



## Health care service provision for country people with developmental disability: an Australian perspective

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### Abstract

Priorities in the delivery of health care to Australian country people with developmental disability were explored through focus groups and interviews of key stakeholder groups from four rural/regional towns. Data were analysed for themes, which converged on lack of access to primary health care providers who lacked knowledge about and had poor attitudes towards developmental disability, discriminatory practices, the burden on support people, and communication difficulties between GPs and people with developmental disability. Potential strategies to address the apparent dissatisfaction with primary health care and GP concerns about working with this group were also evident in the data. In particular, open communication between stakeholders as a mechanism for collaborative problem solving and a strategy to avoid burn out for both support people and GPs is recommended. Facilitation of such communication can best occur through undergraduate training and participation of disability workers in activities of organisations that support GPs.

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Primary health care has presented a number of challenges for people living in rural and remote communities of Australia. There has been a long standing scarcity of general practitioners (GPs) and other health care providers because of problems in recruiting and retaining them in rural positions (e.g., Humphreys & Rolley, 1998; MacIsaac, Snowden, Thompson, & Wilde, 2000; Wilson, Lincoln, & Onslow, 2002). Additional problems faced by country people include the erosion of hospital facilities and lack of access to medical specialists, which may contribute to their poorer health and health outcomes in comparison to city people (Alford, 2000; Department of Health and Aged Care, 2000; Humphreys & Rolley, 1991; Strasser, Harvey, & Burley, 1994). Research by Strasser et al. (1994) suggests that rural communities in Victoria, Australia, for example, are particularly dependent on GPs and their local hospitals for health care services. In addition, support networks through health care service providers are seen as necessary, but fragmentation of services (Alford, 2000) results in problems in obtaining information about and communication between them.

Country people with developmental disability experience even further problems in light of their high incidence of health problems (Beange, McElduff, & Baker, 1995; Durvasula & Beange, 2001), frequent low socio-economic status (Allan, 1999; Bigby & Ozanne, 2001; Martin, Roy, Wells, & Lewis, 1997), dependence on a variety of health and disability services (Kent, Chandler, & Barnes, 2000), and reliance on support people to access and navigate the health care and support system (Iacono, Davis, Humphreys, & Chandler, 2002, 2003). According to Bigby and Ozanne (2001), services for people with intellectual disability in Victoria, Australia are based on a model encouraging choice and flexibility. A premise of this model is that, as a result of deinstitutionalisation, people with intellectual and other developmental disabilities have access to the same range of services as do other people in the community. Acting on that right depends on a certain level of self-determination, which is notably lacking in this group because of limited opportunity (Wehmeyer, Agran, & Hughes, 1998). For most people with developmental disability, varying levels of cognitive, physical and/or sensory impairments preclude accessing required services without considerable help from paid and/or unpaid support people (e.g., Bigby & Ozanne, 2001). These support people may themselves be disempowered because of limited knowledge about services, limited training in developmental disability, and low socio-economic status (Allan, 1999; Bigby & Ozanne, 2001; Martin et al., 1997). Gething and Fethney (1997) argued that people with developmental disability living in rural or remote communities suffer from a double disadvantage that impinges on their ability to access their community, with barriers including attitudinal, cultural, social and psychological factors.

To date, there has been limited research into health care issues faced by country people with developmental disability. One exception in Australia is a study by Gething and Fethney (1997) who found that people with disability in New South Wales (NSW) see GPs as having the primary responsibility for their health care and should also be gatekeepers to a range of community-based services. Unfortunately, there is evidence to indicate that Australian GPs know

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