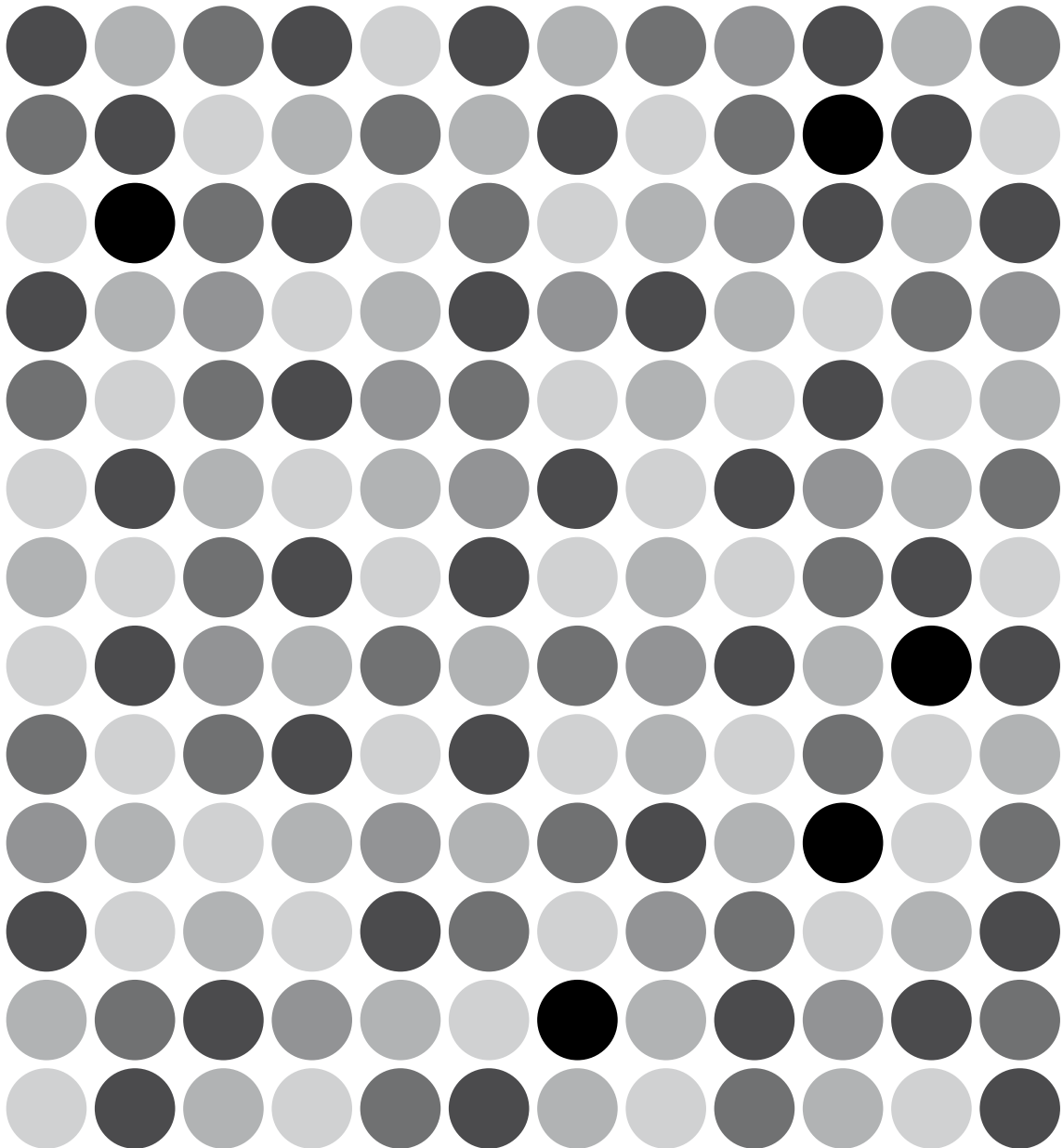IMPROVING THE **IDENTIFICATION** OF ABORIGINAL
AND TORRES STRAIT ISLANDER PEOPLE IN
MAINSTREAM GENERAL PRACTICE

the **Lowitja**
INSTITUTE
Australia's National Institute
for Aboriginal and Torres Strait
Islander Health Research

ANU
THE AUSTRALIAN NATIONAL UNIVERSITY

IMPROVING THE **IDENTIFICATION** OF ABORIGINAL
AND TORRES STRAIT ISLANDER PEOPLE IN
MAINSTREAM GENERAL PRACTICE

AUGUST 2010

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PROJECT REFERENCE GROUP

The project reference group was established to oversee the development and direction of this research project. The project reference group members comprised a range of organisations with insight and experience in both Aboriginal health and general practice. The organisations were:

- Australian General Practice Network (AGPN)

- Australian Indigenous Doctors' Association (AIDA)

- Australian Primary Health Care Research Institute, The Australian National University

- Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN)

- Cooperative Research Centre for Aboriginal Health (CRCAH)

- Department of Health and Ageing, Primary Care Practice Support Branch (DoHA)

- National Aboriginal Community Controlled Health Organisation (NACCHO)

- National Indigenous Health Equality Council (NIHEC)

- Royal Australian College of General Practitioners (RACGP)

- *Onemda* VicHealth Koori Health Unit, The University of Melbourne

- Victorian Aboriginal Community Controlled Health Organisation (VACCHO).

PREFACE

The Australian Primary Health Care Research Institute (APHCRI), The Australian National University is delighted to publish this first stream of research funded by the Institute specifically targeting issues in the delivery of primary health care to Indigenous people. This research was commissioned by APHCRI from the Cooperative Research Centre for Aboriginal Health (CRCAH) in response to the APHCRI Research Advisory Board's desire to help address an Indigenous Health Priority. Poor identification of Indigenous people in mainstream general practice has been identified in previous research as a significant barrier to uptake of Medicare items that may assist indigenous people in the prevention of chronic illness. This research is, therefore, designed as a first step towards improved targeting of health initiatives such as health assessments for Indigenous people.

As with previous research streams funded by APHCRI, this work involves the systematic review and synthesis of current knowledge, as well as the translation of that knowledge into innovative and comprehensive approaches that can provide a strong basis for primary health care policy development. The report provides an analysis of the effectiveness of pre-existing strategies that aim to support identification processes and makes recommendations for future action in this area and the likely costs of doing this.

The CRCAH and the authors of the report are to be congratulated on this important work. We look forward to working together with Indigenous organisations in future to conduct research that will contribute to closing the gap in Indigenous health.

Associate Professor Kirsty Douglas
Senior Research Fellow, APHCRI

TERMS USED IN THIS REPORT

Accreditation is a process, conducted triennially, for the external evaluation of general practices to ensure the delivery of safe, high-quality health care. Accreditation assesses the achievements of primary health care staff in meeting the requirements of established standards (currently the third-edition standards of the Royal Australian College of General Practitioners (RACGP 2007)) in the areas of education, practice management, the rights and needs of patients, and the physical facilities of the practice.

The benefits of accreditation include improved patient safety and overall health outcomes, risk reduction, improved practice efficiency and environment, insurance benefits and access to the Practice Incentives Program (PIP).

Current standards applicable to the care of Indigenous patients are:

- the general practitioners (GPs) at the practice can explain how they access guidelines for specific clinical care of patients who self-identify as Aboriginal or Torres Strait Islander (Criterion 1.4.1E)

- the practice can demonstrate that it is working towards recording the self-identified cultural background of patients (eg Aboriginal and Torres Strait Islander self-identification) in active patient health records (Criterion 1.7.1D)

- the practice can identify important/significant cultural groups within the practice's patient population (eg Aboriginal and Torres Strait Islander patients), and outline the strategies they have to meet their needs (Criterion 2.1.1H).

General Practice Network (GPN), formerly known as Divisions of General Practice, is a Commonwealth initiative to facilitate the implementation of health policy initiatives at a primary care level, to support systems change in general practice and to promote a high standard of primary health care. The focus and activities of the divisions are coordinated by an umbrella body in each state or territory. Nationally, there are 110 local networks with eight state-based bodies. At a local level, the divisions support general practice in operating effectively through medical education and workforce support, emphasising health promotion, early intervention and prevention strategies, and chronic disease management. About 90 per cent of general practitioners, practice nurses and allied health professionals are members of a GPN (AGPN n.d.).

The federal umbrella body of the division network, the Australian General Practice Network, has established a memorandum of understanding with the National Aboriginal Community Controlled Health Organisation (NACCHO) to work cooperatively to improve Indigenous health outcomes. Funding through the 'Closing the Gap' initiative now enables divisions to specifically target training and health promotion activities on Indigenous health issues, including awareness raising among general practice staff, identification of Indigenous patients, and uptake of relevant Medicare Benefits Schedule (MBS) items and immunisation schedules.

The **Practice Incentives Program (PIP)** program was developed to provide incentives to practices to encourage them to improve the quality of care provided to patients. This is a Department of Health and Ageing (DoHA) program, run through Medicare. Practices must be accredited or working towards accreditation to be eligible for PIP.

SHORTENED FORMS

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
AGPN	Australian General Practice Network
AIDA	Australian Indigenous Doctors' Association
AMS	Aboriginal Medical Service
APHCRI	Australian Primary Health Care Research Institute
BEACH	Bettering the Evaluation and Care of Health
CATSIN	Congress of Aboriginal and Torres Strait Islander Nurses
CI	Confidence Interval
COAG	Council of Australian Governments
CRCAH	Cooperative Research Centre for Aboriginal Health
DALYs	disability-adjusted life years
DoHA	Department of Health and Ageing, Primary Care Practice Support Branch
GPII	General Practice Immunisation Incentive
GPN	General Practice Network
GP	general practitioner
MBS	Medicare Benefits Schedule
NACCHO	National Aboriginal Community Controlled Health Organisation
NIHEC	National Indigenous Health Equality Council
NIR	National Immunisation Register
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PBS	Pharmaceutical Benefits Scheme
PHCRIS	Primary Health Care Research and Information Service
PHO	primary health organisation
PIP	Practice Incentives Program
RACGP	Royal Australian College of General Practitioners
SAND	Supplementary Analysis of Nominated Data
VACCHO	Victorian Aboriginal Community Controlled Health Organisation

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EXECUTIVE SUMMARY

In December 2007 the Council of Australian Governments (COAG) committed to inter-jurisdictional cooperation in the reform of Indigenous Australians' health and wellbeing – the 'Closing the Gap' initiative in Indigenous disadvantage. This involves setting targets to close the life expectancy gap within a generation (by 2030) and to halve the gap in mortality rates for Indigenous children under five years of age within a decade (by 2018). Ensuring optimal uptake of these new measures will require improving identification of Aboriginal and Torres Strait Islander people at mainstream general practices.

AIMS AND OBJECTIVES OF THE PROJECT

The project aim was to identify promising strategies to improve identification processes in mainstream general practice. To achieve this aim, the project explored three primary research questions.

- What strategies to improve the identification of Aboriginal and Torres Strait Islander people in mainstream general practice have been trialled before and what is worth trialling (feasible and acceptable) in the future?

- How can mainstream general practice be encouraged to improve identification processes for Aboriginal and Torres Strait Islander people?

- What are the links between improved identification and quality of care?

METHODOLOGY

The study was conducted in two phases. Phase one methods included:

- a systematic review of the literature of interventions to improve identification

- a call for public submissions through the mainstream and Indigenous media

- key informant interviews in Australia and New Zealand

- analysis of Primary Health Care Research and Information Service (PHC RIS) and Medicare general practice data

- reviewing current medical software

- conducting a workshop with 21 experts and key stakeholders from Australia and overseas to review the evidence and provide advice to the next phase of the study.

Phase two methods included:

- 10 case studies of General Practice Networks (GPNs) and their constituent practices

- focus group discussions with general practitioners (GPs) (six), GP educators (three), and practice nurses (one) to discuss how best to embed identification in clinical practice and to develop vignettes to be used in clinical education.

A multilevel approach was adopted to the analysis of all data. The levels included:

- practice level

- community level, including community members who utilise general practices and community organisations

- regional level, which involves alternative health services providers and organisations providing support for general practices

- national level, including the Australian Government, which has a primary role in the design, financing and management of the Australian health care system. It also includes organisations that train GPs and general practice staff and peak organisations involved in health care through advocacy and governance issues.

BEST PRACTICE PRINCIPLES

In assessing strategies to improve identification, the project considered key principles that Aboriginal and Torres Strait Islander people want incorporated in strategies to improve identification and key principles in changing behaviour in general practice.

The Aboriginal and Torres Strait Islander people and organisations consulted for this project indicated that it was important to ensure that the processes used for identification embody respect for Indigenous people, and they have suggested that this could be achieved by promoting cultural safety, explaining why the information is required, and ensuring the Indigenous person's privacy and autonomy are respected. At the regional level it was considered important to involve Indigenous groups in the development and implementation of the processes. At the national level there were concerns expressed about using self-identification as the only means of identifying and the implications for ensuring that funds allocated for Indigenous health were not used for other purposes. There was no outright opposition to the use of self-identification but it was suggested that the strategy be trialled and monitored in the first instance.

THE RESEARCH QUESTIONS

The project explored three primary research questions.

Research question 1: What strategies to improve the identification of Aboriginal and Torres Strait Islander people in mainstream general practice have been trialled before and what is worth trialling (feasible and acceptable) in the future?

An increasing range of activities aimed at improving identification at general practice have been introduced at the community and regional levels and within general practices.

Support for the general practices

General practices need to be supported to implement strategies of identification that are most appropriate to them. GPNs play an important role in this respect but it would appear appropriate that there are incentives at the health system level that impact directly on general practice. Clearly, tightening the accreditation standards and the associated Practice Incentives Program (PIP) have an important role in this respect. Although 'trialling' of these would not appear to be appropriate, discussion around the most suitable standards and incentives would be appropriate. This research would suggest that standards linked to cultural awareness training for staff and GPs would be appropriate.

Support for the community

Aboriginal and Torres Strait Islander communities and community-controlled organisations have been identified as having an important role in Indigenous identification. However, there is little awareness of the reasons why identification is important. Helping communities to understand why it is important may increase the likelihood that community members will identify. A number of strategies aimed to improve awareness of the need for identification. However, few of these originated from within the Indigenous community. From the few examples that are available, it appears that allowing community members to take the initiative in identification (through written identification) makes it easier for general practices to identify their Indigenous patients. Therefore, the development and implementation of activities by communities around issues of identification is one area that would be worth further investigation and trialling.

Support for General Practice Networks

It is clear that the GPNs have an important role to play in assisting in the uptake of Indigenous identification. They develop strategies targeting the community and general practices, and assist general practices in important practical ways. However, they are doing this without support in terms of guidelines about what represents best practice (sometimes without fully understanding cultural safety) and with minimal resources. It would, therefore, appear to be worth developing and trialling adequately resourced 'pilot Indigenous identification projects' for GPNs. While being engineered to fit the needs of individual GPNs, these pilots should contain common elements, such as cultural awareness and change management training for GPNs, strategy development and implementation, and evaluation.

Research question 2: How can mainstream general practice be encouraged to improve identification processes for Aboriginal and Torres Strait Islander people?

Key aspects of Indigenous identification that need to be fostered to 'make change happen' – relevance, attractiveness, achievability and necessity – are outlined below.

Make it relevant

Indigenous identification needs to be relevant:

- **in terms of the patients seen:** Aboriginal and Torres Strait Islander patients generally make up only a small proportion of the patients attending mainstream general practices, so identification is unlikely to be seen as relevant to practice staff; promoting the clinical relevance of identification and including Indigenous identification as part of a broader focus on ethnicity is likely to increase the relevance in relation to patient groups

- **in terms of professional practice:** to the extent that GPs and general practice staff take pride in offering a high-quality service to their patients, there are a number of ways in which emphasising identification can be made professionally relevant. Improving the quality of care includes providing a culturally safe environment for all patients, understanding the cultural factors that influence health and attending to the interpersonal processes of care.

Make it attractive

Indigenous identification needs to be attractive:

- **in terms of practice finances:** for many practices, introducing identification will mean changing standard operating procedures or customary behaviour in general practice; this will be more attractive if there is some benefit (such as PIP) for the practice in making the changes. At the very least, identification should not threaten the financial status of the practice

- **in terms of professional practice:** raising the profile of identification though advocacy and promotion by opinion leaders could help identification become an attractive issue with which to be aligned.

Make it achievable

Indigenous identification needs to be achievable:

- **in terms of the administrative systems:** changing organisational systems can be unsettling and sometimes difficult; helping general practices to identify and adopt systems of identification most appropriate to the practices' situations would assist in the uptake of identification through, for example, allowing for flexibility in adoption

- **in terms of the staff:** the data clearly indicates that staff have difficulty in 'asking the question'. Helping staff to understand and deal with the issues they face in relation to identification would aid in adopting processes of identification.

Make it necessary

Indigenous identification needs to be necessary:

- **in terms of accreditation:** there appears to have been general agreement that the current accreditation standards are too lax in relation to providing culturally appropriate services. Tightening accreditation to focus on cultural safety and identification would move practices that favour accreditation towards providing an environment in which it is safe to identify

- **in terms of community expectations:** increasing the likelihood of patients self-identifying (even without being asked) raises the expectation that this will be taken seriously in mainstream general practices and received appropriately. This can be regarded as pushing practices towards adopting Indigenous identification as standard practice.

Research question 3: What are the links between improved identification and quality of care?

By adopting a definition of quality of care that encompasses the dimensions of access and effectiveness in relation to clinical interpersonal processes of care, the research has made it very clear that there are strong links between improved identification and quality of care.

RECOMMENDATIONS

Recommendations are based on recognition that changing the standard or customary operating procedures in general practices will be difficult. Successful change management will require a systems-based approach that includes (to a greater and lesser extent) all the levels outlined.

Practice level

Recommendation 1: Support the integration of identification into practice management.

1a   Raise awareness of the link between ethnicity and quality of care.

1b   Create an Aboriginal and Torres Strait Islander-'friendly' environment.

1c   Include questions about Indigenous status as part of patient registration information and ensure that the information is visible to clinicians.

1d   Update patient information regularly, including Indigenous status, to enable pre-existing patients to identify their status.

1e   Implement quality assurance processes to follow up missing data.

1f   Consider embedding questions about Indigenous status in more general questions about ethnicity.

1g   Use standard questions to enquire about Indigenous status and/or ethnicity.

1h   Provide patients with an explanation for why they are being asked about their social history that highlights the relevance to their quality of care.

Community and regional level

Recommendation 2: Assist general practices to foster an environment in which Aboriginal and Torres Strait Islander people feel comfortable identifying.

2a   Involve local Aboriginal and Torres Strait Islander organisations and communities.

2b   Raise awareness of the link between ethnicity and quality of care.

2c   Promote incentives to provide enhanced care to Indigenous people.

2d   Provide cultural safety/cultural awareness training for general practices and GPNs.

2e   Develop to support the implementation of health checks.

Recommendation 3: Encourage community members to self-identify.

3a   Raise awareness of the importance and benefits to the Aboriginal and Torres Strait Islander community of identifying.

3b   Promote self-identification in general practices that are Indigenous friendly.

National level

Recommendation 4: Assist general practices to develop systems for identification.

4a   Develop a standard protocol for identification.

4b   Evaluate a standard patient registration form.

4c   Modify information technology/information management to ensure that questions in software reflect standard forms, are exhaustive and provide reminders if the question is skipped.

4d   Develop guidance around cross-sectoral collaboration.

4e   Develop clear guidelines/standards for cultural competency in general practice at a whole-of-practice level.

4f   Evaluate cultural safety/awareness educational materials.

4g   Tighten accreditation standards.

Recommendation 5: Evaluate, promote and advocate best practice models.

5a   Develop an evidence base to identify best practice in improving identification.

5b   Set up regional level pilots to test existing strategies and, where appropriate, develop and test new ones.

5c   The strategies to be tested should aim to improve quality of care as defined in this report.

5d   The organisations involved in running the pilots at all levels (community, service providers including general practices, and regional organisations such as GPNs) should be adequately compensated.
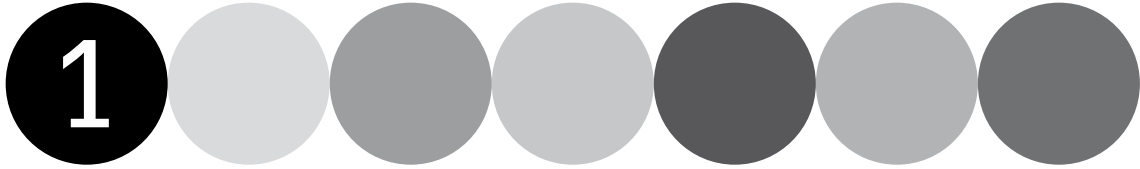
INTRODUCTION

Aboriginal and Torres Strait Islander people (Indigenous Australians) experience significantly more ill health than other Australians (Britt et al. 2007). They typically die at much younger ages and are more likely to experience disability and reduced quality of life because of ill health (AIHW 2007). The burden of disease and injury among Indigenous Australians in 2003 was estimated to be 95,976 DALYs (disability-adjusted life years or years of life lost through premature death or living with disability): this represented 3.6 per cent of the total burden of disease in Australia for a group that makes up 2.5 per cent of the total population (Vos et al. 2007). The leading causes of this burden were cardiovascular diseases, mental disorders, chronic respiratory disease, diabetes and cancer (Vos et al. 2007). The socioeconomic disadvantage experienced by Aboriginal and Torres Strait Islander peoples compared with other Australians places them at greater risk of exposure and vulnerability to health risk factors such as smoking, alcohol misuse and violence (Royal Brisbane and Women's Hospital n.d.).

In December 2007 COAG committed to inter-jurisdictional cooperation in the reform of Indigenous Australians' health and wellbeing. This reform, known as 'Closing the Gap' in Indigenous disadvantage, involves setting targets to close the life expectancy gap within a generation (by 2030) and to halve the gap in mortality rates for Indigenous children under five within a decade (by 2018).

The new initiatives will extend existing Medicare Benefits Schedule (MBS) items for routine health checks and chronic disease management items by:

- encouraging greater uptake of health checks and the provision of follow-up care in a coordinated, accessible and systematic manner

- providing incentives through the PIP for practices to provide improved coordination of health care programs to Aboriginal and Torres Strait Islander people

- supporting Aboriginal and Torres Strait Islander people to actively participate in their own health care through improved access to affordable medicines, multidisciplinary follow-up care, and specialist general practice and allied health services for Indigenous Australians with chronic diseases

- expanding the Indigenous workforce by funding Indigenous project officers and outreach workers at GPNs and Aboriginal and Torres Strait Islander community-controlled health services.

The PIP will require Aboriginal and Torres Strait Islander patients to register with practices, and this will also provide the gateway to the initiative to improve access to medicines.

Enthusiasm about the new initiatives has been tempered by concern that their uptake will be sub-optimal. Poor uptake of existing items is often attributed to characteristics of the items themselves, and uptake of Indigenous items is significantly worse than the uptake of items for other Australians (Kelaher et al. 2005) (see Appendix A). Research examining the reasons for poor uptake of health checks in mainstream general practice suggests that improving identification in general practice would be an important step in expanding uptake of health checks, as well as any other new items (Kehoe & Lovett 2008). Two studies have suggested that, at best, less than a third of mainstream general practices have routine identification processes for all patients (Norris 2004; Riley et al. 2004). Although there is no definitive data on current levels of identification at a national level, overall service use data (MBS data) and survey data suggest that there is much room for improvement in identification of Indigenous people at practice level. Therefore, strategies are required to improve mainstream providers' understanding of Indigenous health issues, Aboriginal and Torres Strait Islander primary health care initiatives and local culture (AHMAC 2008).

POTENTIAL BENEFITS OF ADOPTING POINT-OF-CARE IDENTIFICATION

It is possible for people to identify as Indigenous at two levels in the Australian health system. System level data are collected via the Voluntary Indigenous Identifier, and are held by Medicare Australia and are generally only available for release at aggregate level. They are not visible to GPs at point-of-care. Point-of-care identification information is held at a practice level and is generally visible to GPs.

At a point-of-care level, the primary purpose of identification is to improve the quality of care. Identification at this level is intended to inform practitioner responses to patients and, in this way, helps to ensure that:

• Indigenous Australians have access to appropriate services

• GP assessments of, and responses to, health issues are culturally competent.

Point-of-care identification information informs system level population health initiatives through GP-generated data collection; for instance, notifiable diseases and deaths.

The focus of this project is point-of-care identification. It should be noted, however, that the registration of Aboriginal and Torres Strait Islander patients as part of the PIP creates new synergies between these two levels of identification by constructing an identifier that is available at both levels. This project focuses on self-identification because it will be the standard for eligibility for the new PIP and is the approach currently used in general practice. The use of self-identification as the entry criterion for the new incentives is contested and is discussed in detail in Chapter 3 under the heading 'Key principles wanted by Aboriginal and Torres Strait Islander people'. It should also be noted that brokerage models do exist in some areas where self-identification at general practice is circumvented by the provision of cards denoting Aboriginality by relevant Aboriginal and Torres Strait organisations. These alternative models are described throughout the report.

Figure 1 outlines the potential relationship between processes of identification for Indigenous Australian and elements of the national health performance framework. Identification is a necessary, but not sufficient, condition for health benefits to occur. If patients are identified as Indigenous and the general practice workforce (including GPs) has the appropriate capabilities (including an understanding of the health issues, cultural competency, and knowledge of appropriate initiatives and services for Indigenous patients), it would be expected that this would lead to improved effectiveness, appropriateness, efficiency, responsiveness, accessibility and safety of the health system for Aboriginal and Torres Strait Islander patients. In the absence of workforce capability, identification is unlikely to result in health benefits and may in some cases be harmful, such as by increasing exposure to discrimination.

FIGURE 1: Identification of Aboriginal and Torres Strait Islander patients and the health performance framework elements

Indigenous Identification

IF

Capable
Awareness of health disparities and specific health risks for Indigenous people
Culturally competent
Aware of services and initiatives specific to Indigenous peoples

THEN

Improvement in Health Systems
Effectiveness
Appropriateness
Efficiency
Responsiveness
Accessibility
Safety
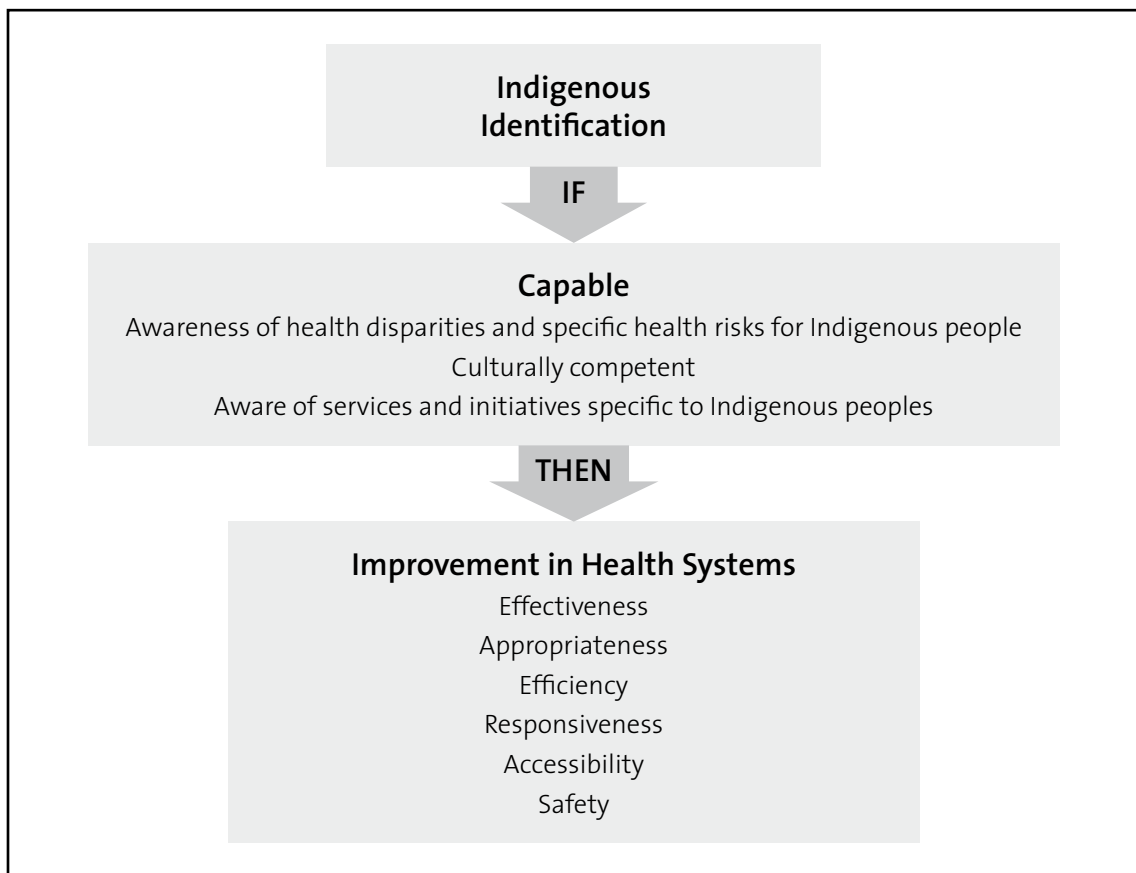
Source: National Health Performance Committee 2003

FACTORS INFLUENCING POINT-OF-CARE PROCESS OF IDENTIFICATION

Factors influencing the implementation and use of identification processes in general practice represent a complex dynamic. Identification processes require the development of culturally appropriate approaches, coupled with the active participation of practice staff and clinicians in providing culturally safe opportunities for identification and a willingness on the part of Aboriginal and Torres Strait Islander people to engage with these opportunities. Figure 2 summarises the routine steps in the process of identification of Aboriginal and Torres Strait Islander people at point-of-care, and helps illustrate the main areas within the practice that would be involved in particular steps. It also highlights where processes may be vulnerable to failure. It is important that any recommendations relating to identification strategies include an analysis of their feasibility in general practice environments.

FIGURE 2: Outline of process of identification

AIMS AND OBJECTIVES OF THE PROJECT

The project aim was to identify promising strategies to improve identification processes for Aboriginal and Torres Strait Islander people in mainstream general practice. To achieve this aim, the project explored three primary research questions.

- What strategies to improve the identification of Aboriginal and Torres Strait Islander people in mainstream general practice have been trialled before and what is worth trialling (feasible and acceptable) in the future?

- How can mainstream general practice be encouraged to improve identification processes for Aboriginal and Torres Strait Islander people?

- What are the links between improved identification and quality of care?

The aims and objectives have been achieved by:

- combining a systematic review and case study data on successful interventions

- developing the evidence base on the clinical impact of identification

- assessing the feasibility and acceptability of strategies through policy analysis and broad consultation.

It should be noted that this project was conducted at a time of major reform for the provision of health services to Indigenous Australians. While the shape these changes will take is generally known, the details of many relevant programs have not been finalised at the time of writing.

OUTLINE OF THE REPORT

This report on the project is organised as follows. After the introduction (Chapter 1), Chapter 2 outlines the methodology, including data sources. Chapters 3, 4, 5 and 6 use a series of questions to analyse the data.

Chapter 3 focuses on what 'best practice' in point-of-care identification could look like. The questions framing the analyses in the chapter are:

- What are the key principles Aboriginal and Torres Strait Islander people want incorporated into point-of-care identification?

- What are the key principles in changing behaviour within general practice?

Chapter 4 examines point-of-care identification strategies within practice level, community level, regional level and national level. This chapter explores the research question:

- What strategies to improve the identification of Aboriginal and Torres Strait Islander people in mainstream general practice have been trialled before and what is worth trialling (feasible and acceptable) in the future?

Chapter 5 further develops the strategy discussion and thinks through what strategies discussed in Chapter 4 will work and how improving identification can be encouraged and supported through these strategies. The chapter addresses the research question:

- How can mainstream general practice be encouraged to improve identification processes for Aboriginal and Torres Strait Islander people?

Chapter 6 focuses on the translation of point-of-care identification into improved quality of care. It seeks to answer the questions:

- What are the links between improved identification and quality of care?

- Under what circumstances is improved identification likely to lead to improved quality of care for Aboriginal and Torres Strait Islander people?

Chapter 7 contains the recommendations of this report.

2

METHODOLOGY

LITERATURE REVIEW

Anne Parkhill from the Global Evidence Mapping Initiative worked with the rest of the project team to refine and conduct searches for the review. A systematic search was conducted of both conceptual frameworks and empirical studies about the identification of Aboriginal and Torres Strait Islander people in outreach and primary practice. Databases searched include Medline (1950 to 12 April 2009), Embase (1980 to Week 15, 2009) and a set of relevant local databases: AGIS-ATSIS, AIATSIS, ATSIhealth, REEF, FNQ and Indigenous Australia. The search strategy framework included text words and MeSH and EMTREE headings that encompass Indigenous issues and combined them with terms for 'identification' and 'cultural competency'. The search was then restricted to citations included under 'general practice', 'family practice', 'primary care', 'outreach' and 'delivery of health-care'. The bibliographies of the retrieved articles were manually searched to identify further publications. We also conducted an extensive search through grey literature to identify relevant reports and publications.

TABLE 1: Literature review search findings by database

Database name	References
Embase	304
Indigenous set • AGIS-ATSIS • AIATSIS • ATSIhealth • REEF • FNQ • Indigenous Australia	271
Medline	1,623
RURAL	5
TOTAL	**2,203**

There are 1,947 references after endnote deduplication, including those already identified: 629 until 1995 and 1,318 from 1996 onwards. Details of the databases and the specific search terms used are included in Appendix B.

Using the review criteria formulated by the research team, 1,947 articles were found. These articles were then filtered for relevance and reduced to 124 relevant articles (Table 2). All articles addressing the identification of ethnicity and its social, cultural and clinical implications were included. The high rate of exclusions reflects a large number of epidemiological studies where identification was discussed in relation to data quality. The filtered articles were then divided between a small team of readers, with two readers for each article. A Microsoft Office Access database was created specifically to assist with the analysis of the articles. This allowed systematic coding of each article to provide a clear method for assessing consensus between reviewers as to the relevance of the articles for the research. A small number of other relevant articles were located in response to team discussion and through scrutiny of the reference lists of the relevant articles.

TABLE 2: Literature review search findings

Articles identified in the search	1,947
Articles included	124
Number reviewed	119 (5 articles not located)

PRIMARY DATA

Public submissions

Written public submissions about the identification of Aboriginal and Torres Strait Islander people in Australian general practice were sought, both through the general media and the networks of professional organisations. The call for submissions focused on detecting effective systems and strategies.

The call for submissions was advertised in three newspapers: the *Weekend Australian* (25–26 April 2009), the *Koori Mail* (6 May 2009) and the *Indigenous Times* (30 April 2009). Additionally, the call was emailed through the Cooperative Research Centre for Aboriginal Health network and through the project reference group network.

Despite wide advertisement coverage, only two submissions were received; one from the Flinders and Far North Division of General Practice, and one from the Centre for Children and Young people at Southern Cross University (see Appendix F). It is assumed that such low submission numbers is partly because many of the organisations that might otherwise have contributed were involved in either the project reference group or the key informant interviews and felt that their views would be clearly articulated through this process. This suggests that a high level of coverage and engagement has been achieved through other components of the study.

Key informant interviews

Thirty-one people were interviewed as key informants during the months of June and July 2009. They were selected from a range of organisations and GPNs related to Aboriginal and Torres Strait Islander health and identification. The project reference group was instrumental in developing the list of contacts for interview, and further interview contacts were discovered through our initial interviewees.

Table 3 shows that the majority of key informants came from GPNs (33 per cent). A number of representatives from the information technology/management areas (18 per cent) were also interviewed about software issues. Two accreditation agency representatives were interviewed about the accreditation criteria for practices in relation to identification (6 per cent) and Area Health Services representatives were also interviewed (6 per cent). Relevant national associations that could not participate in the project reference group were also contacted to give them an opportunity to contribute to the research (12 per cent). Other key informants included those with a background in cultural safety (12 per cent), Public Health Medical Officers (Office for Aboriginal and Torres Strait Islander Health (OATSIH)) (9 per cent) and individuals with experience in the area of Indigenous identification (3 per cent).

TABLE 3: Key informant interview distribution

Key informants	%
General Practice Networks	33
Information technology	18
Relevant national associations	12
Cultural safety informants	12
Public Health Medical Officers (OATSIH)	9
Area Health Services	6
Accreditation agency representatives	6
Individuals with previous experience in identification	3

The interviews addressed the issues surrounding identification of Aboriginal and Torres Strait Islander people and elicited examples of successful and unsuccessful strategies to improve identification. Through this process potential case studies were identified and a wide range of opinions on the topic was expressed.

Focus groups

Most of the findings from the first phase of this study suggested that Indigenous people are happy to be asked about their Indigenous status provided they know the purpose for which the information is being collected. In contrast, considerable concern and discomfort about asking about Indigenous status was expressed by providers. Focus groups were conducted to further develop our understanding in this area. While there was general agreement that the question should be based on the Australian Bureau of Statistics (ABS) standard, focus group discussions with GPs (six), GP educators (three), and a practice nurse (one) were facilitated to engage opinion about how best to embed identification in clinical practice. Two focus groups were run via teleconference with a pre-prepared list of topics and questions for discussion.

Case studies

Case studies were identified through a variety of measures. Initially the research team received case study site suggestion advice from the project reference group. Further sites were identified through state-level GPNs. Other case study options were found through analysis of the publically available PHC RIS data that looked at GPN activities, including work on identification. The project staff contacted the GPNs to discuss their basic framework of interventions implemented to date and success thus far to ensure suitability as case studies. Each potential case study site was then written up and sent to the project reference group for final selection.

When selecting case studies, every effort was made to select sites that represented different location types (with the exception of remote location type), as well as various proportions of Aboriginal and/or Torres Strait Islander people in relation to the total population. Due problems recruiting practices and lack of consensus around the benefits of participating the selected metro–rural sites decided against participating. All jurisdictions except the Northern Territory, the Australian Capital Territory and Tasmania were included, and the case studies represent a variety of intervention models.

Once a final list of potential case study sites was approved, project staff sought final approval from the various sites (and various people and organisations within each site) to visit. Permission was gained to visit 10 sites within the allocated time period. Within these 10 sites, 75 people from a variety of professions were interviewed. Most interviews were conducted individually; however, some people preferred to meet as a group.

Interview topics and questions were pre-written, but the interviews were delivered in a free format to allow the interviewer/s flexibility to discuss issues and topics as they arose. Upon consent, the interviews were recorded, from which notes were taken.

TABLE 4: Case study location and number of interviewees

Location	Number of case studies	% of total	Number of interviewees	% of total
Metro	6	60	42	56
Metro–rural	0	0	0	0
Rural	2	20	9	12
Rural–remote	2	20	24	32
Remote	0	0	0	0
TOTAL	**10**	**100**	**75**	**100**

TABLE 5: Numbers and percentage of case study interviewees by role

Role	Number interviewed	% of total
Practice staff	41	55
GPs	(11)	(15)
Practice managers	(15)	(20)
Practice nurses	(6)	(8)
Receptionists	(9)	(12)
GPN staff	26	35
Partner organisation staff	8	10
Aboriginal Medical Service	(4)	(5)
Other	(4)	(5)
TOTAL	75	100

TABLE 6: Number of people interviewed within each case study by percentage of Indigenous people within the population

Percentage of Indigenous people within the population	Number of case studies	% of total	Number of interviewees	% of total
<1%	2	20	8	11
1% to <2%	2	20	12	16
2% to <3%	3	30	23	31
3% to <4%	0	0	0	0
4% to <10%	2	20	18	24
10% and over	1	10	14	19
TOTAL	10	100	75	100

Aboriginal and Torres Strait Islander people's interviews

During primary data collection, no direct interviews were conducted about how Aboriginal and/or Torres Strait Islander people perceive the importance of identifying as Indigenous within mainstream primary health care services because such research was concurrently being conducted by The Australian National University (ANU) Master of Applied Epidemiology (MAE) student Angela Scotney (Scotney 2009). Ms Scotney's work and findings have been integrated throughout this report.

SECONDARY DATA

A number of existing data sources provided useful insights into the extent of under-identification of Aboriginal and Torres Strait Islander people and current strategies to address these issues. PHC RIS has GPN-level data on clinical performance disaggregated by Indigenous status. The 2006–07 and 2007–08 data was used to examine the level of identification activities within each GPN. The data collected was entered into a specifically created database and analysed with SPSS software to assess gaps in the sampling frame for key informant interviews and assist in the selection of case studies.

PHC RIS data was also linked with GPN-level Medicare data (2006, 2007, 2008) on the use of Indigenous health check items for children, adults and older people. Logistic regression was conducted using Intercooled Stata 10 data management software to examine the relationship between identification strategies and uptake at a GPN level.

International consultation

Examples of strategies to improve the identification of Indigenous people in mainstream general practice were sought internationally, as well as in Australia. Canadian health data do not record Indigenous status; there were, however, examples of strategies in New Zealand. The international consultation involved 10 face-to-face interviews with health service researchers (three), cultural competency providers (two), a Ministry of Health official (one), ethnicity data consultants (three) and a primary health organisation (one). Interviews explored the implementation of strategies to improve identification at various levels.

Medical software review

Upon the advice of the Medical Software Industry Association of Australia, three common medical software programs currently used in general practice were evaluated; Medical Director 3, Best Practice and Genie. It is acknowledged that there are other software systems used by practices that are not represented. The main component of the software evaluated was the software's capacity to record and utilise Aboriginal and Torres Strait Islander patient status and, also, whether the recording of this information assists practice staff in passing on health benefits such as the Aboriginal and Torres Strait Islander health assessment and immunisations.

Quality assurance

In the research and evaluation literature, triangulation of data sources is a recommended practice for ensuring the validity of the research conclusions. Although triangulation of data is important, it does not necessarily assure the validity of the conclusions. In this research a number of triangulation strategies have been used to improve the quality of the research. The first is the collection of primary data from a number of different sources as outlined above. The second is the integration of literature review and primary and secondary data. Third, the process of producing the report was a multi-disciplinary team effort. Members of the research team brought different perspectives and experiences to this report. Finally, the project reference group provided input and feedback at all stages of the research, including the preparation of the final report.

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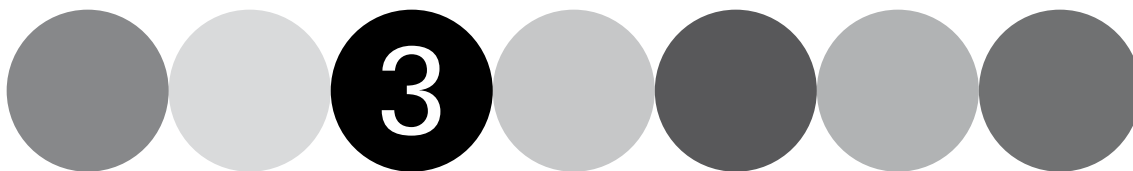
BEST PRACTICE PRINCIPLES

This chapter focuses on what 'best practice' in point-of-care identification could look like. The questions framing the analyses in the chapter are:

- What are the key principles Aboriginal and Torres Strait Islander people want incorporated into point-of-care identification?

- What are the key principles in changing behaviour within general practice?

KEY PRINCIPLES WANTED BY ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The overarching principal that should inform any identification initiative is that it should enable Aboriginal and Torres Strait Islander people to have access to more appropriate care. It is arguable from the uptake of the Voluntary Indigenous Identifier (now >220,000) that Australia's Indigenous people are prepared to identify in the absence of any apparent incentive to do so (Benham 2008). Nonetheless, a clear concept of benefit is an ethical imperative of any strategy to improve identification.

Practice level: respect for Indigenous people

Angela Scotney's research, completed in November 2009 (Scotney 2009), examined how Aboriginal and/or Torres Strait Islander people perceive the importance of identifying as Indigenous within mainstream primary health care services. The study involved interviews with 28 Aboriginal and/or Torres Strait Islander people aged between 18 and 73 years who lived in the Australian Capital Territory and used a mainstream primary health service. Only one of the participants had ever been asked the question if they were Aboriginal, Torres Strait Islander or both. Five had self-identified after establishing relationships with their GPs.

The major findings of the research were that none of the participants fully understood the reasons for asking patients to identify as Indigenous in general practice; all thought the question was asked for statistical purposes. No participant had a problem with being asked; however, all thought others would have such problems. The key findings related to 'respect' and included:

- creating cultural safety by displaying posters and pamphlets about identifying

- asking the question as a general question on the form, along with a brief sentence explaining why it is being asked

- the GP or nurse should ask the question (not the receptionist, who is not seen as the right person), and follow up to clarify when discussing family history.

> *'For Aboriginal and Torres Strait Islander people I think that it comes down to education and making people aware of why it's important. That way it can be consumer driven. You need to provide health literacy so that people can actively seek out care that they need, because it may not necessarily be offered.'*
> Community representative

Community and regional level: consultative process

During the case studies it was pointed out by Indigenous organisations that when developing locally appropriate solutions to improve Indigenous health (including identification), Indigenous people and organisations should lead, or at least be meaningfully involved with, change development. Three GPNs involved in the case studies have strong relationships with a variety of local Indigenous organisations. Through investing in the development of these relationships, all three GPNs gained advice, direction and understanding of the Indigenous community's health priorities and the strategies that are most acceptable.

National level

Autonomy

The ability to choose to whom and in what circumstances Indigenous status is disclosed is an important issue for Aboriginal and Torres Strait Islander people (Riley et al. 2004). This reflects uncertainty about potential benefits of disclosure. For example, one of the concerns about the model for the Voluntary Indigenous Identifier was that the information was automatically provided to Centrelink. Ensuring autonomy precludes approaches to identification in which Indigenous status is automatically visible without allowing individuals the right to choose how this information is shared and to change their minds about their willingness to disclose. For example, a person may be prepared to disclose his or her Indigenous status to a trusted family doctor but be unwilling to identify in hospital when he or she does not know the health professionals involved. However, decisions about disclosure in the absence of systematic approaches to improve community awareness are likely to be made without knowledge of potential benefit. Addressing this issue highlights the need to engage with the community in improving identification.

Minimisation of funds leakage

Access to the new PIP incentives is based on self-identification as an Indigenous person. People will be required to register at their GP and then provide written consent to be involved in the program. Unlike other government programs (with the exception of Centrelink), no documentation of Indigenous status will be required. It can be argued that it is important that the same criteria should be applied in health to ensure that funds intended for Aboriginal and Torres Strait Islander people do not leak to the rest of the community (Practice Incentives Program Advisory Group 2009). However, this would also run the risk of severely limiting access to the intended population. Adopting Indigenous self-identification as the sole criterion may be justified if it could be confirmed (in a pilot) that this poses only a small risk of leakage (Practice Incentives Program Advisory Group 2009) or if appropriate audit processes could be established.

Summary

Aboriginal and Torres Strait Islander people indicated that it is important to ensure that the processes used for identification embody respect for Indigenous people and they suggest that this could be achieved by promoting cultural safety, explaining why the information is required, and ensuring the Indigenous person's privacy and autonomy are respected. At the regional level it was considered important to involve Indigenous groups in the development and implementation of the processes. At the national level concerns were expressed about using self-identification as the only means of identifying and the implications for ensuring that funds allocated for Indigenous health are not used for other purposes. There was no outright opposition to the strategy but it was suggested that the strategy be trialled and monitored in the first instance.

KEY PRINCIPLES IN CHANGING BEHAVIOUR IN GENERAL PRACTICE

Diffusion of innovation

Diffusion of innovation is a theory of system change that has been applied to generating change within the health care system and general practice in particular (Greenhalgh et al. 2004). Diffusion is the process by which an innovation, change or idea is communicated through certain channels over time among the members of a social system and groups. In diffusion theory, group members have traditionally been categorised according to the speed at which they adopt innovations (Figure 3). These include innovators, early adopters (or opinion leaders), early majority (about 34 per cent of members), late majority (about 34 per cent of members) and laggards (the last to adopt any change, about 16 per cent of members) (Rogers 1995).

Diffusion of innovation theorists hypothesise that when a critical mass of members of a social system adopt a change, the spread of the change becomes self-sustaining (Greenhalgh et al. 2004). Thinking in terms of the diffusion of innovations within groups is particularly appropriate for understanding change in the Australian health system, as it can be used to consider change at multiple levels; eg the regional level/GPNs and/or the service delivery level (general practices). At both these levels, the diffusion of innovation approach to change:

- highlights that bringing about change in a system will take time because it will not immediately be taken up by all units within the system

- implies that early implementation activities should be concentrated on achieving uptake to the point of 'critical mass' (i.e. efforts should be focused on the early adopters – the first 13.5 per cent in the system to adopt an innovation after the innovators).

FIGURE 3: Hypothesised timelines for the diffusion of change within a group
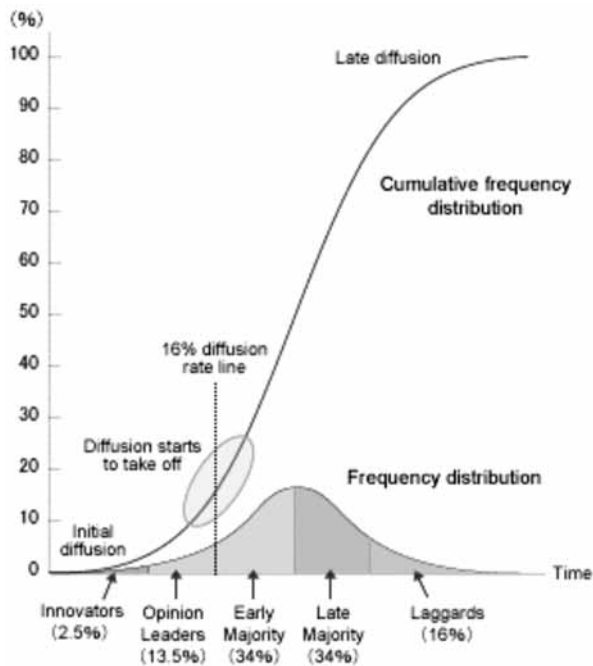
Based on a review of the literature, Greenhalgh et al. (2004) outline the key attributes of innovations, as perceived by adopters, that are likely to enhance the uptake of innovations (Greenhalgh et al. 2004). Based on this work, the major attributes that influence the uptake of innovations (including Indigenous identification) have been defined in the following ways.

- **Work-related relevance:** if potential users see no relative advantage in terms of effectiveness or cost effectiveness, they will generally not consider the innovation further. In addition, if the benefits are visible to the adopters, it will be adopted more easily. However, if the innovation carries a degree of uncertainty about the benefits or advantage it confers, or if it is perceived as risky, then it is less likely to be adopted.

- **Personal compatibility:** innovations are more likely to be adopted if they are compatible with the intended adopters' values, norms and perceived needs.

- **Simplicity:** innovations that are perceived to be simple to use are more likely to be adopted. If the innovation is feasible, workable and easy to use it is more likely to be adopted.

- **Flexibility:** innovations with which the intended users can experiment on a limited basis will be adopted and assimilated more easily. Similarly, innovations that potential adopters can adapt, refine or otherwise modify to suit their own needs are more likely to be adopted.

- **Support:** innovations that are supplied as an 'augmented' product, eg including training and a help desk, are more likely to be adopted.

Diffusion of innovation theory is used as a framework for understanding how strategies to improve identification should be promoted to and situated within general practice.

Multi-level approaches

Health systems can be defined as all organisations, institutions and resources devoted to producing actions whose primary intent is to improve health. In this research, general practice has been placed at the heart of the health care system because the research focused on changing the way general practices operate (i.e. changing their standard or customary operating procedures). The analysis, discussion and recommendations are divided into four levels based on where the influences on general practice are most likely to occur. The spheres of influence are shown in Figure 4. The levels of influence are defined as:

- practice level (centre of the diagram), which is influenced by factors at other levels

- community level (spheres 6 and 7), which includes community members who utilise general practices and community organisations

- regional level (spheres 4 and 5), which involves alternative health services providers and organisations providing support for general practices

- national level (spheres 1, 2 and 3), which includes the Australian Government, which has a primary role in the design, financing and management of the health care system. It also includes organisations that train GPs and general practice staff and peak organisations involved in health care through advocacy and governance issues.

In this schema, strategies and processes can originate in one level and be targeted at the members of a different level. Throughout the analysis, the location of origin and the target have been clearly described. For example, strategies developed by GPNs are considered to be regional level strategies but they may be targeted at community members (population level) and/or general practice.

FIGURE 4: Spheres and levels of influences on general practice

COMMUNITY LEVEL

NATIONAL LEVEL 1, 2, 3

7 People who utilize general practice (eg Population/community members)

6 Community organisations (eg Local Indigenous groups)

1 Health system design and management (eg Australian government)

5 Alternative health service providers (eg ACCHs, AMSs)

PRACTICE LEVEL GENERAL PRACTICES

2 Health system advocacy and self-regulation (eg Peak organisations)

REGIONAL LEVEL 4, 5

4 Services and support for general practice (eg General practice network)

3 Health system workforce education and training

Notes:

1. Peak organisations: peak organisations in Australia are associations of industries or groups. They are generally established for the purposes of developing standards and processes, or to act on behalf of all members when lobbying government or promoting the interests of the members.

2. General Practice Networks: the purpose of the GPN program is to provide services and support to general practice at the local level, through GPNs, to achieve health outcomes for the community that would not otherwise be achieved on an individual GP basis (Department of Health and Ageing 2008).

3. Aboriginal Medical Service (AMS): an AMS is a health service funded principally to provide services to Aboriginal and Torres Strait Islander individuals. An AMS is not necessarily community controlled. If an AMS is not community controlled, it will be a government health service run by a state or territory government. These non-community controlled AMSs mainly exist in the Northern Territory and the northern part of Queensland (NACCHO n.d.).

4. Aboriginal Community Controlled Health Services (ACCHSs): an ACCHS is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health care to the community that controls it (through a locally elected Board of Management). The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national peak body representing more than 140 ACCHSs across the country on Aboriginal health and wellbeing issues (NACCHO n.d.).

The need to take a multilevel approach – to consider barriers to improved identification and strategies to overcome them – is emphasised in Figure 5 and Figure 6.

Figure 5 shows that during the key informant interviews, when generalising the main barriers to improved identification, five themes became apparent; barriers with practice staff (80 per cent), with GPs (68 per cent), with the practice system (60 per cent), with the health system (40 per cent) and, at the community level, the perceived barriers that Aboriginal and Torres Strait islander people may experience (60 per cent). Further exploration of these themes can be found in Appendix G and Appendix H.

FIGURE 5: Key informant interviews: Perceived barriers to improving Aboriginal and Torres Strait identification in mainstream general practice
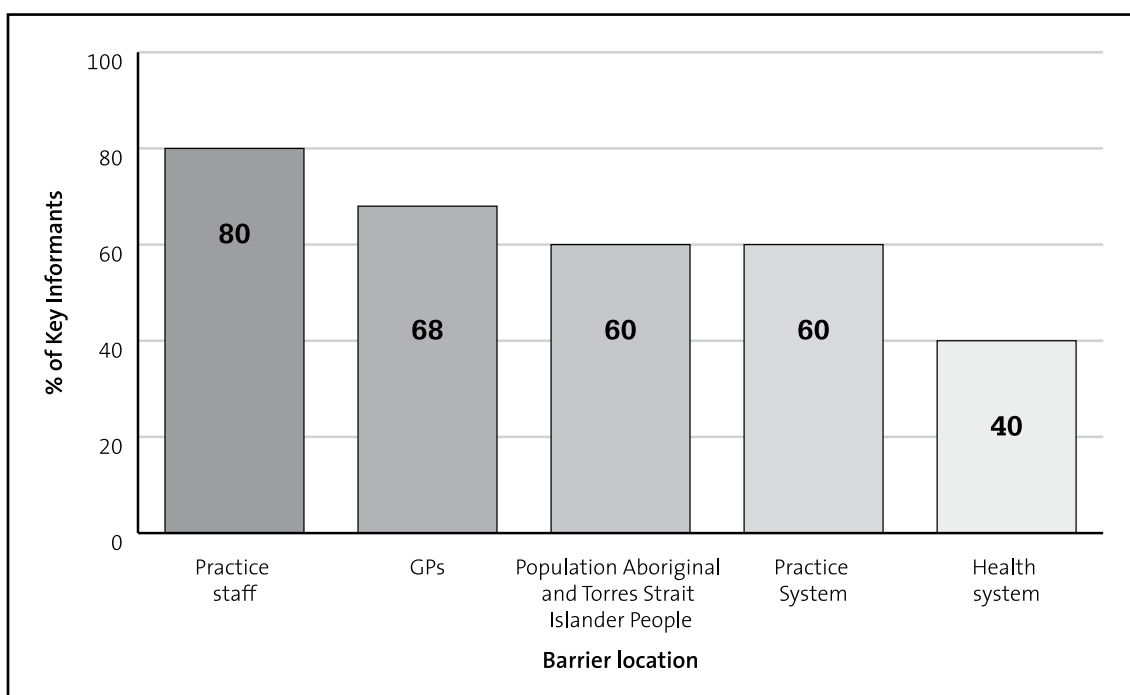
Figure 6 shows that the strategies suggested by key informants to improve identification were also distributed across different levels of the health system. The largest strategy category was GP and practice staff education (80 per cent of key informants), closely followed by community awareness raising (76 per cent of key informants) and information technology and information management improvements (68 per cent of key informants). The data from the key informant interviews and case studies have been organised around these issues.

FIGURE 6: Key informant interviews: Suggested strategies to improve Aboriginal and Torres Strait Islander identification in mainstream general practice
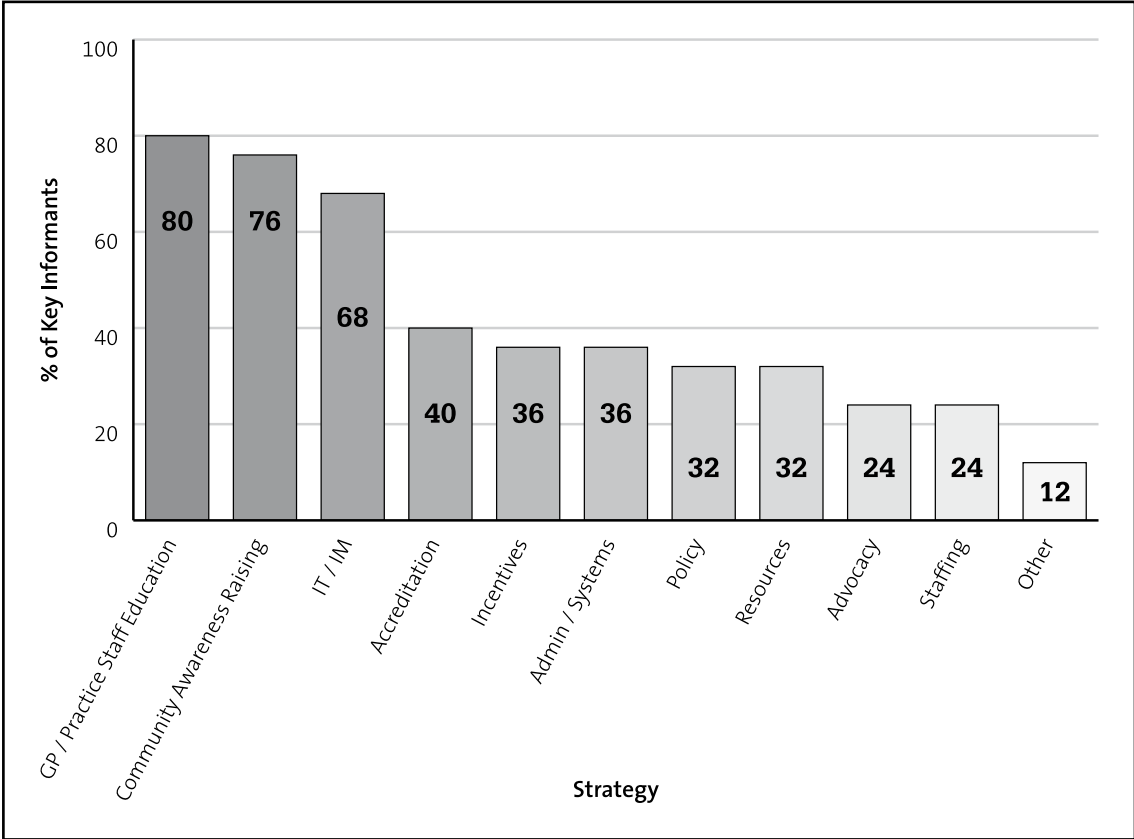
Note: IT/IM: information technology/information management

Summary

Improving identification of Indigenous patients in mainstream general practice is likely to involve multiple sites of intervention. The report is structured to reflect the context and strategies that are likely to be acceptable, feasible and effective at different levels. Diffusion of innovation is used as a theoretical framework for understanding the uptake of strategies across different levels of intervention.

4

STRATEGIES TO IMPROVE IDENTIFICATION

This chapter examines point-of-care identification strategies within practice level, community level, regional level and national level. It explores the research question:

- What strategies to improve the identification of Aboriginal and Torres Strait Islander people in mainstream general practice have been trialled before and what is worth trialling (feasible and acceptable) in the future?

PRACTICE LEVEL STRATEGIES TO IMPROVE IDENTIFICATION

In order to understand how to improve Indigenous identification, it is first important to understand why levels have been so low in the past. Results from two studies that help to explain this are shown in Table 7. In 2006–07, Kehoe and Lovett (2008) undertook a survey in the Australian Capital Territory with general practice staff of the Australian Capital Territory GPN to gauge attitudes to identification and Indigenous health issues.[a] The Brisbane North GPN of General Practice conducted a survey in 2003 of its GP membership. One hundred and ninety-five GPs (28 per cent) responded to the survey. Of these, 62 per cent had at least one Indigenous client (with an average of eight Indigenous clients). Less than half of the GPs with Indigenous patients (40 per cent) reported that they used Indigenous identifiers. Both studies identified three main themes.

TABLE 7: Literature review: Two surveys of GP attitudes to identification

	MAIN THEMES		
	Conceptualising Indigenous status	Lack of clinical justification	Logistical issues
Kehoe and Lovett (2008)	Indigenous status should be determined by appearance (Statements 15, 18: 20% to 28% expressed non-conducive attitudes). It is racist to ascertain Indigenous status (Statement 17: 24% expressed non-conducive attitudes). Negative reaction from patients (Statements 1, 2: 58% expressed non-conducive attitudes).	Indigenous status is irrelevant to the care provided by GPs (Statements 5, 10, 14: 30% to 46% expressed non-conducive attitudes). Few health differences between Aboriginal and Torres Strait Islander people and everyone else (Statements 8, 9, 12, 13: 31% to 39% expressed non-conducive attitudes). Aboriginal and Torres Strait Islander people should receive the same treatment as everyone else (Statements 4, 6, 7, 11: 34% to 47% expressed non-conducive attitudes).	A waste of time and effort (Statements 3, 16: 25% to 58% expressed non-conducive attitudes).
Identification in Communicable Disease Reporting Project Steering Committee (2004)	Feeling uncomfortable. Not knowing who to ask. Identifying these patients seen as discriminatory.	Identifiers not being necessary.	No place on patient record/medical software to record this.

These two studies concentrated on attitudes and perceptions and, apart from mentions of the medical software, failed to address organisational issues that may be barriers to Indigenous ascertainment. A report by the Communicable Diseases Unit (1998) made the point that it was time consuming for GPs to collect Indigenous status and there was no immediate benefit or incentive for them to so do. The report makes the point that if GPs are unable to see the benefits or the relevance for themselves and their patients, they will be unlikely to collect the information (Communicable Diseases Unit 1998). The themes identified in the existing literature strongly resonate with case study and interview data.

Conceptualising Indigenous status

While there was an understanding among participants that Indigenous status is often not visually ascertainable, the common assumption was that if people do not look Aboriginal and/or Torres Strait Islander then they do not have the same health or social issues as people who do. There was also the assumption that non-stereotypical looking Aboriginal and Torres Strait Islander people should not be classified as such because only a small proportion of their heritage is Indigenous; participants also questioned at what point someone should still be able to call themselves Aboriginal or Torres Strait Islander. Scotney (2009) demonstrated that visibly identifiable Indigenous people are often not identified because they are mistaken for people from other ethnic groups (Scotney 2009). This issues was not recognised by participants.

The most prominent issue discussed during both the key informant and case study interviews was difficulties in relation to asking the question. Hesitation to ask about Indigenous status stemmed from an assortment of issues. Largely, these issues revolved around being afraid of possible reactions of both Indigenous and non-Indigenous people alike (44 per cent of key informants). For non-Indigenous patients, practice staff were afraid of offending them. They were afraid of making Indigenous people feel uncomfortable. These beliefs, conflated with embarrassment and discomfort (40 per cent of key informants), mean that practice staff will usually only ask about Indigenous status if the person looks Indigenous (28 per cent of key informants).

There have been two studies in the United Kingdom into collecting ethnic data in general practice (i.e. ethnic monitoring) that suggest that the rate of refusal in the collection of ethnicity data was low (Sangowawa & Bhopal 2000; Jones & Kai 2007) (see Appendix M for more detail). It is not clear whether these results would generalise to Aboriginal and Torres Strait Islander patients in Australia, where the history of engagement is different. However, both the participants in this study and key informants from New Zealand have suggested that negative reactions from patients are uncommon.

Lack of awareness

Four main themes relating to the relevance of Indigenous identification arose during the research. The first theme was a lack of understanding of why these data should be obtained. People commented during the interviews that GPs and practice staff often are either unaware or do not understand the reasons behind identification and, therefore, do not ask (72 per cent of key informants).

It was found during the case study interviews that few GPN staff, practice staff or GPs could easily discuss the importance of identification and there seemed to be much confusion about why or how they need to use this information during a consultation.

The second lack of awareness theme was the assumption by GPs and/or practice staff that they have no Indigenous patients at their clinics (12 per cent of key informants). This assumption is generally not based on any data or analysis but, rather, on unfounded assumptions about their clientele. In towns with active and easily accessible Aboriginal Community Controlled Health Services (ACCHSs), key informants said that the practice staff and GPs sometimes assumed Indigenous people in these areas only go to the ACCHSs rather than attending their practices. During the case studies, it emerged that the main ongoing difficulty for GPN staff is in engaging practices in Aboriginal and Torres Strait Islander health, as many claim they have no Indigenous patients.

The third theme related to GPs saying they wish to treat all patients the same and that it is racist to treat Indigenous patients differently. Some GPs do not ask about Indigenous status because they believe they treat all patients the same and give quality service to all their clients (20 per cent of key informants). GPs frequently talk of a commitment to 'closing the gap'; however, they also say they work to health needs, not cultures.

During the case studies, one practice manager interviewed was unsure why Indigenous patients should receive better quality of care compared with non-Indigenous patients, stating that the kind of service the GPN was advising them to give was the quality they would like to provide for everyone but cannot afford. While this is a laudable aim, such a view does not recognise the much higher health burden suffered by Indigenous people that underlies the need for better quality of care.

The final lack of awareness theme related to a lack of understanding about how difficult it can be for Aboriginal and Torres Strait Islanders to self-identify. Another concern discussed around the issue of asking the question was that practice staff and GPs think that the onus of identifying is on the patient. If patients do not tell the staff about their Indigenous status, the staff do not feel it is their place to ask.

Strengthening the link between Indigenous identification and better clinical practice is critical for garnering support for improved identification, both from the perspective of practices and Indigenous people. Improved identification is only likely to contribute to better health outcomes if it results in better care for Indigenous people. In turn, practice staff are reluctant to ask if they do not see the question as clinically relevant. This suggests that initiatives to encourage general practices to identify their Indigenous patients should be accompanied by strategies to improve the care of those patients. Approaches to conceptualising this link are discussed in more detail in Chapter 6.

Strategies for improving identification at practice level

Three studies from the literature evaluated approaches to improving identification at practice level. Each of the studies (detailed in boxes 1, 2 and 3) addressed a different barrier associated with identification. The Britt et al. (2007) report from the Bettering the Evaluation and Care of Health (BEACH)/Supplementary Analysis of Nominated Data (SAND) study examines the impact of embedding a question about Aboriginality among more general questions about ethnicity. Brindell (2006) describes the impact of improving information systems on the uptake of Indigenous-specific initiatives immunisation (Prevenar™). Finally, the Communicable Diseases Reporting Project examines the impact of legislative change and emphasises the need to monitor and support identification policy in order to elicit change (IIICDRP Steering Committee 2004).

The BEACH/SAND study provides inconclusive support for the embedding of Aboriginality questions in more general ethnicity questions (Britt et al. 2007). The Prevenar™ uptake study (Brindell 2006) shows how small improvements in information flow can contribute to better outcomes. The Communicable Diseases Reporting Project suggests that higher-level policy initiatives require a multilevel approach (IIICDRP Steering Committee 2004).

BOX 1: Literature review: Providing a 'script': BEACH and SAND

The BEACH survey involves a rolling sample of GPs who complete a survey form for each patient contact during a specified period. The question relating to Indigenous status generally takes the form, 'Aboriginal (Yes/No) and Torres Strait Islander (Yes/No)'. A SAND study aimed to validate the routine BEACH questions on language background and Indigenous status using a more extensive suite of questions focusing on the patient's cultural background. The SAND questions were based on the 2001 Census questions.

In the SAND study, 204 (2.4 per cent, 95 per cent CI: 1.3–3.4) encounters involved patients who identified as being of either Aboriginal or Torres Strait Islander origin. This was twice the rate routinely recorded in BEACH (unweighted, 1.2 per cent, 95 per cent CI: 0.8–1.6,). Although the differences in the results were not statistically significant, the authors conclude that the increased identification rate 'provides some evidence that the structured question may be more successful in identifying Aboriginal and Torres Strait Islander respondents in general practice' (Britt et al. 2007).

It is clear from an examination of the SAND questionnaire that it is not only the question that has changed. There are changes in format and location of the Indigenous identifier within the survey form, and GPs were provided with a 'script' for asking the Indigenous ascertainment question. This script took the following form, 'Please ask the patient: "Are you of Aboriginal or Torres Strait Islander origin?"'.[b]

BOX 2: Literature review: Involving Indigenous people, improving uptake of Prevenar™

This intervention was undertaken in western Sydney in 2003. The first step was to clearly identify the underlying reasons for the poor uptake in Indigenous children, namely (i) a lack of vaccine knowledge by parents and (ii) poor identification of Indigenous babies in primary care. The strategies for improving uptake were developed to address these issues.

- **Parent education strategy:** an Aboriginal Liaison Officer visited mothers identified as Indigenous during check-in to the maternity ward and explained the condition and benefits of the Prevenar™ vaccine and that they should remind their doctors or community health nurses about it when attending clinic.

- **Identification strategy:** postcards and identification stickers were pasted into the 'baby blue book' that is given to all mothers after delivery so that the baby's information can be documented and kept together. The immunisation identification sticker also had tick boxes so that service providers could tick off each immunisation as it occurred.

Data for the outcomes are anecdotal but appear to indicate that the intervention may have led to improvements in parents' awareness and that the stickers in the 'baby blue book' aided GPs in the identification of Indigenous babies (Brindell 2006).

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[b] A copy of the questionnaire with the BEACH Indigenous identifier and the SAND Indigenous identifier is included in Appendix I.

BOX 3: Literature review: Auditing and feedback, reporting in communicable disease databases

In three jurisdictions (Victoria, Western Australia, South Australia) the majority of notifications are from medical practitioners (primarily GPs). In Victoria and South Australia there were substantial increases between the mid to late 1990s and 2003 in the proportion of notifications that included Indigenous status.

In Victoria the reason given for the increase from 19 per cent to 46 per cent was legislation mandating GPs to report Indigenous status. In South Australia the reason for the increase from 46 per cent to 73 per cent was considered to be an acknowledgment of the importance of good demographic data (Table 8). However, it is not clear how this was translated into strategies to improve the reporting of Indigenous status.

What is clear from a comparison of the proportion of notifications with Indigenous status recorded is that legislation, by itself, is insufficient to improve reporting of Indigenous status to acceptable levels. As one participant in this study commented, 'if GPs always receive forms back asking for missing Indigenous identification data then they will learn the need for compliance and get better at it – but if no feedback, no penalty, then (GPs) learn that it does not matter' (IIICDRP Steering Committee 2004).

Participants in this national study also expressed some concerns about the quality of the data. It was suggested that some GPs were more likely to make assumptions about Indigenous status, such as on the basis of skin colour, than to ask the ABS standard question. Participants in the three jurisdictions with a heavy reliance on GP notifications were more likely to think that medical practitioner reporting could be improved with some effort; for example, by reminders about their obligations under public health acts, follow-up calls for missing data and education of 'recalcitrant GPs' (IIICDRP Steering Committee 2004).

The authors reported that there were many suggestions for improving the quality of Indigenous identification in communicable disease reporting that could be broadly classified under the headings (i) policy, (ii) incentives, (iii) reporting, (iv) information systems and (v) workplace reforms.

TABLE 8: Reporting of Indigenous status in communicable disease databases

	Victoria	South Australia
Proportion of all notifications that included Indigenous status in 2002	44%	72%
Proportion of all notifications that are notified by medical practitioners	60%	75%
Changes in proportion of notifications that include Indigenous status	19% in 1999 46% in 2003	46% in 1996 73% in 2003
Reasons for change	Legislation enacted in 2001, mandating GPs to report Indigenous status (was previously voluntary).	Main reason is an acknowledgment within the Communicable Disease Control Branch that good demographic data (including Indigenous status) are helpful when investigating clusters of cases.

Source: IIICDRP Steering Committee 2004:20, 29.
Notes: 'medical practitioner' includes GPs in private practice, ACCHSs and prisons, clinicians in hospitals etc. In most states GPs provide the bulk of notifications from medical practitioners.

Encouraging improvements in identification at practice level

Key informants and case study participants outlined many barriers at practice level but also had a number of suggestions about which strategies to improve identification might be most acceptable, feasible and effective in general practice.

GP/practice staff education

Education of practice staff and GPs was the most common strategy key informants discussed. It included training in cultural awareness (72 per cent of key informants), how to ask the question and why the question is important (44 per cent of key informants), data importance (28 per cent of key informants), Medicare item refreshers (24 per cent of key informants) and history lessons, which link how the past affects health today (8 per cent of key informants).

There were diverse opinions about how this training could be delivered (whether it should be done by GPNs en masse, through in-house training, or as independent or integrated training), but most informants believed this was an area that needed much more focused attention.

Also recognised was that definitions of cultural awareness, cultural safety and cultural competence need to be developed and agreed upon because these terms were often used interchangeably.

'While the apology was well received, I think there has until recently been a tendency in this country not to discourage racist views. I think improving that, promoting an understanding of health needs of Indigenous people to the general population, is an important step in gaining support for initiatives to reduce health disparities.' National association representative

Key informants also believed that more work could be done in formal training – in both the medical/nursing degrees (4 per cent of key informants) and reception staff certificate (4 per cent of key informants). There were also calls to create Indigenous administrative health traineeships to provide more opportunity for Indigenous people to work in general practice (4 per cent of key informants). It was thought that if components of identification importance were included within formal training, identification would become standard practice with the GPs and practice staff of the future.

Interviewees in the case studies thought that well-conducted cultural awareness training could be the single critical factor that encourages practice staff to change attitudes and practices so as to facilitate care of Indigenous people (see Box 4 for example).

One GP stated that if the training can provide the motivation, everything else will follow. One GPN staff member made the point that, ideally, at least two people per practice should attend such training. This encourages the whole-of-practice approach and can also ensure that changes continue even if a staff member leaves the practice.

'I think that's where we need to really try and focus, improve understanding of the people who have the first contact, the importance of ethnicity from a medical point of view, from a legal point of view, and from a business point of view is very important, and that they should ask that question from every person who presents for the first time, you know, as a matter of priority, not as a matter of guess or as a matter of convenience, but as a matter of priority, and that will change it a lot.' GP

One practice interviewed considered training for new staff as an important aspect in providing quality care. This practice has a formal orientation period for new staff to shadow more-experienced staff. This shadowing means they are not left on their own to begin with and can learn how to ask questions and how to respond to questions. This practice feels that patient comfort is vital and results from the way staff talk to patients and make sure that all patients are treated with respect. This training period has lead to staff feeling confident in asking questions and they report that there are very minimal negative reactions. If there are, they know why they are asking the question and can respond appropriately.

BOX 4: Case study – Improving quality by improving acceptability

After attending cultural awareness training run through their GPN, staff at one practice began to think about how to better identify Aboriginal patients. It was decided to start by displaying culturally significant emblems throughout the practice. They put up stickers of the Aboriginal flag in the waiting room and on a car (upside down, as it was later pointed out). They also requested a poster from the local GPN that encouraged identification. In addition they framed the cultural awareness certificate from the course and put it in the waiting room.

Before doing the course, they thought there were virtually no Aboriginal people in their area, just one or two transient patients. After putting up the posters and stickers, they got a lot of comments, including racist comments from some patients. However, they also had five or six of their regular patients identify as Aboriginal; they were clearly happy that the practice was making an effort and there was recognition.

Since the training, when they treat an identified Aboriginal patient, they know to introduce themselves, talk a bit about their own family and where their family comes from, because they believe there has to be a two-way communication to establish a trusting relationship.

Thanks to these changes, the practice now has about 20 or 30 identified patients through referrals, and those patients bring family members along also. They are happy to take it slowly, understanding that if people are comfortable coming to the practice, word will spread.

Administrative strategies

Thirty-six per cent of key informants believed that improvement within administrative structures was important for change. Key informants were generally of the opinion that identification is becoming easier and more acceptable in recent times because so many places have a form that asks the question. They felt that identifying on a form was easier and more comfortable that verbalising the question within a reception area. It was commonly suggested that a standard registration form with question and explanation should be created (32 per cent of key informants).

Some research participants were of the opinion that cultural background should be asked of every person, not just Aboriginal and Torres Strait Islander people (4 per cent of key informants). Focus group participants also preferred the broader ethnicity question and felt that it was more inclusive and less likely to produce a negative reaction from the majority of patients.

A number of strategies talked about in the case study interviews demonstrated how practices had changed or used standard operating procedures to ensure quality data relating to Indigenous identification and ethnicity.

- **Clear registration form:** one receptionist discussed the change in identification rates once the registration form was improved and simplified. She stated that up to 20 per cent more new patients self-completed the Aboriginal and Torres Strait Islander question once the practice changed from the Royal Australian College of General Practitioners (RACGP) recommended form to a simplified form provided by the GPN.

- **Updating of patient information:** regular updating of patient information was seen as standard within one practice, and seen as an important part of quality assurance and accreditation. The practice was attempting to achieve a 90 per cent recording of ethnicity within current patient files. Files for updating are marked and when those people attend the practice for their next appointments, all information is updated and it is explained to the patients that this is a practice requirement.

- **New patient triage system:** due to a small and non-private reception area, one case study practice 'triages' all new patients through the practice nurse. Before a patient sees the GP, the nurse meets the patient and goes through the registration information and collects family history, including Indigenous status. The nurse said she has no problem with asking and so far only one person has had a problem with the question and asked, 'what difference does it make', but that has been the only comment. The nurse feels that people are much more willing to discuss Indigenous status within a private environment, where the reasons for identification can be discussed if necessary.

- **GP follow-up:** one practice has the Aboriginal and Torres Strait Islander question on the new patient registration form; if this is not completed at the time of registration, the GP is alerted and the GP will follow up with the patient because it is recognised that some people prefer confidentiality and the opportunity for detailed discussion with their GP.

- **Clear practice policy and guidelines:** a new practice that reportedly has a large number of Aboriginal and Torres Strait Islander patients thinks that part of its success is having staff who are interested and friendly. This practice has a policy in place regarding identification and the staff members do the best they can to make sure that everyone completes the registration form. The question is not mandatory, but if a person does not fill it in, a staff member requests the person to complete the form; if the person still does not fill it in, the doctor will follow up. If the person is having difficulties with filling out the form (reading/writing capacity), the reception staff will assist. The staff feel comfortable with their Indigenous patients and if they see them in the street they will have a chat and also remind them up of upcoming appointments, for themselves or family members.

Staffing

Besides employing an Aboriginal Health Worker (16 per cent of key informants) and delivering staff education (discussed above), it was acknowledged that staffing is an important area to focus on when attempting to improve identification.

It was thought that if a practice has systems in place that make it easy for people to comfortably self-identify and systems in place to run the health check without too much trouble, this makes a big difference in people's willingness to identify. Simple measures such as flags, posters and pamphlets let Indigenous people know that there is an effort made to be inclusive and respectful. Another measure key informants suggested that may improve cultural safety and, in turn, identification was to have Indigenous staff within the health care setting (16 per cent of key informants).

BOX 5: Case study – Employing Indigenous staff

A successful intervention found during the case studies was the example of a practice that employs a receptionist who is Aboriginal and well known in the community. Although this receptionist was not interviewed, it was said that because she is Aboriginal, she does not have a problem with asking whether or not patients are Aboriginal. Both the GP and the practice manager felt she was invaluable in improving quality of care for Aboriginal patients, as she often followed them up if they did not attend appointments and would also contact them when they had health checks and immunisations due.

Most practice staff interviewed during the project understood the imperative to improve Indigenous health and were committed to doing so. However, many did not believe that identification had a role to play in improving clinical care and did not understand why the question needed to be asked. This, along with discomfort associated with asking about ethnicity, often means that practices are not strongly motivated to improve their identification processes.

In practices where effective change has been introduced, it has involved the systematic integration of identification processes in overall practice quality assurance. It has also generally included a whole-of-practice approach to understanding why data is collected and in training staff to collect it.

BOX 6: Case study – The whole-of-practice approach

The phrase 'whole-of-practice approach' was used by a GP and practice manager in a practice where it is considered that in order to identify and retain Aboriginal patients, all the staff need to be equally well informed and committed to the goal of making their patients feel comfortable and respected in the practice. The important role that reception staff play in this regard is particularly recognised. Information and insights from cultural awareness programs or other training, as well as insights gained in the practice, are shared with all staff at the practice meetings. Reception staff are able to take time with patients after a consultation if needed to explain, for instance, where the pathology laboratory is, to reassure Aboriginal patients that they will be bulk billed at the laboratory or to help them arrange transport there. The doctor in this practice related how one Aboriginal patient said that in the practice he formerly attended, 'The doctor was really good but the receptionists did not like us'.

COMMUNITY LEVEL STRATEGIES TO IMPROVE IDENTIFICATION

Despite few examples of population level identification strategies, most people interviewed believed that it was important to include strategies at the community level. One of the main findings of the research was the lack of awareness at all levels about why Aboriginal and Torres Strait Islander patients should identify within a mainstream health environment (for further information about community level barriers, see Appendix C). Many people interviewed, both non-Indigenous and Indigenous, acknowledged that to complement any work done (or potential work) with the GPs and practice staff, community awareness raising about the specific initiatives available and why it is important that Aboriginal and Torres Strait Islander people should inform their GPs is also needed. Many commented that there needs to be a two-way push – from the community, as well as from GPNs – for practices to realise the importance of identification.

There was some support for the promotion of identification to all Australians in workshops and interviews associated with the study. , However the New Zealand experience was that general community campaigns resulted in a backlash because it was felt that collecting ethnicity data would contribute to 'special treatment'. It should be noted that this community reaction occurred in the absence of any specific incentives for Mäori (see the section 'National level strategies to improve identification' below for further discussion). Consequently, any backlash may be greater in Australia. However, the experience of asking for ethnicity data at health services in New Zealand was generally unproblematic. For example, health professionals felt it was important to have brochures explaining why the ethnicity question was being asked but these were rarely used.

Two examples of community-based initiatives are outlined below; a youth self-esteem program (Box 7) and a simple visual mapping exercise aimed at GPs (Box 8).

BOX 7: Case study – Encouraging the community to identify: Youth confidence development

A program run through a local Aboriginal community organisation focused on developing confidence and pride within local youth to proudly identify themselves as Aboriginal. The organisation said that self-esteem development is a vital life skill and assists teenagers to deal competently with many scenarios. This program focused on pride of Indigenous status rather than on reasons why they should identify within health care settings, and assisted with identifying within a health care environment.

After much work in developing self-esteem and pride, however, some of the participating young people, especially those who were fairer-looking, identified at the GP only for the receptionist to reply, 'Oh, you're not, are you?'

BOX 8: Case study – Raising the awareness of mainstream providers: Aboriginal map

In response to a common declaration by practices that they have no Aboriginal patients, one community organisation created a map of the GPN and detailed the suburbs where Aboriginal people (who they knew) lived; the locations of the practices were also marked. Within this GPN there were no ACCHSs, so the only primary health care available was with GPs or the hospital. This simple but effective visual aid helped open the discussion about identification.

Encouraging improvements in identification at community level

Key informants and case study participants had a number of suggestions about which strategies to promote identification might be most acceptable, feasible and effective for the Indigenous community.

Community awareness raising

Key informants said that education should not solely be targeted at service providers but also at service users. There was a belief that consultation with communities about identification and its purpose and benefits should take place (52 per cent of key informants) so that there could be a push from consumers to want to identify and to want a health check. Key informants had a variety of ideas on what this education should entail but common suggestions were for more posters and pamphlets (60 per cent of key informants), Indigenous art works and flags (56 per cent of key informants), locally appropriate media campaigns (12 per cent of key informants), and signage acknowledging the traditional land owners and stating that Aboriginal and/or Torres Strait Islander people should identify to help provide the best care possible.

There was also discussion of incentives for Aboriginal and Torres Strait Islander people. The main incentive discussed was for practices to bulk bill Aboriginal and Torres Strait Islander clients (24 per cent of key informants).

Another strategy was the idea of developing Indigenous-friendly GP lists (8 per cent of key informants). It was acknowledged that although this often happens informally, it would be beneficial to have a list of GPs and practices that are considered to be culturally aware and to provide good services to Aboriginal and Torres Strait Islander people.

Involving Aboriginal and Torres Strait Islander communities either directly or through community organisations or health services is critical to the success of identification strategies. It can also be important in facilitating diffusion of innovation. For example, in one GPN, elders worked with the network to identify practices that they thought were Indigenous friendly. The network worked closely with these practices to improve their capacity to cater for their Indigenous patients and the elders championed the practices in the community. The network is now working with practices that would like to be more Indigenous friendly but had a lower profile in the community. Ensuring that community values are reflected in the strategies developed will help ensure that the impacts of identification on health are positive.

'If you could get a poster in 60 per cent of the practices this would be really good, it says we recognise you, you are important to us, tell us about yourself, rather than them going into a mainstream practice and them thinking this is very clinical and there's nothing I can relate to.' National association representative

'Our history makes Indigenous people anxious and nervous about identifying as they may feel "marked" as Aboriginal and that their children may be at risk. The living memory of losing children is very fresh, or it may be their own experience of being removed.' Community representative

'Divisions are well placed to support general practice in identification of Aboriginal patients. Local engagement with communities is imperative to work out what their needs are, as what works in one place does not [always] work in the next.' GPN representative

REGIONAL LEVEL STRATEGIES TO IMPROVE IDENTIFICATION

Key informant interviews indicated that many GPNs have begun working on improving identification locally. However, work in this area is relatively ad hoc and each GPN has been developing its own strategies based on funding availability, staff ability and interest in Indigenous health initiatives (regional level identification barriers are outlined in Appendix D). At present there is very little understanding of the best techniques to promote change. For this reason, no projects or strategies have been evaluated, leaving only anecdotal evidence of change. Although evidence on which strategies work remains inconclusive, it was clear that GPNs working on improving identification are generally doing so through a variety of activities rather than through one specific activity.

Engaging with the Aboriginal and Torres Strait Islander health sector

The new COAG initiatives (to begin the end of 2009) include funding for Indigenous project officers at GPNs and for Indigenous outreach workers, a parallel initiative, at ACCHSs. At the time of writing the specific role of the project officers and outreach workers was still undefined. Both positions are expected to improve collaboration and communication between the ACCHSs and mainstream primary health care providers. This increased funding for Aboriginal and Torres Strait Islander health at GPNs is likely to cause a significant change in activity. Many GPNs involved in the case studies have had limited engagement in Indigenous health in the past because they had not been funded to do so (although in some cases there was significant unfunded activity). Working with the Aboriginal and Torres Strait Islander health sector and/or the Indigenous community requires a strong understanding of partnership approaches and views around respectful engagement. There were some excellent examples of cross-sectoral partnerships found during the case studies. In other cases, the relationship between GPNs and the community-controlled health services was not working well. For example, in one case both sectors complained about services being duplicated by the other sector. Developing the skills to overcome these barriers may require additional support in some areas.

The new funding will dramatically increase the Indigenous workforce at most GPNs. In some cases existing initiatives to increase the Indigenous workforce have not worked well. This has been because a clear role for Indigenous health workers has not been established, so health workers can find themselves doing 'lackey work' or waiting for clients rather than providing health services. In one case, GPs ended up duplicating work already completed by health workers because they did not 'trust' the Aboriginal Health Workers' competency. More generally, some Indigenous health professionals have been treated with less respect than their non-Indigenous colleagues. For example, one Aboriginal manager said, 'If I go to visit a practice with a white person they always just talk to them, and I'm the manager!' Increasing the Indigenous workforce in health is laudable; however, ensuring that these roles are well supported is critical to their success.

The structure of GPNs and their role in the Australian health system is also being reconsidered at this time. It has been suggested that current GPNs may be reinvented as Primary Health Organisations, a move that may lead to a strengthening of mandates to improve Indigenous identification.

GPN strategies targeting the community

As part of a multi-faceted approach to identification, some GPNs have included community-focused strategies in their identification strategy portfolio. A community-focused approach acknowledges the lack of awareness within the Indigenous community of the Medicare items that Aboriginal and Torres Strait Islander people are entitled to and also the reasons why these items are important. Table 9 shows the GPN-implemented community-focused strategies documented during the case studies.

TABLE 9: GPN strategies for community

Strategy type	Strategy	Strategy description
Community engagement	Community engagement	Focus on relationship development with both community organisations and practices.
Community engagement	Brokerage program	Registration with program entitles one to a card that can be presented at practices for bulk billing and easy identification.
Promotion	Publicity campaigns: TV advertisement	Creation of a TV advertisement, run on a local TV channel, about the availability of Indigenous health checks.
Promotion	Radio show	For years a regular radio show was run through which Indigenous health information, including health checks and the importance of informing GPs of Indigenous status, was discussed.
Promotion	Drink coasters	With a focus on the need to address the reluctance of Aboriginal and Torres Strait Islander people to identify within mainstream general practice, one GPN produced drink coasters that were distributed to local pubs in the area during a busy footy season period.
Community engagement	Roving GP	Transport to health check clinics that are run in non-medical settings, such as community halls or schools, with open consultations that extended family can attend to increase comfort and accessibility.

GPN strategies targeting general practice

Table 10 outlines the large variety of GPN strategies discussed during the case studies. Participants pointed out that local context is important and all strategies need to be adapted to differing contexts. Although different strategies were developed within each GPN, they generally fit under the headings of promotion, cultural awareness, systems change, community engagement, Medicare item review and encouragement/support/hiring of Indigenous staff.

TABLE 10: GPN strategies for general practice

Strategy type	Strategy	Strategy description
Promotion	'Welcome to country' Sign	Through community consultation, a 'welcome to country' sign was created, as well as a 'please identify to your GP' sign, for practices to display. This signage was written in both English and the local Aboriginal language.
Promotion	Art project	Art project organised though the local Aboriginal community organisation to develop work with a health theme that could be used in posters and brochures to be displayed in clinics.
Promotion	Poster development	Distribution of identification posters and pamphlets to practices.
Promotion	Newsletters	A newsletter including Indigenous health information, MBS reminders and updates was distributed to all practices.
Promotion	Website development	Website development with Indigenous health information, including why to identify Aboriginal and Torres Strait Islander patients, how to ask the question, answers to difficult questions, recommendations to update patient records and links to other helpful resources.
Cultural awareness	Online cultural awareness training	Development of online cultural awareness training and online Indigenous health check training.
Cultural awareness	Cultural awareness training	Running cultural awareness training for GPs and practice staff.
Cultural awareness	Indigenous-friendly GP lists	Directed Indigenous people to mainstream GPs who could provide culturally appropriate services.
Cultural awareness	Aboriginal journey	Prior to research, it was assumed no Indigenous people attended mainstream practices. One GPN found that among that 90 per cent of Aboriginal patients in hospital were referred by a mainstream GP.
Systems	Sowing the seed	Indigenous health and identification is integrated throughout almost all programs within the GPN.
Systems	Information technology training	Provision of assistance with software training such as Medical Director. During this training Aboriginal and Torres Strait Islander status can be highlighted.
Systems	Improving data quality	Data extraction tool implementation and training to improve data quality.

Strategy type	Strategy	Strategy description
Systems	Accreditation	The accreditation process is seen as a main driver of change – it is a time when GPNs can highlight identification/system change.
Systems	Registration form	Advice on registration form layout and Aboriginal and Torres Strait Islander identification question.
Systems	Updating patient information	Advice on updating patient information.
Encouragement and support	Encouragement and support	Development of practice support networks. GPN staff in regular contact with the practice to support, inform and update.
Community engagement	Sharing and learning circle/collaboration	Collaboration and relationship building with local Aboriginal organisations. Indigenous health projects developed by community groups in partnership with GPN.
Indigenous staff	GPN Indigenous staff	An Aboriginal staff member to assist with orientation of new practice staff (among other project work).
MBS review	MBS update	Reminders and updates about Medicare.
MBS review	Improving financial viability	The promotion of Indigenous health checks and other Indigenous Medicare items as a way to make practices more financially viable.

Effectiveness of regional strategies on health check uptake

The relationship between GPN strategies (outlined in Appendix J) and uptake of Indigenous health checks was analysed (Table 11). Across all health checks there was a significant linear trend towards increased uptake of health checks over time. There was also a tendency for GPNs with strategies to have lower uptake of health checks overall than GPNs that did not have strategies. This probably reflects the fact that GPNs that were more likely to have strategies were also less likely to have ACCHSs. A major limitation of the data presented is that health checks provided at ACCHSs cannot be distinguished from services provided in mainstream general practices.

However, GPNs with strategies in place showed increased uptake of health checks over time relative to other GPNs. For child health checks, this effect was significantly related to hiring an Aboriginal Liaison Officer. For adult health checks, cultural awareness training, MBS/ Pharmaceutical Benefits Scheme (PBS) review, administrative review and promotional materials were all significantly associated with increased uptake of health checks over time. Health checks for older people were significantly associated with MBS/PBS review, and promotional materials were associated with increased uptake over time. The results suggest that relatively simple measures like MBS/PBS review and the development of promotional materials can have a significant impact on the uptake of health services. The case studies and interviews emphasise that the latter strategy is likely to be successful when the materials developed are locally relevant.

TABLE 11: Relationship between GPN level strategies (PHC RIS 2006/07 – 2007/08) and the uptake of health checks (Medicare 2006–08)

	CHILD HEALTH CHECKS		ADULT HEALTH CHECKS		OLDER HEALTH CHECKS	
	AOR* 95%CI[†]	P value[‡]	AOR 95%CI	P value	AOR 95%CI	P value
SYSTEM CHANGE						
Linear time trend	2.78, 2.4–3.21	<0.01	1.49, 1.3–1.69	<0.01	1.51, 1.28–1.78	<0.01
Strategy	0.67, 0.24–1.83	0.43	0.58, 0.19–1.75	0.33	0.4, 0.17–0.95	0.04
Time trend[§] strategy	0.83, 0.56–1.23	0.35	0.92, 0.73–1.16	0.48	1.02, 0.75–1.4	0.89
CULTURAL AWARENESS						
Linear time trend	2.5, 1.95–3.21	<0.01	1.23, 1.08–1.4	<0.01	1.43, 1.22–1.69	<0.01
Strategy	0.38, 0.16–0.88	0.02	0.45, 0.23–0.87	0.02	0.58, 0.32–1.08	0.09
Time trend strategy	0.99, 0.53–1.86	0.98	1.43, 1.1–1.84	0.01	1.17, 0.83–1.65	0.36
MBS/PBS REVIEW						
Linear time trend			1.39, 1.23–1.58	<0.01	1.51, 1.29–1.78	<0.01
Strategy			0.42, 0.19–0.92	0.03	0.34, 0.13–0.86	0.02
Time trend strategy			2.38, 1.78–3.19	<0.01	2.92, 2.46–3.47	<0.01
GPN ENCOURAGEMENT						
Linear time trend	2.88, 2.45–3.38	<0.01	1.36, 1.19–1.56	<0.01	1.35, 1.16–1.57	<0.01
Strategy	0.84, 0.37–1.92	0.68	0.63, 0.31–1.26	0.19	0.64, 0.32–1.26	0.19
Time trend strategy	0.69, 0.42–1.14	0.15	1.09, 0.83–1.44	0.53	1.44, 0.99–2.1	0.06
ADMINISTRATIVE REVIEW						
Linear time trend	2.38, 1.86–3.06	<0.01	1.38, 1.21–1.57	<0.01	1.52, 1.27–1.82	<0.01
Strategy	0.19, 0.07–0.5	<0.01	0.33, 0.1–1.05	0.06	0.99, 0.33–2.95	0.99
Time trend strategy	3.42, 0.83–14.13	0.09	1.5, 1.14–1.98	0	1.09, 0.75–1.59	0.65
HIRE ABORIGINAL LIAISON OFFICER						
Linear time trend	2.44, 1.9–3.14	<0.01	1.41, 1.24–1.61	<0.01		
Strategy	0.38, 0.03–4.79	0.45	0.77, 0.16–3.77	0.75		
Time trend strategy	1.69, 1.27–2.24	<0.01	0.98, 0.56–1.71	0.93		
PROMOTIONAL MATERIALS						
Linear time trend			1.39, 1.23–1.58	<0.01	1.49, 1.27–1.74	<0.01
Strategy			0.16, 0.06–0.44	<0.01	0.06, 0.01–0.39	<0.01
Time trend strategy			1.88, 1.5–2.36	<0.01	8.53, 2.09–34.78	<0.01

Notes:

* AOR: Adjusted Odds Ratio.

[†] CI: Confidence Interval.

[‡] The 'P value' is the probability, with a value ranging from zero to one, that the hypothesis would assume a value greater than or equal to the observed value by chance.

[§] Adjusted for area remoteness. (Controls for remoteness: all analyses included the remoteness rating of the division of general practice from the PHCRIS data).

'Time trend strategy' is the interaction between a linear trend over time and having a strategy. An odds ratio over 1 indicates that uptake of health checks increased at a faster rate over time in divisions with the strategy than divisions without the strategy.

Encouraging improvements in identification at the regional level

Many promising approaches were discussed during the case studies. Examples of approaches follow.

- **Community contacts:** the development of a relationship between the practice and a key person in the local Indigenous community, or a trusted person who works with the community, can facilitate referrals, ongoing care, and the development of trust between patients and practices. Staff at one practice commented that when the Chronic Disease Care nurse who works closely with the local Aboriginal and Torres Strait Islander community referred patients to them, these patients entered the practice with a degree of trust, which facilitated identification.

- **Using promotional material:** posters and pamphlets asking patients to identify were placed in an obvious place on the reception counter and in the reception waiting room. Some practices and GPNs used the ABS identification posters and pamphlets, and others developed their own.

- **Involving the GPNs:** it was commonly suggested that GPNs are 'best placed' to work on improving identification with practices (12 per cent of key informants). It was believed that hands-on assistance with improving systems would be the best strategy (8 per cent of key informants).

- **Advocacy:** it was thought that due to the importance of this topic, increased advocacy was needed (24 per cent of key informants). Suggestions included discussing the topic in network lunches and meetings (16 per cent of key informants), promoting the topic through papers at conferences (8 per cent of key informants) and increased promotion of identification (to GPs and practice staff) through national bodies (4 per cent of key informants).

- **Provision of resources/incentives:** during the case studies it was pointed out that, as improving identification requires changes to systems and training, there needs to be an increase in financial resources available to practices and/or GPNs to work on identification improvement strategies (20 per cent of key informants). It was thought that an information kit should also be developed so that training and information about the topic could be standardised (16 per cent of key informants). A general website was also suggested to focus on Indigenous health information and to provide GPNs and practices with resources to download (8 per cent of key informants).

The focus groups seemed in general agreement that the question should be asked to everyone as a normal demographic question and they thought that this is best done via a paper registration question at reception. They said that there should be a set explanation given upon patient request. However, if it was stated that answering the question was 'for your best possible care', non-Indigenous people may have an issue with this and feel as though they will not receive 'best possible care'.

It was also agreed upon that whether the question is asked via a form or verbally, there needs to be training of staff to understand why the question is asked so that an explanation can be given to patients who want to know.

GPNs have a strong sense that it is their responsibility to design and disseminate strategies to improve the identification of Indigenous patients. There was also evidence that GPN strategies (particularly employing Indigenous staff, cultural awareness training, MBS/PBS review, administrative review and promotional materials) are associated with improved uptake of Indigenous health checks (Table 11).

NATIONAL LEVEL STRATEGIES TO IMPROVE IDENTIFICATION

Practices and practice staff work within a broad health system environment. When asked about how this broad environment inhibited or drove identification, discussion focused on (i) awareness of Medicare items and their complexity, (ii) the Practice Incentives Program (PIP), (iii) accreditation and (iv) information technology. (National level barriers to identification can be found in Appendix E.)

Initiatives to improve identification of Aboriginal and Torres Strait Islander people in general practice were preceded by hospital-based initiatives. Additional information about approaches to improve identification in Australia is provided by initiatives to improve identification in hospitals. According to Riley et al. (2004), health care provider perceptions regarding Indigenous identifiers vary greatly in the hospital system. Where it is seen as important and useful, the procedure is more likely to be followed (Riley et al. 2004).

A report by the Aboriginal and Torres Strait Islander Health and Welfare Information Unit (1999) indicated that accurate recording appeared to be higher:

• in hospitals in which a higher proportion of Indigenous people lived in the hospital's catchment area (99.4 per cent compared with 66.4 per cent)

• in hospitals outside capital cities (78.5 per cent compared with 90.8 per cent)

However, the authors caution that the trend in relation to the proportion of Indigenous people living in the catchment area only became obvious when then the data for the hospitals was amalgamated and does not mean all hospitals in the areas reflected this trend (Aboriginal and Torres Strait Islander Health and Welfare Information Unit 1999). This conclusion also applies for the differences between hospitals in capital cities and other areas (Figure 7).

FIGURE 7: Percentage of persons for whom Indigenous status was correctly recorded

(N = 11 hospitals)
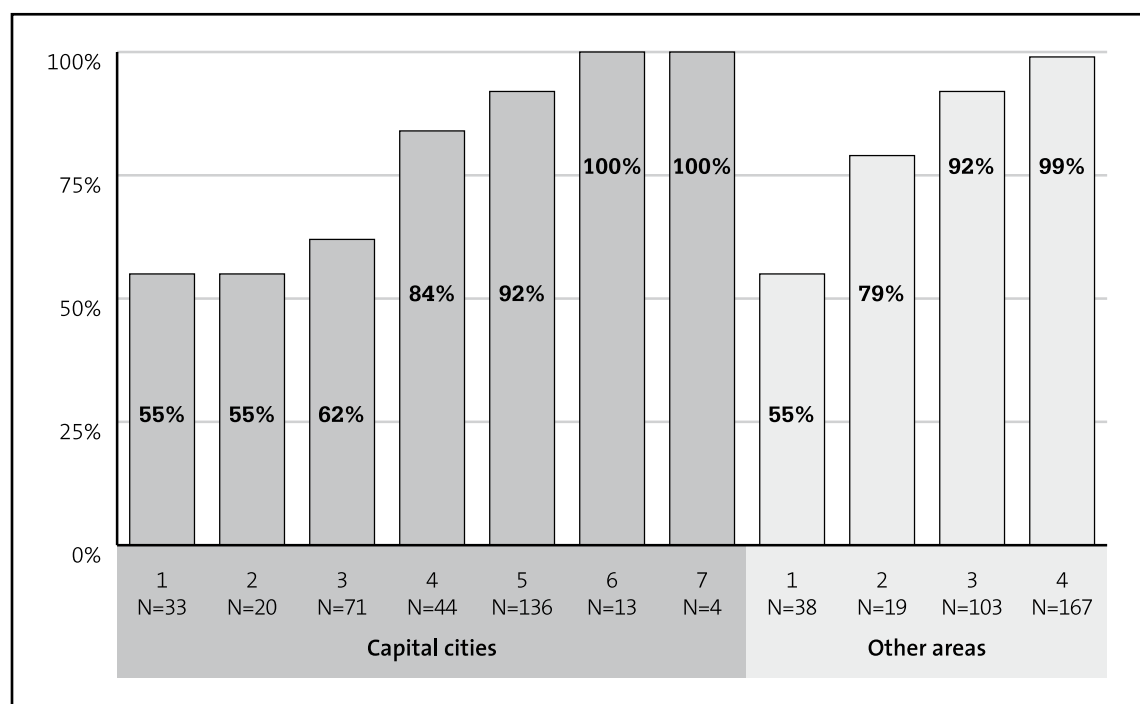
Source: Aboriginal and Torres Strait Islander Health and Welfare Information Unit 1999:15.
Notes: N = number of interviews undertaken to confirm recording of Indigenous status.

According to the Communicable Diseases Unit (1998), three broad and overlapping tasks that need to be completed to successfully introduce Indigenous ascertainment in general practice are:

- convincing people (both Indigenous and non-Indigenous) that collecting Indigenous status is a worthwhile objective

- training service providers to collect the required information in an appropriate and sensitive manner

- developing and implementing processes that facilitate the collection of high-quality data (Communicable Diseases Unit 1998).

It is also possible to assess best practice in terms of other initiatives that have been used to change GP behaviour. Two examples in the literature of introducing change within health systems demonstrate how these tasks have been used to bring about change and are instructive for the current project. The first is the General Practice Immunisation Incentive (Box 9), which was introduced by the Australian Government, and the second is the Improving Care for Aboriginal and Torres Strait Island Patients program in Victoria (Box 10). The common themes in both these case studies are (i) they are multifaceted and involve a range of strategies, (ii) the strategies included financial incentives, and (iii) they focused on providers and the population.

BOX 9: Literature review – General Practice Immunisation Incentive

In 1997 the Australian Government introduced a seven-point plan to promote immunisation coverage. The measures implemented under this plan included:

- facilitation of vaccine supply via state-based services

- provider education

- provider incentives known as the General Practice Immunisation Incentive (GPII)

- facilitation of vaccination history accessibility to providers via registers

- reminders from registers to providers and to parents

- parent incentives

- promotional campaigns, sometimes involving mass media and targeting those to be vaccinated

- mass vaccination programs (Riley et al. 2004)

- GPs and practices registered with the GPII were eligible to receive (i) a service incentive payment for each completed age-appropriate set of the Australian Childhood Vaccination Schedule; (ii) an outcomes payment, with practices with higher levels of vaccination coverage receiving a higher payment; and (iii) an Australian Childhood Immunisation Register notification fee for every valid immunisation report to the register.

Evaluation of the GPII by KPMG Consulting concluded that there was some evidence that immunisation activity was moving from the non-GP sector to GPs but this trend had started before the introduction of the GPII and continued afterwards. In relation to the increase in national immunisation coverage levels, the report concluded that:

all the elements in the Seven Point Plan ... had operated in a systemic way to cause increases in coverage, but it was impossible to separately quantify the impacts of the individual elements. However, there was some indication that the strongest impacts had been through parent inducements – school entry requirements and welfare strategies – with GPII playing a lesser, but significant role (KPMG consulting, 2000)

Indicative costs of the GP financial incentives in the 2004–05 financial year (when 5,480 practices registered to participate in the scheme) were $16.7 million (average $3,047/practice) for total service incentive payments, and $16.5 million (average $3,010/practice) for total outcomes payments.

BOX 10: Literature review – Improving Care for Aboriginal and Torres Strait Island Patients

According to the Australian Institute of Health and Welfare (2009), there have been significant improvements in the quality of Indigenous identification in both New South Wales and Victoria (AIHW 2009a). The Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) program has been significant in improving the data quality in Victoria. This program built on and enhanced the Aboriginal Hospital Liaison Officer program and emphasises that accurate identification and culturally appropriate care of Aboriginal patients is a whole-of-health service responsibility.

The strategies adopted include:

- **a financial incentive:** a premium of 30 per cent on Weighted Inlier Equivalent Separation (WIES) payments for Aboriginal and Torres Strait Islander patients

- **staff training:** project officers and the Koori Human Services Unit arrange and provide training in hospitals in how to collect data on Aboriginal status

- **data verification:** monthly reports by Aboriginal Health Liaison Officers (who have contact with patients) and, where possible, data from these officers are checked against the data available through the Victorian Admitted Episodes Dataset (VAED) to establish whether the same patients are identified by both systems

- **Indigenous staff:** hospitals are employing Aboriginal Liaison and Policy/Planning Officers

- **involvement in tertiary education:** the Koori Human Services Unit accepts two Bachelor of Health Information Management students each year, and delivers lectures as required at Latrobe University.

Source: DHS 2008

HealthConnect SA (2006) points out that bringing about change in general practice is difficult and that there is evidence that 'sound reasons for change do not automatically translate into change in behaviour or practice' within the health care system. There is also evidence that poorly managed change initiatives can lead to hostility and low morale, limited effectiveness and project failure. According to HealthConnect SA (2006), a systemic or systems approach to change management is important.

The only example that could be located of initiatives to improve identification in an international context was in New Zealand. The primary health care strategy in New Zealand is at the heart of government initiatives to reduce health inequalities (King 2001). Changes to the funding of primary health organisations (PHOs), the umbrella groups for primary health care providers, are central to the strategy. The initial funding formula (subsequently removed) paid higher subsidies to PHOs in which 50 per cent or more of their enrolled population was either Mäori or Pacific Islander, or living in a deprived area (as defined by the NZDep2001 Index, which combines eight census variables that reflect aspects of social and material deprivation) (Ashton 2005). This clearly provided a strong incentive for PHOs and their constituent practices to improve ethnic identification. In addition, PHOs are required to report on the ethnicity of their constituent populations quarterly (Bramley & Latimer 2007). Moreover, improvements in ethnic identification benefited the entire population of an area, countering concerns about identification only being relevant to a small proportion of the population. The collection of ethnicity data has been supported by two initiatives: the development of protocols for the collection of ethnicity data; and the introduction of cultural competency as a core requirement for health professionals under the *Health Practitioners Competence Assurance Act 2003* (section 118) (Ministry of Health 2009a).

The protocol for the collection of ethnicity data in health services is based on the census question (Ministry of Health 2004, 2009b). Initially, there was concern that the development of a general ethnicity question rather than a question specifically about Indigenous status might render Māori 'invisible' in discussions about health. However, these concerns were allayed because the Treaty of Waitangi protected the special status of New Zealand's Indigenous people and because having a question that could be applied to everyone had benefits in terms of ensuring a systematic approach to data collection. Various methods have been used by PHOs to identify their populations, including downloading data from the national health index and self-identification, and more problematic methods like name matching (Bramley & Latimer 2007).

A study of PHO data quality compared these data to the National Immunisation Register (NIR) (Bramley & Latimer 2007). For children classified as Māori on the NIR, 62.9 per cent were recorded as Māori on the PHO register, 23.3 per cent were misclassified as European and a further 9.6 per cent were misclassified as unknown. In contrast, for children classified as European on the NIR, 83.2 per cent were recorded as European on the PHO register and 14.4 per cent were misclassified as unknown. This suggests that despite incentives for identification, Māori children were still under-identified. The study also highlights the need for data quality measures and audit processes. Initiatives to improve data quality are underway in a number of districts.

National level incentives and initiatives to improve identification

The COAG 'Closing the Gap' initiative has three main components that will be mediated by GPs:

- expansion of existing Medicare items for Indigenous people

- PIP incentives for the registration of and management of Indigenous patients with, or at risk of, a chronic disease

- enhanced access to PBS medicines.

Self-identification and/or PIP registration is the gateway to these initiatives.

Pre-existing support and incentives for GPs to improve their capacity to care for Indigenous patients through Medicare include:

- child and adult health checks

- child and adult immunisations

- access to an Aboriginal and Torres Strait Islander-specific PBS listing.

These health check items will be further supported by the addition of new items for follow-up care.

The PIP Indigenous Health Incentive aims to encourage general practices to provide better health care for Indigenous Australians, including best practice management of chronic disease. The incentive will commence in May 2010. The PIP Indigenous Health Incentive has three components:

- **sign-on payment:** a one-off payment of $1,000 to practices that agree to undertake specified activities to improve the provision of care to their Indigenous patients; the requirements may include undertaking activities relating to cultural security

- **patient registration payment:** an annual payment to practices of $250 for each Indigenous patient registered with the practice for chronic disease management for a 12-month period

- **outcomes payment:** an annual payment of $250 to practices for each registered patient for whom a target level of care is provided by the practice in a 12-month period. (Medicare Australia 2009)

To be eligible for the PIP sign-on payment, practices must agree to obtain informed consent from all their Indigenous patients to register them with Medicare Australia for the purposes of the 'Closing the Gap' measures. A patient registration payment will be paid per registered patient aged 15 years and over with/or at risk of chronic disease. Registration for PIP will also enable patients to access initiatives to provide PBS medicines at lower cost if they so choose.

Encouraging improvements in identification at national level

In many ways the current set of incentives provided by PIP corresponds to best practice. Incentives are provided to GPs to register patients and develop their ability to meet the needs of Indigenous patients. There is also increased funding at GPNs and ACCHSs to further develop this capacity and overcome logistic barriers. However, there is no explicit strategy to promote the new incentives to Indigenous people at a national level (although arguably this role could be and should be taken up at a regional level). The New Zealand model provides an interesting solution to the barriers related to Indigenous people comprising only a small segment of many GPs' patient populations. However, the disadvantage of this approach is that it explicitly shifts the focus of the strategy from improving Indigenous health to improving the health of all disadvantaged populations. This shift in focus would be even greater in Australia, where the Indigenous population is smaller.

Accreditation

Accreditation is a process, conducted triennially, for the external evaluation of general practices to ensure the delivery of safe, high-quality health care. Accreditation assesses the achievements of primary health care staff in meeting the requirements of established standards (currently the third-edition standards of the Royal Australian College of General Practitioners (RACGP 2007)[d]) in the areas of education, practice management, the rights and needs of patients, and the physical facilities of the practice. The benefits of accreditation include improved patient safety and overall health outcomes, risk reduction, improved practice efficiency and environment, insurance benefits and access to the PIP scheme.

The main health system level barrier that key informants commented on was the lack of accreditation strength (32 per cent of key informants). During the case studies, GPN staff made it clear that, for practices in their area, accreditation was the main driving force behind any changes that have happened. However, currently the accreditation criteria simply says that practices must be 'working towards' improving identification (Medicare Australia 2009). Accreditation organisation representatives stated that this was one of the easiest accreditation criteria to pass. Key informants and some case study interviewees acknowledged that, for many practices, unless they *have* to change, they simply will not. Accreditation was seen as a strong driving factor in improvement and change for practices. Many commented that unless this is strengthened and enforced (such as linked to funding), no significant changes will occur.

Information technology/information management

Throughout the key informant interviews, information technology and information management usage and improvement were prevailing topics of discussion (68 per cent of key informants).[e] Throughout these discussions, there was consensus that they were powerful tools that needed further advancement, without detracting from the fact that this technology is to improve health services.

[d] Details in Appendix L.

[e] A discussion about information technology can be found in Appendix K.

Common thoughts on changes in the software were that software developers should:

- create a mandatory cultural background field (28 per cent of key informants)

- remove the default to non-Indigenous identification (24 per cent of key informants)

- add a 'prefer not to answer/not stated/missing' option, so that it is clear if someone does not want to answer the question; this would also ensure that software does not default to non-Indigenous identification (4 per cent of key informants)

- add 'has the question been asked' so that the reception staff know whether or not they need to follow that data up; this would also reduce the likelihood of a person being asked multiple times (20 per cent of key informants)

- add user-friendly health check wizards and/or templates (8 per cent of key informants) to ensure that identification

To improve information technology/management and to make the above changes, a suggested strategy was that national bodies such as the RACGP and the Australian Association of Practice Managers should increase lobbying and negotiation with the software companies to change and adapt the Indigenous identification data collection in their programs. It was also suggested that the major software companies be paid to make the changes so that changes are done in a fashion that would assist best practice (12 per cent of key informants).

There was also discussion of data analysis programs, such as the Pen tool and the Canning tool, which consolidate practice data into reports which allow practices to easily track data and patient records (32 per cent of key informants). This software can help practices see data gaps, and attempt to improve the quality of the data being inputted (see Box 11 for case study example).

BOX 11: Case study – The fully electronic practice

One practice interviewed is fully computerised and prides itself on having complete and quality records. The GP sees the value of computerisation and said he makes sure that he completes all the records and keeps them up to date. Both the GP and the practice manager are confident that the majority of their Aboriginal patients are identified and recorded in the software. The GP has been working for the practice for four years and has been the driver behind its electronic transformation, with an emphasis on quality data. When he started he said that software was purely used for prescriptions. Over the years the practice has focused on being fully electronic and improving data quality.

LOOKING ACROSS THE LEVELS

The data relating to strategies that are most likely to be acceptable, effective and feasible in the general practice environment are based on the opinions of key informants and participants in the focus groups and case study examples of strategies that have actually been implemented. There is a degree of concordance between the opinions and the implemented strategies, which provide prima facie evidence that these represent the 'best' available evidence relating to how identification can be facilitated in general practice.

The most often mentioned strategies were:

- the development and implementation of education and training packages for general practice staff and GPs based on well-founded understandings of cultural safety and cultural competence, the importance of Indigenous identification for improving the quality of care and how to ask the question

- the development and implementation of administrative systems and processes (including information technology and information management) to help general practice improve Indigenous identification; there were examples of how such systems processes have been individualised by different general practices, some as simple as changing registration forms through to a whole-of-practice approach

- the provision of resources and support for the general practices to overcome the organisational and systemic difficulties in instituting changes in the normal routines

- the provision of training in cultural safety/competence and clear direction on how to institute change management

- tightening accreditation standards, which was seen as instrumental in improving identification; at the health system level the Australian Government also has a role in the provision of resources and support to GPNs and to general practices

- involving the community, which was also seen as important both in terms of providing a push for general practices to improve their identification processes and as having input into the development and implementation of regional strategies by the GPNs.

The strategies outlined highlight the importance of a whole-of-system approach to improving identification encompassing incentives and support at the population level and for general practices.

The literature highlights that change will take time; not all GPNs and general practices will embrace Indigenous identification immediately. The attributes of Indigenous identification that are most likely to encourage its adoption include relevance, simplicity, flexibility, support and compatibility with individual values. Many of these attributes are evident in the approaches that have already been taken or suggested in relation to strategies that are most likely to be acceptable, effective and feasible in the general practice. The literature also indicates that it cannot be automatically assumed that general practices located in areas with high Indigenous populations will be more interested in the uptake of Indigenous identification than general practices located in areas with low Indigenous populations.

SUPPORTING STRATEGIES TO IMPROVE IDENTIFICATION

There is clear evidence that various strategies have been introduced at the community and regional levels and within general practices. All appear to have face value: they appear to have the potential to increase identification in mainstream general practice. However, there has been no formal evaluation and all have been implemented on an ad hoc basis with minimal resources and no guidelines as to what constitutes 'best practice'.

The strategies also appear to have been developed and implemented in ways that suit the needs of the local environment. Bearing this in mind, the discussion in relation to the effectiveness of particular strategies reflects the need for jurisdictional flexibility and focuses on the supports required at the community and regional levels, and for general practice to trial the uptake of Indigenous identification.

Support for the community

Aboriginal and Torres Strait Islander communities have been identified as having an important role in Indigenous identification. However, there is little awareness of the reasons why identification is important. Helping communities to understand why it is important is likely to increase the likelihood that community members will identify. There were a number of examples of strategies that aimed at improving awareness of the need for identification. However, few of these originated from within the community. From the few examples that were available, it appears that allowing community members to take the initiative in identification (through written identification) makes it easier for general practices to identify their Indigenous patients. Therefore, the development and implementation of activities by communities around issues of identification is one area that would appear to be worth further investigation and trialling.

Support for the General Practice Networks

It was clear that the GPNs have an important role to play in assisting in the uptake of Indigenous identification. They develop strategies targeting the community and general practices, and assist general practices in important practical ways. However, they are doing this without support in terms of guidelines about what represents best practice, sometimes without fully understanding cultural safety, and with minimal resources. It would, therefore, be worth developing and trialling adequately resourced 'pilot Indigenous identification projects' for GPNs. These pilots should contain common elements, such as cultural awareness and change management training for GPNs, strategy development and implementation, and evaluation, but should be engineered to fit the needs of individual GPNs.

Support for general practices

General practices need to be supported to implement strategies of identification that are most appropriate to them. GPNs play an important role in this respect but it would appear appropriate that there should be incentives at the health system level that impact directly on general practice. Clearly, tightening the accreditation standards and the associated PIP incentives have an important role in this respect. Although 'trialling' of these would not appear to be appropriate, discussion around the most appropriate standards and incentives would be appropriate. This research would suggest that standards linked to cultural awareness training for staff and GPs would be also be appropriate.
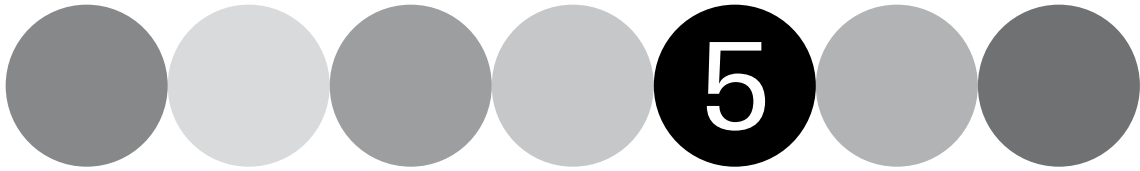
HOW CAN MAINSTREAM GENERAL PRACTICE BE ENCOURAGED TO IMPROVE IDENTIFICATION PROCESSES?

This chapter further develops the strategy discussion and thinks through what strategies discussed in Chapter 4 will work and how improving identification can be encouraged and supported through these strategies. The chapter addresses the research question:

• How can mainstream general practice be encouraged to improve identification processes for Aboriginal and Torres Strait Islander people?

The discussion in relation to this question draws on the lessons learned in relation to the strategies that will be most acceptable to mainstream general practice. The focus for the discussion is on 'making it happen' and the key aspects of Indigenous identification that need to be fostered to achieve this outcome, namely relevance, attractiveness, achievability and necessity. As outlined below, there are a number of issues relevant to each of these aspects.

MAKE IT RELEVANT

Indigenous identification needs to be relevant:

• **in terms of the patients seen:** Aboriginal and Torres Strait Islander patients generally make up only a small proportion of the patients attending mainstream general practices, and identification is unlikely to be seen as relevant; including Indigenous identification as part of a broader focus on ethnicity is likely to increase the relevance in relation to patient groups

• **in terms of professional practice:** to the extent that GPs and general practice staff take pride in offering a high-quality service to their patients, there are a number of ways in which emphasising identification can be made professionally relevant. Improving the quality of care includes providing a culturally safe environment for all patients, understanding the cultural factors that influence health, and attending to the interpersonal processes of care. Effective social history taking can not only improve quality of care but enable general practices and their patients to access the additional support that they need.

'We treat every single person who walks through the door differently. They all have different health issues but they also have different cultural backgrounds, different education, age, everything.' GP

'It's not just about them identifying and ticking a box, it's about them feeling comfortable to identify.' GPN staff member

MAKE IT ATTRACTIVE

Indigenous identification needs to be attractive:

- **in terms of practice finances:** for many practices, introducing identification will mean changing standard operating procedures or customary behaviour, which will be more attractive if there is some benefit for the practice in making the changes, such as through PIP incentive payments; at the very least, identification should not threaten the financial status of the practice

- **in terms of professional practice:** raising the profile of identification though advocacy and promotion by opinion leaders could make identification an attractive issue with which to be aligned.

'If you've only got a couple patients this funding is not going to make a huge impact on the overall income of the practice.'
Community representative

'This all boils down to having a good system and the time and the resources to do it.' GPN representative

MAKE IT ACHIEVABLE

Indigenous identification needs to be achievable:

- **in terms of the administrative systems:** changing organisational systems can be unsettling and sometimes difficult; helping general practices to identify and adopt systems of identification that are most appropriate to the practice's situation would assist in the uptake of identification, such as allowing for flexibility in adoption, and would also ensure that the information technology systems that practices use can be adapted as a tool for recording Indigenous status

- **in terms of the staff:** the data clearly indicated that staff have difficulty in 'asking the question'. Helping staff to understand and deal with the issues they have in relation to identification would aid in adopting processes of identification.

MAKE IT NECESSARY

Indigenous identification needs to be necessary:

- **in terms of accreditation:** there appears to be general agreement that the current accreditation standards are too lax in relation to providing culturally appropriate services; tightening accreditation to focus on cultural safety and identification would move practices that favour accreditation towards providing an environment in which it is safe to identify. This can be regarded as pulling practices towards increasing the uptake of Indigenous identification

- **in terms of community expectations:** increasing the likelihood of patients self-identifying (even without being asked) raises the expectation that this will be taken seriously in mainstream general practices and received appropriately. This can be regarded as pushing practices towards adopting Indigenous identification as standard practice.

'An Aboriginal person won't give information if they're not asked.'
GPN staff member

REAPING THE BENEFITS: TRANSLATING IDENTIFICATION INTO QUALITY HEALTH CARE

This chapter focuses on the translation of point-of-care identification into improved quality of care. It seeks to answer the questions:

• What are the links between improved identification and quality of care?

• Under what circumstances is improved identification likely to lead to improved quality of care for Aboriginal and Torres Strait Islander people?

According to the Australian Institute of Health and Welfare, ascertaining Indigenous status in general practice will improve quality of care at the individual level by:

help[ing] staff to provide better and culturally safe care, identify[ing] potential language barriers and refer[ing] clients to culturally appropriate services such as Aboriginal Liaison Officers, Aboriginal Health Workers, Aboriginal Health Services and Aboriginal Community Controlled Health Organisations (Aboriginal Medical Services) as appropriate or identified by the person as a desired option (AIHW 2009b:11).

During the focus group discussions there was a clear consensus that knowing that a person was Aboriginal or Torres Strait Islander was important for their care. However, no focus group participants had any real and direct examples of this. In part, this may have been due to the fact that relatively few general practices routinely identify Indigenous patients. However, the focus groups indicated that emphasis on quality of care is crucial to improving identification. When asked what made them aware of the need for identification, the responses included awareness of the health gap, the differences in life expectancy, the increased burden of disease, and the mortality and morbidity statistics. Another difficulty in providing examples of the link between identification and quality of care may also have to do with the rather narrow understanding of what is meant by 'quality of care'.

DEFINING QUALITY OF CARE

According to Campbell, Roland & Buetow (2000), there is no universally accepted definition of quality of care and there has been considerable debate about whether processes or outcomes should be used as measures of quality of care. There does appear to be a degree of consensus that process indicators are more relevant in estimating quality of care because they are, in part, under the control of the health professionals. Health outcomes, on the other hand, may take some time to appear after a change in process and are impacted by factors that are not under the control of, for example, general practices.

In this research a 'disaggregated' approach has been taken to defining quality of care. This approach recognises that quality is complex and multidimensional; each dimension is one part of the whole when viewed in isolation, but taken together the dimensions form a more complete picture. We have used the proposition put forward by Campbell, Roland & Buetow (2000) that quality comprises two overarching dimensions: access and effectiveness.

Penchansky and Thomas (1981) outlined five dimensions of access: availability, accessibility, affordability, accommodation and acceptability. However, since Hausmann-Muela, Ribera & Nyamongo (2003), it has become popular among researchers to use a simplified grouping of factors affecting health-seeking behaviour. The categories are:

- availability, which refers to the geographic distribution of health facilities

- accessibility, which includes transport and roads

- affordability, which includes treatment costs for the individual household or family

- acceptability, which relates to the cultural and social distance and refers mainly to the characteristics of health providers, excessive bureaucracy and cultural safety.

The two processes that Campbell, Roland & Buetow (2000) outline in relation to effectiveness are clinical care and interpersonal care. Clinical care refers to the *application* of appropriate clinical care to health problems; it is the 'technical' aspect of providing high-quality care. Interpersonal care relates to the interaction between the health care provider and the patient. Effective social history taking is a bridge that joins these two aspects of care. A patient's social history can provide information that can enhance interpersonal communication and inform decision making about appropriate clinical options. This provides benefit both for clinicians and patients.

Based on these two dimensions of quality (access and effectiveness in terms of clinical care and interpersonal care), it is clear that there are numerous examples throughout the report where the processes and strategies that have been introduced to improve Indigenous identification will also have direct links to improving quality of care; not the least of these are the direct improvements in acceptability that come from movements towards the provision of a culturally safe environment within general practices. To demonstrate these links, some of the case study material that has been presented in other sections is re-introduced here, together with new case study material.

Improving quality of care by improving access

Accessibility

Box 12 and Box 13 highlight the link between identification and improving quality by improving accessibility.

BOX 12: Case study – Improving access through listening and understanding

An Aboriginal male patient with a number of significant health issues attended a clinic for the first time. As was this doctor's standard practice, upon identification of Indigenous status, the GP spent time getting to know the patient and talking in detail about the patient's medical and social history. Through this broader discussion of the patient's medical history, the GP found out that although previous GPs had given this man referrals for blood tests, he had never had the tests done. When discussing the reasons for this, the GP found out about issues with transport and fears of the tests being expensive. After the consultation, the practice manager called the laboratory, organised bulk billing and helped arrange transport to the laboratory. The blood tests indicated that further medical interventions were necessary.

BOX 13: Case study – Flexible appointment initiative

One practice used to get frustrated with its Aboriginal patients because they would never come to appointments on time or they would not cancel if they were unable to keep appointments. Frustration was also felt because the practice often could not contact the patients because they did not have telephone numbers and because addresses where often out of date. Doctors also found this concerning because when serious health issues needed to be addressed, they could not contact their patients. To work through these issues, the practice created a policy to allow Aboriginal patients to be seen by the doctors without appointments. Doctors also felt that, due to follow-up issues, they would often spend longer with their Aboriginal patients and would 'go that extra mile' to ensure good health because they understood it could be a long time before the patients returned to the practice.

Affordability

Box 14 and Box 15 highlight the link between identification and affordability. Box 14 looks at an example of a regional level program developed by a GPN which targeted the local community. Box 15 looks at a practice level affordability intervention.

BOX 14: Case study – The brokerage program

With the aim to increase access and choice of culturally appropriate quality services for Aboriginal and Torres Strait Islander people within this GPN, a brokerage model was implemented. This is a membership program attempting to link Aboriginal people to local services. All Aboriginal and/or Torres Strait Islander people within the GPN can become members of the program by contacting the GPN. At registration they receive a membership card and also lists of member health services that are able to provide culturally appropriate services and that will also bulk bill. The brokerage model provides training to the member health services to make sure culturally appropriate comprehensive health care can be provided.

BOX 15: Case study – The bulk billing initiative

Bulk billing Aboriginal and Torres Strait Islander patients is considered standard practice within a practice interviewed during the case studies. This practice is not a bulk bulling service, but is happy to provide no-gap services for identified Aboriginal and/or Torres Strait Islander patients.

Acceptability

Box 16 shows how a focus on improving identification led to improvements in access by increasing the acceptability of practice for Aboriginal and Torres Strait Islander people.

BOX 16: Case study – Acceptability through providing a culturally safe environment

After attending cultural awareness training run through its GPN, one practice began to think about how to better identify Aboriginal and Torres Strait Islander patients. It decided to start by displaying culturally significant emblems throughout the practice. Stickers of the Aboriginal flag were put up in the waiting room and on a car (upside down, as it was later pointed out). The practice also requested from the local GPN a poster that encouraged identification. In addition, the framed cultural awareness certificate from the course was also put in the waiting room.

Before undertaking the course, staff at the practice thought there were virtually no Aboriginal and Torres Strait Islander people in their area, just one or two very transient patients. After putting up the posters and stickers, they got a lot of comments, including racist comments, from some of their patients. However, they also had five or six of their regular patients identify as Indigenous and these patients were clearly happy that the practice was making an effort and there was recognition.

Since the training, when staff treat an identified Indigenous patient they know to introduce themselves and talk a bit about their own families and where their families come from, because they believe there has to be two-way communication to establish a trusting relationship.

Thanks to these changes they now have approximately 20 to 30 identified patients through referrals, with these patients also bringing family members along. They are happy to take it slowly, understanding that if people are comfortable coming to the practice, word will spread.

Improving quality of care by improving effectiveness

Clinical care

There were a number of examples produced in the case studies as to how identification had helped improve the clinical care afforded to Indigenous patients. We have not included them all but merely a selection to show the linkages (Box 17 and Box 18).

BOX 17: Case study – Clinical example 1

A man presents to the GP with his nine-year-old daughter. They are new patients. The GP quickly decides that the daughter has a serious flu and prescribes Tamiflu®, and apologises to the father: 'I am going to prescribe her Tamiflu®. It is important that she gets it but you might have a bit of a run around to get hold of it.' The father looks worried, 'Is there an ACCHS near here? Maybe they could help.'

'Are you Aboriginal?', asks the doctor, then she looks at the registration form and realises that the correct box has been ticked. 'Sorry, in that case I can give you some Tamiflu® straight away.' She talks with them about how best to manage the care of the little girl. The GP is relieved that she realised that the family was Aboriginal. Without access to the best possible treatment not only would the health of the little girl have been jeopardised, she could have potentially infected others in vulnerable health states.

BOX 18: Case study – Clinical example 2

A 23-year-old male patient, a footballer, is referred by his GP for minor surgery. He comes back to see his GP, the surgery having been delayed because the patient has to see a cardiologist. The GP is puzzled. 'Why do you have to see a cardiologist?'

'Because of my heart murmur, apparently,' says the patient. 'I had rheumatic fever when I was a kid.'

'But surely you are too young to have had rheumatic fever; we hardly ever see it these days.'

'I don't think it is that unusual at home.'

The doctor realises, on asking where the patient is from, that the patient is probably Aboriginal and this is confirmed when he asks directly.

'That's good to know,' says the doctor. 'There are a number of conditions that primarily affect Aboriginal people or affect them earlier than other Australians. I probably should have screened you for them earlier. Still, we'll make sure that we won't miss anything again.'

Interpersonal care

In one of the case studies a practice nurse talked about the importance of establishing relationships with patients as a way of increasing identification and how this improved the quality of the care provided by the service and, as a result, improved the quality of care provided to patients (Box 19).

BOX 19: Case study – Relationship building

'There is no magic formula; it's about establishing relationships and providing good friendly service and friendship,' said a practice nurse when asked how the practice identifies Aboriginal patients and provides quality care. The nurse went on to say that Aboriginal patients particularly need more of a connection and need to feel comfortable with the practice environment, as well as the staff, for them to come back to the practice. She said that spending extra time with patients to form a relationship with them will also mean that they refer family and friends to the practice. The practice nurse also suggested that connecting and linking with the whole family unit and understanding the family hierarchy means that you can provide a better quality of care as the family can be used to make sure treatments or appointments are adhered to.

Improving quality of care by improving access and effectiveness

There are very few specific examples in the literature of how improvement in identification has led to improvements in health, and mostly these examples refer to improvements as a result of increased immunisation or vaccination coverage. Box 20 highlights four immunisation coverage examples.

BOX 20: Literature examples – Immunisation coverage

- **Western Sydney area:** improvements in the uptake of Prevenar™ in Indigenous children (Brindell 2006) (see Chapter 4).

- **Far north Queensland:** monitoring of public health relating to pneumococcal disease led to the recognition that it was a serious cause of morbidity and mortality in Indigenous populations, and vaccinations were commenced. There was a large improvement in the rate of disease and a program was then brought in for the rest of Australia.

- Hepatitis A was identified as a cause of Aboriginal and Torres Strait Islander child deaths and a large number of hospital cases. A Hepatitis A vaccination program for Indigenous children was instigated and Hepatitis A has disappeared in children (IIICDRP Steering Committee 2004).

- **Northern Territory:** Haemophilus influenzae type b (Hib) was found to be a cause of serious morbidity and the vaccine was introduced in 1993. By 1998 public health staff reported a reduction in the incidence of invasive Hib disease (IIICDRP Steering Committee 2004).

Spurling, Hayman & Cooney (2008) reported on the outcomes of the health checks for urban Indigenous adults attending the Inala Indigenous Health Service. Of the 51 pap tests that were undertaken, six were 'abnormal' (two high grade and four low grade) and the authors indicated that these cases were likely to have been 'picked up' as a result of the health check. They also indicated that 10 cases of depression, six cases of chlamydia, four cases of diabetes, four cases of hepatitis C, two cases of hypertension, two cases of anaemia, plus one case each of suicidal ideas, cataracts and heart murmur were also likely to have been discovered because of the health checks (Spurling, Hayman & Cooney 2008).

An article in *Australian Doctor* prepared by Jenny Reath clearly indicates that knowledge of Indigenous status is important in providing a quality service for Indigenous patients. The article highlights the challenges that doctors face (Box 21).

BOX 21: Indigenous status and quality health care

Peggy Jones is a 40-year-old woman who has recently moved to your town. When she presents to your practice one busy Monday morning complaining of a cough and shortness of breath, it is tempting to take the bronchitis/asthma route, provide a script and give yourself a moment extra with the next patient.

What difference would it make to your management if you knew that she was Aboriginal?

Would you be more inclined to ask about her medical history if you knew that she had between two and four times the age standardized death rate of a non-Indigenous woman?

Would you treat her respiratory symptoms differently if you knew that the death rate from respiratory disease for an Aboriginal woman Peg's age is about 20 times that of a non-Indigenous woman the same age?

Would you consider screening for cardiovascular risk factors if you knew her age specific death rate for cardiovascular disease was 17 times that of a non-Indigenous woman? ... or encourage[e] her to return for a pap smear if you knew that Indigenous women had up to 5 times the incidence of cervical cancer and up to 12 times the mortality compared with non-Indigenous women?

Source: Reath 2006.

Lack of clinical relevance was a major reason for disinterest in improving the identification of Aboriginal and Torres Strait Islander patients. In this section we have provided examples of the ways in which identification can improve quality of care in a clinical context. The examples provided are not intended to characterise Indigenous patients in general. Nor are they intended to imply that knowing a patient is Indigenous will always lead to improved quality of care. In some cases the identification of a patient as Indigenous can lead to clinical and cultural stereotyping, which may undermine both clinical and interpersonal care (Kandula et al. 2009; Varcoe et al. 2009).

Knowing that a patient is Indigenous can help orientate clinicians to a range of issues and health service options that they might not otherwise have considered. However, the relationship between Indigenous status and health at a population level is mediated by the historical, social, environmental and economic sequelae of being Indigenous and a lack of culturally appropriate care for Indigenous people. The extent to which these issues apply and how they apply to any particular individual will vary. Ensuring that identification does result in improved care requires that this information, like any other aspect of social history, should be considered a starting point for enquiry that should reflect the clinical and interpersonal imperatives of any interaction. As one GP said in response to the suggestion that all patients should be treated the same, 'That is ridiculous! We treat every single person who walks through the door differently. They all have different health issues but they also have different cultural backgrounds, different education, age, everything.'
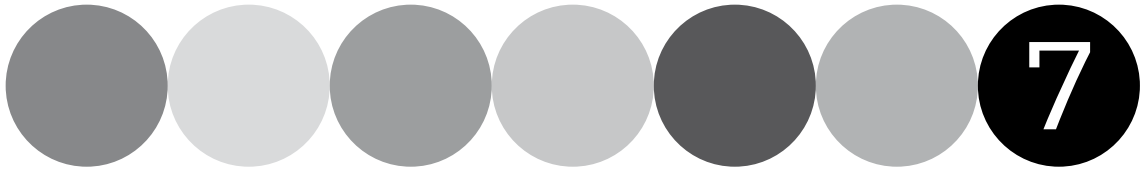
RECOMMENDATIONS

The recommendations in this section are based on recognition that changing the standard or customary operating procedures in general practices will be difficult. Successful change management will require a systems-based approach that includes (to a greater and lesser extent) all the spheres and levels of influences outlined in Figure 4. It is also clear that bringing about change:

- will take time

- has to start somewhere

- will *not* be cost-free.

Each recommendation is couched in terms of a general aim (focus) and strategies to achieve that aim. There is also a step-wise approach to the recommendations. For example, there is concern that trying to implement recommendation 3 (encourage community members to self-identify) before general practices have moved towards providing an environment in which people feel comfortable identifying (recommendation 2) or before they have in place systems for identification (recommendation 4) and measures are put in place to ensure the cultural safety of patients is likely to be counter-productive and may lead to negative experiences for patients who do self-identify.

PRACTICE LEVEL

Recommendation 1: Support the integration of identification into practice management

Where identification has been supported by management and has been written into practice policy, there appears to be better overall systems and support for identification. Supporting these processes is critical to improving identification. Specific recommendations to facilitate this process include:

1a   Raise awareness of the link between ethnicity and quality of care.

Emphasising the clinical importance of identification is likely to be a key motivator for improved practice among GPs and practice staff. This includes measures like cultural competency training and an understanding of new Medicare initiatives for Indigenous people.

1b   Create an Aboriginal and Torres Strait Islander-'friendly' environment.

This could include having promotional materials such as posters and pamphlets in practice waiting/consultation rooms, as well as displaying Aboriginal and Torres Strait Islander art and/or flags.

1c   Include questions about Indigenous status as part of patient registration information and ensure that the information is visible to clinicians.

1d Update patient information regularly, including Indigenous status, to enable pre-existing patients to identify their status.

Many practice staff felt that introducing identification measure would be more difficult for pre-existing patients than for new patients. Including this information in regular updates of all patient information would address this issue with minimal additional burden.

1e Implement quality assurance measures to follow up missing data.

Practice staff need to be provided with a 'script' that helps formulate how they should ask each patient about their Indigenous status or ethnicity if it is not filled out on the form and also includes responses to provide if queried or challenged.

1f Consider embedding questions about Indigenous status in more general questions about ethnicity.

Focus groups with GPs and practice staff suggested that there was a preference for asking about Indigenous status in the context of questions about ethnicity. It was felt that for many practices, particularly those serving diverse populations, this would yield useful information and be more inclusive.

1g Use standard questions to enquire about Indigenous status and/or ethnicity.

The question on Indigenous status should reflect the standard ABS format and provide exhaustive options (including 'not Aboriginal and Torres Strait Islander', 'do not know', 'do not want to answer').

The SAND study provides a protocol for questions about ethnic background, followed by a question on Indigenous status (use SAND as a template). Different identification questions have not been directly tested in general practices. We recommend that standard questions are used because many of the alternative questions are logically flawed.

1h Provide patients with an explanation for why they are being asked about their social history that highlights the relevance to their quality of care.

Indigenous patients often did not understand that questions about their Aboriginality were intended to improve the quality of their care. This suggest the need for an explanation for why the information is being collected. In contrast, most protocols suggest providing an explanation only when challenged. The main reason for this is that providing an explanation for the collection of Indigenous status alone can disrupt the flow of interactions. Explaining that all information contained in a social history is being collected to improve quality of care could reconcile these two perspectives.

COMMUNITY AND REGIONAL LEVEL

Recommendation 2: Assist general practices to foster an environment in which Aboriginal and Torres Strait Islander people feel comfortable identifying.

2a   Involve local Aboriginal and Torres Strait Islander organisations and communities.

The expertise of Aboriginal and Torres Strait Islander people and community-controlled organisations is critical to informing locally appropriate strategies for engaging with Aboriginal and Torres Strait Islander people.

2b   Raise awareness of the link between ethnicity and quality of care.

Emphasising the clinical importance of identification is likely to be a key motivator for improved practice among GPN staff, GPs, practice staff and student health professionals.

2c   Promote incentives to provide enhanced care to Indigenous people.

Practices were not always aware of the incentives that were available. Simply raising awareness had a significant impact on the uptake of health check items.

2d   Provide cultural safety/cultural awareness training for general practices and GPNs.

2e   Develop systems to support the implementation of health checks

Practices also require assistance from the GPN in developing systems for health checks. Practice nurses are a key component in making this an effective strategy.

Recommendation 3: Encourage community members to self-identify.

3a   Raise awareness of the importance and benefits to the Aboriginal and Torres Strait islander community of identifying.

3b   Promote self-identification in general practices that are Indigenous 'friendly'.

Ways to encourage self-identification include having promotional materials such as posters and pamphlets in practice waiting/consultation rooms, as well as attempting to create an Indigenous-friendly environment by displaying Aboriginal and Torres Strait Islander art and/or flags.

NATIONAL LEVEL

Recommendation 4: Assist general practices to develop systems for identification.

4a   Develop a standard protocol for identification.

The results of this study suggest that the protocol should include a statement about why data is being collected. Preferred options for the protocol include questions about ethnic background, followed by a question on Indigenous status (using SAND as a template). The question on Indigenous status should reflect the standard ABS format and provide exhaustive options (including 'not Aboriginal and Torres Strait Islander', 'do not know', 'do not want to answer').

4b   Evaluate a standard patient registration form.

The format and placement of Indigenous status questions on forms made a significant difference to the completeness of data. Developing a standard format with an Indigenous status question on the front page would optimise ascertainment.

4c   Modify information technology/information management to ensure that questions in software reflect standard forms, are exhaustive and provide reminders if the question is skipped.

Questions in software should reflect standard forms, be exhaustive in the responses provided and provide reminders if the question is skipped. Administrative staff and clinical staff often use different sorts of software. Ensuring the interface between these different software is crucial.

4d   Develop guidance around cross-sectoral collaboration.

GPNs are beginning to work in a more concentrated way in Indigenous health. Providing guidance and support for developing effective partnerships with the community, the community-controlled health sector and other Indigenous organisations may assist in furthering the Indigenous health agenda in primary care.

4e   Develop clear guidelines/standards for cultural competency in general practice at a whole-of-practice level.

Ideally, these guidelines should be linked to accreditation. One tool currently being developed by the Telethon Institute for Child Health Research in Western Australia is a cultural competency assessment tool.

4f   Evaluate cultural safety/awareness educational materials.

A number of major peak organisations, including the RACGP and NACCHO, have recognised the need for training materials. However, there has been little evaluation of these materials. Developing an understanding of their effectiveness will help inform their implementation and adaptation across settings.

4g   Tighten accreditation standards.

The revised standard should include a requirement around acceptable levels of identification of Indigenous status. This would be most effectively monitored in the context of standards that focus on ethnicity more generally.

Recommendation 5: Evaluate, promote and advocate best practice models.

5a   Develop an evidence base to identify best practice in improving identification.

5b   Set up regional level pilots to test existing strategies and, where appropriate, develop and test new ones.

5c   The strategies to be tested should aim to improve quality of care as defined in this report.

       The evaluation or pilot needs to have a focus on whether or not these strategies improve the quality of care for Aboriginal and Torres Strait Islander people.

5d   The organisations involved in running the pilots at all levels (community, service providers including general practices, and regional organisations such as GPNs) should be adequately compensated.

APPENDIX A: DIFFERENCE IN UPTAKE OF INDIGENOUS AND NON-INDIGENOUS HEALTH CHECKS, 2006–08

The following table presents a logistic regression analysis looking at the relationship between the uptake of health checks for Indigenous and non-Indigenous Australians over time. The data indicate the uptake of adult and older health check items was significantly lower for Indigenous health items than items for other Australians.

Both types of health checks were increasing over time; however, the uptake of health checks for Indigenous adults was slowing relative to other Australians over time. The opposite trend was apparent for health checks for older Australians.

The analysis tested for differences in uptake between non-Indigenous and Indigenous health checks. Two different time trends were also tested; linear and quadratic trends. A linear trend tests for consistent increasing or decreasing changes over time. A quadratic trend tests for changes over time where there is a change in direction; for example, when a new incentive is introduced, there is often a flurry of activity that is unsustained in some sectors. The interaction between changes, time trends and uptake of health checks was tested.

	Adult health checks		Older health checks	
	OR 95%CI	p value	OR 95%CI	p value
Indigenous	0.79, 0.56–1.11	0.17	0.44, 0.31–0.63	<0.01
Indigenous* linear	0.6, 0.52–0.69	<0.01	1.34, 1.15–1.55	<0.01
Indigenous* quadratic	0.73, 0.7–0.76	<0.01	0.97, 0.9–1.04	0.34
Year – linear	2.37, 2.26–2.48	<0.01	1.11, 1.09–1.13	<0.01
Year – quadratic	1.43, 1.41–1.45	<0.01	0.99, 0.98–0.99	<0.01

APPENDIX B: SEARCH STRATEGIES BY DATABASE

The following table details the databases and the specific search terms used in the project.

Database name	Strategy
Indigenous set	identif* AND (health OR medicine OR medical)
Medline/Embase	1. indigenous.mp. 2. Oceanic Ancestry Group/ 3. aborigin*.mp. 4. torres strait.mp. 5. exp American Native Continental Ancestry Group/ 6. inuit*.mp. 7. (first adj (nation or nations)).mp. 8. metis.mp. 9. (american adj2 indian*).mp. 10. (alaska adj2 native*).mp. 11. eskimo*.mp. 12. (native adj2 american*).mp. 13. (hawai* adj2 native*).mp. 14. or/1-13 15. (identify or identification).mp. 16. cultural competency/ 17. exp Culture/ 18. or/15-17 19. general practice.mp. or Family Practice/ 20. exp Primary Health Care/ 21. outreach.mp. 22. exp 'Delivery of Health Care'/ 23. or/19-22 24. and/14,18,23
RURAL	cultur* AND competenc*

DATABASE DETAILS

AGIS-ATSIS: Attorney-General's Information Service – Aboriginal and Torres Strait Islander Subset. Covers legal issues such as land rights, native title, customary law, Aboriginal deaths in custody, Aborigines in the criminal justice system, racial discrimination, Indigenous intellectual property, and Aboriginal youth and juvenile justice, and is produced by the AGIS Section of the Lionel Murphy Library, Commonwealth Attorney-General's Department, in Canberra.

AIATSIS: Indigenous Studies Bibliography. Covers published and unpublished material on Australian Indigenous studies and is compiled by Pat Brady, Barry Cundy and Alana Garwood at the Australian Institute of Aboriginal and Torres Strait Islander Studies Library.

ATSIhealth: Aboriginal and Torres Strait Islander Health Bibliography. Covers Australian Indigenous health and is compiled by Neil Thomson and John Sutherland at the School of Health Studies, Edith Cowan University.

EMBASE.com: provides access to more than 16 million validated biomedical and pharmacological bibliographic records from EMBASE and MEDLINE (produced by the United States National Library of Medicine). The database can be searched by field, drug, disease and article.

FNQ: Far North Queensland Collection. Covers Indigenous issues of the geographical region of far north Queensland, from Ingham in the south to Doomadgee in the west and encompassing the Torres Strait, Gulf, Cape York Peninsula, Daintree and the Atherton Tablelands, and is produced by the Library, Tropical North Queensland Institute of TAFE.

Indigenous Australia: represents the collections of the Aboriginal and Torres Strait Islander Commission Library and covers Aboriginal and Torres Strait Islander studies, the Stolen Generations, removal of children, arts, copyright issues, racism, discrimination, Internet and telecommunications facilities, and communities.

Ovid MEDLINE: the United States National Library of Medicine's premier bibliographic database providing information from the following fields: medicine, nursing, dentistry, veterinary medicine, allied health and pre-clinical sciences. The MEDLINE database is the electronic counterpart of Index Medicus, Index to Dental Literature and the International Nursing Index.

REEF: Great Barrier Reef Marine Park Province Database. Covers material on the Great Barrier Reef, including coastal zone management, conservation, coral reef ecology, economics, environmental impact assessment, fisheries, history, Indigenous natural resource management, marine archaeology, marine biology, marine park management and planning, natural resource management, oceanography, recreation, scuba diving, sea rights, shipping and ports, social studies, tourism, water quality, world heritage and zoology, and is produced by the Great Barrier Reef Marine Park Authority.

RURAL: Rural and Remote Health Database. Covers rural and remote area health issues and care, and the practice and educational needs of health providers, in particular medical practitioners and nurses, and is produced by the Monash University School of Rural Health.

APPENDIX C: COMMUNITY LEVEL BARRIERS TO IDENTIFICATION

Approximately 30 per cent of key informants were of Aboriginal and/or Torres Strait Islander descent. With this in mind, when key informants were discussing the barriers to identification for Aboriginal and Torres Strait Islander people, these comments need to be seen in terms of perceived inhibitors. During the case studies there was an attempt to interview GPN partners within the community, such as local ACCHSs, to gauge relationships and levels of communication between the local Indigenous communities and practice/GPNs.

MISTRUST

Given Australia's historical context, many key informants felt that Aboriginal and Torres Strait Islander people may be suspicious of data collections. It was thought that Indigenous people may be afraid to disclose their status for a number of reasons such as being afraid of what the data will be used for (32 per cent of key informants). There was also a perceived concern over who owns the data (8 per cent of key informants) and how it is relevant to their health care.

Fear of the repercussions of identifying was raised by a community representative during the case studies. Some believed that there may be communication between different government departments or official bodies. Key informants said that history still felt very recent and fresh and produces anxiety and fear.

Varcoe et al. (2009), in a Canadian study, found that while most leaders and health care workers felt there were potential benefits associated with having ethnicity data, these benefits were largely imagined on the basis of future action being taken to reduce inequities. In contrast, leaders from ethno-cultural communities and patients of diverse identities anticipated potential harm arising both from having ethnicity data and the process of collection (Varcoe et al. 2009). Australian studies have supported this latter perspective (Cunningham 2002) and strongly suggest that concerns about racist treatment need to be taken seriously in any initiative to improve identification. The research by Varcoe et al. (2009) suggests that informing patients about the reasons for data collection and how their data will be treated is an important step in improving identification.

Patients' concerns are exacerbated by a lack of awareness of any link between identification and quality of care (Scotney 2009). Scotney (2009) points out that there is an apparent gap in awareness at a community level about the reasons for identification. Key informants also pointed out this issue and said there was a lack of awareness of the incentives that identifying may bring about (36 per cent of key informants). However, Scotney's research also suggests that the level of reluctance around identification is often overestimated by Indigenous and other Australians.

'Aboriginal and Torres Strait Islander people are quite protective of their privacy and suspicious of research or bureaucratic processes that might interfere with it; justifiably so given our history.' National association representative

NEGATIVE EXPERIENCES

Key informants also considered that Aboriginal and/or Torres Strait Islander people may be hesitant to identify if family or friends have had bad experiences when identified in the past, and that they may be worried that they will get treated differently (worse) if they identify (28 per cent of key informants). Kandula et al. (2009), in a Californian study, demonstrated that anxiety about providing ethnicity data was associated with past exposure to racism.

CONFIDENTIALITY

Fear of loss of privacy was suggested as another reason why Indigenous people do not identify. Many people attend the ACCHS for some conditions and attend mainstream practices for other services, especially more confidential issues. Going to a mainstream practice is often about preserving confidentiality, especially when the community is small and tightly knit.

UNCERTAINTY AROUND PROOF OF STATUS

Another perceived identification barrier was that in some places there are more general identification issues around inability to prove Indigenous status and also questioning by the community about who is allowed to claim Indigenous status. Many people cannot 'prove' their Indigenous status so may be afraid to identify in a formal health care setting (4 per cent of key informants).

CLINICAL AND CULTURAL STEREOTYPING

Identification can in some cases improve care and in other cases detract from it. Overt racism is an example of this. However, more subtle forms of racism can also affect quality of care. Cultural and clinical stereotyping are examples of these. There is a spectrum of beliefs and customs within any culture. Cultural stereotyping occurs when it is assumed that people within a particular ethnic group are culturally homogenous (Hall 2002). For example, it is culturally inappropriate to make eye contact with some groups of Indigenous people, but for other groups of Indigenous people it is culturally inappropriate not to. Assuming that people have a particular set of beliefs without asking can lead to inappropriate care (Canales, Rakowski & Howard 2007).

Clinical stereotyping is another reason why there is hesitation to identify within mainstream general practice. Clinical stereotyping is a version of the ecological fallacy where a doctor assumes that population level data apply to a particular individual. This can also lead to inappropriate care (Canales, Rakowski & Howard 2007). Scotney (2009) reports a story of a young women identifying to her GP when attending for a simple matter of the flu, and the next question the GP asked was, 'Are you having safe sex?'. Similarly, an Indigenous woman with a strong family history of breast cancer was told that the breast cancer could not have come from her mother's side of the family because 'Indigenous women don't get breast cancer'.

APPENDIX D: REGIONAL LEVEL BARRIERS TO IDENTIFICATION

Effective regional action on identification is primarily generated through GPNs. Regional level barriers are primarily difficulties engaging with general practice and also difficulties engaging with Aboriginal and Torres Strait Islander organisations and/or communities.

ENGAGEMENT WITH GENERAL PRACTICE

General practices are private businesses with different clientele, different management structures and different overall objectives. Points were made that a real barrier is that some practices are just not interested in Aboriginal and Torres Strait Islander health, or that it is low on their list of priorities. It will be difficult to convince these practices to implement improved identification procedures or change their care practices. It was suggested that interventions should be targeted at GPs with higher percentages of Indigenous clients to get the best results.

Remuneration is seen to be a hurdle for many practices in changing and improving their systems. The small numbers of Indigenous clients were regularly discussed as a barrier to financing and building systems (20 per cent of key informants). Questions were raised about how much emphasis practices should put on changing systems and asking the question if they have a very small chance of ever treating an Indigenous patient. It was also thought that even if practices have a few Indigenous patients, the Indigenous Medicare item rebate is not going to make a huge impact on the overall income of the practice. It was acknowledged that identification was 'good practice' but will be difficult to sell to most practices and is unlikely to happen in these practices.

Many research participants made it clear that for Indigenous people to identify, a culturally safe environment is necessary. Due to the time-limited nature of private practice, there is less emphasis on getting to know patients and in making them feel comfortable. It was highlighted that many Indigenous people prefer to be able to make connections with staff before they are able to discuss private matters such as cultural background. However, this is not always a possibility in busy practices.

During the case studies, one practice manager stated a major barrier to change was not the systems required themselves but rather funding the staff members to write and implement new systems. Another commented on the time and financial constraints around attending training. She said even if the training is free, the practice still has to pay double time for staff attendance after work hours.

'If we set up a good rapport, and one of the things is [that] we'll just go and sit down maybe and have a one on one with the staff or have a morning tea or something like that and talk about some of those things, but I do not want to do it begrudgingly, you know, I want them to be wanting to do it.' GPN staff member

There were a number of issues discussed during the interviews that come under the heading of resistance to change in general practice. These included (i) difficulties associated with the uptake of the Indigenous-specific Medicare items (Table 11), (ii) the difficulties of engaging staff in cultural awareness training and (iii) staffing.

CULTURAL AWARENESS TRAINING

During the case studies there were a number of issues discussed relating to the uptake of cultural safety. GPs can obtain RACGP points for attending cultural awareness training. However, GPNs have found that they often are preaching to the converted, those who already have an interest in Aboriginal and Torres Strait Islander health or culture. In the view of one GPN staff member, the doctors who attend tend to be the 'community minded doctors' who also attend sessions on refugee health, for example. The numbers tend to be small at these sessions. They do not seem to be a high priority for local GPs, who have many competing demands for their time, especially when they have small numbers of Indigenous patients.

Indigenous health is seen as a difficult area of work and can perhaps be a question of whether GPs want to take on this work and to be seen as doctors who are willing to see Aboriginal patients. It is thought that there needs to be a balance between provision of good care but not advertising so as to overwhelm the clinic with Aboriginal and Torres Strait Islander patients who have much more complex needs than most non-Indigenous patients.

In the offering of cultural awareness training there tends to be a focus on the GP. This is a barrier because receptionists and other practice staff are all part of the patient journey and need to make patients feel comfortable and safe.

Once again, because of the perception that Indigenous clients are only a small percentage of their patients, many interviewees in the case studies found it difficult to comprehend why such time and effort should be spent on such a low percentage of clients.

RECRUITMENT AND RETENTION OF GPS

During the case studies there was also discussion about difficulties in recruiting and retaining GPs. A small or stable practice may be able to develop and maintain initiatives in identification; however, high staff turnover can mean understandings gained may be lost and programs disrupted. An inability to attract GPs is a huge problem in many practices, resulting in pressure on remaining staff who are less likely to be interested or able to think about new initiatives due to limited, or no, spare time.

One GPN that has considerable difficulty attracting GPs said that almost two-thirds of its GPs are international medical graduates. A need for general cultural awareness training and orientation for these graduates was noted. They need assistance to understand mainstream Australian culture, as well as Indigenous culture. However, the GPN did not want to overburden new GPs with training. There was discussion around how much background information is needed and also hesitation about overloading people with too much information.

APPENDIX E: NATIONAL LEVEL BARRIERS TO IDENTIFICATION

COMPLEXITY OF THE MBS ITEMS

The complexity of systems for claiming Medicare items and understanding all the Medicare item lines was seen as a barrier to identification (4 per cent of key informants). It was commented that Medicare item lines and criteria are very difficult to keep up to date with, therefore GPs often use a standard set of billing items. Given most practices have a very low percentage of Aboriginal and/or Torres Strait Islander patients, knowledge of the item lines and ability to claim the Indigenous-specific items was considered to be beyond many regular GPs' Medicare understanding. The simplification of health assessment items may reduce these problems.

It was also considered that even if GPs were informed of the Medicare items available to Aboriginal and Torres Strait Islander people, there may be the perception that they just do not have time to perform the extra health care benefits (28 per cent of key informants). This was attributed to a lack of systems and/or administrative capacity. It was also thought that the items were not viable from a business point of view.

During the case study interviews, one GPN staff member suggested that GPs see prevention activities such as health checks as a luxury because they have so many acutely sick people to deal with on a daily basis. One GP interviewed was very hesitant to do Aboriginal and Torres Strait Islander health checks because the GP had previously done a health check but Medicare had rejected the claim because the patient had already had a health check within the set period of allowed time. He said this happened despite asking the patient whether he/she had already had one. He acknowledged that you can call Medicare but this was time consuming and the amount of time waiting on the telephone with Medicare was equivalent to doing the health check anyway. Other GPs felt that existing health check items did not enable them to engage with their clients in an ongoing way. This issue may be addressed with the introduction of follow-up items and the new PIP scheme.

> 'On the one hand it's all very well to help mainstream GPs identify and it's important but I worry how it might impact negatively on ACCHS if the main motivation for some mainstream GPs is to get the money.'
> Community representative

PRACTICE INCENTIVE PAYMENTS

During the interviews, and also at the time of writing, further details about the PIP were still unclear; however, there was concern among some key informants about how the PIP scheme has been designed. Not all ACCHSs are accredited as PIP practices and some do not have doctors. In both cases, the practices would be ineligible.

The Department of Health and Ageing conducted consultations with Indigenous stakeholders and key medical organisations on the PIP Indigenous Health Incentive. Indigenous identification will be based on self-identification. Medicare Australia's Voluntary Indigenous Identifier will not be accessed for the incentive and the data will not be cross-checked. Stakeholders have raised concerns about possible leakage of payments caused by non-Indigenous patients claiming Indigenous status.

Issues were also raised around obtaining informed patient consent, particularly with regard to how this should be recorded. Some stakeholders considered that asking patients to sign a form did not represent informed consent as not all patients would be able to understand what they were signing. Concerns were also raised about allowing the GP to note on the patient record that the GP had provided information to the patient and verbal consent had been obtained, particularly given the financial incentives for registering patients.

Stakeholders raised concerns that GPs may register Indigenous patients for whom they are not their usual doctor. One option to allay these concerns is to require practices to sign a declaration that a GP in their practice is the patient's usual doctor, in order to receive a patient registration payment. A definition of a patient's usual doctor will also be included in the guidelines.

These concerns were echoed in key informant interviews with ACCHSs. Mainstream services, generally speaking, were thought to be savvier in regards to Medicare and more able to enrol their patients as soon as the PIP is implemented. There was concern that if the local GP registers Indigenous people before the ACCHS, then, even if the ACCHS is the patient's main health care provider, the GP will receive the PIP. However, there was very little discussion of the initiatives or awareness of them in the general practices interviewed.

It was commented on that many places already have tense relationships between the local ACCHSs and GPs, and there was a fear that the introduction of new incentives may exacerbate these tensions . It was considered that Indigenous primary health care funds should be allocated in another way to avoid GPs and ACCHSs directly competing. It was also pointed out, though, that mainstream general practices are not particularly good at identification at present and that there are still many barriers before they will be able to systematically do this.

INFORMATION FLOW

Another health system barrier mentioned was the lack of information flow between hospitals and GPs (4 per cent of key informants). It was expressed that if referrals between the two could have better information clarity, identification would improve. During the case studies, one GPN told us about its strong relationship with the local hospitals, and feels that this greatly assists its work in Aboriginal and Torres Strait Islander health. It was commented, though, that this relationship needs to become structured and formalised so both parties can make best use of information sharing.

APPENDIX F: PUBLIC SUBMISSIONS

Written public submissions about the identification of Aboriginal and Torres Strait Islander people in Australian general practice were sought. The following two submissions were received.

SUBMISSION 1: FLINDERS AND FAR NORTH DIVISION OF GENERAL PRACTICE, 27 APRIL 2009

Re; CRCAH Improving the Identification of Aboriginal and Torres Strait Islander People in Mainstream General Practice project

We have not had time to make a formal submission but a few points keep coming up in our discussions with the Aboriginal community.

Reasons why the question needs to be asked needs to be clear in information directed to GPs, practice staff and the community. For info to the community the language particularly needs to be simple and clear – otherwise it is a waste of time. Our GPN Aboriginal Advisory Group has suggested that ultimate aim is to 'close the Gap' and so it needs to be clear how identification can help do this.

The question needs to be asked of everybody – Aboriginal and non-Aboriginal – and no assumptions are to be made.

GPs and staff need training in how to ask the question, including what to do if they get a negative response.

Everyone in the practice needs to understand the importance of identification and support it.

You probably have all this info but we just wanted to state it again.

SUBMISSION 2: CENTRE FOR CHILDREN AND YOUNG PEOPLE, SOUTHERN CROSS UNIVERSITY, 22 MAY 2009

I'm emailing in response to the below request from a recent email list-serv. As a population & community researcher, it is an issue that's troubled me for a while (although not specifically in the GP context), since realising the extent to which the Census underestimates the Aboriginal population in our area (Northern NSW) and just wanted to share some local learnings that may be of interest.

In preparing for a community-wide telephone survey here in 2006, we were keen to ensure a proportionate representation of Aboriginal community members but aware of the problems associated with non-identification. Following informal discussions with local Aboriginal people and workers re: their perceptions about the local extent of non-identification and local barriers to identification and our own reflections on the standard Census question *(Do you identify as Aboriginal or Torres Strait Islander?)* as potentially isolating, we developed an alternative way of asking about ethnicity for our survey:

Which of the following best describes your ethnicity: Aboriginal Australian, non-Aboriginal Australian, overseas-born Australian or other (please specify)?

Positioning *Aboriginal Australian* as the first option was a conscious decision to implicitly acknowledge their history as the original Australians and to enhance its acceptability as an option (rather than being seen as a belated add-on). By requiring an answer from all respondents, we hoped to reduce the 'finger-pointing' perception and the option for passive non-identification (where questions are often presented as *'Tick if you're Aboriginal or Torres Strait Islander'*. Our approach seems to have been successful, with 13% of the families surveyed identifying as Aboriginal, which is about double the proportion estimated in local Census data and in keeping with estimates from people working with local Aboriginal families.

We have subsequently used this question as part of our standard demographic items in many written survey and evaluation tools, many of which are routinely administered through our various partnering community organisations, and encountered no problems with people not answering it. Of course, it may not work everywhere – depending on the local barriers to identification ... and many areas would need further exploration/options for non-Australian community members (who make up only a very small proportion of our community) ... but some of the issues may be more generalisable.

All the best with your work in this area – I'll be interested to follow its progress.

APPENDIX G: KEY INFORMANT BARRIERS TO IDENTIFICATION

The table shows the categories for each of the barriers identified by key informants and percentage of key informants mentioning each barrier.

Category	Key informant barriers	Key informant %
Practice staff	Do not know why question is asked	72
Practice staff	Do not want to ask the question	40
Practice staff	Only ask if the person looks ATSI Assume who is and is not	28
Practice staff	Afraid of reactions to questions (from both Aboriginal and non-Aboriginal)	44
Practice staff	Feel uncomfortable or embarrassed to ask	40
Practice staff	Do not want to offend	44
GP	Not sure why they should ask	48
GP	GP not aware of MBS/PBS/IMM benefits	28
GP	They want to treat all patients the same	20
GP	Only ask if the person looks Aboriginal Assume who is and is not	8
GP	Consultation time constraints	12
GP	Too time consuming to do Aboriginal health checks	28
GP	See no benefit or incentive to asking	36
GP	Think they have no Aboriginal clients	12
GP	Lack full understanding of Indigenous health	24
GP	Do not want to get involved in the Aboriginal health politics	4
Practice system	No registration forms with question	16
Practice system	No system in place to run health check	16
Practice system	Only small % of clients	20
Practice system	Expensive (time and money) to change systems	16
Practice system	General software issues	36
Practice system	Software not easy or not able to register as Aboriginal	32
Practice system	Software not able to show if question has been asked	12
Practice system	Software does not display status to GP	20
Practice system	Health check wizards not functional	12
Practice system	Software defaults to non-Aboriginal if not entered	12

Category	Key informant barriers	Key informant %
Aboriginal and Torres Strait Islander	Afraid of discrimination or racism	28
Aboriginal and Torres Strait Islander	Do not understand why it is asked or relevance to health	36
Aboriginal and Torres Strait Islander	Not aware of Medicare benefits	8
Aboriginal and Torres Strait Islander	Issues around who owns the data	8
Aboriginal and Torres Strait Islander	They do not want to identify	16
Aboriginal and Torres Strait Islander	Non-culturally safe environment	16
Aboriginal and Torres Strait Islander	Suspicious of data collection and government	32
Aboriginal and Torres Strait Islander	Not able to prove identity	4
Health system	Medicare complexity	4
Health system	Accreditation weakness	32
Health system	Lack of information flow between hospitals and GPs	4

Notes

IT/IM: information technology/information management

APPENDIX H: KEY INFORMANT SUGGESTED STRATEGIES

The table shows the categories for each of the barriers identified by key informants and percentage of key informants mentioning each barrier.

Category	Key informant suggested strategy	Key informant %
Training	Data importance training	28
Training	IT/ IM training	8
Training	Cultural awareness training	72
Training	How to ask the question How to deal with difficult questions training	44
Training	Revision of Aboriginal MBS/PBS/immunisation items	24
Training	Integrate identification trainings into all trainings	8
Training	History lessons – how effects health today	8
Training	Include identification component in medical degree	4
Training	Include identification component in reception certificate	4
Promotion	Posters/Aboriginal art	60
Promotion	Pamphlets	56
Promotion	Media: local context	12
Community	Community education about benefits to identification	52
Community	Create Indigenous-friendly environment	56
Community	Aboriginal-friendly GP list	8
IT/IM	Improve software	60
IT/IM	Pay software companies to change	12
IT/IM	Include 'question asked' component on software	20
IT/IM	Mandatory cultural background field	28
IT/IM	Remove default to non-Indigenous	24
IT/IM	Add: prefer not to answer/not stated/missing	4
IT/IM	Better wizards and templates for health checks	8
IT/IM	Use of data analysis tool	32
Accreditation	Strengthen accreditation criteria	36
Accreditation	Link cultural competence with funding and accreditation	8
Policy	Quality improvement reporting	4
Policy	Simplify Medicare items and reporting	8
Policy	Mandatory asking of question to all patients	20

Category	Key informant suggested strategy	Key informant %
Advocacy	Promotion through peak organisations	4
Advocacy	Present importance at conferences	8
Advocacy	Include topic in network lunches and meetings	16
Advocacy	Increase use of GPNs to address issue	12
Incentives	Bulk billing (individual level)	24
Incentives	PIP (practice level)	24
Resources	Availability of financial resources	20
Resources	Information kit development	16
Resources	Aboriginal health website	8
Staffing	Employ an Aboriginal Health Worker	16
Staffing	Upper management need to support measures	12
Staffing	Aboriginal leader or champion to promote identification	8
Staffing	Aboriginal administrative health traineeships development	4
Administrative	Standard registration forms with question and explanation	32
Administrative	Hands-on assistance with improving systems	8
Administrative	Identify all cultural backgrounds, not just Aboriginal	4

Notes
IT/IM: information technology/information management

APPENDIX I: INDIGENOUS ASCERTAINMENT QUESTION – BEACH AND SAND

The regular BEACH survey and the SAND sub-study each contain an Indigenous ascertainment question, as shown below.

PLEASE READ CAREFULLY

The shaded section of the following forms asks questions about **PATIENT CULTURAL BACKGROUND.**
You may tear out this page as a guide to completing the following section of forms.

INSTRUCTIONS

Please ensure that you ask the patient all questions exactly as they are worded on the form. It is important that the responses are based on the patients' answers rather than assumptions or impressions.

ASK THE PATIENT

Please ask the patient where they were born. If their country of birth is not on the list provided, please tick the box labled 'other' and write in the country of birth.

In which country were you born?
(tick one box only)

☐ Australia ☐ New Zealand
☐ England ☐ Viet Nam
☐ Scotland ☐ Other
☐ Greece (please specify)
☐ Italy _____

Ask the patient about where there parents were born. If the patient was adopted they should answer for their natural parents if known. If not known, leave this question blank.

Was your father born in Australia or overseas?

☐ Australia
☐ Overseas

Was your mother born in Australia or overseas?

☐ Australia
☐ Overseas

Please ask the patient "are you of *Aboriginal or Torres Strait Islander* origin?"

For persons of both Aboriginal and Torres Strait Islander origin, mark both "Yes' boxes.

Are you of Aboriginal or Torres Strait Islander origin?
(Mark both 'Yes' boxes if both apply)

☐ No
☐ Yes, Aboriginal
☐ Yes, Torres Strait Islander

Please ask the patient if they speak a language other than English at home. If more than one language (other than English) is spoken in the home, write the one that is spoken most often.

Include indigenous languages in 'other'. Include sign languages in 'other' if these apply in the home.

For babies and young children, or people who cannot speak, write "Not able to speak" in the space provided.

Do you speak a language other than English at home?
(tick one box only)

☐ No, English only ☐ Yes, Arabic
☐ Yes, Italian ☐ Yes, Vietnamese
☐ Yes, Greek ☐ Yes, other
☐ Yes, Cantonese (please specify)
☐ Yes, Mandarin

APPENDIX J: INTERVENTION STRATEGY CATEGORY DEFINITIONS

The sections below outline the themes used to code strategies reported by GPNs.

SYSTEM CHANGE

System changes include activities such as implementing changes and improvements to data collection software, data collection and data entry training for GPs and practice staff, re-designing templates for patient details, and data guidelines creation.

CULTURAL AWARENESS

Cultural awareness mainly looks at improving staff awareness about why data is collected (the reasons why it is important) and development and provision of cultural awareness training. Other activities are community and/or cultural day attendance and participation, and consulting with local Aboriginal and/or Torres Strait elders and community members about development of culturally appropriate strategies.

ABORIGINAL AND TORRES STRAIT ISLANDER MBS/PBS BENEFIT REVIEW

This category is about making sure there is increased awareness (through training, reminders, meetings, newsletters etc.) of the Medicare and pharmaceutical benefits that are available for Aboriginal and/ or Torres Strait Islander patients.

PROMOTION: POSTER/LEAFLETS/DVD/RADIO

This intervention category looks at whether or not promotional materials such as posters, leaflets or other signage are made available to display at reception to encourage self-identification. Other promotional materials such as DVD development and radio programs are also included in this category.

DIVISIONAL ENCOURAGEMENT

Divisional encouragement looks at whether or not the GPN actively encourages practices to identify. This may be through a variety of measures such as regular onsite visits or telephone calls, newsletters and regular reminders for practice staff to identify patients.

ADMINISTRATIVE RECORD REVIEW

The administrative record review criteria considers whether the division actively promotes and assists with updating administrative procedures such as patient questionnaires, promoting regular update of patient records, and data baseline reviews/studies.

HIRE ABORIGINAL LIAISON OFFICER

This category looks at whether the division/GPN hired an Aboriginal Liaison Officer/Aboriginal Health Worker to work on improving Aboriginal health and to work with the practices within the division.

APPENDIX K: INFORMATION TECHNOLOGY AND INFORMATION MANAGEMENT ISSUES

Throughout the key informant interviews, information technology and information management issues, and the ways in which they impact the effectiveness of point-of-care identification, were prevailing topics of discussion.

Utilisation and recent developments in information technology/management are creating vast change in the mainstream general practice landscape. In terms of improving identification, four areas are important to consider: (i) medical software, (ii) data extraction tools, (iii) the Practice Health Atlas and (iv) ehealthNT.

MEDICAL SOFTWARE FUNCTIONALITY

Medical software has the ability to improve information flow and, potentially, quality of care. With an ever-growing proportion of practices transforming from paper-based to paperless, this opens many opportunities for changes in identification, as well as creating challenges.

The two main medical software programs, Best Practice and Medical Director, both have the ability to enter Indigenous status at either reception or within the consultation. Both are easy to alter at anytime. Smaller, less popular software programs used by practices that participated in the case studies often had the ability to register Indigenous status somewhere on the registration form. However, this was not on the 'front page', easily accessible or obvious.

NOT ABLE TO RECORD QUESTION BEING ASKED

No medical software evaluated currently has the capacity to mark whether or not the question has been asked (12 per cent of key informants). There is also an issue that patients often cannot be entered as non-Indigenous. For these reasons there tends to be further hesitation from practice staff to ask about Indigenous status, as they are afraid that the person may have been asked many times before and may not have responded or the answer is 'non-Indigenous'. Research participants suggested that the software should also include options such as 'not stated', 'missing' and 'prefer not to answer'.

DEFAULT TO NON-INDIGENOUS

Another software issue raised by the research participants is that the patient record often defaults to non-Indigenous if the question is not asked or not recorded (12 per cent of key informants). For this reason, many Indigenous patients are incorrectly recorded as non-Indigenous.

PROMPTS AND REMINDERS

Recall and reminder systems considerably assist practices in providing quality care and follow ups. However, research participants suggested that these need to be improved, or added to, in some software. Practice staff say that these systems need further refining and improvements for ease of use. The reminder system was said to be helpful with Aboriginal and Torres Strait Islander patients (once identified), as pop ups would remind the GP about immunisations and health checks.

'We have had real difficulties locating any templates to use for the child and adult health check.' National association representative

Only a few software packages have health check wizards embedded into the software. Comments on these wizards were that they need to be more user friendly (12 per cent of key informants). Health check wizards were said to be valuable.

It was thought that unless software can utilise prompts, reminders and wizards, the information entered will be purely administrative (20 per cent of key informants).

DIFFERENT SYSTEMS

There are many different brands of both medical and administrative software currently being used in general practices across Australia. This variety of software and variety of combinations of medical and administrative software limits the ability to standardise data input.

During the case studies, practice staff and GPs often identified the lack of communication between the clinical software and the administrative software as a barrier to identification. It is necessary for the doctor and nurse to have this information in order to perform the appropriate health care. In some software programs, there is no spot on the 'front page' to display status.

LIMITED USAGE

Despite the potential of the software, many GPs do not utilise its full capacity. Due to lack of training, the software often is used for prescriptions only.

DATA EXTRACTION TOOLS

Relatively new to general practice is the data extraction tools or the Clinical Audit Tools such as The Pen Tool (PCS n.d.) and The Canning Tool (Canning Division of General Practice n.d.). These data extraction tools are being rolled out to practices by some GPNs. Both the Canning and Pen tools are clinical information systems that aim to support practices to improve information management. The tools work in conjunction with most software programs to transform the information they collect from patients into meaningful clinical information.

Clinical Audit Tools can take a 'snapshot' of the data already inputted and can inform practice staff of the data areas they are lacking and areas that need improving, such as, for example, Aboriginal and Torres Strait Islander identification. Another function that GPNs highlight when attempting to improve identification is the practice income estimator. This tool estimates the amount of income a practice is losing through not identifying Aboriginal and Torres Strait Islander patients.

The recent introduction of the tool has led to training that highlights the importance of data quality in which practices are able to see the areas where they need to improve data entry. It is also useful to prompt discussion about registration processes and updating of client details processes.

PRACTICE HEALTH ATLAS

The Practice Health Atlas (AWGPN n.d.) is another data analysis tool. The Practice Health Atlas looks at the area in which a practice is located and compares the data with the available statistics. Its main aim is to support practice decisions to assist with the development of improved quality health data and usage.

ehealthNT

The Shared Electronic Health Record (Northern Territory Government n.d.) currently being trialled in the Northern Territory is a summary of individual medical records and is transferable between health professionals. Upon consent, this record allows the GP or nurse instant access to previous health issues and medications, plus personal details such as Indigenous status. The ehealthNT specifies Indigenous status and, once registered, this information is always available (rather than each individual health agency being required to ask the question for each visit).

COST OF CHANGE

In 2007 Acumen Alliance prepared a report about including an Aboriginal and Torres Strait Islander identifier on pathology forms. It estimated the cost of modifying general practice software to incorporate an Indigenous identifier that could be printed on pathology forms to 'be between $2,000 and $3,000 per GP if the change is undertaken nationally'; however, if the change was undertaken in only one jurisdiction, the cost 'may be in excess of $10,000 per GP and the suppliers may charge an on-going fee to maintain a separate version of their software' (Acumen Alliance 2007). This report also estimated the cost for medium to large general practices (those that service more than 600 patients a day) to back-capture Indigenous status would initially be in the region of $3,000 to $5,000 annually. However, this would decrease as existing patient records were updated.

'It's about getting the GPs to want to have the information to then push for the product to be changed.' National association representative

Software functionality was a key issue discussed, both in terms of a major barrier and a potential strategy in improving Indigenous identification. A large barrier to software change is that software companies are hesitant to change due to the cost and work involved for a relatively minor adjustment to their software. It was said that there already has been much negotiation with software companies about improving the Indigenous identification components of the software. However, as these companies are private businesses, they want to be paid large sums of money to make any changes to their product.

It was thought that if the GPs (the software company consumers) could advocate for these changes, they would be more likely to influence the software companies. It was also suggested that if the accreditation standard was strengthened, this may assist in the push for better software.

TRAINING AND EDUCATION

It is recognised that software is often only as good as the user's ability. It is understood that even if software systems are the best they can be, this improvement needs to go hand in hand with training of GPs and practice staff. It was largely believed that even if identification in systems becomes mandatory, if GPs and practice staff do not want to ask the question or are too embarrassed, the data will only be as good as what is collected and what is entered.

Many GPNs interviewed regularly assisted practice staff in learning the major software packages – often on a one-to-one basis. This was ongoing training whenever and wherever it was required. GPNs stated that there was considerable need for regular training for many reasons, such as high staff turnover and the limited time staff are available for training.

'You have to convince health services that it is about health care delivery not just data collection.'
Community representative

APPENDIX L: REVISION OF ACCREDITATION STANDARDS PROCESS

In 2003 the RACGP embarked on a review of the *Standards for General Practices* (2nd edn). The review included an extensive consultation process with:

- face-to-face meetings with 137 individuals including GPs and practice staff, and 38 stakeholder organisations

- review by three expert working groups (Practice Management, Care Outside Normal Opening Hours and Information Management), which included representatives from the RACGP, Australian Association of Practice Managers, Australian Divisions of General Practice (ADGP), Australian Medical Association, Consumers' Health Forum and the Rural Doctors' Association of Australia

- analysis of questionnaires distributed at the ADGP GPN of General Practice Network Forum conference in November 2003 to 980 delegates, and at the Australian General Practice Accreditation Limited conference in February 2004 to 650 delegates

- direct invitation for comments from 47 key stakeholder organisations, including accreditation providers

- a fax survey of more than 1000 rural RACGP members in March 2004

- receipt of 115 formal submissions between October 2003 and June 2004 from GPs, practice staff and other stakeholders.

In July 2004 the draft of the revised *Standards for General Practices* (3rd edn) was released for public comment and active feedback was sought. Between July 2004 to February 2005, 134 formal submissions were received.

As part of the consultation process, in the development of this edition of the *Standards*, the RACGP conducted a national field test of the revisions. The field test was conducted in collaboration with both accreditation organisations, 200 general practices around Australia and 144 general practice accreditation surveyors. The field test generated qualitative and quantitative data and collected information about which indicators general practices were currently achieving, which indicators general practices found acceptable, and which indicators practices and surveyors found feasible to include in this edition of the *Standards*. In addition, the field test tested the achievement, acceptance and feasibility of the revisions in the *Standards* in diverse general practices, exploring results in relation to the rurality of the practice, size of the practice, information management system used by the practice, whether the practice was undergoing accreditation or re-accreditation, and if the practice was an Aboriginal Medical Service.

The field test formed one component – albeit a significant component – of the process used by the RACGP to revise the draft *Standards* prior to finalising this edition. Consideration was also given to a number of other aspects when finalising these Standards, including:

- feedback from the consultation process between August 2004 and January 2005

- consideration of structure, process and outcome indicators

- the evidence base for the indicators

- the relevance of the indicators for Australian general practices

- the capacity for practices to alter processes to meet the indicators

- reliability of measurement of indicators

- capacity of indicators to be described unambiguously

- capacity for indicators to differentiate between high- and low-quality practices

- any duplication of indicators

- the number of indicators in the *Standards*.

Source: information cited from RACGP 2005.

APPENDIX M: ETHNIC MONITORING IN GENERAL PRACTICE IN THE UNITED KINGDOM

The following table shows case studies of ethnic monitoring in general practice in the United Kingdom.

Practice details	Data collected	Comments
4 GPs list size 7,344	0%	Withdrew after 6 months without having collected any data, due to staff shortages, difficulties due to the open appointment system which meant that large numbers of patients arrived as the surgery opened and concerns over confidentiality.
5 GPs list size 7,166	1% (<100 patients)	Experienced considerable difficulties attempting to implement the data collection. The practice was frequently short staffed, the practice manager was reluctant to ask staff to take on additional tasks, the reception area was surrounded by screens and there was nowhere to leave forms for patients to complete or space for staff to assist patients. After long delays in the beginning the data collection, the practice concluded it was not possible to collect the data in reception in this practice. The practice also felt unable to undertake a mailing to patients, due to lack of staff
GP list size 3,200;	4% (130 patients)	Found it difficult to implement the data collection as the GP went on sick leave and the practice manager was on maternity leave. Data had been collected on 130 patients after 6 months and none had been entered on the computer system.
GP + locum list size 3,670	12%	A large number of patients who are unable to speak English, including refugees and asylum seekers. Bilingual receptionists assisted patients with the form where possible. This was time consuming and often there was insufficient staff time to do this. This practice sometimes asked patients to take the form home to get help to complete it, and gave them an envelope to return it. The practice said they did not wish to do a mailing as they preferred to ask their patients in person.
4 GPs list size 5,850	26%	Included the form with the letter about flu immunisation sent to patients and asked patients to return it when they attend the flu clinic. The number of patients who had completed the form increased from 15% to 50% in the 65-90 years age group during this period
3 GPs, list size 5,500	30%	Collected data on over 30% of their patients in 3 months, but as time passed, staff found it unrewarding and collected little additional data (about 2 patients per surgery). Data collection ceased altogether both in reception and for new patients following the resignation of the practice manager.
GP + locum list size 3,400	45%	Collected all their data in reception. (No other details given)
4 GPs list size 6,150	62%	Used a variety of methods to collect the data, but most of it was collected in reception. A mailshot was organised by the practice at the beginning of the data collection to patients who had not attended the surgery in the previous 12 months and achieved a 45% response rate. Two subsequent mailing to non-attenders had lower response rates (approx 35%). When the data collection slowed down, the practice arranged for all appointments booked in advance to be marked with an E on the arrivals screen of their computer system so that the reception staff could target only those patients known not to have already completed a form. This was effective in maintaining the momentum for the data collection with staff.

Source: Jones & Kai 2007:215.

APPENDIX N: RESPONSES AND STATEMENTS ABOUT ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH ISSUES

The following table shows responses to 18 statements about Aboriginal and Torres Strait Islander health issues by Australian Capital Territory general practice and GPN staff.

Statement	N	Non-conducive attitudes	Conducive attitudes
1. Asking all patients whether they are Aboriginal or Torres Strait Island would offend our non-Indigenous patients	141	58%*	41%
2. I'm apprehensive about what reaction I might get if I ask patients whether they are Aboriginal or Torres Strait Islander origin	144	58%*	41%
3. There may be a few Aboriginal or Torres Strait Islanders in our practice, but it's such a small percentage, it's not feasible to ask everyone if they are of Aboriginal or Torres Strait Islander origin	137	52%*	47%
4. I do not see why Aboriginal people or Torres Strait Islanders should have problems using the same medical services as everyone else	142	47%*	52%
5. We treat all patients as individuals here so there's no need to identify subgroups such as Aboriginal people or Torres Strait Islanders	141	46%*	54%
6. When it comes to health services, Aboriginal people and Torres Strait Islanders should be treated no differently from other people, otherwise it's discriminatory	144	41%*	58%
7. Aboriginal people and Torres Strait Islanders should be entitled to specialised health treatment	144	39%#	61%
8. Aboriginal people and Torres Strait Islander in Canberra are generally as healthy as non-Indigenous people	143	39%*	60%
9. Aboriginal and Torres Strait Islander health problems occur mainly in rural and remote areas	144	37%*	63%
10. Our practice treats everyone equally so it does not make sense to record Aboriginal or Torres Strait Islander status	140	35%*	64%
11. Aboriginal people and Torres Strait Islanders get too much money spent on them	143	34%*	66%
12. Aboriginal people and Torres Strait Islanders do have poorer health but it's largely a problem of their own making	143	33%*	67%
13. People who obviously look Aboriginal or Torres Strait Islander may have health issues, but for many of the others who look much the same as everyone else, I cannot see they have specific health issues different from other patients	144	31%*	68%
14. Knowing whether a patient is of Aboriginal or Torres Strait Islander origin is relevant to the health care GPs provide	144	30%#	69%
15. You can usually tell who might be Aboriginal or Torres Strait islander by appearance	145	28%*	72%
16. Collecting data on Aboriginal or Torres Strait Islander status is meaningless – it's just political correctness	145	25%*	74%
17. Asking people to identify as Aboriginal or Torres Strait Islander is racist	143	24%*	74%
18. If people do not look Aboriginal or Torres Strait Islander I do not think they should be able to say they are	145	20%*	79%

Source: based on Kehoe & Lovett 2008:1036.
Notes: * Strongly Agree/Agree/ Neutral; # Strongly Disagree/Disagree/Neutral

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