Australian Government

Australian Institute of Health and Welfare

Taking the next steps: identification of Aboriginal and Torres Strait Islander status in general practice

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Contents

Acknowledgments

Terminology

To acknowledge the separate Indigenous peoples of Australia, the term 'Aboriginal and Torres Strait Islander people' is preferred in AIHW publications. The term 'Indigenous' is, however, also used interchangeably, especially in the context of 'Indigenous status' or where it assists readability.

Executive summary

The Australian Institute of Health and Welfare (AIHW) was commissioned to evaluate the implementation of the *National best practice guidelines for collecting Indigenous status in health data sets* (the Guidelines) across health sectors as part of the National Indigenous Reform Agreement. The general practice sector was prioritised in this evaluation because it has a unique role in providing access to health interventions specific to Aboriginal and Torres Strait Islander people, as well as in providing input to data collections. This report summarises the evaluation and support project work in the general practice sector between January 2011 and December 2012. Over this period, the project investigated:

- available information on Indigenous identification in the sector
- barriers to identification and the impact of sub-optimal identification processes
- changes introduced since the Council of Australian Governments Closing the Gap commitments
- measures to improve identification.

The AIHW convened national workshops for general practice sector stakeholders in December 2011 and November 2012. These workshops provided a unique forum for stakeholders to discuss and progress issues. Outcomes from the workshops helped direct the focus of work in the sector.

Sub-optimal collection and recording of Aboriginal and Torres Strait Islander status in the general practice sector is a longstanding problem, as in other sectors. Improving this process by implementing the Guidelines is not straightforward. While state and territory governments undertook to implement the Guidelines throughout the health system, general practice is not part of their jurisdictional responsibilities. The Australian Government has some capacity to influence behavioural change but reforms require multi-layered strategies and the involvement of sector-specific stakeholders.

Consensus on barriers, enablers and recommendations for improving rates of Indigenous identification has emerged from studies undertaken in this field. These recommendations, which were supported and extended by the general practice workshops, focus on making changes through multiple channels, while ensuring these are centrally coordinated and integrated in an overall plan.

The Council of Australian Governments Closing the Gap Indigenous health initiatives, which focused on primary health care, have helped to improve identification in the sector and led to improved uptake of health interventions specific to Indigenous people. These reforms have helped to address some of the barriers to identification, but there are opportunities for further improvements and for the potential of reforms to be fully realised.

Some of the identified barriers which have not yet been addressed include the need to:

- establish a central point of national responsibility and organisation, for example, through the establishment of a taskforce of relevant government and non-government stakeholders, with the remit of improving both data collection and the service delivery outcomes
- improve clinical information systems
- inform Aboriginal and Torres Strait Islander people about the GP-mediated health interventions for which they may be eligible.

1   Background and context

Setting the scene

What is the problem?

The general practice sector plays a key role in providing primary health care for Aboriginal and Torres Strait Islander people, but opportunities to further improve care have been identified. For example, in the 2-year period from July 2008 to June 2010, rates for potentially preventable hospital admissions were 5 times as high for Indigenous people as for non-Indigenous Australians (AHMAC 2012). This includes admissions that could have been avoided through effective preventive measures or early diagnosis and treatment.

Improving the identification of Indigenous patients in general practice settings is vital to improving both the uptake of GP-mediated health interventions specifically for Indigenous people and the health data to which general practices contribute. Important changes have been implemented since the Council of Australian Governments (COAG) Closing the Gap commitments to address Indigenous disadvantage were made, and research about Indigenous data collection processes has not been undertaken since that time. However, available data indicate that only a minority of general practices have effective processes to routinely collect Indigenous status data from patients/clients, and that there are considerable barriers to implementing these processes. In addition, the structure of the general practice sector means that improving Indigenous data collection faces different challenges compared with other health settings.

Making change in the general practice sector

About 24,700 GPs were estimated to be working in 7,035 practices across Australia as at June 2011 (PHCRIS 2012), with most GPs working in private practices under corporate or individual ownership. As of 2011-12, about 10% of GPs worked in solo practices, 40% in practices of between 5-9 GPs, and over 20% in practices of 10 or more GPs (Britt et al. 2012). Smaller numbers of GPs work in Aboriginal Community Controlled Health Services (ACCHS), acute care hospitals, 24 hour clinics, and other settings. Geographic distribution of GPs varies. In 2009, *Major cities* had the highest ratio of doctors, with 372 doctors per 100,000 population; correspondingly, *Inner regional* areas had 212 per 100,000; *Outer regional* areas had 188 per 100,000; and *Remote* and *Very remote* areas combined had about 216 per 100,000 (Health Workforce Australia 2012).

The general practice sector is primarily composed of private businesses with substantial levels of autonomy. Policy and funding levers with potential to facilitate change are controlled by the Australian Government, and some initiatives supporting greater engagement with Aboriginal and Torres Strait Islander health have been instigated. However, changes such as ensuring all patients/clients are asked the national standard Indigenous status question cannot easily be centrally mandated or enforced by government—they require the engagement and cooperation of many stakeholders.

Funding for some of the government-initiated support measures has been channelled through sector-specific stakeholders, including Medicare Locals and the Royal Australian College of General Practitioners (RACGP). As well, some stakeholders, such as the RACGP, have undertaken additional relevant reforms of their own volition. Further improvements

would be facilitated by greater recognition of these non-government stakeholders as essential partners in this change process.

The private ownership and autonomy of general practices also contribute to the diversity of clinical information systems used. These systems are an important element in supporting Indigenous identification improvements but there is no centralised process to require the use of standard identification processes. Once Indigenous status data are recorded in practice systems, this information should ideally be linked with clinical support processes to facilitate best practice in Aboriginal and Torres Strait Islander health. For example, software should prompt the practice team to offer Indigenous-specific health checks to patients recorded as Aboriginal and or Torres Strait Islander. However, these processes are in the early stages of development.

Service delivery and data collection

Links between the identification of Indigenous status for the purposes of service delivery and data collection are especially important in the general practice sector.

This sector controls access to the majority of health interventions specifically for Indigenous people. Historically, the uptake of such interventions has been low, and poor identification processes have been recognised as a contributory factor (Kehoe & Lovett 2008; Norris et al. 2004; Riley et al. 2004). GPs cannot provide health interventions specifically for Aboriginal and Torres Strait Islander people if they do not know which patients are Indigenous. At the same time, GPs have little reason to seek the Indigenous status of their patients if they are not aware of the range of Indigenous-specific health interventions available.

Although there is no specific national data collection covering the general practice sector, it contributes to a number of key data sets, including cancer and Pap smear registers. Despite some relevant legislative requirements, including Indigenous status in these data contributions is largely optional. Stakeholders have emphasised that members of the general practice team do not generally identify themselves as 'data collectors'; instead, data generation can best be improved when it is embedded in the clinical or financial core business of practice management and provision of health services to patients. Data quality improvements should be presented as a by-product of improved service delivery to Aboriginal and Torres Strait Islander people, predicated on the accurate collection and recording of Indigenous status. Improved identification of Indigenous status in the general practice sector therefore depends on integrating service delivery and data collection goals.

Range of stakeholders

Aboriginal and Torres Strait Islander people are the primary stakeholders who are affected by Indigenous identification processes in general practice. Currently, they are missing out on health services targeted to their needs, and improving processes to ask Indigenous status will help increase the provision of these services through general practice. Policy and program development for Aboriginal and Torres Strait Islander health issues is also impeded because of inaccurate and incomplete Indigenous data in national health data collections. Ensuring that the input from general practice contains complete and accurate Indigenous data will provide better information for government, policy makers and health services.

In addition, a wide range of government and non-government organisations plays a role in, or would benefit from, improved Indigenous identification (Appendix F). The importance of

communication and integrated effort is evident in the large number and diversity of stakeholders in the sector.

Service delivery and data collection are administered by different government agencies, and collaborative effort across these areas to improve Indigenous identification has been minimal to date. For example, generic data collection resources do not recognise the lead role of service delivery in the general practice sector.

Different Indigenous-specific health interventions are also administered by different parts of government agencies and these are not always presented in a seamless way to providers and consumers. For example, the various information sources describing health interventions for Aboriginal and Torres Strait Islander people could be consolidated via a single government web portal.

The lack of an existing forum for cross-stakeholder communication provided the impetus for the Australian Institute of Health and Welfare (AIHW) to convene the national general practice workshops.

Indigenous identification context

The approach taken by the Australian Government to recognise a person's Indigenous status varies across different programs; sometimes written evidence is required. The most common version is a statutory declaration signed by the individual and a letter of confirmation with common seal signed by the Chairperson of an incorporated Indigenous organisation. However, in the health sector, a person's response to the national Indigenous status question (Box 1.1) is the only requirement for recording Indigenous status and for providing access to Indigenous-specific health interventions and services—no further evidence is needed. Other issues important to note about Indigenous identification are listed below.

- How the question is asked—and in what context and for what purpose—affects how the question is answered.
- Non-Indigenous people should have their status recorded as non-Indigenous.
- Because Indigenous status impacts on service delivery in the general practice setting, service providers should explain to patients the implications of choosing not to disclose their Indigenous status, and advise what specific health services are available for Indigenous people.

Choosing to disclose one's Indigenous status is voluntary. People may or may not be prepared to disclose their Indigenous status depending on the situation; others may be discovering or acknowledging their Indigenous status for the first time.

Box 1.1: National standard Indigenous identification question

'Are you [is the person] of Aboriginal or Torres Strait Islander origin?'
 Responses:

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander.

Source: The Indigenous status data element METeOR, AIHW: <meteor.aihw.gov.au/content/index.phtml/itemId/291036>.

COAG context

The COAG Closing the Gap commitments aim to achieve health equality between Indigenous and non-Indigenous Australians (Box 1.2). COAG processes included two main elements relevant to identifying Indigenous status in the general practice sector.

- First, COAG acknowledged that measures targeted specifically at the needs of Aboriginal and Torres Strait Islander people were needed to close the gap, and increased the number and range of these measures. As GPs are the access point for most of these measures, they must have processes in place to seek the Indigenous status of their patients in order to offer these targeted services to their Aboriginal and Torres Strait Islander patients.

- Second, COAG highlighted the need to accurately measure the health gaps between Indigenous and non-Indigenous people, and to monitor progress in closing those gaps. Accurately identifying Aboriginal and Torres Strait Islander people and recording their Indigenous status in national data collections should result in more effective responses to unmet needs in the Aboriginal and Torres Strait Islander population. The links between Closing the Gap commitments and asking the standard Indigenous identification question are shown at Figure 1.1.

Box 1.2: COAG Closing the Gap commitments

The COAG commitments made in 2008 are:

- to close the gap in life expectancy within a generation
- to halve the gap in mortality rates for Indigenous children under 5 within a decade
- to ensure all Indigenous 4 years olds in remote communities have access to early childhood education within 5 years
- to halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade
- to halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020
- to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

Indigenous Chronic Disease Package

The Indigenous Chronic Disease Package constitutes the Australian Government's contribution to achieving the health goals of the COAG Closing the Gap commitments. The package was in large part focused on the general practice sector; half of its 14 measures either targeted GPs or established services to be accessed via GPs. These new measures built on existing targeted interventions, taking the suite of health interventions specifically for Indigenous people mediated by GPs to a substantial new level (Box 2.1).

The general practice sector was therefore assigned a critical role in achieving the Australian Government's contribution to achieving COAG's health commitments. How well this role can be played, however, mainly depends on how effectively Indigenous status is ascertained.
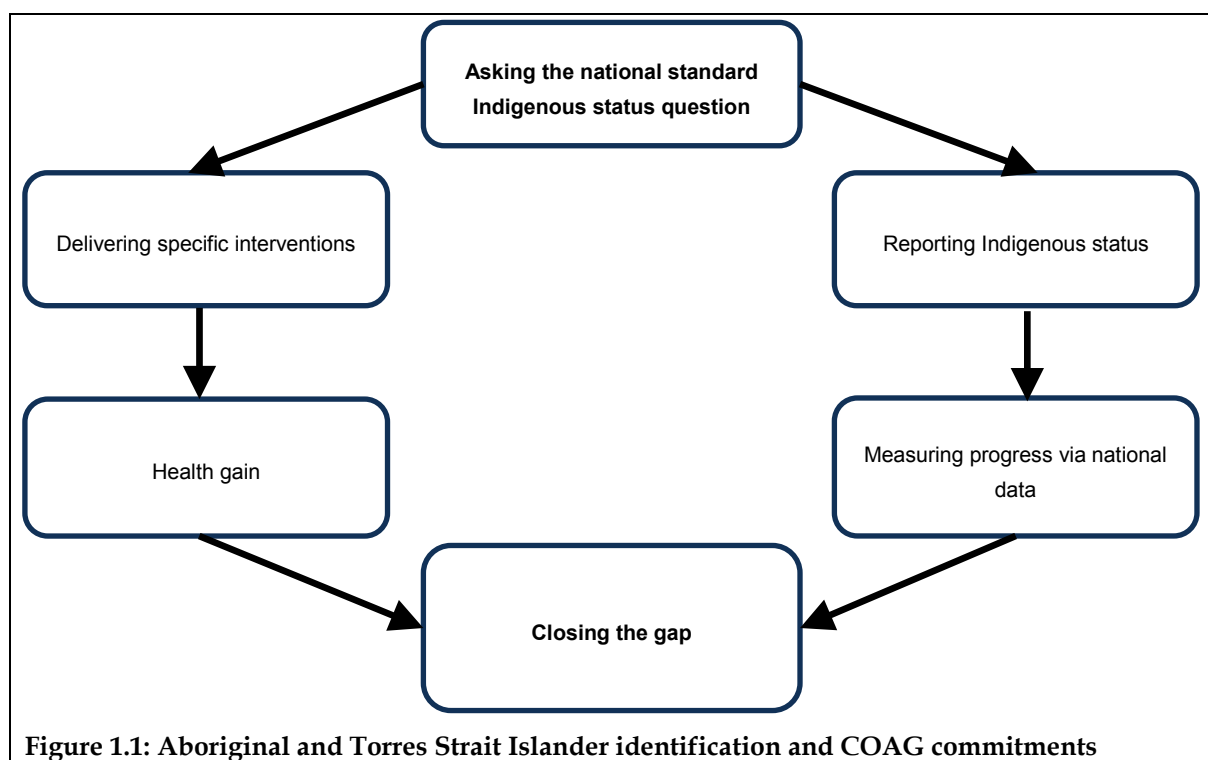
Figure 1.1: Aboriginal and Torres Strait Islander identification and COAG commitments

National best practice guidelines for collecting Indigenous status in health data sets

COAG data quality improvement processes included a commitment by jurisdictions to implement the *National best practice guidelines for collecting Indigenous status in health data sets* (the Guidelines) throughout the health system by December 2012 (AIHW 2010).

The Guidelines were informed by a review of research into Indigenous under-identification in data collections, and were developed in consultation with stakeholders, service providers, health authorities and data custodians for the range of key health data collections covered by the Guidelines. The Guidelines, which apply to a range of health settings including general practice, support a systematic approach for collecting and recording accurate information on the Indigenous status of clients. As well as committing jurisdictions to implementation, COAG processes also tasked the AIHW, together with the Australian Bureau of Statistics (ABS), to evaluate this implementation in their respective areas of responsibility.

The AIHW has completed the first phase of this evaluation and support project (AIHW 2013b). The general practice sector was prioritised in this evaluation because it has a unique role in providing access to health interventions specific to Aboriginal and Torres Strait Islander people, as well as in providing input to data collections.

State and territory governments are able to implement the Guidelines in a number of areas for which they have responsibility, such as hospitals, but are not equipped to make change in general practice. Capacity to implement the Guidelines in this sector lies with the Australian Government as the policy and funding levers able to influence this sector are within national, rather than state or territory, control.

2   Indigenous identification in the general practice sector

Research studies specifically investigating general practice identification processes predate the impact of recent reforms, which have taken place largely since 2010. These studies showed only a minority of mainstream general practices had routine identification processes in place for all patients (Kehoe & Lovett 2008; Kelaher et al. 2010; Norris et al. 2004). While specific investigations have not been repeated since the reforms were implemented, overall data on general practice activity indicate little change in the proportion of patients recorded as Aboriginal or Torres Strait Islander. This proportion was 1.2 in 2002–03 and 1.6 in 2011-12, but the variation between the beginning and end of this period was not statistically significant (Britt et al. 2012).

Data indicate that rates of collecting and recording Indigenous status are higher within the Aboriginal Community Controlled Health Services sector, where about 95% of clients have their Indigenous status recorded (AIHW 2011b). While this sector is central to improving Aboriginal and Torres Strait Islander health, it is estimated that between 50–60% of Aboriginal and Torres Strait Islander people access health care elsewhere (AHMAC 2011; Couzos 2009).

Mainstream general practice is therefore a potentially important source of both improved data collection and service delivery for Aboriginal and Torres Strait Islander people, and improved identification processes are fundamental to achieving these outcomes.

Studies of Indigenous identification

Studies of Indigenous identification in general practice settings have not been conducted since relevant reforms have taken place, mainly from 2010. Earlier research findings remain relevant as they provide the context and rationale for recent reforms; they identify issues not yet addressed; and, until new studies are conducted, they provide the best available indication of barriers to and facilitators for change.

Barriers to improving rates of Indigenous identification in the general practice sector have been investigated in a number of studies (IIICDRPSC 2004; Kehoe & Lovett 2008; Kelaher et al. 2010). Barriers identified across these and similar studies include:

- lack of routine identification processes and little commitment to implementing change
- assumptions that no Indigenous people attend any particular practice (despite not having formal processes to ascertain this)
- lack of awareness of any reason to identify Aboriginal and Torres Strait Islander patients, reflecting low awareness of both health interventions specifically for Indigenous people and of benefits of data collection. In addition, some GPs were not convinced that health interventions specifically for Aboriginal and Torres Strait Islander people would result in health gains
- a number of process barriers, which make recording and using Indigenous status difficult: in particular, some general practice software does not facilitate the identification or uptake of GP-mediated health interventions specifically for Indigenous people
- resistance to asking longstanding patients the identification question, though there was some preparedness to ask it of new patients. However, in 2011-12, less than 8% of GP

encounters were with new patients (Britt et al. 2012), so asking only this group would not be effective.

- assumptions that the onus was on Aboriginal and Torres Strait Islander people themselves to 'self-identify' without being asked by practice staff.

Other barriers described focused on the lack of support processes or incentives to improve identification: there was little assistance provided by general practice agencies, no appropriate training and no accreditation requirement to do so.

It was noted that Divisions of General Practice lacked coordinated engagement with Aboriginal and Torres Strait Islander health issues generally and the issue of Indigenous identification specifically. As discussed later in this section, measures to address these barriers have since been implemented.

The same studies indicated a number of underlying attitudinal issues that work against routine identification. Some such attitudes related to how general practice services should be provided and included views that Aboriginal and Torres Strait Islander patients were only one of many high-needs subgroups, and therefore special treatment was not justified. This was connected to beliefs that general practices should treat all patients equally and that providing different services to Aboriginal and Torres Strait Islander people undermined this position.

An extension of this was the view that general practices should treat the individual who presents to them rather than taking a population health approach targeting high-risk groups. Perceptions that if people did not 'look' Aboriginal or Torres Strait Islander they did not have the same health issues as people who did were also reported. This was linked to the view that, as the proportion of Aboriginal or Torres Strait Islander heritage decreased, people had less reason or justification to identify as such. These attitudes sometimes stemmed from misunderstandings about the definition of Indigenous status (for example, the misconception that only 'full-blood' people were authentically Indigenous). Out-dated terms such as 'half caste' and 'quarter caste' were encountered in the context of checking eligibility for Indigenous-specific interventions.

Service provider beliefs that Aboriginal and Torres Strait Islander people did not wish to be asked to acknowledge their Indigenous status, and that non-Indigenous patients could be offended if asked if they were Indigenous, were also described.

There were some indications that some members of the practice team, such as administrative staff, may have different views from GPs. As Indigenous status may often be sought by administrative, as well as clinical staff, it is important that all members of the practice team are involved in improving Indigenous identification processes.

Aboriginal and Torres Strait Islander people's views

Studies about Aboriginal and Torres Strait Islander people's views on identifying show that people are prepared to identify in appropriate circumstances. This is also backed up by the high enrolment rate in Indigenous identification programs.

A Queensland study examined identification for the purposes of immunisation (Riley et al. 2004). The study reported feedback from Aboriginal and Torres Strait Islander adults that the identification question should be asked respectfully and in private, and be accompanied by a full explanation of how the information was to be used. Reasons for not wishing to answer the identification question were articulated by both Indigenous and non-Indigenous people and included anticipating a lesser level of service after identifying or a display of racist attitudes.

Focus group studies (ABS 2012b) reported views of Aboriginal and Torres Strait Islander participants that identification would be encouraged by:

- consistent use of a national standard question by service providers
- creation of a more culturally appropriate and safe environment in which to ask the question
- clear communication of the implications for Aboriginal and Torres Strait Islander clients of identifying.

A qualitative study of a group of Aboriginal and Torres Strait Islander people in the Australian Capital Territory investigated views about identification (Scotney et al. 2010). Participants reported that they would be prepared to identify as Indigenous if asked, as long as they were informed about the rationale for the question and the benefits of identifying as Indigenous. Focus group studies conducted for another project suggested the wording of such explanations is important (Kelaher et al. 2010). For example, stating that answering the question was 'for your best possible care' may cause concern among non-Indigenous people who might feel they would not receive the same standard of care as Aboriginal and Torres Strait Islander people.

The enrolment rate in the Voluntary Indigenous Identifier Program also indicates that Aboriginal and Torres Strait Islander people are willing to identify when given the opportunity to do so. The program was begun in 2002; by May 2012, about 339,300 people had chosen to identify as Indigenous (nearly 60% of the total estimated Aboriginal and Torres Strait Islander population) (AHMAC 2012).

General practice service delivery

Health interventions specifically for Indigenous people

There is a range of general practice-mediated health interventions available specifically for Aboriginal and Torres Strait Islander people, which are designed to address the higher morbidity and mortality levels in this population (Box 2.1). Some interventions were introduced as a result of the Indigenous Chronic Disease Package after implementation in 2009, while others were introduced at earlier stages.

The major health interventions are described in more detail in this section, along with available data on take-up rates (Figure 2.2). Generally, uptake of GP-mediated health interventions specifically for Indigenous people has been sub-optimal. Lack of effective routine processes to collect Indigenous status has been identified as one of the barriers to better uptake (Kehoe & Lovett 2008; Norris et al. 2004; Riley et al. 2004).

> **Box 2.1: Main GP-mediated health interventions specifically for Indigenous people**
>
> **Pre-Indigenous Chronic Disease Package**
>
> - MBS-rebated health checks specific to Aboriginal and Torres Strait Islander people (MBS item 715) <http://bit.ly/11qFSbL>
> - Practice nurse or registered Aboriginal Health Worker follow-up services (MBS item 10987) after a health check (increased under Indigenous Chronic Disease Package from 5 to 10 follow-up services) < http://bit.ly/15FOITC>
> - Allied Health follow-up services (MBS items 81300–81360) after a health check <http://bit.ly/10XtQDu>
> - Pneumococcal and influenza immunisations for Aboriginal and Torres Strait Islander adults <http://bit.ly/13kmOf6>
> - Differential Aboriginal and Torres Strait Islander children's immunisation in some states and areas <http://bit.ly/13kmOf6>
> - Listings on the Pharmaceutical Benefits Scheme (PBS) for Aboriginal and Torres Strait Islander people only <http://bit.ly/11DEMox>.
>
> **Introduced via Indigenous Chronic Disease Package**
>
> - Cheaper medicines through the PBS co-payment measure <http://bit.ly/10PdEYp>
> - Support via Indigenous-specific care coordinators <http://bit.ly/11qGJsO>.
>
> *Note:* Measures not mediated by GPs (e.g. community-based healthy lifestyle workers and tobacco action workers) are not included here.

MBS-rebated health checks

MBS-rebated health checks tailored to the specific needs of Indigenous people were instituted progressively, with annual checks specific to people aged 55 and over introduced in 1999, 2-yearly checks for people aged 15–54 introduced in 2004 and annual checks for children aged 0–14 introduced in 2006. In 2010, the three separate checks were amalgamated into a single MBS item number (715) able to be billed every 9 months, and this is now available for Aboriginal and Torres Strait Islander people of any age (DoHA 2012a).

These early detection and treatment interventions are especially important for Indigenous Australians who have a greater burden of undiagnosed and untreated illnesses than non-Indigenous Australians.

The number of health checks provided each year has risen steadily, with greater increases since July 2009 than in previous years (Figure 2.1). Part of the increase is likely to be caused by the shift from 2-yearly checks for people aged 15–54 to checks able to be done every 9 months: this means the same people may be having checks more frequently. However, there are also indications of checks being done for those who have not previously received health checks (Menzies School of Health Research 2013). These increases coincide with, and may be linked to, the introduction of the Indigenous Chronic Disease Package. For example, there are reports that some health services offer health checks when patients are registered for the Practice Incentive Payment Indigenous Health Incentive or PBS co-payment initiative.
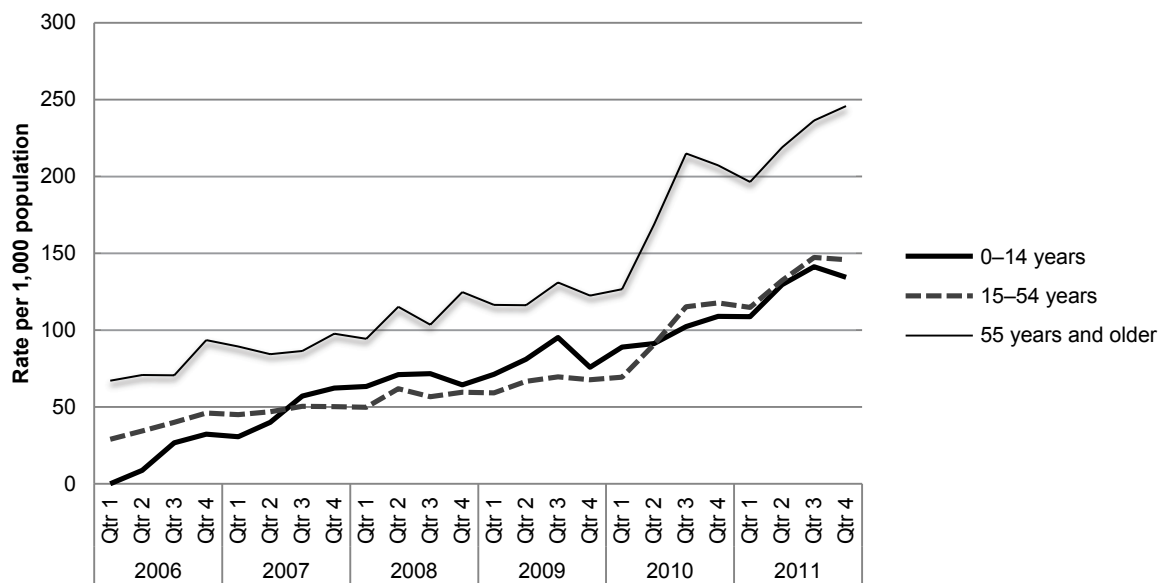
Figure 2.1: Number of Aboriginal and Torres Strait Islander people receiving MBS health checks per 1,000 population

Notes

1. Rates were calculated using the Indigenous population estimates for 2006–11, divided by four to obtain quarterly rates for each year.

2. MBS item 715 was added to the MBS in May 2010; MBS items 704, 706, 708 and 710 were reclassified as 715 for previous years.

3. Data for 0–14 year olds for quarter 1, 2006 were not available.

Source: Medicare statistics.

During 2010–11 about 71,400 MBS-billed health checks were provided, including about 22,400 for children aged 0–14, about 38,300 for people aged 15–54 and about 10,600 for people aged 55 and over (Medicare 2011). As this represents about 13% of the Aboriginal and Torres Strait Islander population, there is considerable potential to increase access to health checks for Indigenous people (see Figure 2.2 on page 13).

Health check follow-up services

On the basis of needs identified through the health check, GPs can initiate MBS-rebated follow-up services undertaken by:

- practice nurses or registered Aboriginal Health Workers (MBS item 10987). The number of follow-up services was increased under the Indigenous Chronic Disease Package from 5 to a maximum of 10 services per patient in a calendar year.

- allied health professionals (MBS items 81300–81360) up to a maximum of 5 services in a calendar year.

The number of follow-up services provided by practice nurses or registered Aboriginal Health Workers is increasing. About 13,400 services were claimed in 2010-2011 and this has risen to about 27,600 services in 2011–2012 (Medicare 2013).

The number of follow-up services provided by allied health professionals is also increasing but has much lower coverage. About 4,100 services were claimed in 2010-2011 compared with 8,000 services in 2011–2012 (Medicare 2013).

Use of follow-up services should reflect the higher burden of disease (estimated to be 2.5 times greater than for non-Indigenous Australians) and chronic illnesses (responsible for 70% of this health gap) in the Indigenous population (Vos et al. 2007). Use of follow-up

services is increasing, but overall numbers are low relative to need and there is scope for further improvement.

Immunisation

Reflecting different morbidity profiles and risk factors, Indigenous children in some locations, and Indigenous adults throughout Australia, have different recommended immunisation programs than non-Indigenous people. While not the sole provider, the general practice sector plays an important role in ensuring optimal immunisation coverage. Achieving this outcome is one measure of the effectiveness of the primary health care system (AHMAC 2011).

All Aboriginal and Torres Strait Islander people aged 50 and over, and those at risk in the 15–49 age group, have access to free pneumococcal and influenza vaccines (AHMAC 2012). The 2004-05 National Aboriginal and Torres Strait Islander Health Survey found that coverage of the influenza vaccine was higher than for the pneumococcal vaccination (Figure 2.2 on page 13). Around 60% of Aboriginal and Torres Strait Islander people aged 50 and over reported they had been vaccinated against influenza in the previous 12 months, while 34% reported that they had been vaccinated against invasive pneumococcal disease in the previous 5 years. For those aged 18–49, 23% reported that they had been vaccinated against influenza in the previous 12 months, while 12% reported that they had been vaccinated against invasive pneumococcal disease in the previous 5 years.

Coverage for adult vaccination for influenza and invasive pneumococcal disease has increased, but opportunities to further improve coverage exist. Around 30% of all Indigenous Australians who had never been vaccinated against influenza or invasive pneumococcal disease had visited a doctor in the previous 2 weeks, reflecting missed opportunities for general practice to initiate vaccination for these patients (AHMAC 2012).

Additional vaccinations are recommended for Aboriginal and Torres Strait Islander children in some areas:

- in Queensland, the Northern Territory, Western Australia and South Australia, Aboriginal and Torres Strait Islander children aged 12–18 months require a booster dose of a pneumococcal vaccine, and those aged less than 5 are eligible for free Hepatitis A vaccinations
- in the Northern Territory and some remote areas of South Australia, Aboriginal and Torres Strait Islander children aged under 12 months require a specific *Haemophilus influenzae* type B vaccination.

Indigenous data quality in childhood immunisation information is high (Rank & Menzies 2007). This information shows that immunisation coverage of Aboriginal and Torres Strait Islander children differs from that for other Australian children, with some age groups showing lower levels of immunisation (AHMAC 2012). In 2011, immunisation coverage for Indigenous children at 12 months of age was 7 percentage points less than that for non-Indigenous children; correspondingly, the gap at age 2 was less than 1 percentage point and by age 5 about 3 percentage points.

Specific PBS-listed medicines

In order to improve access to necessary medications, a number of items are included in the PBS for limited prescription to Aboriginal and Torres Strait Islander people at PBS-subsidised rates (DoHA 2013a). This program is separate from the special supply arrangements administered under Section 100 of the *National Health Act 1953*, which allow for PBS

medicines to be provided to clients of Aboriginal and Torres Strait Islander primary health-care services in remote areas without the need for a prescription and at no cost.

Listing these medicines under the PBS acknowledges the different morbidity profile in the Aboriginal and Torres Strait Islander population, and assists access to necessary medications by providing them at PBS-subsidised rates.

Tackling the much higher rates of smoking in Aboriginal and Torres Strait Islander communities has been identified as a key element in overcoming health disparities between Indigenous and non-Indigenous Australians. Nicotine replacement therapy via transdermal patches (PBS item code 9198D), for example, was initially introduced as an Indigenous-specific item under this scheme, before being extended to all Australians. Between December 2008 (when nicotine replacement therapy was added as an Indigenous-specific PBS listing) and February 2011 (when this was extended to all Australians), prescriptions for nicotine replacement therapy specifically for Aboriginal and or Torres Strait Islander people totalled about 3,200. The recommended dosage of this form of nicotine replacement therapy is longer than 8 weeks, which requires three prescriptions per person (Zwar et al. 2011). Therefore, the number of prescriptions (3,200) represents 1,066 people using the medication as recommended, or up to 3,200 people if only one prescription per person was used. This means that up to 3% of Indigenous smokers aged 15 and over in non-remote areas had some access to nicotine replacement therapy in this time period (Medicare 2011) (Figure 2.2).

PBS co-payment measure

The PBS co-payment measure was introduced in July 2010 under the Indigenous Chronic Disease Package to help address financial barriers that Aboriginal and Torres Strait Islander people may face in accessing PBS medicines in non-remote locations. These arrangements assist with the cost of PBS medicines for eligible Aboriginal and Torres Strait Islander people with, or at risk of, chronic disease. For eligible patients, the co-payment is reduced to the concessional rate, while for concessional patients, the co-payment is reduced to zero (DoHA 2010a).

In non-Indigenous Australians, health service usage rises with illness level: people with one serious medical condition have MBS and PBS expenditures about 4 times the national average, and expenditure rises to 12 times the average for people with 5 conditions (Dwyer et al. 2004). The higher morbidity and mortality rates in Indigenous people should therefore lead to correspondingly greater levels of health expenditure compared with that for the non-Indigenous population. However, expenditure levels suggest Aboriginal and Torres Strait Islander people face major barriers in accessing PBS medicines. In 2010–11, standard PBS benefits for Aboriginal and Torres Strait Islander people (excluding Section 100 arrangements, which provide improved access in remote areas) was $193 per person, whereas for non-Indigenous people, it was $330 per person. This means in non-remote areas, the level of expenditure for Indigenous Australians was 58% that of non-Indigenous Australians (AIHW 2013a).

As at 30 June 2012, about 150,000 Aboriginal and Torres Strait Islander people (representing about 38% of the Aboriginal and Torres Strait Islander population in non-remote areas) had accessed the PBS co-payment initiative, with 96% (5,127) of pharmacies participating and 2.7 million prescriptions dispensed (DoHA 2012b) (Figure 2.2).

Figure 2.2: Estimated uptake of some GP-mediated Indigenous-specific health interventions and related measures

*Note: *Practice Incentive Program Indigenous Health Incentive.*

Sources: AHMAC 2012; DoHA 2013b; Medicare 2011. See Appendix E for details of calculations.
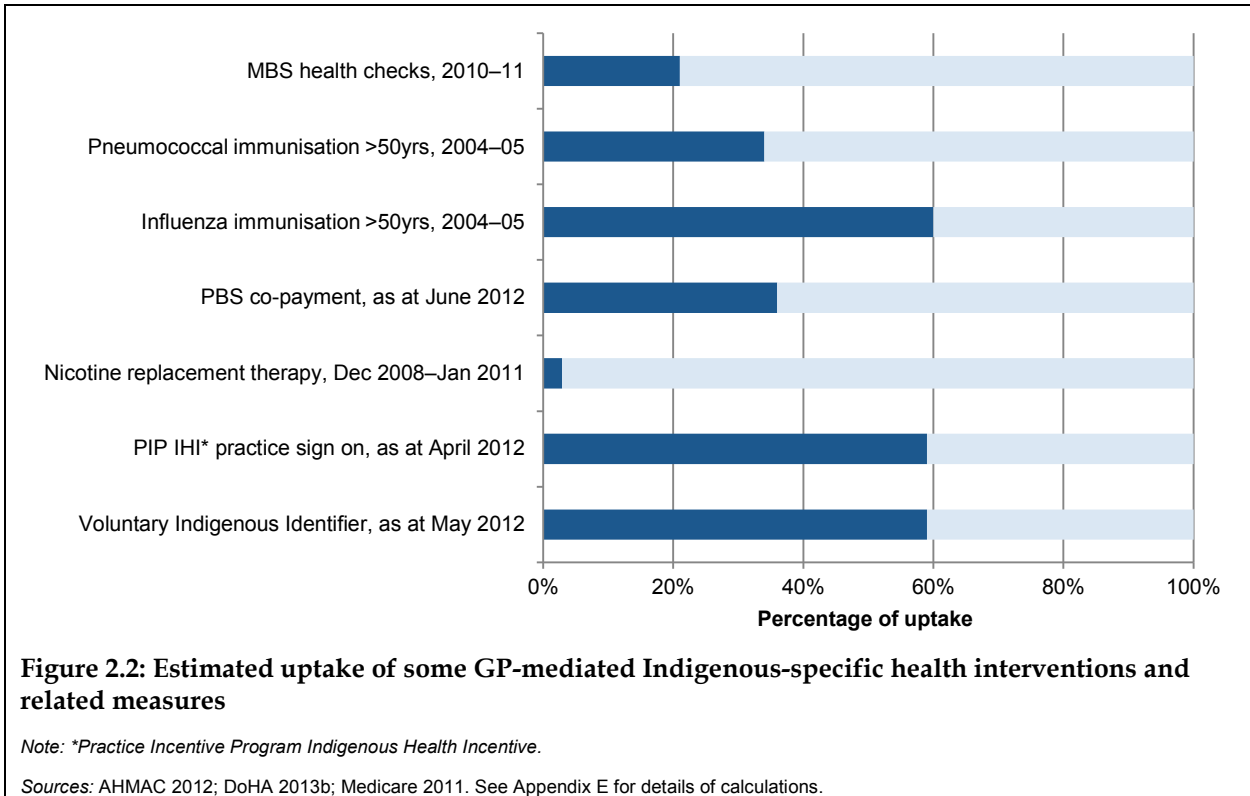
Care coordination

Care coordinator positions were established as part of the Indigenous Chronic Disease Package. Care coordinators help patients to access services required by their care plan, including by arranging services, assisting the patient to attend appointments and ensuring regular reviews by the GP.

General practices engaged in the Practice Incentive Program Indigenous Health Incentive (PIP IHI) can refer Aboriginal and Torres Strait Islander patients for assistance from care coordinators (largely based at Medicare Locals) if they have prepared a care plan and the patient meets eligibility requirements (DoHA 2012c).

As at December 2012, about 100 full-time-equivalent care coordinators were employed: over 60 full-time-equivalents in Medicare Locals and the remainder in the Aboriginal Community Controlled Health Services sector (DoHA 2013c).

Access to care coordination support is increasing: as at June 2011, nationally, less than 160 patients had received such services (Menzies School of Health Research 2013), while 3,220 patients, nationally, received care coordination in the October–December 2012 quarter (DoHA 2013d).

Care coordination is similar to follow-up services after a health check: rates of access should reflect the higher burden of disease (estimated to be 2.5 times greater than for non-Indigenous Australians) and chronic illnesses (responsible for 70% of this health gap) in the Indigenous population (Vos et al. 2007). Use of care coordination services is increasing, but overall numbers are low relative to need and there is scope for further improvement.

Related measures

Commonwealth agencies

Commonwealth agencies such as the Department of Health and Ageing (DoHA) and the Department of Human Services (DHS) are responsible for a number of policy measures that relate to the collection of Indigenous status in the general practice sector. These measures, which are outlined below, include the PIP IHI, support positions in Medicare Locals and the Voluntary Indigenous Identifier Program.

PIP IHI

The PIP IHI was introduced in 2010 as part of the Indigenous Chronic Disease Package. It aims to support general practices and Indigenous health services to provide better health care for Aboriginal and Torres Strait Islander patients, including best practice management of chronic disease.

The incentive comprises three levels of payment made to participating mainstream practices and Indigenous health services (Table 2.1).

- The first level is a standard payment that rewards practices for agreeing to implement improved processes.
- The second level of payment is for each eligible patient registered.
- The third level payment has two parts: Tier 1 is for each registered patient for whom a GP Management plan or team care arrangement is developed and reviewed, Tier 2 is for each registered patient for whom a practice provides the majority of care with a mimum of 5 eligible MBS services.

Therefore, practice involvement in level one payments indicate initial engagement, level two payments provide a process indicator and level three payments suggest achievement of care provision outcomes.

Table 2.1: Components of PIP IHI

Component	Payment	Required activity
Sign-on payment	$1,000 per practice/service	One-off payment to practices/services that agree to undertake specified activities to improve the provision of care to their Aboriginal and Torres Strait Islander patients with a chronic disease
Patient registration payment	$250 per eligible patient per calendar year	A payment to practices/services for each Aboriginal and/or Torres Strait Islander patient aged 15 and over, registered with the practice/service for chronic disease management
Outcomes payment total: up to $250 per registered person	Tier 1: $100 per eligible patient per calendar year	Payment to practices/services for each registered patient for whom a target level of care is provided by the practice/service in a calendar year (development and review of a GP Management Plan or Team Care Arrangement)
	Tier 2: $150 per eligible patient per calendar year	Payment to practices/services for providing the majority of care for a registered patient in a calendar year with a minimum of 5 eligible MBS services.

To sign-on to the PIP IHI, practices are required to:

- agree to obtain consent to register their eligible Aboriginal and Torres Strait Islander patients for the PIP IHI and/or the PBS co-payment measure
- establish and use a mechanism to ensure their Aboriginal and Torres Strait Islander patients aged 15 and over with a chronic disease are followed up (for example, through

use of a recall and reminder system or by staff actively seeking out patients to ensure they return for ongoing care)

- undertake cultural awareness training within 12 months of joining the incentive
- annotate PBS prescriptions for Aboriginal and Torres Strait Islander patients participating in the PBS co-payment measure.

By April 2012, an estimated 2,900 practices and Indigenous health services had signed on for this incentive, representing 58% of the estimated 5,000 practices participating in the Practice Incentives Program (PIP) overall (DoHA 2013b) (Figure 2.2).

The number of people in the target population (that is, Aboriginal and Torres Strait Islander patients aged 15 and over with a chronic disease) cannot be known with certainty as data on the prevalence of all forms of chronic disease are insufficient. However, chronic disease is responsible for 70% of the health gap between Indigenous Australians and non-Indigenous Australians; this is the reason for the chronic disease focus of Closing the Gap health interventions. Although the proportion of practices signing on is encouraging, the proportion of Aboriginal and Torres Strait Islander people being registered for chronic disease management is low relative to this quantum of disease burden. Noting that practices must renew patient registrations each calendar year, estimated numbers of Aboriginal and Torres Strait Islander patients registered since the IHI started were as follows: 31,000 in 2010, 40,000 in 2011 and 29,000 in the 4 months to April 2012. These numbers of registered patients represent between 7.5% and 10.7% of the Aboriginal and Torres Strait Islander population aged over 15.

Outcomes payments for registered payments show mixed results. In 2010, while about 80% of registered patients triggered the Tier 2 payment (paid to the service delivering the majority of care over a minimum of 5 MBS items per calendar year), only about 4% of those registered triggered the Tier 1 payment (which requires the development and review of the GP Management Plan or Team Care Arrangement) (Menzies School of Health Research 2013).

Support positions in Medicare Locals

The Indigenous Chronic Disease Package funded new support positions within the then Divisions of General Practice (now Medicare Locals) comprising:

- 86 full-time equivalent Indigenous outreach workers: to encourage and support Aboriginal and Torres Strait Islander people to access primary health-care services and to ensure follow-up treatment is accessed (for example, by helping people travel to and from appointments)
- 86 full-time equivalent Indigenous health project officers: to provide leadership in Aboriginal and Torres Strait Islander health issues within Medicare Locals, including increasing awareness and understanding of the various Closing the Gap initiatives relevant to mainstream primary care.

One of the objectives of these positions is to encourage improved Indigenous status identification in mainstream general practice. In addition, as noted above, the majority of care coordinators are based in Medicare Locals.

Voluntary Indigenous Identifier Program

The Voluntary Indigenous Identifier Program (VII), where people can choose to record their Indigenous status in the Medicare database, was introduced in 2002 (DHS 2012). By 1 May 2012, 339,310 people (nearly 60% of the total estimated Aboriginal and Torres Strait Islander

population) had identified with Medicare as being either Aboriginal, Torres Strait Islander or both (AHMAC 2012) (Figure 2.2).

The VII data have been considered to be of sufficient quality to calculate deidentified statistics about the use of Medicare by Indigenous Australians. However, due to privacy provisions, identifying details have not been released—for example, to service providers such as general practices. The information, therefore, has not been used to improve either the uptake of Indigenous-specific health initiatives or Indigenous status information in data collections to which general practices contribute.

RACGP

As part of its commitments to improving Aboriginal and Torres Strait Islander health, the RACGP has implemented a number of important reforms.

Accreditation standards

Australian general practices choosing to participate in accreditation are assessed against the RACGP standards. Accreditation against these standards is a prerequisite for access to the PIP.

Requirements regarding the recording of Indigenous status have been strengthened in the current fourth edition of the *Standards for general practices* (RACGP 2010). The previous edition included a non-mandatory element which suggested practices should be 'working towards' recording Indigenous status, and may have given the impression that it was the patient's, rather than the practice's, responsibility to 'self-identify'. Practices being accredited against the fourth edition of the standards must be able to demonstrate that they routinely record Aboriginal and Torres Strait Islander status in their active patient records.

Position statement

The RACGP has issued a position statement to explain the new accreditation requirement (RACGP 2011b). As noted in the statement, identifying Indigenous status is a necessary precondition for participation in the Closing the Gap initiative, because if practices are not aware of their Indigenous status, Aboriginal and Torres Strait Islander patients cannot benefit from the targeted measures implemented in the Indigenous Chronic Disease Package. The statement explains that practices need to:

- adopt the national standard Indigenous status question and record responses on their data collection forms and information systems
- improve procedures for identifying and recording Aboriginal or Torres Strait Islander status information by training the practice team about how and why to ask the national standard Indigenous status question and to raise staff awareness about its importance
- develop and implement initiatives to raise the awareness of Aboriginal and Torres Strait Islander patients about the importance of identifying as such when accessing services.

Online cultural awareness training

Under contract from the Department of Health and Ageing (DoHA), the RACGP has developed a 6-hour online training activity on cultural awareness and cultural safety (RACGP 2011a).

This training aims to improve the primary health-care services provided to Aboriginal and Torres Strait Islander people by increasing the cultural awareness of the practice team. Undertaking this training satisfies the conditions of the PIP IHI which requires two members

of the practice team (at least one of whom must be a GP) to undertake prescribed cultural awareness training.

General practice input to national data collection

Indigenous status information generated by the general practice sector contributes to a range of data collections (Box 2.3). Most general practice-generated data are transferred from the practice level to data collections via pathology processes, but most pathology request forms do not include an Indigenous status identifier. This means Indigenous identification data cannot flow from general practices to pathology laboratories and from pathology laboratories to the state and territory health data collections. Improving Indigenous status information in pathology processes is a longstanding policy goal; work in this area is discussed in Chapter 4.

Box 2.2: General practice-generated data contributions

Mainly generated via pathology request forms:

- cancer registers
- Pap smear registers
- notifiable communicable disease registers.

Non-pathology generated:

- mortality data sets, via death certificates.

Cancer registers

Although it is known that cancer causes considerable levels of disease and death within Aboriginal and Torres Strait Islander communities, current national collections for cancer data are not adequately provided with the Indigenous status of patients.

Pathology request forms, including those generated by general practices, are the main source of cancer data. However, in many instances, the Indigenous status of the referred patient is not recorded on these forms. Even when the form includes a field for the recording of Indigenous status, this field is rarely completed by the requesting clinician.

Where there is no Indigenous status information on the pathology report, data matching with subsequent reports, such as hospital admissions or death registrations, is undertaken to establish the Indigenous status of a person with cancer. Data matching is undertaken for most patients, as only a small number of cancer cases (for example, melanoma) rely on the pathology report alone for patient demographic information. In some cases where Indigenous status is missing on other sources, the information may be obtained through direct follow–up with the hospital or treating doctor.

Despite these data matching efforts, remaining deficiencies in Indigenous status are carried into the Australian Cancer Database, the national repository of cancer incidence. A recent study showed that Indigenous cancer incidence rates probably underestimate cancer incidence by 15–25% (Zhang 2011).

Pap smear registers

The incidence of cervical cancer for Indigenous women is more than twice that for non-Indigenous women, and mortality due to cervical cancer for Indigenous women is more

than 5 times that for non-Indigenous women. Up to 90% of the most common type of cervical cancer could be prevented through regular screening (AHMAC 2011).

National data include Indigenous status for incidence of and mortality from cervical cancer, but not for participation, rescreening, cytology and histology in screening programs. This is because registers can only record information passed on from pathology laboratories, and, as noted above, Indigenous status is generally not included on pathology forms (AIHW 2012).

There is evidence, however, that Aboriginal and Torres Strait Islander women are under-screened. Binns and Condon and Coory and others estimated the participation of Aboriginal and Torres Strait Islander women in communities with high proportions of Aboriginal and Torres Strait Islander women in the Northern Territory and Queensland, respectively (Binns and Condon 2006; Coory et al. 2002). These researchers found that, on average, participation by Aboriginal and Torres Strait Islander women was close to 18 percentage points below that for the respective jurisdiction, with both studies showing considerable variation between communities or regions (AIHW 2012).

It has been recognised that Aboriginal and Torres Strait Islander women face cultural, linguistic and physical barriers to cervical screening (DoHA 2004). State and territory cervical screening programs have developed initiatives to increase participation in cervical screening by Indigenous women, such as employing Aboriginal Health Workers, with the Australian Government supporting these initiatives by developing principles, standards and guidelines for screening Aboriginal and Torres Strait Islander women (DoHA 2004). However, without being able to measure the participation of Aboriginal and Torres Strait Islander women in cervical screening, it is not known to what extent initiatives are reaching their desired aim (AIHW 2012).

Notifiable communicable diseases

Australian governments have developed a list of communicable diseases which are required to be notified and provided to the Commonwealth's National Notifiable Diseases Surveillance System. These notifiable communicable diseases include some forms of bloodborne diseases, gastrointestinal diseases and sexually transmitted infections. Pathology processes, including those generated by general practices, are an important data source for the National Notifiable Diseases Surveillance System. Indigenous status is not completed for all records in notifiable communicable disease registers, and this impedes the development of policy and program responses. It is known, however, that Indigenous people suffer from a range of notifiable communicable diseases, including tuberculosis and hepatitis, at rates higher than those for the non-Indigenous population (AHMAC 2011; Health*InfoNet* 2011). Data on sexually transmitted infections for 2011 indicate over 60% of diagnoses of hepatitis C infection and about 50% of diagnoses of chlamydia did not have Aboriginal and Torres Strait Islander status recorded (Kirby Institute 2012).

Work to improve Indigenous identification in notifiable communicable disease registers is ongoing. The Communicable Disease Network Australia has identified a number of diseases for which a target of achieving 90% completion of Indigenous status has been agreed. In 2008, there were 7 diseases for which notifications were 100% complete (donovanosis, measles, leprosy, tetanus, Murray Valley encephalitis, Japanese encephalitis, and kunjin virus infection) and a further 5 diseases that exceeded 90% completeness for Indigenous status (typhoid, tuberculosis, meningococcal infections, *Haemophilus influenzae* type b infection, and syphilis) (DoHA 2010b).

Mortality data sets

Medical practitioners, including GPs, complete medical certificates of cause of death and these are a major contributor to national deaths data. These certificates should include information about the Indigenous status of the deceased person but are not always complete or accurate. Most deaths data (over 99%) provided to the ABS include a response to the Indigenous status question, but there are concerns regarding the accuracy of these responses (ABS 2012a). There are also cases where Indigenous status is not stated. In 2010, there were 1,220 deaths registered in Australia for whom Indigenous status was not stated, representing 0.9% of all deaths registered.

Improvements in Indigenous identification in the general practice sector will help to increase the quality and completeness of deaths data.

3 The 2011 general practice workshop

Workshop proceedings

Aims

In hosting the 2011 workshop, the AIHW aimed to:

- raise awareness of the importance of accurately collecting and recording Aboriginal and Torres Strait Islander status in general practice settings
- raise awareness of the Guidelines and this evaluation and support project
- build shared understandings of current developments
- enable participants to see their role in a broader context
- facilitate information sharing and coordination through a better understanding of stakeholder roles and relationships
- promote networking and collaboration
- allow participants to identify duplication of and gaps in processes and service delivery
- inform the AIHW of the range of views and breadth of stakeholders involved
- clarify and promote the AIHW's role in this area
- build consensus on next steps in improving Indigenous identification in the general practice sector.

Process

Invitations were extended to a range of stakeholders involved in Indigenous identification in general practice. This included representatives from relevant government departments (DoHA, DHS), peak Indigenous organisations (NACCHO, CATSIN), medical colleges (RACGP), related professional associations (APNA, AAPM) and other organisations with a key role to play (AMLA)(see Appendix A). The workshop format involved presentations from speakers as well as panel discussions. This created opportunities for participants to discuss the implications of issues for their situations (see Appendix B).

Panel discussions overview

Panel discussions on national policy and program issues focused on two key target areas: resolving current software issues, and better informing providers and patients/clients about why the Indigenous identification question is asked. Some of the issues flagged were:

- ensuring e-health collected and transmitted Indigenous status data from the outset, rather than incrementally over time
- differentiating between standards (which are mandatory) and guidelines (which are not), and the need to change the Guidelines into standards
- addressing attitudinal issues in the general practice team: to raise awareness, combat stereotypes and build commitment
- ensuring all patients (Indigenous and non-Indigenous) understood the importance of the Indigenous identification question
- dealing with negativity from some non-Indigenous people when the question is asked

- acknowledging the importance to Aboriginal and Torres Strait Islander people of the setting and the rationale provided for the question being asked
- using information to monitor and report on COAG initiatives and commitments.

Panel discussions on the front-line situation for general practices in collecting and recording the Indigenous status of patients focused on:

- inconsistencies across practice software that undermined implementing a standard process for collecting and recording the Indigenous status of patients
- changes in practice software needed to drive and support Indigenous identification and improved service delivery
- lack of knowledge among many Aboriginal and Torres Strait Islander people about the impact of identifying themselves as such in a general practice setting.

Feedback from workshop participants

For many participants, the workshop was the first time they had collectively discussed Indigenous identification in the general practice sector. The collaboration promoted during this workshop aimed to increase the network capacity of the sector; namely, to disseminate findings of projects and strategies, transfer knowledge and skills, provide intellectual companionship and extend the productivity of individual organisations. Networking and development of multilateral conversations to build collaboration were evident throughout the day. Feedback from participants indicated the workshop was useful in accessing new knowledge, networking with others and raising awareness of relevant relationships and links.

Key issues

This section outlines the key issues identified by workshop participants. More detail on the discussion of these issues is included at Appendix C.

Promotion of national integration

Participants advocated raising the profile of the issue of Indigenous identification in general practice settings and better integrating national efforts across all areas. Building integration across disparate stakeholders was seen as necessary to coordinate and optimise efforts to improve the accuracy of Indigenous identification and the recording of Indigenous status in general practice.

E-health and practice software

Software requirements and functionality to record Indigenous status data are of paramount importance in improving the collection of this information. Shifting the status of the Guidelines from optional to mandatory was seen as an important step in achieving this outcome. Inconsistency in how practice software promoted the collection and recording of Indigenous status information was identified as a major barrier to improved identification of Aboriginal and Torres Strait Islander patients.

The advent of e-health provided opportunities to drive consistency and mandate compliance with the Guidelines across all software used in the general practice sector. Participants wanted to ensure e-health record design and implementation supported optimal collection of Indigenous data and service delivery outcomes from the outset, rather than being

incrementally added over time. They were concerned that if Indigenous status were mandated on an incremental basis it would not only further delay much needed reform, but also establish patterns of behaviour based on poor-quality data collection, which would then be difficult to rectify in the future.

General practice team

New processes to ensure the routine collection of Indigenous status for all patients faced additional challenges compared with other change processes. The more superficial barriers of knowledge, process and technical issues were underpinned by attitudinal issues that made this matter sensitive and complex. These barriers contributed to low rates of routine identification and high levels of variability in processes.

Comprehensive, whole-of-practice team training was identified as a key strategy to change processes in the general practice sector. Issues needing to be addressed in this training included practice software, whole-of-team approaches, clinical rationale, and attitudinal change.

Awareness raising for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people needed information to empower and encourage them to identify as Indigenous in the general practice setting. People needed to know that disclosing their Indigenous status would not disadvantage them; rather, this information was needed to provide better health-care support and generate accurate data on which to base policy and funding decisions. In order for a person to accurately identify, there needed to be a shared cultural understanding—for both the service provider and the service recipient to be prepared and resilient. Currently, without adequate training and support for clients and providers, cultural safety was seen as limited.

There were differing reasons why Aboriginal and Torres Strait Islander people identify as such in a service context. Building awareness of interventions targeting the specific health needs of Aboriginal and Torres Strait Islander people was needed, along with an understanding that these are based on clinical need. References to these interventions as 'entitlements' may be counterproductive, as this could be seen as similar to welfare entitlements, which some Aboriginal and Torres Strait Islander people might not consider relevant to them.

Awareness raising for non-Indigenous people

The attitudes of some non-Indigenous people were identified as a major barrier to improved Indigenous status identification processes in general practice. Workshop participants suggested awareness raising for non-Indigenous people as an important priority. This could address the widespread lack of knowledge about Aboriginal and Torres Strait Islander specific health interventions and their rationale, as well as refute commonly held misconceptions and prejudices. It was noted this aim was absent from current and previous efforts in this area.

Build a community of practice

No single agency had overall responsibility for integrating accurate Indigenous identification and driving a sustained national level response to improve the situation. This was evidenced by the lack of a forum to bring together the range of stakeholders needed to implement the

Guidelines in this sector. This lack prompted the AIHW to convene the workshop to help coordinate efforts in this sector.

Many participants at the workshop had not previously communicated with others working in this space, or had not seen their work as being linked to the bigger picture of improving the accuracy and completeness of Indigenous status data in general practice.

Other suggestions for investigation

There were a number of national strategies that participants thought had potential to improve Indigenous status data collection and recording. Some would need further investigation to determine their feasibility.

These strategies comprise:

- VII (Medicare data) potential
- Australian Primary Care Collaboratives
- closing the data loop—by providing relevant information to general practices, community members and others about the uptake of GP-mediated measures specific to Aboriginal and Torres Strait Islander people
- re-examining the Indigenous status question
- extending the need to ask the Indigenous question to all health-care providers, not just GPs.

Workshop recommendations

Recommendations were aligned with each of the key issues identified above. These, together with agencies responsible for implementation where these are known, are summarised at Table 3.1. Information about how the workshop recommendations relate to recommendations from previous studies is included at Appendix C.

Table 3.1: 2011 workshop—areas recommended for further action

Aim	Workshop suggestions	Responsible agency
1. Promote national coordination by building cohesive interagency commitment to improved rates of Indigenous identification in general practice		
Ensure e-health record design and implementation supports optimal Indigenous data and service delivery outcomes	• Refer to software and e-health	Not allocated
Improve cross-government agency coordination	• Interdepartmental committee and formal communication: including ABS, DOHA, Centrelink, Medicare, OATSIH	Not allocated
2. Ensure general practice software and e-health agenda optimises Indigenous identification		
Ensure e-health record design and implementation supports optimal Indigenous data and service delivery outcomes from the outset (not incrementally added over time)	• Seek COAG endorsement through NAGATSIHID	Not allocated
	• AIHW, MSIA, RACGP memorandum of understanding to ensure data needs are addressed and drive consistency	The AIHW to advocate change to improve Indigenous identification in general practice software and e-health by liaising with relevant organisations (DoHA and NEHTA) and national committees
	• Formal interdepartmental communication between ABS, DHS, DoHA, OATSIH to ensure data needs are addressed	
	• Ensure any Australian Standards regarding the collection of Indigenous status information are based on the Guidelines	
Implement mandatory requirement for all general practice software to support optimal Indigenous data and service delivery outcomes	• Align software requirements and e-health and ensure consistency for best outcomes for Indigenous identification	
3. Change promotion: general practice team		
Provide sector-specific targeted support	• Provide support targeted to the needs of the general practice sector as project resources allow	AIHW
Provide cultural training and education for general practice team	• Develop and provide sector-specific education for the general practice team: – desensitise the question, combat stereotypes and prejudices regarding Aboriginal and Torres Strait Islander people – promote a team approach, and create environments that encourage Aboriginal and Torres Strait Islander people to identify – normalise the question in clinical practice (bring it back to basics) • Develop training, as there is none directly addressing this issue at present. Training should be multidisciplinary and needs government funding; it needs to focus on: – how to ask the question; what to ask; when to ask; how to record; use of software • Align campaign with high-profile issues such as proposed Constitutional reforms	Not allocated

(continued)

Table 3.1 (continued): 2011 workshop—areas recommended for further action

4. Awareness raising: Aboriginal and Torres Strait Islander people

Empower Aboriginal and Torres Strait Islander people by providing them with information about specific health interventions for which they may be eligible	• Ensure clinical and financial implications of identifying/declining to identify are explained to all Aboriginal and Torres Strait Islander people and specifically as patients in general practice setting • Align campaign with high-profile issues such as proposed Constitutional reforms • Encourage patients to raise identification with GP if it is not raised by general practice team	Not allocated

5. Awareness raising: non-Indigenous people

Provide whole-of-population education	• Desensitise and normalise the question for the whole population by extending knowledge of this issue through campaigns (for example: *Get Up!*, radio); encourage patient-driven revolution—everyone should insist on being asked; encourage patients to raise identification with GP if it is not raised by general practice team • Engage with communities, noting that small populations have limited capacity to do so • Link campaign with media-intensive movement such as the proposed Constitutional reforms	Not allocated

6. Build a community of practice for Indigenous identification in general practice

Build integration across disparate stakeholders to coordinate and optimise efforts to improve Indigenous status recording in general practice	• Hold an annual forum regarding recording Indigenous status of patients in general practice with relevant stakeholders	AIHW

7. Investigate other suggestions for improvement

Investigate potential of VII to improve service delivery and data collection	• Investigate broader application of NCIRS methodology used in Child Immunisation Campaign	Not allocated
Investigate potential of collaborative models to improve identification	• Engage the Australian Primary Care Collaboratives to further the Indigenous identification agenda	Not allocated
Close data loops, via implementing best practice in Aboriginal and Torres Strait Islander health data and research	• Report data back to Aboriginal and Torres Strait Islander people and their health providers in meaningful and accessible ways; feed data back to general practices, Aboriginal Medical Services and communities (perhaps at Divisional level)—could include uptake of GP-mediated Indigenous-specific health services (for example, health checks); promote positive reinforcement of data collection strategies, rather than focusing on negatives; highlight factors such as increased uptake, etc.	The AIHW to investigate
Re-examine wording of the Indigenous status question	• Are we asking the right question?—consider re-examination (race vs. socioeconomic factors) • Reconsider context and setting when asking question; should be part of many pieces of information collected	The AIHW to refer to ABS review
Non-GP clinicians	• Consider widening scope to include non-GP clinicians; for example, pharmacies could be drivers of change, not just GPs	Not allocated

Note: See Abbreviations list for full names of abbreviations listed.

4 Work during 2012

Work undertaken by the AIHW during 2012 to improve the identification of Aboriginal and Torres Strait Islander status in the general practice sector was informed by the outcomes of the 2011 workshop. This included providing regular updates to relevant advisory bodies such as the National Indigenous Reform Agreement Performance Information Management Group (NIRA PIMG) and the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID).

In addition, the AIHW promoted Aboriginal and Torres Strait Islander status issues with the medical software industry through an information stall at a vendors' workshop (July 2012). This evaluation and support project also provided a presentation to a national conference of Medical Software Industry Association members (November 2012).

Activity against the key issues identified is summarised in Table 4.2 (pages 28-29).

The main area of work was directed to improving identification in e-health systems and this is described below.

Personally Controlled Electronic Health Record

The Australian Government approved the development of the Personally Controlled Electronic Health Record (PCEHR) system in 2010, and allocated funding to build key national components of this system by July 2012. The 2012–13 Budget announced further funding over 2 years to operate the PCEHR system national infrastructure. Since July 2012, consumers have been able to register for an e-health record.

The AIHW conducted a detailed analysis of the PCEHR and e-pathology programs to investigate the extent to which these initiatives support improved Indigenous status collection and transmission. The investigation indicated Indigenous status had not been included in a standardised way in PCEHR clinical documents (Table 4.1).

The second release of the PCEHR system in November 2012, however, was amended to allow consumers to record their Indigenous status when they registered for a PCEHR. This information is sought from registrants directly and is available for providers to view. The information is collected according to the National Health Data Dictionary standard codes.

The extent to which this change will result in better data collection or service delivery is not yet clear. For example, it is not known if Indigenous status on the PCEHR will be visible to general practices. More work will be needed to ensure that e-health changes contribute to improvements in Aboriginal and Torres Strait Islander health through better access to Indigenous-specific health interventions and through improved data collection.

Table 4.1: Features of current PCEHR clinical documents

Clinical document name	Who provides to the PCEHR?	NEHTA data specification template available?	Indigenous status required?
Shared health summaries	Author of the information	Yes—embedded in the PCEHR, not a document to be uploaded	Yes
Event summaries	Author of the information	Yes—embedded in the PCEHR, not a document to be uploaded	Yes
Discharge summaries	Author of the information	Yes	No
Specialist letters	Author of the information	Yes	No
Referrals	Author of the information	Yes	Yes
Prescribing and dispensing Information	Author of the information	No—not finalised	Unknown as template not finalised
Pathology result reports	Author of the information	No—not required as already using Australian Standards for messaging	Optional field in the current Health Level 7 messaging standard; not a required element

Note: 'Required' in this case means that a value must be entered. If a value is not entered, the document will not be able to be loaded to the PCEHR, and will return to the health-care provider for a corrected version.

Pathology processes

One of the issues of particular concern is that of data generated by pathology testing processes. Currently, most pathology request forms do not include an Indigenous status identifier. This means Indigenous identification data cannot flow from medical practitioners and hospitals to pathology laboratories and to the state and territory health registers. This is a major limitation to improving Indigenous identification in communicable disease and cervical screening data, which largely rely on pathology reports as the source of patient information. It is also a limitation to improving Aboriginal and Torres Strait Islander identification in cancer data.

Improving Indigenous identification in cervical screening registers, and on cancer and communicable disease notifications by including Aboriginal and Torres Strait Islander identification on pathology forms, has been a priority area on NAGATSIHID's work plan for a number of years.

As part of data quality improvement initiatives agreed under Schedule F of the National Indigenous Reform Agreement (NIRA), the AIHW developed a business case for including Indigenous status on pathology request forms, with the aim of improving Aboriginal and Torres Strait Islander identification in the communicable disease, cervical screening and cancer registers nationally (AIHW forthcoming).

Consultations between the AIHW and state and territory communicable disease registers, cervical screening and cancer registers, as well as NAGATSIHID, indicated widespread support for an initiative such as including Indigenous status on pathology forms to improve Indigenous status information.

When completed in June 2011, the business case made the following recommendations:

- **long-term**: national implementation to improve Indigenous identification in the national health registers as part of broader projects currently underway, aimed at improving primary care data collection within the context of the e-health agenda and development of a National Minimum Data Set for Primary Health Care

- **short-term**: jurisdictions to progress (or continue to progress) the inclusion of Indigenous status on pathology request forms through mechanisms such as continuing pilot projects to include Indigenous status on pathology forms, and considering their roll-out state-wide; progressing required changes to public health legislation and regulations; and progressing required changes for disease registers to adhere to the national standard format for Indigenous status.

The business case noted, however, that the goal of including Indigenous status in pathology systems would require investment in relation to programming and software changes, and that there would be costs to pathology service providers and software vendors. It also noted that improvements in identification in these systems were dependent on Indigenous status information being available from the 'source' of pathology requests, that is, medical practitioners (AIHW forthcoming).

E-pathology program

Indigenous status is currently an optional (not mandatory) requirement in the Australian Standard for health messaging (AS 4700.2). Making this requirement mandatory would not only begin to improve Indigenous status data in pathology-generated data, but also mesh with other developments in the general practice sector to drive improved identification processes at the point of care.

As health-related work increasingly moves to electronic formats, new opportunities are available to improve Indigenous data collection. This evaluation and support project used its analysis of Indigenous status in e-health processes to highlight the need to make Indigenous status a mandatory requirement for health messaging to both the National E-Health Transition Authority (NEHTA) and DoHA. The AIHW also provided briefings to both NAGATSIHID and the National Aboriginal and Torres Strait Islander Health Standing Committee on these issues to ensure common understanding of the current situation regarding Indigenous status in e-health. Continued efforts are needed to ensure this issue is addressed.

Table 4.2: Summary of progress on 2011 workshop recommendations during 2012

Recommendation	Current status	Details of progress
1. Promote national coordination by building cohesive interagency commitment to improved Indigenous identification in general practice through the following:		
(a) Advise the COAG through the NIRA PIMG	Underway	Engagement with the NIRA PIMG was undertaken throughout the evaluation and support project: • the AIHW has provided progress reports • the AIHW will provide copies of the Phase 1 report. Input from jurisdictions on implementing the Guidelines was also sought through the NIRA PIMG.
(b) Advise AHMAC through NAGATSIHID	Ongoing	Liaison with the AHMAC takes place via NAGATSIHID, which provides broad strategic advice to the AHMAC and its National Health Information and Performance Principal Committee. Project progress reports are provided at each NAGATSIHID meeting, including September 2011, March 2012 and September 2012.
(c) Improve collaboration and coordination between the AIHW, MSIA and RACGP	Ongoing	The AIHW has worked with the RACGP and MSIA during 2012. The AIHW provided information on the importance of Indigenous identification in software at MSIA conferences in Sydney in July and November 2012.
(d) Improve collaboration and coordination between DoHA, ABS, OATSIH and DHS to ensure data needs are addressed	Ongoing	The AIHW has worked closely with DoHA on e-health and collecting Indigenous status in e-health and e-pathology processes The AIHW has met with the ABS to discuss progress in their respective data sets.
2. Ensure general practice software and the e-health agenda optimise Indigenous identification by:		
Ensure the *National best practice guidelines for collecting Indigenous status in health data sets* are endorsed as Australian Standards via Standards Australia processes	Ongoing	The AIHW has pursued avenues to include the Guidelines in pathology messaging under 4700.1 and 4700.2. This is currently unresolved. Indigenous status is in these standards as an optional data element (not mandatory). The AIHW has not pursued making the Guidelines a standard of itself, as the mandatory element of Indigenous status identification lies with the Health Data Dictionary.
3. Ensure general practice software and the e-health agenda optimises Indigenous identification by:		
(a) Align software through NEHTA and MSIA to ensure national consistency	Ongoing	The AIHW has worked with NEHTA since January 2012 on including Indigenous status in the PCEHR and e-pathology processes. This culminated in a letter of 6 June 2012 to NEHTA and DoHA expressing concern that Indigenous status had not been collected systematically in the new e-health reform processes. Changes to the PCEHR to allow Indigenous status to be recorded are positive but ongoing work is needed.
(b) DoHA and MSIA to ensure practice software vendors take a uniform approach to recording and reporting Aboriginal and Torres Strait Islander status		

(continued)

Table 4.2 (continued)

Recommendation	Current status	Details of progress
4. Implement change promotion in general practice team		
(a) Provide sector-specific targeted support	Ongoing	The AIHW has provided support to the general practice sector through the 2011 and 2012 workshops, providing communication opportunities across diverse stakeholders.
(b) Provide cultural training for general practice team	Not done by AIHW	DoHA-funded online cultural awareness training being provided by the RACGP.
5. Raise awareness among Aboriginal and Torres Strait Islander people		
Empower Aboriginal and Torres Strait Islander people by providing them with information about specific health interventions for which they may be eligible	Limited support provided by AIHW	The AIHW National Indigenous Data Improvement Support Centre (NIDISC) Helpdesk is mainly used by service providers, but also responds to Aboriginal and Torres Strait Islander people seeking information about access to specific health interventions.
6. Raise awareness among non-Indigenous people		
Provide whole-of-population education	Not done by AIHW	
7. Build a community of practice for Indigenous identification in general practice by:		
(a) Report workshop findings to all invited organisations	Done	Report of the 2011 workshop was circulated both to the attendees of the 2012 workshop and to the attendees/ invitees of the 2011 workshop.
(b) Establish subject-specific working groups to advance particular recommendations	Not done	
(c) Convene annual stakeholders forum on Indigenous identification	Done	Workshops were held in 2011 and 2012.
8. Investigate the following suggestions for improvement:		
(a) Applying Voluntary Indigenous Identifier data to improve service delivery and data collection	Not done	
(b) Applying the Australian Primary Care Collaboratives approach	Not investigated	
9. Investigate the following suggestions:		
(a) Closing the data loop, through feedback to general practices and Aboriginal and Torres Strait Islander people	Done passively	The AIHW publishes publicly available data online. It has not, at this stage, been fed back in an active manner to general practices and Aboriginal and Torres Strait Islander people.
(b) Re-examining the Indigenous status question	Deferred	This issue was deferred for consideration via the ABS review 2013.
(c) Involving non-GP clinicians	Not investigated	

Note: See Abbreviations list for full names of all abbreviations listed.

5   The 2012 general practice workshop

The positive response to the 2011 workshop gave impetus to the AIHW's plans to convene a second such national forum. The 2012 workshop was held at the Australian Institute of Aboriginal and Torres Strait Islander Studies in Canberra on 1 November 2012.

With more lead time and a better understanding of additional stakeholders, more agencies were invited and more were able to attend. Importantly, the 2012 workshop included greater representation from peak Indigenous organisations. More representatives from the National Aboriginal Community Controlled Health Organisation attended the 2012 workshop, and the Australian Indigenous Doctors Association, the Congress of Aboriginal and Torres Strait Islander Nurses, the Closing the Gap Campaign and the National Aboriginal and Torres Strait Islander Health Worker Association also participated for the first time. Given the importance of engaging with Aboriginal and Torres Strait Islander stakeholder organisations, this improved level of participation at the second workshop was encouraging. However, there was also considerable change in representation: of the 39 external participants who attended, 6 had also attended the 2011 workshop.

Workshop proceedings

The report and recommendations from the 2011 general practice workshop were circulated to all participants before the workshop. Outcomes from the 2011 workshop and developments since that time were considered by AIHW staff and six themes for discussion were developed:

- promoting national coordination on Indigenous identification in general practice
- optimising Indigenous identification in general practice software and e-health
- implementing change promotion in the general practice team
- raising awareness about the importance of identification
- improving uptake of GP-mediated health interventions specifically for Indigenous people
- building a community of practice for Indigenous identification in general practice.

The workshop was well received by those who attended. Feedback from participants indicated that it was helpful in sharing knowledge, networking and understanding links between stakeholders.

Key issues

Key issues are discussed in the categories of the six themes above. More details on these discussions are included at Appendix D.

Promoting national coordination

Improving Indigenous identification in mainstream general practice involves a wide range of stakeholders. There is no single point of national coordination to ensure collaboration across disparate stakeholders and programs. Participants discussed the need for improved national coordination, and options for building such coordination. It was agreed that responsibility for promoting the recording of Indigenous status by general practices should be clearly allocated so work could be coordinated and tasked appropriately.

Optimising Indigenous identification in general practice software and e-health

General practice software and e-health emerged as key issues at the 2011 workshop, and workshop groups shared information on developments since that time. Participants agreed while much work had been completed in this space by several stakeholders, more needed to be done.

The groups discussed the scope and meaning of the term 'e-health' to ensure shared understandings. Participants felt it was important to build interoperability between software, as well as to encourage key stakeholders in e-health to develop a sense of shared purpose. There were also discussions around standardisation, both through Standards Australia and through standardising Indigenous status collection across the board. It was suggested that Medical Director, the software vendor with the largest market share in the general practice sector, should be approached to work on these issues. The aims would be to ensure that Indigenous status is collected and recorded in line with the Guidelines, is included as a mandatory field and does not default to 'not stated' if not completed.

The final recommendations stressed there should be further engagement with existing e-health committees, rather than creating new ones.

Implementing change promotion in the general practice team

Workshop groups discussing this theme emphasised that the general practice team included practice managers, practice nurses and administrative staff as well as GPs. Change promotion in the general practice team was considered to be the process of moving from the current status of low routine identification and low uptake of Indigenous-specific health interventions to a future state where identification would become standard practice and uptake of specific health interventions would be optimised. Change promotion could be made by factors related to training (including awareness raising and culture change) as well as other factors. For example, it was noted that if recommendations relating to standardisation of software were implemented, the need for specific training would be considerably lessened.

Raising awareness about the importance of identification

Participants felt that, in order to progress this theme, it would be best to start by developing a communication plan clearly identifying messages to be communicated, who would communicate them, and who the target audience would be. In terms of the communication process, a range of ideas was discussed, including using champions and professionals, mass media, and strong clinical messages; maintaining and building on positive environments; and showcasing examples of good practice. The idea of a single source of information for Indigenous and non-Indigenous people was raised numerous times. Users of this resource could include GPs, practice team members, Aboriginal and Torres Strait Islander patients and non-Indigenous people. The resource would include a central place for information regarding the identification of Aboriginal and Torres Strait Islander people in general practice, as well as links to information on the various Indigenous-specific health measures and other relevant and useful information. It was noted that the resource would need to be co-designed with the involvement of a range of organisations, with agreement on its role clear from the outset.

One of the identified barriers to raising awareness was the lack of coordination between agencies involved in the general practice sector. Participants felt cross-program integration and a more collaborative approach would benefit all the organisations involved. This would

also raise the profile of the importance of asking the question and the role of data in informing policy.

Improving the uptake of GP-mediated health interventions

This theme focused on mechanisms to support increased uptake of the GP-mediated health interventions specifically for Indigenous people, particularly through better use of uptake data. Options such as supporting uptake through improving feedback to local levels on the numbers of such measures were discussed. For example, Medicare Locals could be provided with information on the number of MBS-rebated health checks conducted in their catchment, which could be shown as a proportion of the estimated Aboriginal and Torres Strait Islander population in the area.

Building a community of practice for Indigenous identification

Reflecting the breadth of stakeholders and the lack of national coordination, creating and maintaining a community of practice for organisations and individuals involved in the work of improving Indigenous identification was recognised at the 2011 workshop. Discussions at the 2012 workshop focused on how this process could be supported.

Workshop recommendations

At the final session, participants reconvened as a plenary group. Each home group presented three or four key recommendations developed from the discussions throughout the day. These recommendations were endorsed by workshop participants (Table 5.1).

Common issues

While developments since the 2011 workshop were acknowledged, participants agreed much work in improving the identification of Aboriginal and Torres Strait Islander people in mainstream general practice remained to be done. In general, participants agreed general practice training regarding the process and purpose of identification was lacking and there was a need to increase knowledge among general practices about the recording of Indigenous status in their sector.

Another common thread connecting many of the workshop discussions was recognition of the need for collaboration and coordination between agencies involved in the general practice sector. Work in this area is undermined by the lack of a single coordinating agency to drive ways forward and keep people engaged in change.

Key issues common to many of the workshop group sessions led to these recommendations:

- improved coordination and collaboration between agencies
- establishment of a single comprehensive and easily accessible source of information for general practices (a single comprehensive web resource)
- improved and expanded general practice training to include the whole practice team
- definition and formalisation of national standards and accreditation standards
- raised awareness among both Indigenous and non-Indigenous people about the importance and implications of asking the Indigenous identification question
- adoption of a coordinated approach by e-health agencies to improving Indigenous status in all e-health developments.

Table 5.1: Key recommendations endorsed at the 2012 workshop

Theme	Key recommendations
1. Promoting national coordination on Indigenous identification in general practice	• The AIHW to take on a coordination role for data assessment and development (including gaps), for synthesis of best practice, for mapping existing activities/data in liaison with stakeholders, and for discussion of roles and responsibilities. • Annual workshops • Single comprehensive web resource for general practices, evidence synthesis

2. Optimising Indigenous identification in general practice software and e-health	• Undertake scoping study of software and software vendors. Selection criteria: interoperability, standardisation and quality and safety (Stakeholders: AMLA, NEHTA)
	• Create a shared purpose between consumers, providers and stakeholders (Stakeholders: ABS, AIHW, consumer organisations, data collectors, general practices, hospitals, MSIA, NACCHO, National Health Leadership Forum, primary health care providers)
	• Develop best practice and research methods surrounding e-health and data:
	  – around patient informed consent of data use and data linkage
	  – with all agencies in e-health coming together (working group) to address the current issues, via existing bodies, not by creating new ones

3. Implementing change promotion in the general practice team	• Agree specific content for identification in general practice training. Should include:
	  – cultural competency, clinical rationale, accreditation standards
	  – all GP-mediated health interventions specifically for Indigenous people
	  – social determinants of health
	  – normalising—asking the question
	  – clarity, consistency, availability (for example, internet based)
	• Marketing and promotion of identification—define what must remain consistent (such as the national standard question) and identify which parts have potential for localisation
	• Data—feedback and closing the data loop

4. Raising awareness about the importance of identification	• Communicating the relevance, value and importance of asking the question – targeting both Indigenous people and non-Indigenous people (Stakeholders: NIRA process) • Communication plan — identify what the messages are, who is best to provide them and who the audience is. Funding for mainstream media. (Stakeholders: NIRA process) • Single source of information—guidelines and initiatives; co-designed and agreed on single point of reference (Stakeholders: AAPM, ACRRM, AGPAL, AMLA, APNA, DoHA, GPA-Plus, NACCHO, OATSIH, RACGP) • Cross-program integration—collaborative approach; integration at government level
5. Improving the uptake of GP-mediated Indigenous-specific measures	• Education and training of communities and the general practice team (peer-to-peer processes and revised curriculums) (Stakeholders: ACCHS, APNA, DHS, GP colleges, MLs, RACGP) • Central coordination information point, simpler, better presented (Stakeholders: AAPN, ACCHS, AMLA, APNA, DHS, DoHA, GP colleges, NACCHO, RACGP) • Quality improvement—use of local level data to improve practice and adherence to standards and guidelines (Stakeholders: AIHW, AMLA, APCC, MBS, NHPA)
6. Building a community of practice for Indigenous identification in general practice	• Investigate potential to get feedback from accreditation processes on identification processes (identified as pragmatic; to be progressed by AGPAL,GPA-Plus, RACGP) • Identify and invite other bodies (including ACRRM, Rural Doctors Association and others) to these annual seminars; provide resources (for example, the Guidelines) • Group with terms of reference – formal collaboration; provide pre-emptive program design to DoHA—for example, data to support policy implementation (identified as pragmatic; to be progressed by ACRRM, AIHW, MSIA, NEHTA, RACGP, RDA)

Note: See Abbreviations list for full names of all abbreviations cited.

6   Conclusion

COAG Closing the Gap commitments recognised the important opportunities to enhance care provided by the general practice sector to Aboriginal and Torres Strait Islander people. COAG processes added to existing GP-mediated health interventions specifically targeted to address health disparities faced by Aboriginal and Torres Strait Islander people. The package of these interventions is now substantial, and the clinical consequences of identification have never been greater, as Aboriginal and Torres Strait Islander people are eligible for a larger range of specific health services than ever before.

Effective identification of Aboriginal and Torres Strait Islander patients is a necessary first step in optimising uptake of these health interventions. It is also needed to improve the health data to which general practices contribute, but data improvements can best be progressed by emphasising identification as the gateway to improved service delivery. Therefore, service delivery uptake is essential to improved data collection, and the two goals should be progressed in tandem.

Improvements to date

General practices now have unprecedented support, as described below, to improve identification of their Aboriginal and Torres Strait Islander patients.

- Divisions of General Practice (now Medicare Locals) are nationally equipped with staffing specifically focused on Aboriginal and Torres Strait Islander health.
- General practices have financial incentives to systematically engage with Aboriginal and Torres Strait Islander health issues.
- Accreditation standards for the general practice sector mandate the routine collection of Indigenous status from all patients/clients.

These changes have brought real benefits. Over one-third of the Aboriginal and Torres Strait Islander population in scope has accessed cheaper PBS medicines, and the number of Indigenous health checks provided each year has risen steadily.

Remaining barriers

There is, however, scope for further improvement. The coverage of health checks and follow-ups is low relative to population numbers and known levels of need, as is progression to markers of improved chronic disease management under the IHI. Weaknesses in general practice clinical information systems limit the implementation of a number of Indigenous Chronic Disease Package measures, and the lack of standard Indigenous status requirements in pathology processes undermines general practice-generated data conveyed by these mechanisms.

Reforms to date have addressed only some of the known barriers to improving identification in the general practice sector, and additional efforts should therefore focus on addressing these remaining barriers (Table 6.1 summarises the key issues). Participants at the 2011 and 2012 general practice workshops noted the persistence of some of these obstacles, and endorsed and extended previous recommendations for change.

National integration

There was a widely recognised need for a central point of national responsibility and organisation. One option to address this could be to establish a dedicated taskforce of relevant stakeholders, able to develop and promote implementation of a national strategy for improving Indigenous identification. This strategy would integrate the uptake of GP-mediated health interventions specifically for Indigenous people with improved collection and recording of Indigenous status in health data collections.

Clinical information systems

Improvements to clinical information systems would also improve identification rates. Recommended systems design improvements included:

- once-only collection and increased transfer of Indigenous status data, including via e-health options
- liaison with software providers to improve and standardise Indigenous identification in general practice software, and to ensure Indigenous status drove clinical support mechanisms facilitating uptake of health interventions specifically for Indigenous people
- improved pathology systems to support the collection and reporting of Indigenous status.

Informing Aboriginal and Torres Strait Islander people

It was also agreed that a greater focus on Aboriginal and Torres Strait Islander consumers was needed. Campaigns to inform Aboriginal and Torres Strait Islander people about the health interventions for which they were eligible and to empower them to seek these from their general practices were recommended. At the practice level, Aboriginal and Torres Strait Islander people should be advised of the specific health interventions for which they may be eligible and how disclosing or choosing not to disclose their Indigenous status would impact on access to such interventions.

Improving feedback loops

Feedback loops were identified as important change support processes, which would enable monitoring of and reporting on identification levels in general practices in order to provide feedback and benchmarking to practices. In the same way, reporting of meaningful data back to Aboriginal and Torres Strait Islander communities was also recommended.

Integration of service delivery and data collection

In line with the primary role of practice teams as health-care providers, it was recommended that change management in the general practice sector be presented to practice teams on the basis of improved service delivery and clinical benefits to patients. Arguments based on improved data collection alone were seen as unlikely to be persuasive.

Training and awareness-raising

Training designed to overcome attitudinal barriers in the general practice sector was also recognised as important. Supports needed to assist this process included developing an evidence base to identify and disseminate best practice in improving identification and assessing health benefits from targeted interventions. Establishing a 'one-stop-shop' website

would help address the lack of knowledge about GP-mediated health interventions specifically for Indigenous people. At the same time, awareness raising efforts were also needed to address commonly-held prejudices within the non-Indigenous population.

Next steps

The consensus of study recommendations and workshop input is that changes should be made through multiple channels, while ensuring these are integrated in an overall plan that is centrally coordinated and led. The different areas of expertise and responsibility of various agencies and non-government stakeholders should be recognised, but should have a point of integration at the national taskforce level. This would enable greater coordination and better overall outcomes.

Responses to outstanding barriers, work to capitalise on existing reforms, and responsiveness to new opportunities would all be most effective when underpinned by the establishment of a clear point of leadership, coordination and accountability, coupled with the implementation of a systematic approach. This point of national integration is needed to drive continued improvements in Indigenous status collection in the general practice sector and to deliver consequent better service access and data collection.

The AIHW has an overall interest in improving Indigenous identification in the general practice sector, and has prioritised this sector within the support and evaluation project. During the life of this project, the AIHW will continue to contribute to the awareness raising and communication needed to inform next steps in improving Indigenous status identification in general practice settings.

Table 6.1: Indigenous identification in general practice: pre-2008, current status and next steps

Pre-2008 status	Current status	Start date	Next steps
No nationally funded positions or focus on Indigenous health in Divisions of General Practice, now MLs	MLs funded for 86 Aboriginal and Torres Strait Islander Outreach Workers, and 86 Indigenous Health Project Officers	Outreach workers: 2010 Indigenous Health Project officers: 2009	Maximise potential and coordination of new positions
No financial support/incentives for practice change	PIP IHI initiated	From May 2010	Monitor effects of IHI participation: refine as needed
General practice accreditation standards did not mandate routine identification	Routine Aboriginal and Torres Strait Islander identification mandated in accreditation standards	Fourth edition, from December 2011. Will be gradually implemented over time as practices seek renewal of accreditation	Monitor uptake and impact
No requirement for practices to undertake cultural training Prevalence of attitudes militating against routine identification processes	Introductory cultural awareness training developed by the RACGP and required for participation in PIP IHI	From 2011	Need to build on basic introductory material Targeted program needed
Diversity of clinical information systems: no standardisation of identification or links to service delivery required	Opportunity for improvements to be made via e-health agenda	PCEHR registration open to all Australians from July 2012	Need to optimise Aboriginal and Torres Strait Islander identification for data collection and service delivery in e-health; improvements needed to clinical information systems
Pathology processes generally do not include Indigenous status, so data collection via pathology processes undermined	Pathology Business Case prepared by the AIHW E-pathology processes do not mandate inclusion of Indigenous status	Some improvements made at jurisdiction level; no national requirements for Indigenous status collection in paper or e-processes	The AIHW to continue to liaise with relevant agencies to ensure Indigenous status is identified in e-pathology processes. Additional work is required
Lack of national integration/ systematic approach	AIHW contribution via national workshops	Not addressed	No point of national coordination or systematic approach
Lack of single point of reference for all general practice-mediated Indigenous-specific health interventions	Some work done through the Indigenous Chronic Disease Package but incomplete	2010	The AIHW to progress
Lack of awareness raising for Aboriginal and Torres Strait Islander people	A component of Indigenous Outreach Workers' role	2010	Requires additional work
Lack of awareness raising for non-Indigenous people	Role not allocated or funded	Not addressed	Requires recognition

Note: See Abbreviations list for full names of all abbreviations cited.

Appendixes

Appendix A: Invitations and attendance lists

Table A1: List of invitees and attendees

Organisation	Invited 2011	Attended 2011	Invited 2012	Attended 2012
Australasian Medical Writers Association	X	X	✓	X
Australian Association of Pathology Practices	X	X	✓	X
Australian Association of Practice Managers	✓	Linda Osman	✓	Linda Osman
Australian Bureau of Statistics	✓	Sybille McKeown	✓	Mary Jackson Sharon Pech
Australian College of Rural and Remote Medicine	✓	X	✓	X
Australian Diabetes Educators Association	X	X	✓	Clair Matthews
Australian General Practice Accreditation Limited	✓	X	✓	X
Australian General Practice Network (now Australian Medicare Locals Alliance)	✓	Paul MacDonald Ross Nable	✓	Traven Lea
Australian Indigenous Doctors Association	✓	X	✓	Alyce Merritt
Australian Institute of Aboriginal & Torres Strait Islander Studies	✓	X	✓	Ray Lovett Jaky Troy
Australian Institute of Health and Welfare	✓	Fadwa Al-Yaman Anthony Cowley Helen Johnstone Meke Kamps Helen Kehoe Gordon Tomes Adrian Webster	✓	Fadwa Al-Yaman Claudia Caton Anthony Cowley Bernice Cropper Helen Johnstone Meke Kamps Helen Kehoe Graeme Morris Ronda Ramsay
Australian Medical Association	✓	X	✓	X
Australian Paediatric Endocrine Group	X	X	✓	X
Australian Practice Nurses Association	✓	Sally Cotterell	✓	Sandy Anderson
Australian Primary Health Care Research Institute	✓	X	✓	X
Cancer Australia	✓	X	✓	Christine Biondi
Close the Gap Campaign	X	X		Clarke Scott

(continued)

Table A.1 (continued): List of invitees and attendees

Organisation	Invited 2011	Attended 2011	Invited 2012	Attended 2012
Committee of Presidents of Medical Colleges, National Aboriginal and Torres Strait Islander Medical Specialist Framework Project	X	X	✓	Netra Khadka
Communicable Diseases Network of Australia	✓	X	X	X
Congress of Aboriginal and Torres Strait Islander Nurses	✓	X	✓	Robyn Coulthard
Consumer Health Forum	X	X	✓	x
Department of Families, Housing, Community Services and Indigenous Affairs	X	X	✓	Darren Benham (half-day attendance)
Department of Health and Ageing				
Bowel Screening, Population Health Division	X	X	✓	Anne Kingston
E-health	X	X	✓	X
General practice, Nursing and Midwifery Section, Medicare Financing and Analysis Branch	✓	Hugo Cook	X	X
Medical Specialist Services Branch, Medical Benefits Division	X	X	✓	Megan Keaney
Office of Aboriginal and Torres Strait Islander Health	✓	Kirrily Harrison Alison Killen Deb Reid (half-day attendances)	✓	Kirrily Harrison
Office of Health Protection	✓	X	✓	Mark Power Heather Thomas
Practice incentives section, Primary Healthcare Practice Support Branch	✓	Sarah Fahey	X	X
Pharmaceutical Benefits Division	X	X	✓	X
Primary and Ambulatory Care Division	X	X	✓	Linda Grallelis
Tobacco Control	X	X	✓	x
Department of Human Services (Centrelink, Medicare and Indigenous services)	✓	Ben Healey Joy Lobo	✓	Ben Healey
Diabetes Australia	X	X	✓	Ashlynn Stewart
General Practice Education and Training	✓	X	✓	Glenn McMahon
Indigenous Allied Health Australia	✓	Craig Dukes	✓	Craig Dukes
Karabena Consulting Pty Ltd	✓	Kerry Arabena	✓	Kerry Arabena
Leaders in Indigenous Medical Education	✓	X	✓	X
Medical Software Industry Association	✓	X	✓	Vince McCauley

(continued)

Table A.1 (continued): List of invitees and attendees

Organisation	Invited 2011	Attended 2011	Invited 2012	Attended 2012
National Aboriginal and Torres Strait Islander Health Officials Network	X	X	✓	X
National Aboriginal and Torres Strait Islander Health Worker Association	X	X	✓	Clarke Scott#
National Aboriginal Community Controlled Health Organisation	✓	Janine Engelhardt (half-day attendance)	✓	Lisa Briggs Heather Volk Mark Wenitong Renee Williams
National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data	X	X	✓	Lisa Briggs
National Centre for Immunisation Research and Surveillance	✓	Robert Menzies	✓	Brendon Kelaher Robert Menzies
National Congress of Australia's First Peoples, National Health Leadership Forum	✓	X	✓	X
National E-Health Transition Authority	✓	X	✓	Larissa Breidis
National Indigenous Reform Agreement Performance Information Management Group	X	X	✓	X
National Rural Health Alliance	X	X	✓	X
Pharmaceutical Society of Australia	✓	Lindy Swain	✓	X
Pharmacy Guild of Australia	✓	Stan Goma	✓	Louise Cooke
RACGP Oxygen	✓	Ben Johnston	✓	X
Royal Australian College of General Practitioners	✓	Jill Dixon Hung The Nguyen Angela Forrest	✓	Jill Dixon Judy Evans
Royal College of Pathologists of Australasia	X	X	✓	X
Sexual Health Family Planning Australia	✓	X	✓	X
South Eastern Melbourne Medicare Local	X	X	✓	Paul MacDonald
Technical Reference Group members	✓	Sybille McKeown	✓	Darren Benham Ray Mahoney Ray Lovett Sharon Pech
University of Melbourne (Bree Heffernan, Jane Freemantle)	X	X	✓	X

Some participants represented more than one organisation.

Appendix B: Workshop agendas

2011 Workshop agenda

Timing	Agenda item	Presenter
10:00–10:10	Welcome to country	Aunty Agnes Shea
10:10–10:25	Opening remarks	Kerry Arabena (facilitator)
10:25–10:40	Introductions	Participants
10:40–11:00	Overview from the Australian Institute of Health and Welfare	Fadwa Al-Yaman
11:00–11:15	Morning tea	
11:15–11:45	Panel One: The national perspective	Sybille McKeown, Australian Bureau of Statistics Rob Menzies, National Centre for Immunisation Research and Surveillance Gordon Tomes, Australian Institute of Health and Welfare Deb Reid, Office for Aboriginal and Torres Strait Islander Health
11:45–12.15	Panel Two: Indigenous identification at the front line	Sally Cotterell, Australian Practice Nurses Association Jill Dixon, Royal Australian College of General Practitioners Traven Lea, Australian General Practice Network (unable to attend: Ross Nable proxy) Linda Osman, Australian Association of Practice Managers
12:15–1:00	Mapping of roles and key issues	Facilitator
1:00–1:30	Lunch	
1:30–2:45	Discussion: Key issues	Facilitator
2.45–3.00	Afternoon tea	
3:00–3:45	Discussion: Evaluation issues	Facilitator
3:45–4:15	Recap and close	Facilitator

2012 Workshop agenda

Timing	Agenda item	Presenter
10:00–10:10	Welcome to country	Aunty Agnes Shea
10:10–10:25	Opening remarks and introductions	Kerry Arabena, Facilitator
10:25–10.45	Overview of issues and outcomes from the 2011 workshop	Fadwa Al-Yaman, Australian Institute of Health and Welfare
10.45-11.15	Updates on progress from participants	Facilitator and participants
11:15–11:30	Morning tea	
11.30– 11.40	Introduction to workshops on the six key themes: 1. Promoting national coordination on Indigenous identification in general practice 2. Optimising Indigenous identification in general practice software and e-health 3. Implementing change promotion in the general practice team 4. Raising awareness about the importance of identification 5. Improving the uptake of GP-mediated Indigenous-specific measures 6. Building a community of practice for Indigenous identification in general practice	Facilitator
11:40–12.10	Session 1 workshops	Participants
12.10–12.35	Session 2 workshops	Participants
12:35–1.00	Session 3 workshops	Participants
1.00–1:30	Lunch	
1.30–1.55	Session 4 workshops	Participants
1.55–2.20	Session 5 workshops	Participants
2.20–2.45	Session 6 workshops	Participants
2.45-3.00	Afternoon tea	
3:00–4.00	Agreed outcomes from the workshops and priority areas for further work	Facilitator and participants
4.00–4:15	Recap and close	Facilitator

Appendix C: 2011 workshop discussions and outcomes

This section provides more details on the key issues identified by participants at the 2011 workshop.

Promotion of national coordination

What is the problem?

Participants advocated for raising the profile of the issues of Indigenous identification in general practice settings and for better integration of national efforts across all areas. Building integration across disparate stakeholders was seen as necessary to coordinate and optimise efforts to improve the accuracy of Indigenous identification and the recording of Indigenous status in general practice.

Issues for further investigation:

- Which existing advisory bodies and structures should be involved in this work?
- How can the importance of accurately recording the Indigenous status in the general practice sector be elevated as an issue with policy and decision makers?
- How can national integration best be progressed?

Box C1: What did participants suggest?

Suggestions raised to improve cross-government agency coordination included:

- seek COAG support (possibly via the NIRA PIMG)
- issue a joint AIHW, Medicare Software Industry Association, RACGP memorandum of understanding to ensure data needs are addressed and drive consistency
- prepare and implement a joint position between DoHA, ABS, Office of Aboriginal and Torres Strait Islander Health, Department of Human Services to ensure data needs are addressed
- obtain ministerial support for making the question mandatory—consider approaching the Australian Health Ministers' Advisory Council through NAGATSIHID.

Which agencies need to be involved?

Statistical agencies: ABS, AIHW

Policy agencies: DoHA

General practice stakeholder groups: Australian General Practice Network, RACGP

Groups involved in e-health and software: Medical Software Industry Association, NEHTA

Alignment with previous studies

Similar approaches were recommended in previous studies (IIICDRPSC 2004; Kehoe 2007a).

E-health and practice software

What is the problem?

One of the strongest messages from the workshop was that software requirements and functionality to record Indigenous status data are of paramount importance to improving the collection of this information. Shifting the status of the Guidelines from optional to mandatory was seen as an important step in achieving this outcome. Inconsistency in how practice software promotes the collection and recording of Indigenous status information has been identified as a major barrier to improved identification of Aboriginal and Torres Strait Islander patients.

Participants were clear that software was a critical element in supporting change at the practice level. E-health and practice software are closely linked. The advent of e-health provides opportunities to drive consistency and to mandate compliance with the Guidelines across all software used in the general practice sector. Participants wanted to ensure that the design and implementation of e-health records supported the optimal collection of Indigenous data and service delivery outcomes from the outset, rather than being incrementally added over time. Participants were concerned that if Indigenous status were mandated on an incremental basis it would not only further delay much needed reform, but also establish patterns of behaviour based on poor-quality data collection, which would then be difficult to rectify in the future.

Participants identified the following issues as barriers to achieving these outcomes.

- General practice software is variable: not all software facilitates asking and recording responses to the national standard question in line with the Guidelines.
- E-health initiatives provide an opportunity to standardise practice software, as software providers wishing to participate in e-health will need to comply with minimum standards.
- The aim is to ensure that criteria set by NEHTA support the nationally consistent requirements for asking and recording Indigenous status. Metadata Online Registry (METeOR) data requirements set mandatory elements and the best outcome may be to link these with NEHTA requirements, allowing the status of the Guidelines to remain as advisory support materials.
- Workshop participants agreed that the collection and recording of Indigenous status should be a requirement from the outset. Nonetheless, it seems, currently, that the Indigenous status aspect of e-health will be introduced as mandatory although software vendors will be allowed to gradually improve their compliance before being required to be fully compliant 2 years after implementation.

Issues for further investigation

The following issues were identified for further investigation:

- What should be done to ensure practice-wide flowthrough of Indigenous status data? Problems of data transfer have been reported in the past; for example, reception staff could ask and record a patient's Indigenous status on their software (for example, PracSoft) but it was unclear if this was transferred to the software used by the GP (for example, Medical Director).

- What should be done to ensure that e-health best supports Aboriginal and Torres Strait Islander health issues, both for national data collection and point of service care delivery?
- How will e-health developments help to address problems with obtaining Indigenous status data in various data sets including cancer registers, Pap smear registers, communicable/notifiable diseases, mortality data and hospital morbidity?
- What are the steps involved in attaining the status of an Australian Standard via Standards Australia? And at which point in this process are the Indigenous status requirements?
- The first step is getting Indigenous status data recorded correctly in a patient's record. Once this is achieved, what should be done to ensure that Indigenous status is linked to clinical decision support software?
  - For example, how can the sidebar tool 'shareware' being developed by RACGP Oxygen best support Indigenous health? The RACGP and the National Aboriginal Community Controlled Health Organisation (NACCHO) have recently updated the *National Guide to a preventive health assessment in Aboriginal and Torres Strait Islander peoples* (the National Guide), and hope to be able to incorporate this material in the sidebar; ideally, this would operate seamlessly with the existing *Guidelines for preventive activities in general practice* (the Red Book) guidelines. This process should be checked to ensure that it includes prompts for all GP-mediated health interventions specifically for Indigenous people: this would strengthen its potential to improve GP use of these measures. How can the sidebar work to integrate Indigenous identification in clinical decisions? Can the sidebar provide data on Indigenous status collection processes?
- How can e-health address the longstanding problem of poor-quality information about the Indigenous status of referred patients on pathology requests? The lack of national standardisation of pathology forms in respect of Indigenous status means that pathology-dependent data are of poor quality for that identifier. Pathology forms are the source of all information for Pap smear registers, and for a considerable proportion of information for cancer registers, and notifiable communicable diseases registers. How can Indigenous status data that is generated by pathology forms be improved? How will e-health developments influence this issue?
- Should Indigenous status be considered a (generally) constant attribute, similar to gender and name? There are two conflicting positions on this issue, described below.
  - Indigenous status information should, in line with other data principles, be collected once and used many times. The best approach is to obtain Indigenous status initially, then transfer to other data sets and settings so that all records are consistent.
  - Indigenous status can be voluntarily disclosed, not disclosed, or differently described over time, in different contexts and for various purposes. The best approach is to seek the person's Indigenous status on each and every contact, and to record Indigenous status for only that purpose and context—it should not be transferrable across data sets, health providers or even episodes of care. (This is the approach considered the 'gold standard' in hospital settings.)

> **Box C2: What did participants suggest?**
>
> Proposals for action made by participants included:
>
> - use cross-government advocacy mechanisms (as outlined above)—for example, write to COAG advocating for workshop recommendations
> - institute a mandatory requirement for all general practice software to support optimal collection of Indigenous data and service delivery outcomes
> - make the Guidelines (or the relevant METeOR data elements) an Australian Standard, to be applied in all relevant settings including e-health implementation
> - explore the potential for e-health initiatives to drive these changes
> - ensure e-health record design and implementation mandates Indigenous status data recording from the outset (not incrementally added over time), and that capturing and transferring these data are always mandatory, rather than optional.
>
> *Note*: As e-health facilitates greater data sharing, discrepancies may become more obvious where Aboriginal and Torres Strait Islander people have been identified differently in different data sets.

Which agencies need to be involved in this issue?

- Software and e-health organisations: Medical Software Industry Association, NEHTA, RACGP Oxygen. Note that both the Medical Software Industry Association and NEHTA were not present at the workshop. Both organisations are critical to these discussions and will need to be informed about workshop processes.
- General practice support organisations: Australian General Practice Network, RACGP.
- Statistical agencies: AIHW.

Alignment with previous studies

Similar approaches were recommended in previous studies (IIICDRPSC 2004; Kehoe 2007b; Kelaher et al. 2010).

Change promotion in the general practice team

What is the problem?

Participants noted that making change was challenging in any environment and the general practice sector was no different. One participant offered that practice teams are often resistant to change and the introduction of new processes.

However, the changes needed to ensure the routine collection of Indigenous status for all patients face additional challenges compared with other change processes; namely, that the more superficial barriers of knowledge, process and technical issues are underpinned by attitudinal issues that made this matter sensitive and complex.

These barriers result in low rates of routine identification and high levels of variability in processes to do so.

Comprehensive, whole-of-practice team training was identified as the key strategy to change promotion in the general practice sector. Issues needing to be addressed in this training included practice software, whole-of-team approaches, clinical rationale, and attitudinal change.

Practice software: beyond asking the question

As discussed above, practice software and e-health changes were seen as integral in driving change. However, ensuring practice software facilitates the correct recording of Indigenous status is only the first step. Ensuring that software supports best clinical decision making is the next important step, and is needed to make these data meaningful at the practice level. Participants discussed the example of some practice software prompting a health check for Aboriginal and Torres Strait Islander patients. The software has a reminder so that staff cannot continue into the patient's files until they acknowledge the patient has not had a health check. Previous studies have highlighted the lack of templates, wizards and prompts in practice software in relation to Aboriginal and Torres Strait Islander health. Examples of good practice need to be tested and disseminated, ensuring that software facilitates and supports the general practice team to undertake health interventions specifically for Indigenous people.

Whole-of-team approach

The changes needed to improve Aboriginal and Torres Strait Islander health through better Indigenous status data involve the whole practice team: receptionists, administrative staff, practice managers and practice nurses as well as GPs themselves. Change in practice settings does not come about because of information; change is a process that needs to be managed in a practice setting and needs support, commitment and involvement from all staff.

Clinical rationale

Feedback from general practices shows that a compelling clinical rationale is needed in order to instigate routine Indigenous identification. Therefore, it is important to research the benefits of GP-mediated health interventions specifically for Indigenous people. The extent to which these lead to measurable health improvements needs to be identified and promulgated; a greater evidence base will help drive improved data collection with a view to improving service delivery.

Attitudinal change

As noted by one of the Indigenous workshop participants, staff asking the Indigenous identification question can comply with the exact wording of the standard question and still 'get it wrong'. Attitudes can be clearly expressed via body language, tone and context. Where patients are asked the question, who asks the question, and how it is asked, will, to a large extent, dictate how prepared they are to disclose their Indigenous status. It is important to get the systems working, but practices will also need to address intangible issues such as staff attitudes, prejudices and stereotypes to facilitate accurate identification.

Training required

Training needs to address all the issues above. Training strategies are critical in bringing about systems change, staff attitudinal change, the introduction and use of IT, improved cultural awareness and better uptake of GP-mediated health interventions specifically for Indigenous people. This is currently an under-resourced area where collaborations across agencies could achieve much more than one agency alone.

Better education and training for the entire general practice team was seen as an important step in building change. It was noted this needed to be team-based, as the changes required to improve Indigenous status collection and service delivery were practice-wide.

This type of training is currently not available: the cultural awareness training developed by the RACGP, which can be used to fulfil training requirements for participation in the PIP IHI, deals with the identification of Aboriginal and/or Torres Strait Islander patients as a fundamental issue in terms of access to a range of services. It addresses some of the assumptions and misunderstandings around Indigenous status and identity, and conveys some of the key 'how to' messages reflected in the Guidelines. Nonetheless, it is not in itself a training resource on Indigenous identification.

Also, not all practices will participate in the PIP IHI. Therefore, the development of sector-specific training materials may be required to support practices to routinely check and record Indigenous status in accordance with the Guidelines.

Issues for further investigation

To what extent does the role of Indigenous Health Project Officers address identification issues?

How do the supports offered by the RACGP and Divisions of General Practice intersect? Are there opportunities for closer collaboration?

Pursuing further research to build the evidence base for improved identification:

- Should the standard question be in the context of administrative or clinical questioning?
- Should the rationale for asking of the Indigenous identification question be provided proactively or reactively? How detailed should such information be?
- What is the impact of being asked verbally or in writing?
- What are the implications of minor modifications to the standard question? Do local variations in the question facilitate or impede valid identification?
- How can the uptake of GP-mediated health interventions specifically for Indigenous people be improved? To what extent can uptake be monitored/reported to help drive continued improvement, benchmarking and quality assessment?
- What is the best form of individualised and ongoing support to practices to enable change management? Are Division-based models (for example, such as Divisional immunisation coordinators) most appropriate? How can continuous quality improvement in identification processes be supported by monitoring and reporting to provide feedback and benchmarking to practices?
- Can other supports addressing resourcing barriers promote uptake of GP-mediated health interventions specifically for Indigenous people—and thereby identification (for example, by providing centralised practice nurse or Aboriginal Health Worker assistance to assist with health checks)?
- How can the broader issues of accessibility for Aboriginal and Torres Strait Islander people in general practice be addressed (for example, access to bulk billing)?

Which agencies need to be involved?

Statistical agencies: AIHW

General practice team stakeholder groups: Australian Association of Practice Managers, Australian College of Rural and Remote Medicine, Australian General Practice Network, Australian Practice Nurses Association, RACGP.

Alignment with previous studies

Similar approaches have been recommended by previous studies (IIICDRPSC 2004; Kehoe 2007a; Norris et al. 2004; Riley et al. 2004).

Awareness raising: Aboriginal and Torres Strait Islander people

Client perspectives

Aboriginal and Torres Strait Islander people take great pride in their heritage and identity (). However, Aboriginal and Torres Strait Islander people may be apprehensive about identifying as such to health professionals and government bodies, especially when the reasons for doing so are not clear to them.

Participants agreed that Aboriginal and Torres Strait Islander people need information to empower and encourage them to identify as being Indigenous in the general practice setting. People need to know that disclosing their Indigenous status will not disadvantage them; rather, this information is needed to provide better health-care support and to generate accurate data on which to base policy and funding decisions. This information should be sufficient to enable Indigenous people to make an informed decision about whether they wish to identify or not, so information about the GP-mediated health interventions specifically for Indigenous people is essential. The health and financial benefits for Indigenous people should be explained.

Cultural safety and resilience

Participants discussed the issue of cultural safety in different service settings as being relevant to why some Aboriginal and Torres Strait Islander people choose, or choose not to, disclose their Indigenous status. In order for a person to accurately identify, there needs to be a shared cultural understanding—for both the service provider and the service recipient to be prepared and resilient. Currently, without adequate training and support for clients and providers, there is limited cultural safety. One participant related the experience she had of being asked her status in a general practice and how this highlighted the importance of the 'human element'—attitudes and personal understandings of the Aboriginal and Torres Strait Islander community, as well as the need for an organisational approach to education. In this person's experience, front-line staff acted as though they were ashamed to ask her about her Indigenous status.

Box C4: What participants said:

'There needs to be a greater understanding—Aboriginality is not something we are ashamed of, we are proud of it. The biggest barrier is not Aboriginal and Torres Strait Islander people not wanting to be asked, but non-Indigenous people being resilient about asking. It used to be a no-no to ask about age or religion. That is no longer the case. This should be done…General practices are where many uncomfortable questions get asked. I suspect that there are deep-seated attitudinal issues, which impede better Indigenous status identification.'

Affirmation or entitlement?

There are differing reasons why Aboriginal and Torres Strait Islander people identify as such in a service context. Building awareness of interventions targeting the specific health needs of Aboriginal and Torres Strait Islander people is needed, along with an understanding that these are based on clinical need rather than welfare 'entitlements'.

There is an emergent group of Aboriginal and Torres Strait Islander people who want services to recognise their changing economic position in the Australian community. It is becoming important to promote the success of Aboriginal and Torres Strait Islander people, as much as the disadvantages. It may be that many Aboriginal and Torres Strait Islander people attend general practices but do not want to be perceived as requiring an entitlement, which could be perceived as being based on a rationale of disadvantage.

In addition, an awareness raising campaign for Aboriginal and Torres Strait Islander people may impinge on government concerns including:

- sensitivities in suggesting consumers should initiate own health care
- MBS limitations regarding 'screening' activities
- attention being drawn to GP-mediated health interventions specifically for Indigenous people, in particular to access to cheaper PBS medicines. (Traditionally, this has been seen by government as potentially divisive; fears have been raised regarding a 'backlash' and precedent-setting for other disadvantaged groups.)

> **Box C5: What did participants suggest?**
>
> Aboriginal and Torres Strait Islander people need information to empower and encourage them to disclose their Indigenous status in the general practice setting.
>
> The awareness raising program provided to Aboriginal and Torres Strait Islander people should include the key points described below.
>
> - General practices are required to ask all patients the Indigenous status question—if they don't ask, the patient should check why they have not asked and seek to have their Indigenous status recorded.
>
> - Aboriginal and Torres Strait Islander people are eligible for targeted and specific health interventions designed to detect and treat the conditions that cause Indigenous people to get sick and die too young. The check-ups are designed for everyone, not just people who feel sick. It is just as important for people who feel well to have a health check to make sure they stay healthy. Vaccinations to prevent sickness may be different and Aboriginal and Torres Strait Islander people may be eligible for access to cheaper medicines.
>
> - Ideally, the program should promote the use of GP-mediated health interventions specifically for Indigenous people—in particular, the MBS-rebated health checks, which are the starting point for much of these.

Which agencies need to be involved?

Currently, there is no national campaign aiming to provide Aboriginal and Torres Strait Islander people with information about the specific health interventions for which they may be eligible. Previous 'road shows' coordinated by the Office of Aboriginal and Torres Strait Islander Health (part of DoHA) focused primarily on the Aboriginal Community Controlled Health Services sector.

Alignment with previous studies

There is substantial alignment between views expressed at the workshop and previous findings (ABS 2012b; Kelaher et al. 2010; Scotney et al. 2010).

Awareness raising: non-Indigenous people

Client perspectives

The attitudes of non-Indigenous people have been identified as a major barrier to improved Indigenous status identification processes in general practice. Workshop participants suggested addressing widespread racial biases, misconceptions and prejudices among the non-Indigenous population as an important priority, and one that was absent from current and previous efforts in this area.

As noted above, potential sensitivities for publicising GP-mediated health interventions specifically for Indigenous people will need to be considered.

Which agencies need to be involved?

This work is currently an unallocated responsibility.

Alignment with previous studies

Little research has been conducted into the non-Indigenous population's perceptions of Aboriginal and Torres Strait Islander identification for the purposes of data collection and improved service delivery.

Build a community of practice

What is the problem?

Despite the fundamental importance of accurate Indigenous identification in general practice in achieving the Closing the Gap targets, and the wide range of programs and services undermined by under-identification, no single agency has overall responsibility for integrating these issues and driving a sustained national level response to improve the situation.

This is evidenced by the lack of a forum that brings together the range of stakeholders needed to implement the Guidelines in this sector. The AIHW was prompted to convene this workshop to address this gap, and to help coordinate efforts in this sector. Many workshop participants had not previously communicated with others working in this space, or seen their work as being linked to the bigger picture of improving the accuracy and completeness of Indigenous status data in general practice. The workshop was seen as important in addressing these issues and the majority of participants wanted to be involved in follow-up activities from the workshop. The main issue for further investigation is that resourcing and ownership of this role is currently unallocated. It may represent an opportunity for the AIWH to provide coordination.

Which agencies need to be involved?

Cross-agency issue (government and non-government).

Alignment with previous studies

Aligns with recommendations from previous studies (Kehoe 2007a).

Other suggestions for investigation

There were a number of national strategies that participants thought had the potential to improve Indigenous status data collection and recording. Some will need further investigation to determine their feasibility.

These strategies comprise:

- VII potential
- Australian Primary Care Collaboratives
- closing the data loop
- re-examining the Indigenous status question
- widening the clinical team.

VII

Participants raised the potential of the VII as a mechanism to improve data collection and service delivery. It was noted that the Australian Childhood Immunisation Register successfully increased rates of Indigenous identification from 42% of the estimated national cohort of Indigenous children aged 12–14 months in 2002 to 95% in 2005 (Rank & Menzies 2007). This was primarily due to VII data being transferred to the Register.

Points to investigate:

- How can we use the VII to its potential to improve data collection/quality to aid targeted service delivery?
- Can we change the VII so it is visible at service delivery level in order to improve service delivery?
- Noting the precedent set by the transfer of Indigenous status data from the VII to the Australian Childhood Immunisation Register, how can VII identification be carried forward to other data sets to improve or confirm Indigenous status data?

Australian Primary Care Collaboratives

Participants suggested the Australian Primary Care Collaboratives (APCC) may provide a model to improve identification.

Background

The APCC Program is funded by the Australian Government to support Australian general practices to deliver systematic and sustainable improvements in the quality of primary care they provide to their patients. The program focuses on three areas:

- the secondary prevention of coronary heart disease
- diabetes and access
- care redesign.

The APCC Program has resulted in key changes within Australian primary care and better health outcomes for patients with chronic disease, including:

- improved patient care through better management of chronic disease
- increased best practice care through better use of information systems (both medical and business systems)
- evolving roles among practice staff to better meet patient demand
- a cultural shift from individual patient care to population-based care.

The APCC Program has worked with the Queensland Aboriginal and Islander Health Council and the Divisions of General Practice in Queensland to improve Indigenous peoples' access to, and identification in, primary health care. This has led to increased rates of Indigenous identification in those practices, and improved uptake of health checks.

This model is easily transportable and may have broader application; for example, a specific Closing the Gap collaborative could be implemented.

Participant suggestions

Points to investigate:

- Is there potential to use the Collaboratives model to drive and support better rates of Indigenous identification in the general practice sector?
- What lessons can be learnt from the Queensland study?

Closing the data loop

Participants suggested improving the information flow back both to the general practice team and to Aboriginal and Torres Strait Islander people.

Background

Descriptive data are of limited benefit if they are not applied in practice. As data custodian, the AIHW is separate from policy making and funding decisions. Nevertheless, the Institute has an obligation to data collectors and the people who provide their Indigenous status information to be part of the ethical use and application of that data.

It should be demonstrated, not simply claimed, that data collection beyond the practice level leads to improved health service delivery.

Improving data feedback is in line with the National Aboriginal and Torres Strait Islander Health data principles and guidelines for research involving Aboriginal and Torres Strait Islander people (NHMRC 2003). Such improvements have been recommended by previous reports (IIICDRPSC 2004).

A model of data feedback is provided by the Indigenous Community Engagement Strategy implemented by the ABS, which supports the return of information in meaningful ways to individual Indigenous communities and organisations (ABS 2012c).

Participant suggestions

Participants reported that those who collect Indigenous status data, as well as the people asked to disclose their Indigenous status, are more likely to support and participate in data collection when they understand why this is important.

The general practice team and Aboriginal and Torres Strait Islander people should be provided with information about how the data collected are being used to improve Indigenous health, and what the data show about their local or regional area.

Data fed back to general practices, AMSs and communities (perhaps at Divisional level) must be in meaningful and accessible forms. Such data could include the uptake of GP-mediated health interventions specifically for Indigenous people (for example, health checks and Closing the Gap prescriptions issued under the PBS co-payment measure) and numbers of Aboriginal and Torres Strait Islander people registered for the PIP IHI. This would help promote positive reinforcement of data collection strategies by highlighting 'wins' such as increased uptake.

Participants described how data feedback can help to drive improved service delivery. For example, Australian Childhood Immunisation Register data is provided to Divisions and practices so that each practice knows the percentage of children aged under 7 who have been fully immunised. This is part of integrated practice support, including incentive payments, which comprise the General Practice Immunisation Incentive.

Practices can also see where they sit in a 'league table' of other practices in their Division. This benchmarking helps support continuous quality improvement, as Divisional immunisation support officers offer targeted support to practices falling short of the target of at least 90% of children under 7 years of age attending their practices being fully immunised.

Points to investigate:

- How can local health data be provided in meaningful ways to Aboriginal and Torres Strait Islander people and their health providers?
- How can existing models (for example, the General Practice Immunisation Incentive and the ABS Strategy) be applied in this setting?

Re-examination of the Indigenous status question

Background

The standard Indigenous identification question is based on establishing Indigenous status only, rather than any other ethnic or cultural background.

Differential health services for Aboriginal and Torres Strait Islander people are based on evidence that the health disadvantage of Indigenous people is largely independent of financial/educational factors. Data indicate that Aboriginal and Torres Strait Islander health problems persist even when income or education levels increase (Glover et al. 2004). At the same time, misconceptions that Aboriginal and Torres Strait Islander people are inherently unhealthy (due to genetics or race-based flaws) need to be rebutted.

As long as the health gap between Indigenous and non-Indigenous people is considered sufficiently large to warrant specific remedial action, the need to identify Indigenous patients and offer them specific services will remain.

Moving away from a direct focus on Indigenous status also risks supporting one of the barriers in the general practice sector, which is the misconception that the health characteristics of Aboriginal and Torres Strait Islander peoples are not sufficiently different from those of other sectors of the population to warrant specific attention.

Participant suggestions

Some workshop participants raised the issue of reappraising the inquiry to consider a broader approach. For example, one approach may be to reduce barriers to asking the question by asking a more inclusive question—for example, about migrant status or ethnic heritage. A recommendation along these lines has been raised previously, where it was proposed that consideration be given to embedding the Indigenous status question in more general questions about ethnicity (Kelaher et al. 2010).

The issue of whether socioeconomic factors were more important than Indigenous status was also raised. This issue rests on a consideration of whether Indigenous status is a valid proxy marker of health disadvantage, or whether health disadvantage is more strongly linked to socioeconomic disadvantage.

It was acknowledged at the workshop that there is a growing proportion of Aboriginal and Torres Strait Islander people who are employed and well educated, and who do not face socioeconomic disadvantage. It is important to recognise these successes because to assume that all Indigenous people are in need of special assistance is incorrect and patronising. References to specific health care interventions as 'entitlements' may be counterproductive, as this could be seen as similar to welfare entitlements, which some Aboriginal and Torres Strait Islander people may see as inappropriate and potentially distasteful.

Points to investigate:

- How can we build support for using the standard Indigenous status question?
- How can the relationships between socioeconomic disadvantage, Indigenous status and poor health be better communicated to the non-Indigenous population and general practice teams?

Non-GP health providers

Background

The focus of the workshop was specifically on the general practice team. While there are important roles for health professionals (beyond the general practice team) to support Indigenous health initiatives, they are generally neither sources of data for national data collections nor gatekeepers of Indigenous-specific health services in the way that general practices are.

Participant suggestions

Some participants suggested that the potential role of other members of the primary health care team (for example, pharmacists and allied health professionals) in Indigenous health should also be considered. Pharmacists, for example, were important in facilitating access to Closing the Gap prescriptions under the PBS co-payment measure for Aboriginal and Torres Strait Islander people. There may be a need to consider developing supplementary guidelines to help apply the existing generic Guidelines to the settings.

It was noted there are areas where improvements in Indigenous status data in service delivery beyond the general practice sector would be of benefit. For example, before the workshop, concerns regarding the level of Indigenous access to the Home Medicines Review Program were raised. The federally-funded Home Medicines Review Program, initiated in 2001, helps people living at home to manage their medication. Under the program, in cooperation with the individual's GP, a pharmacist visits the individual at home, reviews their medicine regimen, and provides the GP with a report. The GP and consumer then agree

on a medicine management plan. Qualitative reviews have indicated low access to the program by Aboriginal and Torres Strait Islander people, and noted the program's structural barriers to Indigenous participation. However, exact access levels are not known as the Indigenous status of people participating in the Home Medicines Review Program is not recorded. The program exemplifies how lack of Indigenous-specific data can undermine assessments of program effectiveness.

Appendix D: 2012 workshop discussions and outcomes

Theme 1: Promoting national coordination on Indigenous identification in general practice

(Facilitator: Bernice Cropper)

Theme 1 recommendations

- The AIHW to take on a coordination role to assess current data, identify gaps, synthesise best practice and map existing activities in liaison with stakeholders, and lead a discussion of who does what
- Annual workshops
- Single comprehensive web resource for general practices, evidence synthesis.

Table D1: Theme 1—mapping roles and responsibilities

What	Who
Coordination/info Sharing Ongoing workshops and publications Assessment of identification in data Increased access to information Ongoing, what progress?	AIHW
E-health Indigenous Chronic Disease Package, MBS, PBS Publication of progress in HPF?	DoHA, DHS, NEHTA
ACCHS • Coordination across sector • Synthesis of data/monitoring (AIHW) • Indigenous status in PCEHR (DoHA)	NACCHO, affiliates and ACCHS
Medicare Locals Education/accreditation	AMLA, Medicare Locals, RACGP
Support for health workers and promotion of importance of identification	NATSIHWA
Population health (stakeholder and support) Sharing information/change management E-health	States and territories
Streamlining the patient journey—partnerships with others Data Education/communication with community	PGA
Supporting data Mapping data	Diabetes Australia

Note: See Abbreviations list for full names of all abbreviations cited.

Table D2: Theme 1—suggestions for ways forward

What	Who
Development of a primary health-care data set	AIHW
Promotion of clinical utility	
Influence	
Evidence-based medicine—clinical outcomes	
E-health pathology input	AAPP, RCPA
Single point of info for general practices	AAPM, AMLA, APNA, NACCHO, RACGP
Implementation guidance	
Agreed set of resources/working groups	
Ongoing revision/quality control	
Clearinghouse	
Consultation/revision	

Table D3: Theme 1—other material

Themes	Who/What?
Change management—not just at GP level but practice level	AAPM, ACRRM, APNA, NACCHO, RACGP and others
	Become champions of identification
	Promote business incentives (set target)/value
	Champion at practice level
	Attitudinal change—renewal of fellowship by the RACGP should be linked to compliance with asking Indigenous status question? Or accreditation?
Portal/Clearinghouse for general practices	For data
	Information resources—need to ask general practices if they need this?
Need a baseline: • Reporting • Measuring improvement	BEACH? Medicare research? E-health? Case studies Primary health-care data set PCEHR?
High-level coordination agency	To coordinate all Closing the Gap activities (health)
	Has risks

Note: See Abbreviations list for full names of all abbreviations cited.

Theme 2: Optimising Indigenous identification in general practice software and e-health
(Facilitator: Meke Kamps)

Theme 2 recommendations

- Undertake scoping study of software and software vendors. Selection criteria:
    - interoperability
    - standardisation
    - quality and safety.
    - Stakeholders: AMLA, NEHTA
- Create a shared purpose between consumers, providers and stakeholders
- Stakeholders: ABS, AIHW, consumer organisations, data collectors, general practices, hospitals, Medical Software Industry Association, NACCHO, National Health Leadership Forum, primary health care providers
- Develop best practice and research methods surrounding e-health and data:
    - Around patient informed consent of data use and data linkage

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All agencies in e-health come together (working group) to address the current issues, via existing bodies, not creating new ones.

Table D4: Theme 2—mapping roles and responsibilities

What	Who
Analysis of software compatibility	Community health services, general practices, hospitals, NACCHO, outpatient services, pharmacies, registered health practitioners
Hospitals—discharge planning	
Rarely recorded at the moment	
To be published soon—time lag to software	Custodians of data, Standards Australia, Health Level 7, METeOR
Responsible for implementation	
Current focus on PCEHR developments	DoHA, Department of Human Services (hold data), Medical Software Industry Association, NEHTA, software providers/vendors
Not mandatory at present	
Provider needs to be willing to ask	

Note: See Abbreviations list for full names of all abbreviations cited.

Table D5: Theme 2—suggestions for ways forward

What
Make system (e-health) user friendly: improve patient journey (streamlined)
Collecting info once only
Storage of data and ownership
Standardisation of indicators/consistent software
Link Indigenous-specific health measures with PCEHR
Clinical prompting of Indigenous-specific health measures available (sidebar)
Consent of use of data— full consent (clear)
Ensure only registered health practitioners can add to e-health record and address barriers to becoming registered
Make Indigenous status a mandatory field (no bypassing)
Have all Indigenous-specific measures in one place
Indigenous data linked to performance indicators (Indigenous Chronic Disease Package, for example)
Have software between pharmacy and general practice linked (radiology and pathology and general practice)
Flow from one identification on—all through e-health records etc.
Link identification with patient (Medicare number) not practice (not possible at this stage [IHI]); when scripts are included in new system, the 'Closing the Gap' annotation should be made automatic
Discharge scripts not part of Closing the Gap (hospital)
What does consent mean? Privacy, security, quality, use
Education and context
Close clinical feedback loop
Clinical care and money
Interoperability—system to system
Data linkage
Have information available in one place for patients to access—allow own management of health (PCEHR)
Clinical prompting—electronic decision support

Note: See Abbreviations list for full names of all abbreviations cited.

Table D6: Theme 2—other material

Theme	Comments
Analysis of software compatibility	Interoperability
	Standardisation
	Quality and safety— Australian Primary Care Collaboratives program and the Improvement Foundation
Consent	Patient consent (informed)
	Ownership/custodianship/storage/governance
	Is it compatible with collect once/use many times?
	Sharing of data
Indicators	Performance indicators
Shared purpose	Vision/purpose/goals
	Health outcomes
	Good news stories/benefits realisation
Data correlation	Get out of silos (departments work together)
Data linkage	Legislation problems
	State versus Australian Government availability
Optimise	Use the ones with market share
	Code out optionality
	Do not allow to move past without answer
	No default
	Do not try to fix it all at once

Note: See Abbreviations list for full names of all abbreviations cited.

Theme 3: Implementing change promotion in the general practice team

(Facilitator: Helen Kehoe)

(*Note:* general practice team includes GPs as well as all others on the team—practice managers, practice nurses, administrative staff etc.)

Theme 3 recommendations

- Agree specific content for identification in general practice training. Should include:
    - cultural competency
    - clinical rationale
    - accreditation standards
    - all GP-mediated health interventions specifically for Indigenous people
    - normalising – asking the questions
    - clarity, consistency, availability (for example internet based).
- Marketing and promotion of identification:
    - Define what must remain consistent: identify which parts have potential for localisation
- Data – feedback and closing the data loop.

Table D7: Theme 3 — mapping roles and responsibilities

What	Who
Through clinical placements within NACCHO membership	NACCHO
Provide cultural awareness training to promote levels of burden of disease, resources, roles, cultural ways of working at local, regional and state level	Face to face
Pharmacist/educators link	
General practice links	
Collaborate with Aboriginal Health Workers: involvement, employment, local engagement; communication/education; developmental work; relationship building with general practice groups/practices and Aboriginal organisations/groups	
MLs support of general practices in identification	MLs
Practice nurses	
Immunisation program	
Tailored practice level support	
RACGP accreditation standards are mandated: • education • follow AIHW guidelines • practice software used	RACGP
Department of Human Services/Medicare – liaison officers	DHS/Medicare
ML boards work agenda (Divisions of General Practice)	MLs
Remote area nurses, nurse practitioners, school nurses, palliative care nurses etc.	Practice Management Association and CRANA, Practice Nurses Association
Coordination with national level initiative such as the CPMC Indigenous Medical Specialist Program	

Note: See Abbreviations list for full names of all abbreviations cited.

Table D8: Theme 3 — suggestions for ways forward

What
Booking online to see GP
Guidelines into practice via local software and clinical decision support
Increase employment of Indigenous people in the health sector, with support network
Culturally safe environment to identify
Link with MLA workforce
Local forums for link of services with Aboriginal community
Local champions
Medicare card should indicate 'Aboriginal/Torres Strait Islander or not' Indigenous status —link to VII—or could be in a separate card similar to Department of Veteran's Affairs?
Should it be mandatory to ask when getting a Medicare card? (not context-specific) (*Note:* Indigenous status is asked on Medicare enrolment form.)
Mandatory to ask Indigenous status at general practice
Indigenous identification visible to pharmacist – Medicare card?

Note: See Abbreviations list for full names of all abbreviations cited.

(continued)

Table D8 (continued): Theme 3—suggestions for ways forward

General practice training to include:

- Cultural competency
- Clinical rationale
- Accreditation standards
- MBS and PBS Indigenous items, etc.
- Social determinants
- Normalise 'asking the question'
- Available on internet

Changing behaviour—education (ACRRM, GPET, RACGP)

Normalising—new versus existing patients—why now? Link to information on
culturally and linguistically diverse status

Better integration across life-cycle of medical training—vertical integration

Health checks

- Do they make a difference?
- evidence
- clinical rationale

Shifting focus

Collaboratives—getting and disseminating information

RACGP online training links with MLs and AIHW

Improved coordination—marketing and promotion is consistent

Examples of national standards made to grass roots

Colleges having mandatory Aboriginal and Torres Strait Islander curriculum

Should we be targeting and focusing efforts on high-population areas/states to start asking the question?

Translate the Guidelines into a form (for example, DVD) that general practices can easily absorb and use to train
staff

Training and awareness—evidence-based bytes to explain to GPs

Initiatives:

- monetary incentives
- improve data
- benefits and evidence
- business case for implementing identification and health plans/services that are subject to initiatives

National campaign

Review of standard question re identification

Further strengthening the RACGP accreditation standard regarding identification

Feedback loop of achievement against implementation targets/standards, like immunisation rates, health checks

Note: See Abbreviations list for full names of all abbreviations cited.

Theme 4: Raising awareness about the importance of identification

(Facilitator: Ronda Ramsay)

Theme 4 recommendations

- Communicating and educating the relevance, value and importance of asking the question, targeting both:
  - Indigenous people
  - non-Indigenous people: professionals, community, different audiences and different speakers (including the Australian Medical Association).

  Identified as pragmatic

  Stakeholders—NIRA process

- Communication plan—identify what the messages are, who is best to provide them and who the audience is. Funding for mainstream media.

  Identified as aspirational and political

  Stakeholders—NIRA process

- Single source of information—guidelines and initiatives
  - co-designed, agreeing on single point of reference.

  Identified as aspirational and political

  Stakeholders – Australian Association of Practice Managers, Australian College of Rural and Remote Medicine, Australian Medicare Local Alliance, Australian Practice Nurses Association, DoHA, GP-Plus, NACCHO, Office of Aboriginal and Torres Strait Islander Health, RACGP

- Cross-program integration
  - collaborative approach
  - integration at government level

  Identified as pragmatic.

Table D9: Theme 4—mapping roles and responsibilities

What	Who
Work to align state-based legislation	Not stated
Online training—practice teams	RACGP
Practice teams (and primary health-care teams)	Practice teams
ML workforce work with clients and educate practice	MLs
National anti-racism campaign	Australian Human Rights Commission
Affiliates work with hospitals on asking question	NACCHO
Work on importance of identifying	Funeral directors

Note: See Abbreviations list for full names of all abbreviations cited.

Table D10: Theme 4—suggestions for ways forward

What
Need better alignment of systems—national standards/ formalise national standards
Use mass media to get message across as an important issue—public health level
Who should ask the question and where?
Asking the question needs to be normalised
Strong clinical messages
Target behaviour of people who should be asking the question
Role of DoHA–Office of Aboriginal and Torres Strait Islander Health (OATSIH) in raising awareness
What role can the PCEHR play?
Deal with racism (take the heat out of the question)
Maintain and build on advocate (positive) environment
Peak Aboriginal and Torres Strait Islander groups are important
Non-Indigenous people/professionals to market and raise awareness
Use Aboriginal Health Workers etc. to advocate/raise awareness/support
Availability of meaningful training in cultural safety—more than just cultural awareness
More champions (range of non-Indigenous and Indigenous)
Roll out similar model to that in all medical colleges (15) like GP—at policy statements stage now
Showcase good things that are happening

Note: See Abbreviations list for full names of all abbreviations cited.

Theme 5: Improving the uptake of GP-mediated health interventions specifically for Indigenous people

(Facilitator: Helen Johnstone)

Theme 5 recommendations

- Education and training of communities and the general practice team (peer-to-peer processes and revised curriculums)

   Stakeholders: Aboriginal Community Controlled Health Services, Australian Practice Nurses Association, Department of Human Services, GP colleges, MLs, RACGP

- Central coordination information point, simpler, better presented

   Stakeholders: Australian Association of Practice Managers, Aboriginal Community Controlled Health Services, Australian Medicare Local Alliance, Australian Practice Nurses Association, DoHA, Department of Human Services, GP colleges, NACCHO, RACGP

- Quality improvement – use of local level data to improve practice and adherence to standards and Guidelines

   Stakeholders: AIHW, Australian Medicare Local Alliance, Australian Primary Care Collaboratives, MBS, National Health Performance Authority.

Table D11: Theme 5 — suggestions for ways forward

What	Who
Awareness—target resources General practice distribution resource kit	DoHA
Reporting—Health Performance Framework	DoHA
Provide guidance on MBS, GP measures	MLs
Provide information and resources to affiliates and member organisations Use existing resources Develop own resources	NACCHO
Compliance advice and practice support Reporting	DHS—Medicare
Indigenous community education Talking posters Use Medicare shopfronts to inform people Developing local resources	Centrelink, DHS, Indigenous specialist officers Medicare liaison officers MLs, community
Simpler way of presenting the measures	DoHA, practice managers, RACGP
Send information to practice managers and GPs	Practice managers
Increase awareness of registrars through training	GPET, MLs Standards Group, NHPA
Include GP-mediated measures in online identification module	RACGP
Embedding Closing the Gap in MLs	MLs
Strengthen curriculum for GP training	Colleges
Education of GPs, allied health, nurses, practice staff	DoHA, MLs
Quality improvement at local level Reporting uptake rates back to local level (*Note:* MBS payment system not levels of care) Specific items	AIHW, APCC, MLs, NHPA
Use RACGP—clinical indicators for GPs	DoHA, MBS online RACGP, software developers
Central point of information for general practices	
Explore providing data on uptake at the general practice level on a range of measures	DoHA, MBS, RACGP
Evaluation of the Indigenous Chronic Disease Package Implementing recommendations Using to improve practice Identify which elements work best Sentinel sites	DoHA

Note: See Abbreviations list for full names of all abbreviations cited.

Table D12: Theme 5 — other material

What	Who
Investigation of best practice method in dealing with Aboriginal and Torres Strait Islander patients in general practice	GPs, nurses, practice managers, whole of practice
Melbourne University paper—research conducted	Melbourne University
Synthesising existing research and using findings to inform practices/information /general practice training	AIHW, AMA, DoHA, RACGP

Note: See Abbreviations list for full names of all abbreviations cited.

Theme 6: Building a community of practice for Indigenous identification in general practice

(Facilitator: Anthony Cowley)

Theme 6 recommendations

- Investigate getting feedback from accreditation processes (for example, patient feedback) on identification processes

  To be progressed by Australian General Practice Accreditation Limited, GPA Plus and RACGP

  (*Note*: This recommendation was not endorsed by all)

- Identify and invite other bodies (including the Australian College of Rural and Remote Medicine, Rural Doctors Association and others) to these annual seminars (*Note:* The Australian College of Rural and Remote Medicine was invited to both 2011 and 2012 workshops but was unable to attend.)

- Progress formal collaboration by establishing a group

  Provide pre-emptive program design to DoHA (for example, data to support policy implementation) and frame appropriate terms of reference

  Identified as pragmatic

  Stakeholders include: Australian College of Rural and Remote Medicine, AIHW, Medical Software Industry Association, NEHTA, RACGP, Rural Doctors Association.

Table D13: Theme 6—mapping roles and responsibilities

What	Who
Standards of General Practice, fourth edition	RACGP and implementing collaborators AGPAL and GPA
Practices being accredited now for PIP	
Cycle: 3 years	
Curriculum	
General practices need processes to collect identification	
Software development	
Administrative records	Individual practices and laboratories (Pathology) software Pharmacol
Standardising system	
Training	GP
Standardisation	MSIA, software industry
Recipients	Registers
Dissemination	
Facilitator of data	NEHTA
Implementation/alignment of specs and guidelines with PECHR	
Practice management information	AAPM
Work with software and staff training practice policy	
Commonwealth policy co-ordination	DoHA
Close the Gap	
Impartial advice to DoHA	AIHW and collaborators (including MSIA)
Stakeholder engagement	AMLA, NACCHO, NATSIHWA
Critical influence	
Implementation of best practice	State-based groups, practice nurses
Champions and leaders	AMA, ANF

Note: See Abbreviations list for full names of all abbreviations cited.

Table D14: Theme 6—suggestions for ways forward

What	Who
Community governance and coordination	General practice, local council, local infrastructure, MLs, Pharmacol
Support	
Stakeholders	
Identified as pragmatic	
Cultural brokerage	Local Aboriginal Health Workers
Involvement in programs and advice	
Employment	
Identified as pragmatic	

Note: See Abbreviations list for full names of all abbreviations cited.

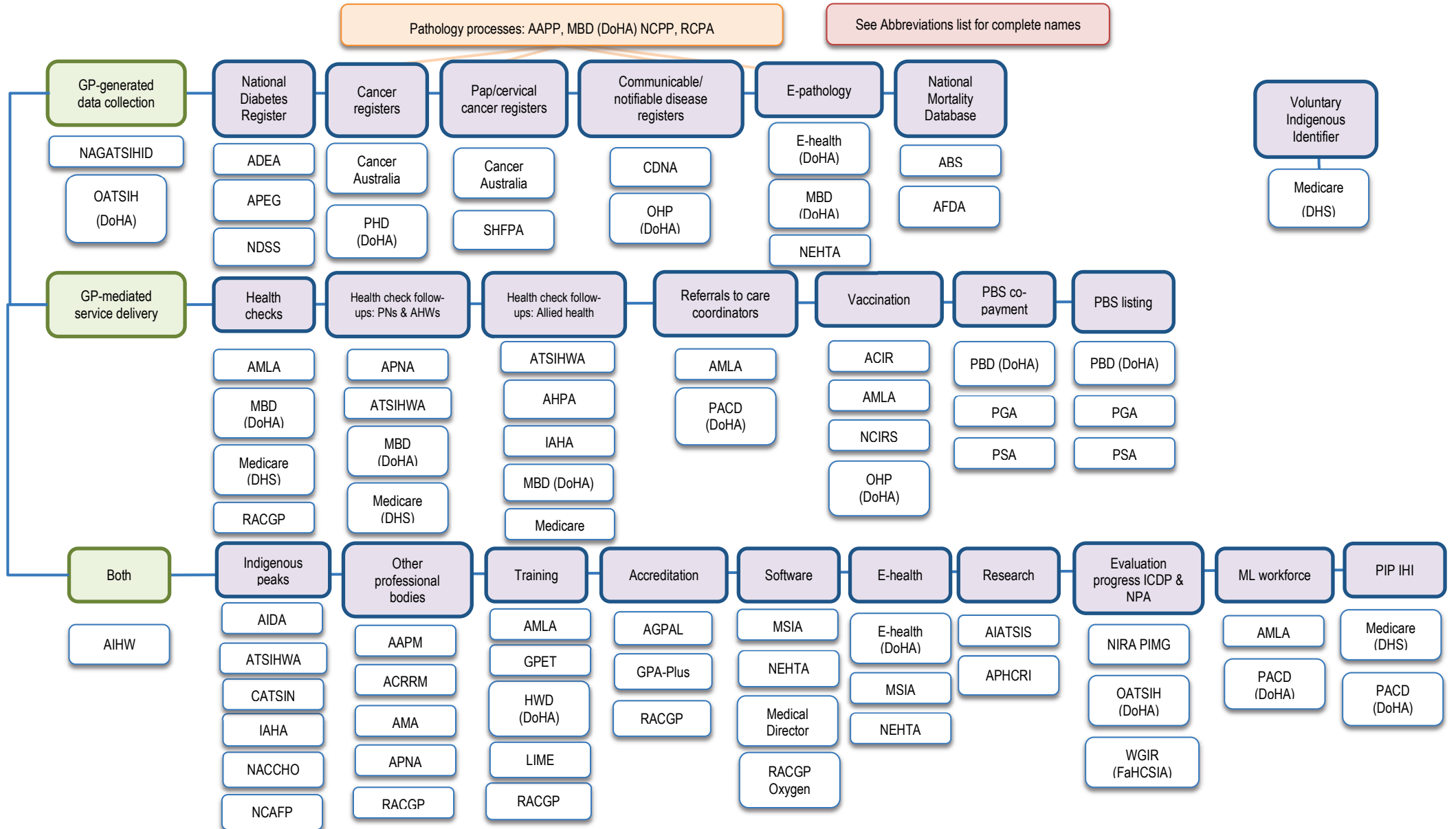**Table D15: Theme 6—other material**

What	Who
Co-design resources for example online tools for awareness raising of benefits to doctors, community and so forth of improved identification Local customisable content addressing regional concerns/issues via community engagement Identified as pragmatic	AAPM, AMLA, APNA, DoHA, NACCHO, other nurses and allied health groups, RACGP
Community practice workshops—'training about raising the awareness of consumers and providers in asking the question' The AMLA to focus down to MLs, AIHW Identified as pragmatic	AAPM, AMLA, APNA, DoHA, NACCHO, NACCHO, other nurses and allied health groups, RACGP
National responsibilities need to be broadened; for example, immunisation function Identified as aspirational	Not stated
State registers Standardisation of pathology software Identified as aspirational	Not stated
National community practice—collaboration, communication	Not stated
Standardisation of resources among stakeholder groups	Not stated
Local focus—community ownership/responsibility—community knowledge	Not stated

Note: See Abbreviations list for full names of all abbreviations cited.

Appendix E: Data on uptake of GP-mediated health interventions specifically for Indigenous people

Measure	Target population/ population in scope	Estimated number in scope	Estimated uptake/ Coverage (approx.)	Outcome
MBS health checks	All Aboriginal and Torres Strait Islander people regardless of age	575,552 (2011) 3238.0 Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021	71,369 health checks conducted 2010–11	71,369 / 575,552 = 12.4%
Pneumococcal immunisation for people aged over 50	Aboriginal and Torres Strait Islander people aged over 50	Excerpt from Aboriginal and Torres Strait Islander Health Performance Framework (AIHW 2011a)		
PBS co-payment	Aboriginal and Torres Strait Islander people of any age with, or at risk of, chronic disease in non-remote areas who meet eligibility requirements	*Note:* No data on numbers/ proportion with, or at risk of, chronic disease No. of Aboriginal and Torres Strait Islander people in non-remote areas = 389,727 30 June 2006 revised rebased Indigenous Estimated Resident Population by state by remoteness area by sex by 5-year age groups	150,000 people had accessed PBS co-payment prescriptions at June 2012	150,000/ 389,727 = 38.5%
Nicotine replacement therapy	Aboriginal and Torres Strait Islander smokers aged over 15 in non-remote areas	Estimated number of Indigenous smokers in non-remote areas = 109,900 Aboriginal and Torres Strait Islander Health Performance Framework (AIHW 2011a)	3,184 Aboriginal and Torres Strait Islander-specific nicotine replacement therapy scripts issued between December 2008 and February 2011 (individuals can access two repeats for each script)	3,184/109,900 = up to 2.9%
PIP IHI practice sign-on	ACCHS and mainstream general practices that are accredited against RACGP standards (therefore eligible to participate in PIP)	5,000 practices (DoHA 2013b)	2,900 practices had signed on by April 2012 (DoHA 2103b)	2,900 /,5000 = 58%
Voluntary Indigenous Identifier	All Aboriginal and Torres Strait Islander people		339,310 people registered as Indigenous as at May 2012 (AHMAC 2012)	Nearly 60% of the Aboriginal and Torres Strait Islander population (p.11 AHMAC 2012)

Appendix F: Stakeholder map

Pathology processes: AAPP, MBD (DoHA) NCPP, RCPA

See Abbreviations list for complete names

GP-generated data collection
- NAGATSIHID
- OATSIH (DoHA)

National Diabetes Register
- ADEA
- APEG
- NDSS

Cancer registers
- Cancer Australia
- PHD (DoHA)

Pap/cervical cancer registers
- Cancer Australia
- SHFPA

Communicable/ notifiable disease registers
- CDNA
- OHP (DoHA)

E-pathology
- E-health (DoHA)
- MBD (DoHA)
- NEHTA

National Mortality Database
- ABS
- AFDA

Voluntary Indigenous Identifier
- Medicare (DHS)

GP-mediated service delivery

Health checks
- AMLA
- MBD (DoHA)
- Medicare (DHS)
- RACGP

Health check follow-ups: PNs & AHWs
- APNA
- ATSIHWA
- MBD (DoHA)
- Medicare (DHS)

Health check follow-ups: Allied health
- ATSIHWA
- AHPA
- IAHA
- MBD (DoHA)
- Medicare

Referrals to care coordinators
- AMLA
- PACD (DoHA)

Vaccination
- ACIR
- AMLA
- NCIRS
- OHP (DoHA)

PBS co-payment
- PBD (DoHA)
- PGA
- PSA

PBS listing
- PBD (DoHA)
- PGA
- PSA

Both
- AIHW

Indigenous peaks
- AIDA
- ATSIHWA
- CATSIN
- IAHA
- NACCHO
- NCAFP

Other professional bodies
- AAPM
- ACRRM
- AMA
- APNA
- RACGP

Training
- AMLA
- GPET
- HWD (DoHA)
- LIME
- RACGP

Accreditation
- AGPAL
- GPA-Plus
- RACGP

Software
- MSIA
- NEHTA
- Medical Director
- RACGP Oxygen

E-health
- E-health (DoHA)
- MSIA
- NEHTA

Research
- AIATSIS
- APHCRI

Evaluation progress ICDP & NPA
- NIRA PIMG
- OATSIH (DoHA)
- WGIR (FaHCSIA)

ML workforce
- AMLA
- PACD (DoHA)

PIP IHI
- Medicare (DHS)
- PACD (DoHA)

Abbreviations

AAPM	Australian Association of Practice Managers
AAPP	Australian Association of Pathology Practices
ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Services
ACIR	Australian Childhood Immunisation Register
ACRRM	Australian College of Rural and Remote Medicine
ADEA	Australian Diabetes Educators Association
AFDA	Australian Funeral Directors Association
AGPAL	Australian General Practice Accreditation Limited
AGPN	Australian General Practice Network
AHMAC	Australian Health Ministers' Advisory Council
AHPA	Allied Health Professionals Australia
AIDA	Australian Indigenous Doctors Association
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMLA	Australian Medicare Local Alliance
ANF	Australian Nursing Federation
APCC	Australian Primary Care Collaboratives
APEG	Australasian Paediatric Endocrine Group
APHCRI	Australian Primary Health Care Research Institute
APNA	Australian Practice Nurses Association
ATSIHWA	Aboriginal and Torres Strait Islander Health Worker Association
BEACH	Bettering the Evaluation and Care of Health
CATSIN	Congress of Aboriginal and Torres Strait Islander Nurses
CDNA	Communicable Disease Network of Australia
COAG	Council of Australian Governments
CPMC	Committee of Presidents of Medical Colleges
CRANA	Council of Remote Area Nurses of Australia
DHS	Department of Human Services
DoHA	Department of Health and Ageing

FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
GP	General practitioner
GPA-Plus	General Practice Australia-Plus
GPET	General Practice Education and Training
HWD	Health Workforce Division (part of DoHA)
IAHA	Indigenous Allied Health Australia
ICDP	Indigenous Chronic Disease Package
LIME	Leaders in Indigenous Medical Education
MBD	Medical Benefits Division (part of DoHA)
MBS	Medical Benefits Schedule
METeOR	Metadata Online Registry
ML	Medicare Local
MSIA	Medical Software Industry Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NAGATSIHID	National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data
NATSIHSC	National Aboriginal and Torres Strait Islander Health Standing Committee
NATSIHWA	National Aboriginal and Torres Strait Islander Health Worker Association
NCAFP	National Congress of Australia's First Peoples
NCIRS	National Centre for Immunisation Research and Surveillance
NCPP	National Coalition of Public Pathology
NDSS	National Diabetes Services Scheme
NEHTA	National E-Health Transition Authority
NHLF	National Health Leadership Forum
NHPA	National Health Performance Authority
NIRA	National Indigenous Reform Agreement
NIRA PIMG	National Indigenous Reform Agreement Performance Information Management Group
NPA	National Partnership Agreement
OATSIH	Office of Aboriginal and Torres Strait Islander Health (part of DoHA)
OHP	Office of Health Protection (part of DoHA)
PACD	Primary and Ambulatory Care Division (part of DoHA)

PBD	Pharmaceutical Benefits Division (part of DoHA)
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Record
PGA	Pharmacy Guild of Australia
PHD	Population Health Division (part of DoHA)
PIP	Practice Incentives Program
PIP IHI	Practice Incentives Program - Indigenous Health Incentive
PSA	Pharmaceutical Society of Australia
RACGP	Royal Australian College of General Practitioners
RCPA	Royal College of Pathologists of Australasia
RDA	Rural Doctors Association
SHFPA	Sexual Health and Family Planning Australia
VII	Voluntary Indigenous Identifier
WGIR	Working Group on Indigenous Reform

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The general practice sector needs to collect the Indigenous status of patients in order to provide GP-mediated health interventions specific to Aboriginal and Torres Strait Islander people and to provide Indigenous status data to national data collections. Effective Indigenous identification processes are not widespread in the sector and this undermines both service delivery and data collection. This report describes the problem and discusses how Indigenous identification could be improved.