior doctors early, before they commit to a specialty:

- [Australian Primary Care Prevocational Program \(APCPP\)](#): formerly the John Flynn Prevocational Doctor Program, this offers general practice experience by delivering rotations in primary care settings (usually 10-11 weeks).

In WA, the program is delivered by [WACHS](#), with ACCHS eligible to apply as training sites.

- [Pre-Fellowship Program](#): specifically supports IMGs to gain primary care experience in rural communities before entering formal vocational training.

In WA, this is delivered by [Rural Health West](#).

⁸⁸[GP Supply and Demand Study](#)

Vocational GP Training Pathways

Prospective GPs typically choose between two general practice training colleges, both of which have accredited ACCHS training sites across Australia.

RACGP

The [RACGP](#) offers core vocational training over 18 months (after 12 months of hospital-based training), in addition to 6 months of extended skills training. Programs include the [Australian Government-funded Australian General Practice Training \(AGPT\) program](#) and the self-funded [Fellowship Support Program \(FSP\)](#) for doctors with prior experience. Successful training leads to Fellowship of the RACGP (FRACGP). Registrars may also pursue additional training to achieve the [FRACGP-RG \(Rural Generalist\)](#).

ACRRM

The [Australian College of Rural and Remote Medicine \(ACRRM\)](#) focuses on a Rural Generalist (RG) scope of practice. [Programs](#) include the AGPT and a self-funded Independent Pathway. Training consists of three years of Core Generalist Training (CGT) and 12-24 months of Advanced Speciality Training (AST), for example in obstetrics, Aboriginal and Torres Strait Islander health or emergency medicine. Training leads to Fellowship of ACRRM (FACRRM), providing qualifications as a specialist GP and Rural Generalist.

Remote Vocational Training Scheme (RVTS)

The [RVTS](#) is another national training program for medical practitioners seeking GP and RG training (either through RACGP or ACRRM). It is special because it supports doctors to stay in one place for the duration of their training, and can support training in remote places through flexible remote supervision, support and training. RVTS has a focus on training doctors for Aboriginal and Torres Strait Islander communities, and includes an Aboriginal Medical Service stream for doctors working in ACCHS in MM2-7 locations.

Rural Generalism

A [Rural Generalist \(RG\)](#) is a GP who has specific expertise in providing medical care for rural and remote communities. RGs provide primary care services, and have training in additional skills. These skills may be procedural (e.g. obstetrics, anaesthetics, emergency medicine) or community-based (e.g. mental health, Aboriginal and Torres Strait Islander health, palliative care). Rural Generalist Medicine is recognised as a specialist field within general practice in Australia. Rural Generalist training can be undertaken through RACGP or ACRRM.

In WA, WACHS supports RGs through the [Rural Generalist pathway](#).

GP Registrar Funding and Salary Support

The financial disparity between hospital-based and community-based training salaries is a known barrier to promoting GP training. Several initiatives work to bridge this gap, including initiatives that incentivize training in ACCHS for both ACCHS and GP registrars.

The [AGPT Aboriginal and Torres Strait Islander Salary Support Program](#) enables ACCHS to employ GP registrars for training placements by providing salary support payments with the aim of maximising the number of GP training placements delivered in Aboriginal and Torres Strait Islander health settings. [Maximum salary support hourly rates](#) are determined by MM region, which assist with covering a large portion of a registrar's salary (noting they will also be generating MBS income for the ACCHS).

For AGPT registrars, supervisor (teaching) and practice payments are available to the practice. Incentives and flexible registrar payments are also available to some registrars based on individual circumstances and/or training location, particularly to incentivise training in regional, rural and remote areas. All available payments are outlined in the [National Consistent Payments Framework](#).



GP Registrar Cultural Support and Training

Most ACCHS will offer site-specific cultural safety and/or awareness training relevant to their local region. This is an important aspect of building a culturally secure health service for all new staff, including GP registrars and new GPs.

The [Joint Colleges Training Services \(JCTS\)](#) is a nationwide organisation which delivers cultural education for GPs and GP registrars and provides GP training support to ACCHS. JCTS employs highly skilled cultural educators and mentors and is a joint venture of the RACGP and ACRRM with a primary role of supporting the cultural safety and education of GP trainees. All ACCHS with GP registrars should pursue an active relationship with their state or territory JCTS team.

AIDA offer a cultural safety training program developed and delivered by Aboriginal and Torres Strait Islander doctors for clinicians. Both in-person and online training is available and can be booked through [their website](#).

Other Medical Specialty Training

[Public Health Medicine Advanced Training](#) offers another vital speciality pathway within the ACCHS Sector, provided through the Australasian Faculty of Public Health Medicine (AFPHM) of the Royal Australasian College of Physicians (RACP). This three-year specialty program focuses on the health and care of populations, encompassing health promotion, disease prevention, the assessment of community health needs and cultural competency.

ACCHS are uniquely positioned as comprehensive training sites, and given ACCHS clinicians intimate involvement in core public health functions (see Chapter 10), they are well placed to train in Public Health Medicine. To qualify for entry, doctors must

typically have three years of postgraduate clinical experience and have completed a Master of Public Health (MPH). A significant advantage of undertaking this training within the sector is that approved positions can include a clinical component, enabling trainees to maintain their face-to-face patient skills while pursuing a public health fellowship. Public health training can occur in a variety of training settings, which need to be accredited, including ACCHS, NACCHO, and NACCHO affiliates. AFPHM Fellows are required to provide registrar supervision. [NACCHO](#) provides a range of support to public health registrars and supervisors within the sector.

International Medical Graduates (IMGs)

IMGs are a vital component of the Australian GP workforce, particularly in rural and remote areas where they help to address significant GP supply gaps. To support their entry to Australia, [Rural Workforce Agencies](#),

such as [Rural Health West](#) in WA,

provide recruitment assistance to ACCHS and recruits, professional support, and help navigating the administrative requirements for gaining Ahpra registration, visas and provider and prescriber numbers.

For IMG GPs seeking specialist recognition in Australia, the [Ahpra expedited specialist pathway](#) offers a fast-track to registration for doctors with specialist GP qualifications from Ireland, New Zealand or the United Kingdom. Rural Workforce Agencies can advise on pathways for specialist IMGs from other countries, which may at times require intensive clinical supervision on arrival which may not be feasible in ACCHS without supervision capacity. It is important to note that IMGs are generally restricted to practising in [Distribution Priority Areas \(DPAs\)](#), which automatically include all MM 2 to 7 locations, to access Medicare benefits (the [10-year moratorium](#)).

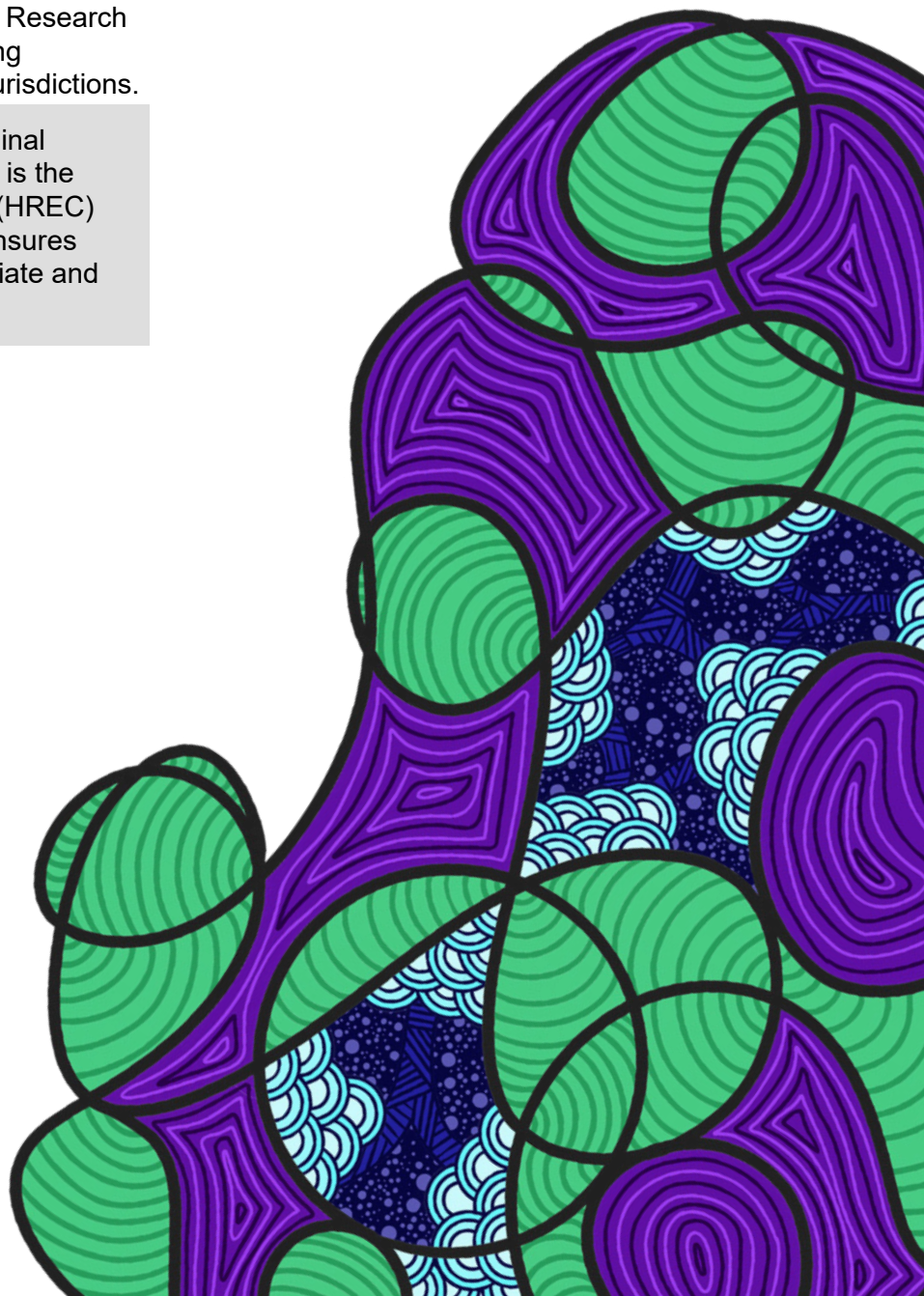
Teaching and Supervision

For Fellowed GPs, the ACCHS Sector offers rich opportunities for teaching and supervision. GPs can become clinical supervisors for registrars ([RACGP](#); [ACRRM](#)), and participate in teaching and supervision of medical students. ACCHS GPs may also hold teaching positions with universities, including rural clinical schools.

Research and Ethics

When involved in health research related to Aboriginal and Torres Strait Islander people, clinicians must adhere to the [Ethical guidelines for research with Aboriginal and Torres Strait Islander peoples](#) and ethical processes and approvals set out by relevant Human Research Ethics Committees (HRECs), including Aboriginal-specific HRECs in some jurisdictions.

In WA, the Western Australian Aboriginal Health Ethics Committee (WAAHEC) is the Human Research Ethics Committee (HREC) for Aboriginal health research, and ensures research is ethical, culturally appropriate and benefits Aboriginal communities.



Chapter 13 Special Conditions

There are some diseases and special conditions which, whilst not unique, may occur with greater frequency among Aboriginal and Torres Strait Islander people in some areas. It is important for clinicians to be familiar with the diagnosis, management and referral pathways for these conditions, and to review relevant local, state and national guidelines. A key resource for all clinicians working in ACCHS is the [National guide to preventive healthcare for Aboriginal and Torres Strait Islander people](#) by the RACGP and NACCHO.

This chapter will provide a brief overview of some of these special conditions, and link to some helpful resources.

Acute Rheumatic Fever and Rheumatic Heart Disease

Acute Rheumatic Fever (ARF) is caused by an abnormal immune response to an untreated Group A Streptococcal (GAS) infection of the throat or skin. ARF usually presents several weeks after the primary GAS infection and with symptoms that may include sore joints, rashes, abnormal movements, fever, and carditis. Diagnosis of ARF can be challenging and is easily missed. ARF can lead to irreversible damage of heart valves, which is known as Rheumatic Heart Disease (RHD). Although ARF can occur at any age, it most commonly affects children between 5 and 14 years.

Aboriginal and Torres Strait Islander people are disproportionately affected by ARF and RHD. In 2024:

- There were almost 12,000 people on the ARF/RHD registers nationally.
- 93 per cent of ARF diagnoses were among Aboriginal and/or Torres Strait Islander people, with children aged 5 to 14 years most commonly affected.

- Around three in four people living with RHD were Aboriginal and/or Torres Strait Islander people.

Prevention and management of ARF and RHD involves a multi-level approach. Primordial prevention addresses social determinants including healthy environments; primary prevention focuses on early treatment of GAS infections (sore throats and skin infections); secondary prevention requires long-term intramuscular (IM) Benzathine Benzylpenicillin every 21-28 days to prevent recurrence of ARF (known as 'secondary prophylaxis'); and tertiary prevention involves management of RHD (including valve surgery where indicated).

Both ARF and RHD are serious conditions. It is important to note Australian guidelines which recommend prompt empirical antibiotic treatment of sore throats and skin infections in people at high risk of ARF. Risk group for primary prevention of ARF are outlined within the [Australian guideline for the prevention, diagnosis and management of ARF and RHD](#). It is important to become familiar with these guidelines as they also present the diagnostic criteria for ARF, including the major and minor manifestations. Most commonly, children present with one or more sore joints. Sydenham chorea is present in up to one-quarter of ARF presentations. Ideally, anyone suspected to have ARF should be admitted to hospital as soon as possible for specialist review and echocardiography (see guidelines).

The [ARF RHD Guidelines App](#) is a useful tool to assist primary care clinicians with diagnosis and management.

Both ARF and RHD are serious conditions, and are notifiable in several states and territories.



In WA, clinicians must notify all cases of ARF and RHD to the [RHD register](#). Clinicians are also required to notify the register of any treatment provided to people with ARF and RHD, including provision of secondary prophylaxis. Each ACCHS will have their own process to ensure notification requirements are met for patients with ARF and/or RHD.

Acute Post-Streptococcal Glomerulonephritis (APSGN)

APSGN is an acute immune-mediated kidney condition following GAS skin infection or pharyngitis. In Australia, APSGN is a disease of childhood disadvantage with incidence highest among Aboriginal and/or Torres Strait Islander children in northern Australia, although cases in other regional and metropolitan areas also occur⁸⁹. The peak age group for APSGN is 5 to 14 years (often seen from 12 months to 17 years, and can occur in older people), and sporadic cases and intermittent outbreaks can occur in communities at higher risk due to the higher burden of GAS infection⁹⁰. APSGN is an important cause of acute kidney injury in children, which can result in acute complications (such as hypertensive emergency) and may contribute to the development of chronic kidney disease (CKD) later in life.

Children commonly present with a nephritic picture (facial oedema and/or haematuria (“coca-cola urine”). Blood pressure (BP) may be elevated and should be assessed using appropriate measurement techniques, and charts with reference ranges for a child’s sex, age and height (checking if BP is over the 95th percentile). Investigations may include swabs of skin lesions and/or throat, and blood tests for renal function, complement, and streptococcal serology.

Early intervention is the key to prevent complications, and guidelines usually recommend suspected cases are discussed

with specialists (such as paediatricians or nephrologists) as admission may be considered particularly to manage blood pressure and to prevent hypovolaemic complications if these cannot be managed in the community. Treatment with IM Benzathine Benzylpenicillin (or appropriate alternative) is usually recommended to eradicate any GAS, but this does not change the immune process. In some states and territories APSGN is notifiable to public health.

In WA, suspected cases must be notified to the local public health unit, who will assist to facilitate contact tracing and any public health follow-up required (which can include clinical assessment and/or treatment for GAS infection in contacts, or the wider community in the setting of an outbreak).

Available guidelines and resources include: [Kimberley Aboriginal Health Planning Forum Clinical Guideline – APSGN](#); [AJGP – A refresher on the primary care and public health management of APSGN](#); [WA Health – APSGN](#).

Chronic Kidney Disease (CKD)

Up to one in five Aboriginal and Torres Strait Islander people were found to have signs of CKD in a 2012-13 health survey, and this increases to one in two among those 65 years and over⁹¹. Aboriginal and Torres Strait Islander people experience eight to nine times the rate of Kidney Replacement Therapy (KRT) than non-Indigenous people⁹². Despite this, Aboriginal and Torres Strait Islander people are less likely to be waitlisted for transplantation due to systemic access barriers, including cultural bias. The major contributor to CKD among Aboriginal and Torres Strait Islander people is type 2 diabetes mellitus⁹³, however there are multiple other aetiological contributors including hypertension and autoimmune disease.

Many people are unaware that they have CKD, highlighting the importance of regular screening for Aboriginal and Torres Strait Islander people

⁸⁹J. Paediatric Child Health: Clinical characteristics of hospitalised children with acute post-streptococcal glomerulonephritis in the top-end of Australia

⁹⁰AJGP: A refresher on the primary care and public health management of acute post-streptococcal glomerulonephritis

⁹¹AIHW: Kidney disease

⁹²MJA: Recommendations for culturally safe clinical kidney care for First Nations Australians: a guideline summary

⁹³Australian Government: Reducing the high rate of CKD in First Nations communities

with national [guidelines](#) recommending annual screening with BP, eGFR and urine albumin-creatinine ratio (ACR) from 18 years. Early diagnosis, staging and management are essential to slow the progression of disease. eGFR declines late in disease - interventions to reduce progression to end-stage kidney disease are most effective if started early. A variety of models of kidney care, in conjunction with nephrologists, exist within ACCHS, including for CKD prevention, management and KRT.

Available guidelines and resources: [CKD Management in Primary Care Handbook \(Kidney Health Australia\)](#); [National guide to preventive healthcare for Aboriginal and Torres Strait Islander people – CKD \(NACCHO; RACGP\)](#).

Diabetes

Around 8 per cent of Aboriginal and Torres Strait Islander people self-report living with diabetes⁹⁴, however prevalence is known to be much higher in many regions with prevalence known to increase with remoteness (some studies showing prevalence of more than 30 per cent in adults). There is also a high burden of young-onset type 2 diabetes among Aboriginal and Torres Strait Islander people. [National guidelines](#) recommend annual screening for type 2 diabetes with an HbA1c (or fasting blood glucose) for Aboriginal and Torres Strait Islander people from 18 years. Children aged 10 years and over are also recommended to be screened if they have one or more recognised risk factors (see [national guidelines](#)).

In Australia, GPs are primarily responsible for the screening, diagnosis and management of type 2 diabetes, usually with support from a multidisciplinary team (diabetes educators, dietitians, exercise physiologists, podiatrists) whose services can be accessed following an MBS Chronic Conditions Management Plan (CCMP) (see Chapter 6). Referrals to specialists can assist where management is more challenging (endocrinologists and/or general physicians). Cardiovascular risk should be calculated using the [Australian Cardiovascular Risk Calculator](#), and management should focus on a reduction in cardiovascular risk.

RACGP guidelines outline [goals for optimal management](#), which assist to prevent complications. Complications including CKD, neuropathy, cardiovascular disease and eye disease (including diabetic retinopathy) are important to screen for and monitor. Given the high prevalence of type 2 diabetes in young Aboriginal and Torres Strait Islander people management of diabetes in pregnancy (and gestational diabetes) should be understood by ACCHS GPs, as inadequate glycaemic control contributes to increased risk of diabetes in children.

There are a number of glucose-lowering medications available through the PBS, and cardiovascular risk, renal impairment, weight management and gastrointestinal conditions should be considered when initiating or changing agents. [The Australian Diabetes Society has developed an algorithm](#) to assist clinicians with pharmacological management of diabetes.

[The National Diabetes Services Scheme \(NDSS\)](#) is an initiative of the Australian Government by Diabetes Australia which provides support services and subsidised products for people with diabetes. Patients must be registered to access NDSS services.

Resources and guidelines: [Management of type 2 diabetes: a handbook for general practice \(RACGP\)](#); [National Diabetes Services Scheme \(NDSS\)](#); [National guide to preventive healthcare for Aboriginal and Torres Strait Islander people – Type 2 diabetes](#).

Otitis Media

Otitis media (OM) is common among Aboriginal and Torres Strait Islander children with the prevalence of its most severe form, chronic suppurative otitis media (CSOM), being one of the highest in the world. All forms of OM can cause hearing loss, with chronic OM resulting in permanent hearing loss which can have impacts on education, employment and psychosocial development. Aboriginal and Torres Strait Islander children tend to experience OM and resulting hearing loss earlier, more persistently

⁹⁴AIHW: Diabetes: Australian facts



and more seriously and on average have 32 months of OM, compared to only three months in the non-Indigenous population. Management of ear disease and hearing loss can make a significant positive difference to a child immediately, and into their adult life.

For acute OM, antibiotics are recommended in those at high-risk of CSOM (rather than a 'watch and wait' approach). Children at high risk include (but are not limited to): those who live in remote communities, less than two years of age, who have had their first episode of OM before 6 months of age, under two years of age with fever >38.5 , under two years of age with bilateral acute OM, and those with a family history of CSOM. The [Australian Otitis Media Guidelines](#) are available through a free

app, which assists clinicians with diagnosis and management. Guidance is also available through the Therapeutic Guidelines.

Sexually Transmitted Infections (STIs) and Blood-Borne Viruses (BBVs)

Aboriginal and Torres Strait Islander people are disproportionately affected by STIs and BBVs. STIs are often asymptomatic but can have long-term consequences. Regular testing (screening), treatment and contact tracing are key to reducing the rate of STIs and BBVs. [National guidelines](#) recommend regular (at least annually) screening for chlamydia, gonorrhoea, syphilis and HIV for Aboriginal



and Torres Strait Islander people under 30 years (under 35 years in remote areas). Trichomoniasis is endemic in some rural and remote populations and should be tested for according to local guidelines.

In some regional/remote parts of Australia gonorrhoea infections are still susceptible to penicillin, and a 'ZAP pack' can be used as empirical treatment for STIs chlamydia/gonorrhoea (Azithromycin 1g, Amoxicillin 3g, Probenecid 1g). In most parts of Australia, however, a 'LAC pack' is used (Azithromycin 1g, Ceftriaxone 500mg and 2mL lignocaine (1%) IM). Check local guidelines for recommended treatment.

In WA, nurses and Aboriginal Health Practitioners (AHP) with relevant training can initiate this treatment (see Chapter 7 - SASAs).

Syphilis infections have been increasing in Australia, with an associated resurgence of congenital syphilis⁹⁵, with Aboriginal and Torres Strait Islander communities particularly affected. All ACCHS clinicians should understand the clinical stages of syphilis, and remember that clinical features can be wide and varied (syphilis is 'The Great Masquerader'). Syphilis serology should be used for screening and diagnostic testing, with swabs taken for syphilis PCR of genital-anal ulcers, mucous patches and suspected condylomata lata. All women should receive at least three syphilis screening tests during pregnancy (refer to local guidelines). Public health units and/or sexual health physicians can be contacted to assist with syphilis serology interpretation, staging, or for advice on management (which is with IM benzathine penicillin – treatment course is based on syphilis staging).

Hepatitis C is treatable, and Direct-Acting Antivirals are available on the PBS. Populations at risk include those with injecting drug use and those previously incarcerated. Many [models of care for Hepatitis C treatment](#) are available in Australia – including specialist-led, GP-led, nurse-led and models in custodial settings.

Health promotion and prevention include education about safe sex and safe injecting, pharmacotherapy (e.g. PrEP for HIV) and immunisation where appropriate (Hepatitis A and B, and HPV).

Guidelines and resources include:

[The Therapeutic Guidelines](#),
[Australian STI Guidelines, ASHM](#):

[WA STI and BBV Guidelines \(Silver book\)](#).

Cancer

In 2018, cancer and other neoplasms were the leading cause of death for Aboriginal and Torres Strait Islander people, accounting for 23 per cent of total deaths, and 10 per cent of the total disease burden. This burden is 1.7 times higher than for non-Indigenous Australians, with mortality rates 1.4 times higher. Lung, female breast, bowel (colorectal) and prostate cancer were the most commonly occurring cancers between 2014 and 2018.

Smoking is a significant contributor (two-fifths of the cancer burden is attributed to smoking), and while smoking rates are falling, Aboriginal and Torres Strait Islander people are 2.9 times more likely to be a current smoker (an estimated 29 per cent of those 15 years and over are smokers)⁹⁶. Smoking cessation resources are available through the [Tackling Indigenous Smoking Resource and Information Centre](#).

The evidence shows that disparities in cancer survival for Aboriginal and/or Torres Strait Islander people are multifactorial and complex, with social, cultural, economic and health system elements⁹⁷. This includes reduced access to culturally safe mainstream health services as a barrier to appropriate cancer care⁹⁸. As such, ACCHS play a vital role in providing culturally appropriate and wrap-around supports for those affected by cancer.

See Chapter 10 for information on population cancer screening programs in Australia. Guidelines which advise on cancer prevention are available from the RACGP ([Redbook - guidelines for preventive activities in general](#)

⁹⁵ [AJGP: The resurgence of syphilis in Australia](#)

⁹⁶ [AIHW: Tobacco use; Tackling Indigenous Smoking: Facts about smoking](#)

⁹⁷ [Dasgupta et al: Factors associated with cancer survival disparities among Aboriginal and Torres Strait Islander peoples compared with other Australians: a systematic review](#)

⁹⁸ [AIHW: Aboriginal and Torres Strait Islander Health Performance Framework – Cancer](#)

[practice](#)) and NACCHO ([National guide to preventive healthcare for Aboriginal and Torres Strait Islander people](#)). [Our Mob and Cancer](#) provides information for patients. NACCHO's Aboriginal and Torres Strait Islander Cancer Plan is available [online](#).

Human T-Lymphotropic Virus Type 1 (HTLV-1)

HTLV-1 is an oncogenic retrovirus that causes a chronic infection affecting CD4+ T cells and has a demonstrated high prevalence in Aboriginal communities in central Australia (prevalence up to 38.6 per cent)⁹⁹. Transmission requires the transfer of cell-containing fluids (blood, semen, breast milk), with sexual and vertical transmission (including during breastfeeding) likely to account for most transmission. Most people with HTLV-1 will remain asymptomatic, however those with a higher proviral load are at increased risk of developing some HTLV-1 associated conditions (Adult T Cell Leukaemia-Lymphoma, myelopathy/tropical spastic paresis, uveitis, infective dermatitis), and there is evidence HTLV-1 infection is associated with increased all-cause mortality.

In high-prevalence communities, testing should only be done following a decision by the patient, after a process of informed shared decision making. Guidance on who should be offered testing, prevention of transmission, and management has been developed in the [Australian Clinical Guidelines on HTLV-1 for Aboriginal Primary Health Care Settings](#).

Leprosy

Leprosy was introduced to Australia during European colonisation, and although now rare, impacts Aboriginal and Torres Strait Islander communities (particularly in remote areas) disproportionately. It is also known as Hansen's disease, and in some areas may be referred to by other names locally. Given the long and variable incubation period (2-30 years), new cases of leprosy continue to be diagnosed in families previously impacted by the disease.

Additionally, many Aboriginal and Torres Strait Islander people were subject to mandatory isolation (even after effective treatment became available), contributing to intergenerational trauma, with the impact of these government policies continuing to impact families and communities today. Leprosy can present with non-healing skin lesions (often first thought to be fungal or infective), shiny thickened skin on the face (lion facies), swelling or nodules in the face and earlobes or with neurological symptoms (motor or sensory). Early diagnosis and treatment can prevent disability. Refer to local guidelines.

In WA, investigation and management is guided by the [Anita Clayton Centre \(WA Tuberculosis Control Program\)](#). The leprosy notification rate is significantly higher among the Kimberley Aboriginal population in WA. The leprosarium outside of Derby was the largest institution for people with leprosy in Australia, and closed in 1986¹⁰⁰. WA guidelines include [Guidelines for the Diagnosis, Management and Prevention of Leprosy \(WA Health\)](#) and the [KAHPF Leprosy Clinical Guideline](#).

Skin Infections

Skin infections are a significant cause of morbidity in Aboriginal and Torres Strait Islander people, and in some locations can be a principal reason for clinic attendance. Common skin infections include impetigo (commonly GAS, MRSA or mixed), scabies, cellulitis, abscess, fungal (i.e. tinea corporis, capitis and other), and head lice. Significant complications of skin infections include ARF, RHD, APSGN, CKD and invasive bacterial infection (including sepsis, septic arthritis and osteomyelitis), which makes prompt management essential.

High rates of scabies and impetigo are experienced in some communities (particularly remote communities), with some studies finding prevalences of up to 50 per cent skin infections (including impetigo and scabies) in admitted children in some rural regions¹⁰¹. Environmental determinants of health, including inadequate design, construction

⁹⁹NACCHO and ASHM: HTLV-1 Guidelines

¹⁰⁰Find & Connect: Derby Leprosarium

¹⁰¹MJA: Skin infections in Australian Aboriginal children: a narrative review

and maintenance of housing (often government-provided) are major contributors to the burden of skin infections in these communities. Crowded housing can be common with large extended families often living together for cultural, financial and practical reasons, and due to an undersupply of adequate and culturally appropriate housing.

The [Therapeutic Guidelines](#), [National Healthy Skin Guideline](#) and [DermNetNZ](#) are helpful resources to guide diagnosis and management of skin infections, but clinicians should also ensure they are aware of any local guidelines, which recommend antibiotic use based on local resistance patterns.

Trachoma

Trachoma is a disease of the eye caused by chronic infection with *Chlamydia trachomatis*. Without treatment it leads to chronic inflammation, scarring of the eyelid (tarsal conjunctivae), entropion, corneal scarring and loss of vision. Trachoma infection [still occurs in some remote Aboriginal communities](#) in the Northern Territory, South Australia and WA, with Australia being the only developed country where trachoma still occurs. Trachoma control is guided by the World Health Organization's SAFE strategy (surgery for trichiasis, antibiotics, facial cleanliness and environmental improvements).

Trachoma screening in identified communities is coordinated by state and territory health departments¹⁰². Clinicians working in remote areas can contact their local public health unit to understand if trachoma is an identified public health concern in their area. Active trachoma diagnosed outside of screening programs should be treated in keeping with [national guidelines](#), which includes advice for treatment of household contacts. Assessment for trichiasis is an important component of the annual Aboriginal and Torres Strait Islander Health Assessment for people 40 years and older, as identification and referral to ophthalmology for surgery can preserve vision.

Tuberculosis

While tuberculosis (TB) is uncommon in the non-Indigenous Australian-born population, it continues to disproportionately affect Aboriginal and Torres Strait Islander communities (with a notification rate five times higher). Outbreaks have occurred, and continue to occur, particularly in regional and remote communities, with the social determinants of health being the major drivers. Aboriginal and Torres Strait Islander people with TB infection are also more likely to present with advanced disease, and clinicians may not 'think TB' given the very low rates generally seen in Australia. Clinicians should have a high index of suspicion for TB infection in patients with a cough present for more than three weeks, unexplained fever, unexplained weight loss or lymphadenopathy (especially of the neck)¹⁰³. Initial investigation includes sputum collection for AFBs and chest x-ray. If TB is suspected, seek advice from your state or territory TB control program.

In WA, the [WA TB Control Program \(WATBCP\)](#) offers statewide advice, assessment, case management and public health follow-up for TB. Collaboration with ACCHS is growing, and ACCHS are often also well-placed to assist the WATBCP with case management and the public health follow-up of contacts and communities where resourcing permits. AHCWA can support ACCHS with advocacy and advice through the Public Health Medical Officer. WA Guidelines are available: [Guidelines for Tuberculosis Control in Western Australia](#).

As of early 2026, NACCHO is finalising National Guidance for the Prevention and Response to TB in Aboriginal and/or Torres Strait Islander Communities.

Chronic Wet Cough

Chronic respiratory disease, including bronchiectasis, is a major cause of morbidity and mortality among Aboriginal and Torres Strait Islander people¹⁰⁴. The most common cause of

¹⁰² [National Guide to Preventive Healthcare for Aboriginal and Torres Strait Islander people: Trachoma](#)

¹⁰³ [WAPHA: Think TB](#)

¹⁰⁴ [ERJ: Prevalence of chronic wet cough and protracted bacterial bronchitis in Aboriginal children](#)

bronchiectasis in Aboriginal and Torres Strait Islander people is post-infectious. Chronic wet cough is the most common symptom of chronic suppurative airway disease (including protracted bacterial bronchitis (PBB) and bronchiectasis), and can often be normalised by patients and clinicians¹⁰⁵.

Chronic wet cough lasting more than four weeks in children should be treated with antibiotics to help prevent permanent lung damage and bronchiectasis, and specialist referral made where indicated as per guidelines.

Resources include: [Perth Children's Hospital Protracted Bacterial Bronchitis, Chronic Suppurative Lung Disease and Bronchiectasis – Paediatric Empiric Guidelines](#), [Royal Children's Hospital – Cough](#), [KAHPF Clinical Protocol – Cough in Children](#), and [National guideline to preventive healthcare for Aboriginal and Torres Strait Islander people: bronchiectasis and chronic suppurative lung disease](#).

Other

Other conditions of which clinicians should be aware include: parasitic worm infection (including strongyloides) and [snake bite](#) (which can occur anywhere in Australia).

Important Tools and Guidelines

Key tools validated for Aboriginal and Torres Strait Islander populations:

- [Kimberley Indigenous Cognitive Assessment \(KICA\)](#): the KICA is a valid, culturally appropriate screening tool for Aboriginal and Torres Strait Islander people in Australia. Originally developed in the Kimberley, it has been revalidated in other regions and adapted for use across Australia and in several other countries.
- [Kimberley Mums Mood Scale \(KMMS\)](#): the KMMS is a culturally appropriate perinatal depression and anxiety screening tool, originally developed in the Kimberley. Training is available through the [NACCHO Online Learning portal](#).

Some key guidelines for GPs:

- [Clinician Assist WA](#)
- [Therapeutic Guidelines](#) (subscription required)
- [Australian Medicines Handbook](#) (subscription required)
- [Australian Immunisation Handbook](#)
- [Royal Children's Hospital Clinical Guidelines](#)
- [Australian STI guidelines](#)
- [Heart foundation clinical guidelines and position statements](#)
- [Australian CVD risk calculator](#)
- [Management of type 2 diabetes: a handbook for general practice](#)
- [Australian Asthma Handbook](#)
- [COPD-X Plan: Australian and New Zealand Guidelines for the Management of COPD](#)
- [National Guide to preventive healthcare for Aboriginal and Torres Strait Islander people](#)
- [Gastroenterological society of Australia \(GESA\)](#)

Some key guidelines for ACCHS GPs:

- [National guide to preventive healthcare for Aboriginal and Torres Strait Islander people](#)
- [CARPA Remote Primary Health Care Manuals](#)
- [KAHPF clinical guidelines](#) (Kimberley specific but can be useful reference point for other regions)
- [Otitis media guidelines](#) (and app)
- [ARF and RHD guidelines](#) (and app)
- [National healthy skin guideline](#)

¹⁰⁵[National guideline to preventive healthcare for Aboriginal and Torres Strait Islander people: bronchiectasis and chronic suppurative lung disease](#)

Chapter 14 Self-Care

As we come to the end of this Handbook, hopefully it is clear that working in an ACCHS is uniquely rewarding and results in a high level of job satisfaction. However, the role also requires navigating complex social and clinical landscapes.

This chapter provides guidance on maintaining your own wellbeing and staying safe, particularly while working in rural and remote Australia.

Managing the Emotional Impact of Practice

Clinicians in the ACCHS Sector frequently manage and support patients impacted by intergenerational trauma, social disadvantage and systemic racism. You will encounter conditions that are deeply tied to these

social determinants, including substance use disorders, mental health conditions (including suicide), and family and domestic violence.

It is normal to find these issues confronting. Recognising the historical, political and social factors that have contributed to these inequities is the first step in providing culturally safe care. You may also at times experience moral distress (the feeling of knowing what care is needed but being constrained by systems, access, or circumstance) and vicarious trauma from repeated exposure to suffering. These should not be viewed as a personal failing, but rather a challenging aspect of the profession, which can be managed with support. Please seek help and support early, including by reaching out to colleagues and friends.





Seek Support

You are not expected to manage the challenges described above alone – there is always someone to ask within an ACCHS (while maintaining appropriate patient confidentiality), and the team-based model of care means you can rely on the expertise of others to support patients, and your own wellbeing.

Additionally, all clinicians (including GPs!) should have their own GP from whom they can seek support. In small towns it can be challenging to find a GP outside of your own practice. Where a local GP is not available, telehealth options can be explored.

Employee Assistance Program (EAP)

Most ACCHS will have an EAP, which is a confidential, employer-funded program that includes access to counselling services. ACCHS staff are strongly encouraged to seek support through their employer's EAP.

Other Support

For those moving to a rural or remote area, an additional challenge can be the experience of social isolation. Some people are separated from family, their own culture, and familiar support systems. Feeling lonely or disconnected is common and understandable. Actively building social connections outside of work is an important part of self-care.

Tailored support may be available based on your location.

In WA, Rural Health West (RHW) offer support to the rural health workforce and their families living and working in rural WA through their [Family Program](#). Peer support is available through RHW regional Health Professional Networks and annual conferences (including a rural health and Aboriginal health conference each year). Sign up for RHW newsletters [here](#).

Staying Safe in Rural and Remote Australia

You will have the opportunity to travel in rural and remote parts of Australia, particularly if you work in a rural location.

It is important to remember that while there are some real risks while driving, swimming and travelling through rural Australia, these can be managed well by asking for advice before leaving, understanding the risks and planning well. Seeking advice from locals, including other ACCHS staff, and avoiding solo travel is recommended.

Road Safety

When travelling for work, ensure you are aware of and follow organisational policies. In remote areas, these will often include requirements for checking vehicles before leaving, carrying ample water in case of issues, and carrying a satellite phone or Personal Locator Beacon (PLB). Additionally, if working in remote communities permission is often required to enter the community (which can be arranged through your ACCHS).

When travelling for personal reasons (for example, camping holidays or travelling to another town) it is important to be aware of road safety advice for rural Australia. Animals, unsealed roads and long stretches of straight roads impacting fatigue are common in rural areas. Always carry extra water and food with you, let people know where you are going and when you are expected to return, and be cautious about night driving (in some parts of Australia night driving outside of a township should be avoided – check with locals for local advice and information, or the local tourist information centre). Mobile telephone reception can be absent in many parts of rural Australia, particularly outside of townships. It is good practice to carry a first aid kit when travelling in rural Australia.

Road safety tips for rural Australia available from [Road Sense Australia](#).

Animals

Check with locals about animals' safety tips relevant to your area. For example, in Northern Australia it is important be cautious of estuarine crocodiles ('salties'). Only swim where it is known to be safe to swim, for example, where there are designated safe swimming signs. Crocwise information is available for [Western Australia](#), the [Northern Territory](#) and [Queensland](#).

There are up to 3,000 snakebites per year, with 2-4 people dying, in Australia. Understanding how to [prevent snake bites](#) is important (e.g. wear long pants and sturdy shoes when outdoors, especially in bushland, make noise as you walk etc). Snakebite should be taken seriously and ensure you are aware of snakebite first aid. Further information available [online](#) and in the [Australian Resuscitation Council guidelines for First Aid Management of Australian Snake Bite](#). First aid kits should include a pressure immobilisation bandage, and ensure you know how to apply it as part of first aid.

Mosquito-borne infections are important in some parts of Australia (e.g. Ross River Virus, Murray Valley Encephalitis, Japanese Encephalitis Virus). Mosquito bite prevention advice should be followed.

In WA, see the [Fight the Bite campaign](#).

Beach Safety

Australians love to go to the beach. It is important to understand how to stay safe when at the beach – particularly to understand where it is safe to swim, how to spot a rip and what marine creatures to watch out for. At lifeguard patrolled beaches, the Red and Yellow Flags on a beach show safe places to swim. Not every beach in

Australia is patrolled by lifeguards – if there are no flags on the beach this means there are no lifeguards and swimming at the beach is not recommended, especially if you are unfamiliar with the area and have limited swimming ability or experience. Further safety information is available from [Royal Life Saving Australia](#).

Protecting your skin from the sun is also important in Australia – remember to [Slip Slop Slap Seek and Slide](#) (the five sun smart steps).

Conclusion

Working in an ACCHS is a privilege and will be a rich and rewarding experience, where you can make a difference serving the community you are based in. You will be challenged clinically and in other ways, but there is always support on hand. Remember to look after yourself, in the same way you would look after your patients.



Appendix Getting Ready to Start: A Checklist for GPs

So - you have achieved Ahpra registration, a visa and an employment contract. What next? This checklist guides you some of the key things you should do in the lead up to and during the first few days or weeks of work.

Many people are available to support you through these steps, so if you are unsure, please ask. A good starting place is the Human Resources team or a senior clinician at your employing ACCHS.

The [Rural Workforce Agency](#) in your state or territory can also provide support.

Essential registrations and applications

- 1 Set up [Provider Digital Access \(PRODA\)](#) and log into [Health Professional Online Services \(HPOS\)](#)
 - Set up or confirm your provider and prescriber numbers
 - Enter correct banking details for MBS and incentive programs
- 2 Register for a [CPD Home](#) and understand [CPD requirements](#)
- 3 Arrange professional indemnity insurance
- 4 Apply for a Working with Children (WWC) check
- 5 Register for [ScriptCheckWA](#)

Cultural orientation

- 1 Develop a reading / listening / watching list
Ask locals about content relevant to your region. Some starting points could include:
Watching: [Rabbit-Proof Fence](#); [In My Blood It Runs](#)
Listening: [The GP Show - #169 Cultural Education with Dr Hung The Nguyen](#); [BLA.C.K. Medicine Podcast](#)
Reading: [Remote As Ever \(Dr David Scrimgeour\)](#); [Growing Up Aboriginal in Australia](#)
- 2 Utilise online cultural awareness resources
For example, [RACGP - An introduction to Aboriginal and Torres Strait Islander health cultural protocols and perspectives](#); [RHW - Cultural Wealth Community Health](#); [WA Health – Journey of health and wellbeing](#)
- 3 Participate in local cultural training when you arrive (arranged by your ACCHS)
Additional opportunities through: [Rural Health West \(RHW\)](#), the [Joint Colleges Training Services \(JCTS\)](#) or the [Australian Indigenous Doctors' Association \(AIDA\)](#)
- 4 Meet with Aboriginal and/or Torres Strait Islander workforce
Introduce yourselves to your ACCHS AHWs and AHPs and learn about their scope of practice.

Other training

- 1 Attend clinical software training (arranged by your ACCHS)
- 2 Complete any other mandatory training outlined by your ACCHS
e.g. [Mandatory Reporting of Child Sexual Abuse in WA](#)
- 3 Complete [Mental Health Skills Training](#)
To enable optimised MBS claiming for Mental Health Treatment Plans

Referral pathways and support programs

- 1 Learn about local referral pathways
- 2 Find out how [the Integrated Team Care \(ITC\)](#) program works in your region
- 3 Look at which diseases and conditions are notifiable and learn how to notify
In WA, these [diseases and conditions are notifiable](#)
- 4 Review patient travel support arrangements where patients need to travel for healthcare
In WA, WA Country Health Service provides the [Patient Assisted Travel Scheme](#)
- 5 In WA, link in with your region's [health professionals' network](#)

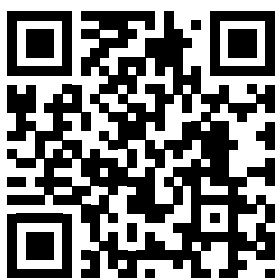
Clinical essentials

- 1 Bookmark key guidelines
 - [Therapeutic Guidelines](#) and [Australian Medicines Handbook](#) (ask ACCHS about subscription access)
 - [National Guide to Preventive Healthcare for Aboriginal and Torres Strait Islander People](#)
 - [Australian Immunisation Handbook](#)
 - [PneumoSmart Vaccination Tool](#)
 - [Australian CVD Risk Calculator](#)
 - [Clinician Assist WA](#)
 - [WA STI and BBV Guidelines](#)
- 2 Ask about any local treatment or clinical guidelines for your region
- 3 Review key MBS items and resources, for example:
 - [MBS Item 715](#) (Annual Health Assessment)
 - [MBS Item 965](#) (Chronic Condition Management Plan)
 - [AHCWA MBS Quick Guide](#)



4 Download important clinical decision apps

[ARF & RHD Guideline App – with ARF diagnosis calculator](#)

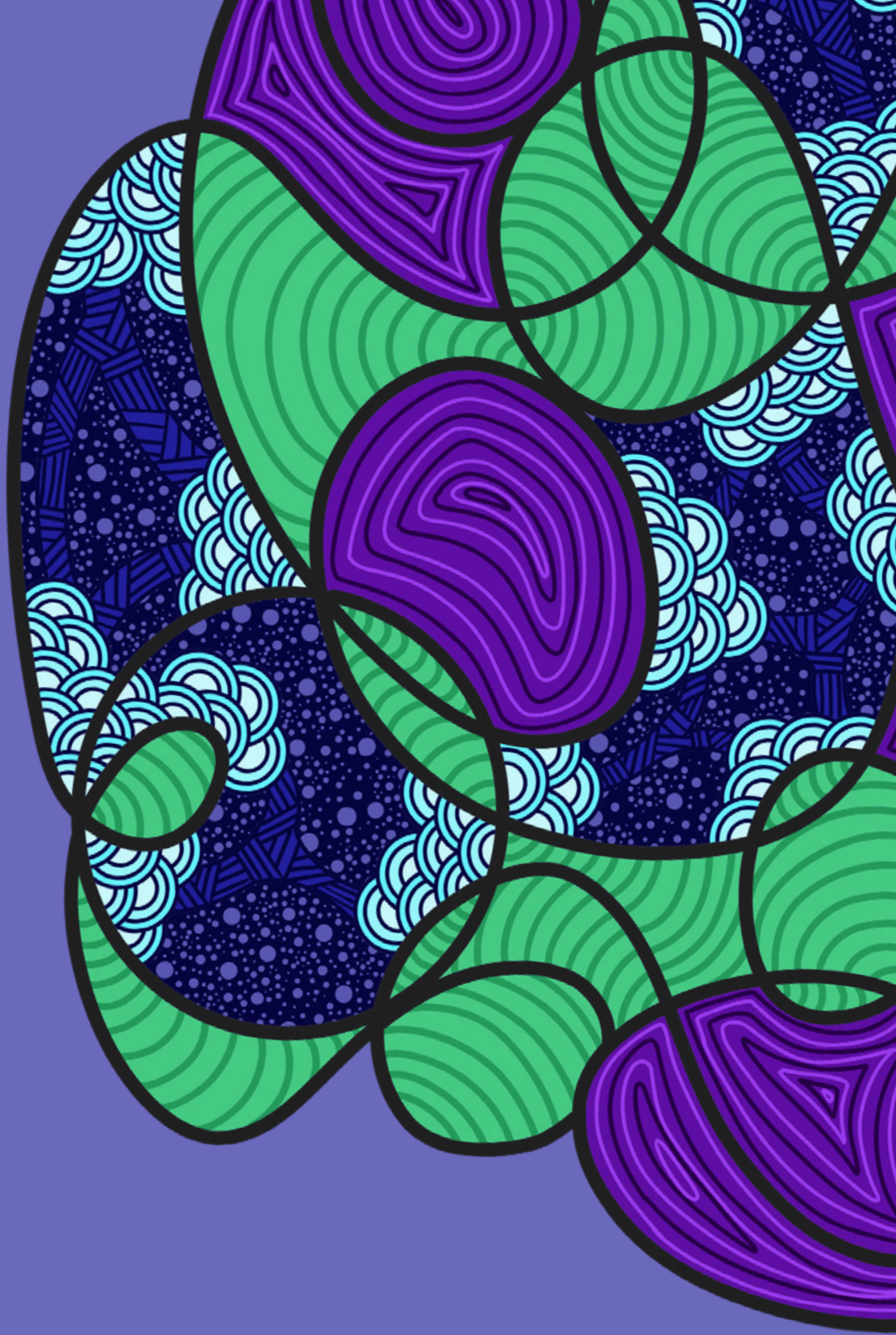


[Otitis Media Guidelines App \(OMApp\)](#)



*Got a suggestion for how we
can improve this handbook?*





NACCHO
National Aboriginal Community
Controlled Health Organisation



**Aboriginal
Health Council
of Western Australia**