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**Relating well to people: a mixed methods evaluation of preventive care
implementation for Aboriginal and Torres Strait Islander people in mainstream,
urban general practice**

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Abstract

Introduction

There is potential for health gain by Aboriginal and Torres Strait Islander people in Australia through better primary health service in urban areas. Preventive health care delivered with social sensitivity is critical to addressing chronic disease. In the mainstream urban general practice setting, three key linked processes of Indigenous identification, health checks and immunisation for Indigenous people should be improved.

Background

The history and current lived experience of Aboriginal and Torres Strait Islander people influence access to mainstream health care services. Known access facilitators in urban areas are low cost, convenience and delivery in a culturally safe setting by practitioners with compatible values and professional culture. In contrast to community controlled health services, mainstream general practices have few practitioners with Indigenous care experience, and low levels of Indigenous identification and Indigenous health check delivery.

This thesis presents the development, implementation and evaluation of an intervention in Brisbane designed to address known and suspected barriers to Indigenous people's access to preventive care in mainstream urban general practice.

The following research questions were considered:

1. Based on the best evidence, what intervention by Division of General Practice and Public Health Unit staff was appropriate and feasible to promote increased coverage of Indigenous health checks and immunisation in mainstream urban general practices?
2. What were the effects of the intervention targeting mainstream practitioners on Indigenous identification, immunisation and health checks, and what were the other effects?
3. How could existing barriers to immunisation and health checks in mainstream general practice be overcome?

Methods

The Promoting Indigenous Preventive Care in General Practice (PIPCGP) study used a realist-inspired framework of enquiry and a mixed methods approach. Division of General Practice and Public Health Unit staff used existing resources to provide intensive practice support through an educational workshop, package of activity support materials, progressive audit and feedback, and ongoing contact over twelve months. Seventeen General Practices in two intervention groups were enrolled. Audit data were gathered at the practice, returned to practices, and collated for evaluation purposes. In-depth interviews were conducted with 35 participants, including clinical and non-clinical staff of practices and Indigenous community members.

Results

The inner suburban group had low attrition, showed a steep rise (78%) in Indigenous patient numbers, and increased health check delivery. Half the Indigenous children aged 2 to 5 years had immunisation data missing from their record prior to intervention, which was rectified. Child immunisation coverage for all vaccines, including Indigenous-specific vaccines, was 46% at the end of the period. The outer suburban group had a high attrition rate of 50%.

Preventive care processes for over two thousand Indigenous patients were included in the study. Increased Indigenous identification came from both current and new patient groups. Practices with higher health check activity had staff experienced in Indigenous health, were already delivering checks prior to intervention, and increased their activity. Few low activity practices had previously undertaken checks, and half of these commenced. Difficulties reported were a low level of patient willingness to undergo a check, and organisational processes: poorly adapted electronic records, long consultation time, and uncertainty about sharing assessment components between team members.

Indigenous identification was welcomed, was associated with acknowledgement of culture, and helped build relationships. Providers experienced in Indigenous health aligned with patients in emphasising the staff-patient relationship as a barrier to preventive care, and provided guidance on relationship building. Other providers focused solely on practical barriers. Most providers and community members

expressed the need for links between practices, the Indigenous community, and Indigenous organisations.

Discussion

The PIPCGP study confirms that Indigenous identification can be quickly improved in mainstream General Practices, and highlights an additional range of practical and social issues to be addressed in increasing access to preventive care. These include knowledge of the Indigenous immunisation schedule, improved completeness of immunisation record keeping, and teamwork to plan adequate time and cooperation for health checks. Information system deficits exist in Indigenous identification recording, on-screen activity prompt and recall/ reminder. The success factor of staff experienced in Indigenous health enabled a patient relationship-building focus and influenced system change in the practice.

Conclusion

Mainstream practice efforts to strengthen patient-centred care of chronic disease, should include Indigenous cultural and relationship-focused training for staff, Indigenous patient service planning and quality improvement. A continued dialogue and partnership between Community Controlled Health Services and Primary Health Networks, with the assistance of Public Health Services, is essential to support practices with concentrations of Indigenous patients. Supply of general practice information systems in Australia which support tailored care for Indigenous people could be another lever for change, as could more detailed activity monitoring linked to financial incentives to provide high quality preventive care.

Declaration by author

This thesis is composed of my original work, and contains no material previously published or written by another person except where due reference has been made in the text. I have clearly stated the contribution by others to jointly-authored works that I have included in my thesis.

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Publications included in this thesis

No publications included.

Submitted manuscripts included in this thesis

No manuscripts submitted for publication.

Other publications during candidature

No other publications.

Contributions by others to the thesis

Professor Cindy Shannon drew my attention to the situation that she was working to improve, with Indigenous colleagues at the Institute for Urban Indigenous Health, inspiring me to take up the work. Cindy provided encouragement and advice, linking me with the Institute for Urban Indigenous Health (IUIH), where Chief Executive Officer Adrian Carson and Research Director Dr Yvette Roe facilitated my continuing engagement with Indigenous colleagues for the purpose of planning, data collection, and for presentation and feedback at several points during the project. Professor Maxine Whittaker and Dr Andrew Page from the University of Queensland and Drs Christine Selvey and Hai Phung from Queensland Health Communicable Disease Control Unit helped me to conceptualise and design the research.

Dr Cathie Chan, Ms Kym Kilroy, Ms Tammy Pope, Ms Nancy Collins, Ms Angela Keegan and Mr Brett Shannon contributed to the development of the intervention undertaken in the study.

Nancy Collins, Angela Keegan and David Knobel, based at the two Divisions of General Practice, provided workshop sessions, and visited practices to collect audit data and /or provide ongoing support to practice staff throughout the project.

Kym Kilroy facilitated several of the interviews that I undertook with Indigenous community members, and undertook practice waiting room observation. Winsome Goldfeder facilitated several of the general practice group interviews. These were

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Associate Professor Frances Boyle, as my principal supervisor during the writing stage, helped me to draft the document by providing regular feedback and suggestions including short segments of text. Fran Boyle, Professor Maxine Whittaker and Associate Professor Linda Selvey critically reviewed my writing, providing comments on my drafts. Associate Professor Jon Willis and Associate Professor Peter Hill formally reviewed the work, providing helpful suggestions.

Statement of parts of the thesis submitted to qualify for the award of another degree

No works submitted towards another degree have been included in this thesis.

Research Involving Human or Animal Subjects

The research project (HREC/10/QHC/8) was approved by the Queensland Health Human Research Ethics Committee, Centres for Healthcare Improvement, on June 23, 2010.

A Site-Specific Assessment was provided to the committee for the Moreton Bay Public Health Unit, endorsed by the area's Queensland Health manager, which was acknowledged by the Human Research Ethics Committee (HREC) on 8 February 2011. An amendment to the project was approved by the same Queensland Health committee on 16 April 2012.

The project, identified as 2011001330, was granted an expedited approval (#2011001330) by the University of Queensland Behavioural and Social Sciences Ethical Review Committee on 6 December 2011, based on prior approval by the Queensland Health committee. The project amendment approved by Queensland Health as above, and an extension to the end date, was given by the same University of Queensland committee on 25 January 2016.

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Dedication

This work is dedicated to three Aboriginal women: Mrs Marjorie Stanley,
Ms Kym Kilroy and Professor Cindy Shannon.

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List of Abbreviations used in the thesis

ABCD	Audit of Best Practice in Chronic Disease (Project)
ABCDE	Audit of Best Practice in Chronic Disease extension (Project)
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal and Torres Strait Islander Community Controlled Health Service
AHW	Aboriginal and/or Torres Strait Islander Health Worker
BEACH	Bettering the Evaluation and Care of Health (Research Program)
BOD	Burden of Disease
CMOC	Context-Mechanism-Outcome configuration
COAG	Council of Australian Governments
CQI	Continuous Quality Improvement
DALY	Disability Adjusted Life Year
DGP	Division of General Practice
EPC	Enhanced Primary Care
GP	General Practitioner
HHS	Hospital and Health Service
HREC	Human Research Ethics Committee
HREOC	Human Rights and Equality Opportunity Commission
ICDP	Indigenous Chronic Disease Package
IRSD	Index of Relative Socioeconomic disadvantage (SEIFA index).
IUIH	Institute for Urban Indigenous Health
NAIDOC	National Aboriginal and Islander Day of Observance Committee
NATSISHS	National Aboriginal and Torres Strait Islander Health Survey
NATSISS	National Aboriginal and Torres Strait Islander Social Survey

NATSIHWA	National Aboriginal and Torres Strait Islander Health Worker Association
NHMRC	National Health and Medical Research Council
NPA	National Partnership Agreement on Closing the Gap in Indigenous Health
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PHU	Public Health Unit
PHS	Public Health Service
PIPCGP	Promoting Indigenous Preventive Care in General Practice (Study)
PIP IHI	Practice Incentives Program Indigenous Health Incentive (of Medicare)
RACGP	Royal Australian College of General Practitioners
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
RE	Realist Evaluation
SEIFA	Socio-economic Index for Areas
WAACHS	Western Australian Aboriginal Child Health Survey
WHO	World Health Organization

Notes on terminology used in the thesis

Cultural safety 'Cultural safety is based on the experience of the recipient of care, and involves the effective care of a person/family from another culture by a healthcare professional who has undertaken a process of reflection on their own cultural identity and recognises the impact of their culture on their own practice.' This definition was used as the basis for the National Aboriginal and Torres Strait Islander Health Worker Association Cultural Safety Framework, and was adopted from the Nursing Council of New Zealand definition,¹ a culmination of work begun by Maori midwife Irihapeti Ramsden.² This work, according to the New Zealand Nurses Council, was first documented by Papps & Ramsden in a 1989 nurses journal article titled 'Equalising the partnership'.³

Indigenous peoples: The United Nations Permanent Forum on Indigenous Issues has acknowledged diversity and the right of indigenous peoples to define themselves. Rather than creating a definition, indigenous peoples were described in 2014 by the United Nations affiliated Inter-parliamentary Union as having some or all of the characteristics below, and the approach has been widely adopted

- Self- identification as indigenous peoples at the individual level and accepted by the community as their member
- Historical continuity with pre-colonial and/or pre-settler societies
- Strong link to territories and surrounding natural resources
- Distinct social, economic or political systems
- Distinct language, culture and beliefs
- Form non-dominant groups of society
- Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities.⁴

This approach originated from the work of Jose Martinez Cobo (1982), who documented the diversity of groups in an international report on the Problem of Discrimination against Indigenous Populations.⁵ A later meeting of the African Commission's Working Group of Experts on Indigenous Populations/Communities further highlighted the rights to land and productive resources as an issue impinging on indigenous peoples.⁶ In this thesis, Indigenous people or peoples refer to the indigenous peoples of Australia, unless otherwise specified.

Indigenous peoples of Australia: Aboriginal and Torres Strait Islander peoples

Indigenous status: a term used for the purpose of data collection. As set out in the Australian Bureau of Statistics document Indigenous Status Standard, 2014, Version 1.5, the ABS uses self-report. Status is determined by the person's response to the ABS Standard Indigenous Question: 'Are you of Aboriginal or Torres Strait Islander origin?' for which categories are: 'No'; 'Yes, Aboriginal'; and 'Yes, Torres Strait Islander'. This question allows respondents to report that they are both Aboriginal and Torres Strait Islander if that is how they identify. This is a variable categorising all Australians.⁷

Aboriginal view of Health: As set down in the first National Aboriginal Health strategy, 1989 and adopted by the Constitution of the National Aboriginal Community Controlled Health Organisation, 2006: 'Aboriginal health' means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.^{8, 9}

The National Aboriginal and Torres Strait Islander Health Worker Association, in their professional practice framework set down in 2012 added that 'Although Aboriginal and Torres Strait Islander peoples are culturally, linguistically and ethnically diverse, most share [this] holistic understanding of "health"'.¹⁰

Aboriginal and/or Torres Strait Islander Health Worker: A community health worker with a diverse range of roles. Consistent characteristics are the provision of Aboriginal primary healthcare; cultural security and safety; disease prevention and health promotion; local community knowledge; and a holistic approach to healthcare. Many Aboriginal and/or Torres Strait Islander Health Workers (AHW) have Certificate III level training in Aboriginal Primary Health Care.¹¹ Some AHWs have certificate IV level training in Aboriginal Primary Health Care (Practice). These qualifications confer eligibility for registration with the Aboriginal and Torres Strait Islander Health Practice Board associated with the Australian Health Practitioners Regulation Agency, as Aboriginal Health Practitioners.¹² Other AHWs have tertiary level training and undertake a wider range of roles, for example as Principal Aboriginal Health Worker, in defined positions in the New South Wales Department of Health.¹³

General Practitioner: The Royal Australian College of General Practitioners (RACGP) refers to a General Practitioner as a medical specialist (doctor) who delivers healthcare in the community consistent with the discipline of general practice.¹⁴

General practice: a discipline or specialty within medicine that applies to the practice of primary healthcare in the community. The RACGP has stated 'General Practice provides person centred, continuing, comprehensive and coordinated whole person healthcare to individuals and families in their communities'.¹⁵

The term also describes the sector of healthcare delivering this care, and the premises or business utilised to provide this care.

Patient: A person receiving medical care or treatment, or a person under a health worker's care for a particular disease or condition. The term *patient* has been used to signify a role and situation in the PIPCGP study, as frequently discussed with and by interview participants.

Patient-centred care: Sharing management of illness between patient and doctor. Health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers. According to the Australian Commission on Safety and Quality in Health Care, the widely accepted dimensions of patient-centred care are respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care.¹⁶

Primary Health Networks (PHNs) are a national network of independent primary healthcare organisations that replaced Medicare Locals (MLs) from 1 July 2015, one of their stated objectives being to improve the efficiency and effectiveness of medical services for patients at risk of poor health outcomes and to improve coordination of care, particularly for those with chronic and complex conditions.¹⁷

Public Health Units are regional health services whose role in Queensland is to work at the whole of community level to control vaccine preventable infections and other infections that are a risk to the public, control hazards to health in the local environment, and promote the health and wellbeing of the community.¹⁸

Prologue

'I just want to be treated like a person' was how she summed it up. '...not a number, not a receiver of care, but a respected equal' was how I came to understand what she had said to me, after I had covered this same ground in conversation with many more. I then discovered 'treatment as a "human being"' to be the description of culturally safe healthcare also identified by a group of Canadian Indigenous people in research.¹⁹ I, and an Aboriginal friend / colleague had visited the home of a single, elderly Indigenous woman to conduct the first Indigenous patient interview for my project. My friend thought it was appropriate to help get me started in this way, by accompanying me, and showing me how to behave when visiting the home of an Indigenous person for the purpose of seeking and accepting their help with the research. A local Indigenous Health Worker had given us the woman's contact details, after checking with her. The participant, of low income and fragile health judging by her surroundings, was willing to give me her time, although she knew neither of us personally. The participant knew that she had a role in speaking for and guiding her community. I asked about her experiences in attending mainstream general practice, however she persisted in talking about her social interactions with non-Indigenous people in the distant past and her recent experiences in hospital, before talking a little about her general practice encounter for a health check. This also proved to be a common pattern in the woven threads of discussion. The woman knew better than I did what should be included. This situation illustrated my role as an observer who was fostered and helped despite obvious professionally-based misconceptions, and an incomplete contextual understanding of the landscape I was entering. In a very personal way, I have taken a journey with the assistance of Indigenous people acting as "buddies", key informants, or both, all of whom had an understanding of experiential learning, and an eye to the bigger picture.

Evaluating an intervention for Indigenous people in general practice may seem to be a relatively straightforward task; however, there are complexities. Processes of driving change in primary care structure through governmental measures are complex. Processes of implementing change at the practice level are also complex. Lastly and most importantly, it turns out, complexities arise from relationships between people: doctor-patient, indigene-coloniser and insider-outsider to name a few of the *hyphens* in operation. I use the term *hyphen* in the sense meant by Fine

(1998), in her conceptualisation of relational identities that exist between the researcher and the researched.²⁰ In critical cultural studies where complex and multiple differences between actors are acknowledged and discussed, *Working with the hyphen* has been applied more broadly by Jones & Jenkins (2008) in their critical methodology textbook chapter on rethinking collaboration.²¹ Both the processes I studied and the study methods called for conscious consideration and discussion of my positioning as a researcher in relation to the research participants, as a precursor to collaborative work.

At the outset, I, as a public health physician supporting preventive health service development in a local area with few established Aboriginal community-controlled health services, saw my task as describing and analysing the nuances of practice required of mainstream services for a particular group of patients. I have since come to realise that, in these most systematised of activities, it is not the service setup, but the personal elements that seem to have most impact on life and on health.

Chapter 1 Introduction

1.1 Overview of the issues

This chapter outlines the rationale for the Promoting Indigenous Preventive Care in General Practice (PIPCGP) study. The health inequality experienced by urban Indigenous people, the potential for preventive care to make a difference, and the shortfalls in preventive service are highlighted. Mainstream general practices have provided some or all of the primary health care for a substantial proportion of Indigenous people. There has been little detailed information available about that care, because of incomplete Indigenous identification within general practices. Three linked processes of Indigenous identification, Indigenous-specific immunisation and Indigenous health check delivery had not yet been studied together in detail in mainstream urban general practices. A gap in knowledge to inform practice improvement has been filled by the PIPCGP project.

In collaboration with local stakeholders, research questions were developed to examine the suitability, effects, consequences and enhancement, of a mainstream practice-based intervention which focused on the three linked processes. A realist-inspired evaluation was undertaken, which entailed exploring the local context in detail using mixed methods, and analysing the collected data based on mechanisms and outcomes predicted by an examination of the literature. The chapter concludes by presenting the structure of the thesis.

1.2 Rationale

The work of Marmot, Wilkinson & Bell in describing the social gradient of health^{22 23} has influenced me to take a social view of health. I consider the causes of health inequality to be complex and requiring change at multiple levels of society, in keeping with Solar & Irwin's analysis of the necessary action on social determinants of health.²⁴ Macinko, Starfield, Shi et al., using analytical epidemiology and meta-analyses have shown the great health benefit of primary health care: that primary care doctors and access to primary health care rather than hospital specialists have most influence on longevity on a population,^{25,26} and that a strong system of primary care supports the population's health in a more equitable way, when primary care has more equal geographic distribution and there are efforts to promote access.²⁷ Starfield provided further analyses to show that the health system success factors at country level are universal access to primary health care

with no or low co-payment, in a system which strives for equity of service across population groups.²⁸ This discussion is taken up in section 1.4.

In the Australian health system, improved access to health care and better preventive care are key health service contributors to Indigenous health improvement. Improved access of Indigenous people to Aboriginal Community Controlled Health Services (ACCHS) and mainstream health services is highlighted within the 'My Life My Lead' national consultation report, under 'Priority 6, health service access'.²⁹ I believe that this care should be accessible in the primary care sector via the multiple pathways of healthcare that Indigenous people choose to take. Medicare data published in government reporting estimate the distribution to be around 50% of care by each of these types of service.³⁰ The national cultural respect framework for Aboriginal and Torres Strait Islander Health 2016-2026 has introduced 'consumer designed care', which should apply to both service types.³¹ The government's approach to service development is discussed in section 1.8. Use of one or other service may be determined in many areas by physical access, however the patterns of general practice use and their underlying influences in urban areas, many of which may be social, are not yet fully described or understood in a way that has influenced mainstream services.

Urban areas of Australia are home to the highest proportion of the Indigenous population, and have the most rapid growth rate, due to a shift from the country to the city by Indigenous people.³² Contrary to a common misconception, it is not only Indigenous people of remote areas who suffer a high level of ill health in the community, but also Indigenous people in non-remote areas. According to Vos et al. (2003) 74% of Indigenous people resided in non-remote areas, defined as cities and regional areas. These people carried the highest proportion of the total Indigenous burden of disease, 60%, and this was predominantly chronic disease.³³ This is further discussed in section 1.7.

1.2.1 Addressing disparities

The Council of Australian Governments approved a National Indigenous Reform Agreement in July 2008, setting out six broad Closing the Gap targets and planning for annual reporting. The first of these targets, closing the gap in life expectancy, requires contributory action within the health system to prevent and better manage chronic disease.³⁴ Despite policy- and practice-based efforts across multiple sectors of government and community in Australia over the last ten years³⁵, national reports continue to chronicle high levels of chronic disease morbidity and mortality of Indigenous Australians. For example, in 2012 the self-reported prevalence of cardiovascular disease

in Indigenous adults was 13% and of diabetes was 11%, with 68% of those with diabetes reporting multiple chronic conditions. It was estimated that about one quarter more Indigenous adults are affected but undiagnosed with these conditions,³⁶ hence the importance of health checks. Serious vaccine-preventable infections such as meningococcal disease occur at a higher incidence in Indigenous children, and the higher rates of hepatitis A and pneumococcal pneumonia have decreased in association with the introduction of specific immunisations,³⁷ which illustrates the value of achieving and maintaining high levels of immunisation. Closing the Gap reporting has shown that life expectancy remains ten years less for Aboriginal and Torres Strait Islander people. Acting on this inequality of health outcome has been and remains a national priority for Australian health services³⁸ and an essential step is preventive care.

National Indigenous health planning has set targets for Indigenous health check coverage that are much higher than that currently achieved, to help address the increasing impacts of chronic disease (see section 3.7). Immunisation coverage of both Indigenous children and Indigenous adults must be improved to eliminate disparities in vaccine preventable disease, such as pertussis, pneumococcal disease and influenza. Indigenous infants at one year of age have lower coverage than other Australian infants, the result of delay in immunisation rather than vaccine refusal. There is little information available for ongoing monitoring of adult immunisation (see section 3.8).

1.2.2 Indigenous identification for health care

Ascertainment of Indigenous status in clinical practice is clearly necessary to point clinicians towards appropriate preventive care. For Indigenous people appropriate care would include more frequent health checks, a more proactive approach to immunising on time, and Indigenous-specific immunisation (in many Australian states). Without identifying Indigenous patients, preventive care opportunities are lost and practices are unable to tailor, monitor, and evaluate care. In 2010, the Australian Bureau of Statistics estimated that only 50% of Indigenous people in Australia voluntarily identified to Medicare.³⁰ Medicare Indigenous identification is protected information, not available to general practice staff, who must establish the Indigenous status of patients through personal enquiry.

Mainstream general practice-based research on Indigenous health has been hampered by patients' Indigenous status not being recorded, as was evident from general practice activity reporting within the Bettering the Evaluation and Care of Health (BEACH) program over a long time period, which was reviewed by Fahridin & Britt.³⁹ Sociocultural barriers

have been identified, and according to Lau et al.(2012) are poorly understood in the mainstream general practice setting, where culturally safe care has not been examined in detail.⁴⁰

This low rate of identification corresponds with my experience of challenges with Indigenous identification in maintaining the central immunisation record database for the area.⁴¹ It has led me to ask whether and why Indigenous people were still experiencing a sense of social exclusion within mainstream general practice. Some issues surrounding Indigenous identification for healthcare have been explored and acted upon, but there is more to be understood in practice, and more to be done. This has been suggested also by Schutze, Jackson-Pulver & Harris in a study that identified practical organisational and attitudinal barriers to identification were present in mainstream practices.⁴²

1.2.3 Developing patient-centred or people-centred care

Patient-centred care refers to an approach where preventive care is integrated with long-term care in a manner that is responsive to the patient's preferences, needs, and values, and that enables the patient to be an active partner in managing care. As further explained by Bauman, Fardy & Harris. 'Patient-Centred Care is about sharing management of an illness between patient and doctor...Key features of the doctor-patient interaction are shared goal setting, written management plans and regular follow-up.' The relationship between the doctor and patient is an important feature.⁴³ An extension of this model is the World Health Organization's (WHO) framework of 'integrated people centred health services', which combines long-term patient-centred health and social care with a focus on local community resources.⁴⁴ ACCHSs, operating in a dynamic funding environment, have moved on more quickly than mainstream practices to develop a model of service in keeping with concepts of people-centred care for management of chronic disease, a component of which is preventive care.

Moving general practice towards a patient-centred, chronic-care model is an ongoing process, requiring both practice-system and health-system change.⁴³ This has been catalysed by professional education, practice accreditation procedures, continuous quality improvement (CQI) processes, and Medicare practice incentive funding. A government report states this and Sibthorpe, Gardner and McAullay have made similar comments in a policy review.^{45,46} Medicare provides incentive payments only to accredited practices. The incentives are many, and include incentives related to immunisation coverage, and the Indigenous Health Incentive that provides additional funding based on the number of Indigenous patients registered with the practice for chronic disease care.⁴⁷ Reform in

general practice has been supported by Primary Health Networks (PHNs) and their predecessors, Divisions of General Practice. The key stated objectives of the PHNs are 'increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time'.⁴⁸ (See further discussion in section 3.3.1.)

ACCHSs were a major part of Indigenous coordinated care trials⁴⁹ and have been the primary drivers of systems-based quality improvement approaches such as the Audit and Best Practice in Chronic Disease Extension project (ABCDE), implemented and extensively studied by Bailie et al.⁵⁰ (See section 3.4.2 for further detail.) McAullay et al. found that in the ABCDE project, quality improvement processes were associated with improvements in quality-of-care of Indigenous children.⁵¹ Indigenous Health Workers and nurses have been prominent parts of ACCHS primary care teams. These services have shown that culturally appropriate care is attractive to and accessed by large numbers of Indigenous people.⁵² Holistic care is provided, and practical and social support measures reach out to the community to promote access. Examples are dedicated transport to the service, and community gatherings associated with health-related activity. Community members value this environment as safe: affirming of their culture and free of racism.⁵³

ACCHSs, which were first developed and established in urban areas, have demonstrated success not only in delivery but also in promotion of awareness and choice of preventive care in the Indigenous community. An example is the Deadly Choices campaign-related community events. An evaluation by Malseed et al. showed improvement in participants' short-term knowledge of chronic disease and risk factors and increasing community engagement with local health services associated with these community events.⁵⁴ The style of practice described is rarely achieved in mainstream primary care services, in the current funding environment.

1.2.4 Cultural safety training for general practice

Indigenous people and general practice educators have developed cultural awareness and cultural safety education for GP trainees, and for current general practice staff of many disciplines.⁵⁵ This curriculum and its supplementary online resources, although not available at the time of implementation of the PIPCGP study, have since been taken up nationally by general practice staff, as part of the Practice Incentive Program Indigenous Health Incentive (PIP IHI).⁵⁶ Cultural safety teaching uses case studies to explore power imbalance in clinical settings. It has been successful in New Zealand and is assessed by

Downing, Kowal and Paradies as being the best current model for Australia.⁵⁷ The RACGP's training module includes locally facilitated discussion as a mandatory component.⁵⁵ Impact of this training in the community is not yet known.

1.3 Overview of the research

1.3.1 Realist – inspired evaluation

In considering the form of evaluation, I was drawn to realist evaluation, because of its emphasis on understanding program change as a form of social change, and the rich understanding of context, as explained by Pawson & Tilley.⁵⁸ I considered that understanding the context was the way to tease out the social elements of this healthcare access issue. In realist evaluation, one asks why, how and for whom a program or intervention works, in a specific context.

Context for the realist evaluator is both broad (and external) and narrow (or internal). In this investigation, the external context pertains to wider historical, sociocultural, and policy dimensions while the internal context relates to more specific aspects of health service delivery. Because there was so little known about the internal context, and to keep within the scope appropriate to a PhD project, I chose to give an exposition of the broad context through my literature review, and to focus on the internal context in data collection. It seemed to me that the internal context needed to be well understood to enable change. This decision did enable me to gain useful material; however, it also limited the evidence I gained in relation to next steps for support of practices. Realist evaluations focus on mid-range effects, specific enough to the particular context but broad enough to be generalizable. Many realist evaluations focus on actors at the level of both policy and implementation, interviewing practitioners, managers, and policy makers. The information produced is then easily used by policy makers and planners. My evaluation focused more narrowly on practice staff and Indigenous patients, enabling me to produce information for use primarily within this sphere of action.

1.3.2 Research questions

The study addressed three questions based on the views and experiences of healthcare providers and patients: *suitability* of the intervention, the *effects and consequences* of the intervention, and the *enhancement* of the intervention.

1. Based on the best evidence, what intervention by Public Health Unit (PHU) and Division of General Practice (DGP) staff was appropriate and feasible to promote increased coverage of Indigenous immunisation and health checks in mainstream urban general practices? (*Suitability*)
2. What were the effects of the intervention in mainstream general practices on Indigenous identification, immunisation, and health checks, and what were the other effects? (*Effects and consequences*)
3. How can the existing barriers to immunisation and health checks in mainstream general practice be overcome? (*Enhancement*)

The research used a mixed methods approach to data collection, consisting of both quantitative and qualitative elements. An audit of participating practice activity was conducted concerning the three activities (Indigenous identification, immunisation and health-check delivery) at the time of an educational intervention for practice staff, and periodically over the 12 months following. Interviews were conducted with practice staff during the period of intervention, and with Indigenous patients during and after the intervention. The study development occurred with a specific group of stakeholders, for a specific geographic area.

1.4 Study setting and time period

The PIPCGP study setting was Northern Brisbane. The setting is described in detail in section 5.1. The study commenced in July 2009 and extended over three years. First was a six-month intervention development period, then a twelve month intervention in each of two areas which lasted 12 months. The second area (Outer North) commenced six months after the first area (Inner North). The intervention period was July 2010 to January 2012. Data collection occurred over a two-year period: practice audits and provider interviews were conducted during the intervention periods, and patient interviews were conducted in the six months following the period of intervention.

Table 1-1 PIPCGP Study Timeline

Activities ↓	Phases →	Preparation	Development	Early intervention	Mid intervention	Late intervention	community	Analysis and reporting
Prepare								
Develop intervention								
Workshop + audits, intervention area 1								
Provider interviews intervention area 1 then intervention area 2								
Workshop + audits, intervention area 2								
Indigenous community interviews								
Reporting back								
		Jul 09	Jan 10	Jul 10	Jan 11	Jul 11	Jan12	Jul 12 →

Source: Author

1.5 Contribution of the research

To summarise, health inequalities between Indigenous and non-Indigenous Australians are significant challenges to the Australian health system. The majority of Aboriginal and Torres Strait Islander people live in urban areas, and many suffer poor health and early death. Change in primary healthcare practice may contribute to better healthcare for this group of people. People-centred strategies developed in ACCHs may be applicable to mainstream general practice, improving accessibility and appropriateness of care.

This study aimed to fill gaps in information about urban Indigenous primary health service within mainstream general practice, examining strategies undertaken as a collaborative effort of practices with support agencies, using available resources. It did this by examining in detail some essential steps in preventive care that are taken every day in practice. It has contributed to knowledge and understanding of the concerns of patients and practitioners in relation to preventive care, of how the perspectives of patients and practitioners differ, and has examined the effect of increased Indigenous identification in a mainstream general practice setting.

Understanding differences may motivate practitioners to improve the accessibility of their care. Policy makers and funders may gain additional insight into areas for program management and funding to improve the local and practical conditions that will break down current barriers to preventive care faced by Indigenous people in mainstream general practice. Perhaps one complementary pathway to health can be through improved attention to the active engagement of general practices with their local Indigenous community and ACCHS, in positive support of Indigenous peoples' self-motivated efforts towards personal health improvement.

I consider the PIPCGP study to be important for three reasons. First, it has demonstrated that Indigenous identification of patients in urban mainstream general practice is both implementable and potentially beneficial to professional-patient relationships. Second, it contributes to addressing a gap in the literature regarding Indigenous patients' expectations of urban, mainstream general practitioners (GPs) and other health professionals. Third, it is evident from the study that to have further health impact, the identification process must be associated with investment of time and resources of a practice in development of Indigenous preventive-care service delivery.

At a personal level, undertaking the work has contributed to my development as a researcher. I was able to explore the methodology of realist evaluation, develop

relationships with potential co-researchers in this field of primary healthcare for Indigenous people, and complement the skills I had in service audit processes with those of qualitative research. The recording of local history that I undertook informed me as a practitioner and I hope will be informative for other local practitioners who may read this work.

1.6 Structure of the thesis

First, the context of the PIPCGP study is detailed in Chapter 2 and 3, based on review of the literature. Search strategies are detailed at the beginning of Chapter 2, and this chapter covers the broad or external context. Australia's history of colonisation and its effects on Indigenous people, the current lived experience of Indigenous people which includes racism, and the lack of acknowledgement of racism in healthcare. The contribution of indigenous knowledge is discussed, and the human rights agenda for improvement of Indigenous health. Lenses for thinking about health are presented, such as the social determinants of health, mechanisms of social capital and the cultural safety model for healthcare. In Chapter 3, I describe the immediate or internal context of practices. The focus is on health service. The roles of agencies that support general practices, accreditation of general practice and the influence of Indigenous people on the development of Indigenous primary health care are discussed. The ABCD project, as an example of successful change through quality improvement cycles, is presented.

Research evidence about enablers and barriers to healthcare access, and models arising from literature synthesis are discussed. Reporting of health-check and immunisation service usage is examined, to complete the summary of the knowledge base relevant to the study context.

Research methods for the evaluation are detailed in Chapter 4. In the study, inspired by Realist Evaluation, I employed a framework to guide enquiry, and I used mixed methods to gather a range of data types. Quantitative assessment of practice performance was undertaken using an on-site audit. The views of professional groups and patients were collected using qualitative interviews. An account is given of how the learnings were validated, augmented, and prioritised in collaboration with the supporting DGP and the ACCHOS, as part of the feedback process over the course of the study.

Chapter 5 addresses the first research question. It commences with a review of the underpinning knowledge of barriers to practice change, and strategies to promote change in general practitioners. This is followed by a detailed look at the study site of northern Brisbane and the intervention target, general practices of the area. History, geography,

population and general practice services of the area are described. The details of the development and implementation of the intervention are set out. Modifications made to adapt to local demands, and other challenges, are described. A second study group was added at the request of the DGP, and changes to the audit procedures to accommodate the type of information able to be extracted in the participating practices was required.

The results of the PIPCGP study are presented in two separate chapters: Chapter 6 and 7. Chapter 6 addresses research question 2, presenting the results of the initial practice activity survey and audits. Indigenous identification, health checks, and immunisation performance in the Inner North and Outer North practice groups are examined. Differences between them are described and discussed. High- and low-activity general practices are recognised and described. Chapter 7 primarily addresses research question 3. Interview data analysis is presented, followed by an integrated consideration of results. The analysis of the interview data positions Indigenous patients centrally, in keeping with indigenous knowledge frameworks. Differing perspectives of Indigenous patients and providers with little experience of Indigenous health are highlighted. A suggested model for practitioner–patient interaction is presented in the interviews, to address research question 3, relating to enhancement of practice to overcome barriers to immunisation and health checks. Chapter 8 provides a discussion of overall findings and implications arising from the PIPCGP study. Specific actions for the improvement of mainstream general practice and its supporting network are recommended. System-wide changes are contemplated and are reflected upon.

Chapter 2 **Broad context: a history of adversity**

2.1 Overview

This chapter begins with a description of the search strategies used to investigate context, in both the published and grey literature. The broad or external context is then described based on the literature review, while the internal context is described in the following chapter, based on literature review and experience. Indigenous health, and lenses that can be applied to thinking about Indigenous health and associated disparities, are discussed. Consideration of indigenous knowledge provides depth of understanding of the nature of the experience of adversity. Colonisation is considered as a root cause of health disparities experienced by Indigenous Australians.

2.2 Literature search strategies

Multiple search strategies were used to identify as comprehensive a range of literature as possible. References written in English were sought for the period from January 2005 to 30 June 2017, to capture the evidence relevant to the health system changes fostering preventive care for Aboriginal people in Australia. The 2005 date limit for publications was selected as this coincided with the announcement of the Close the Gap campaign. Original research, reviews and opinion pieces were included.

To derive the search terms, searches using a broad tool and a targeted tool were applied. Relevant articles were identified for extraction of key words contained in the title and abstract, and in the list of the index terms used. First, the University of Queensland Library search tool was used. This captures a broad and extensive range of books, journals, audio-visual material, and electronic materials including the research output of UQ staff and students—theses, conference proceedings, reports and open access subscriptions.⁵⁹ The Lowitja institute Lit.search tool was then used. Developed by Tieman et al., This tool is a pre-filtered menu of topics that can be qualified, directing the user to Aboriginal and Torres Strait Islander Health material on PubMed.⁶⁰ Search strategies were informed by specific advice for database searching provided by the Lowitja Institute as part of their Australian Aboriginal Health Search portal project.⁶¹

In the second more targeted stage, searches using keywords and index terms identified during the first stage were undertaken across PubMed, CINAHL, PsycINFO and Scopus, to collate the broadest range of scholarly domains and materials. These are shown in Table 2-1. PubMed focuses on biomedicine and health and includes journals and online

books from the National Library of Medicine.⁶² PubMed provided numerous materials on all sub searches (as below). CINAHL brings together nursing and allied health journals.⁶³ CINAHL provided additional materials particularly related to non-medical disciplines contributing to primary care and indigenous knowledge related to health practice. Scopus is a more recently developed database that covers science, technology, medicine, social sciences, arts and humanities. It indexes journals, books and conference proceedings.⁶⁴ It was useful in the area of indigenous knowledge, frameworks, and healthcare. By using Scopus, speeches and conference proceedings were captured that otherwise may have been missed, in addition to journal articles from the wider range of disciplines, including education.

Table 2-1 Search terms used to identify relevant literature

indigenous or aboriginal or aborigine or Torres Strait Island* or oceanic ancestry or First Nation or Maori or Inuit or "American Indian" or "Native American" or Amerindian*		
AND		
Coverage or uptake or barrier or enabler or facilitator or access or urban or indigenous identification or Brisbane or Queensland or Australia or Australian or Australians or Canada or Canadians or New Zealand* or Americ* or "New South Wales" or Victoria or "Northern Territory" or "South Australia" or "Western Australia"		
AND		
1.Primary health care or general practice or medical service or health service or public health	2. "Health check" or "health screening " or "Preventive Medicine" [Mesh:NoExp] or "Preventive Medicine" or "Preventive care" or "Preventive health"	3. Immunisation or immunization or vaccination or vaccine
Indigenous knowledge or indigenous frameworks and health care		

As a third process, the reference lists of relevant reports and articles were searched for additional relevant research. Because of the range of ideas and terminology not easily captured in search terms, this was a productive strategy.

In parallel, the fourth process—used to supplement information on history, policy and indigenous knowledge, frameworks, and healthcare—was to seek relevant grey literature. A number of databases relevant to Australian Indigenous health were searched from the Informit collections. Informit is an Australian-based organisation that sources content from publishers, associations, and peak professional bodies. The focus is on regional perspectives and otherwise hard-to-find research for professional audiences in education, government, and corporate sectors.⁶⁵ Databases accessed via Informit included the following three collections: Indigenous, Health, and the Humanities and Social Sciences collection (which includes indigenous studies).

Relevant grey literature was also obtained from internet searching on topics suggested by the literature. Sites searched included the Commonwealth Government, Queensland Government, National Aboriginal and Torres Strait Islander Health Organisation, IUIH, Lowitja Institute, Australian Bureau of Statistics, Australian Institute of Health and Welfare, Indigenous Health Infonet,⁶⁶ Closing the Gap Clearinghouse,⁶⁷ Royal Australian College of GPs, and BEACH surveys, a collection of general practice-based data, at Sydney University.⁶⁸ In relation to indigenous knowledge and health, extra searches of ProQuest Social Science database,⁶⁹ Australian Public Affairs Full Text, Aboriginal and Torres Strait Islander health bibliography and the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) Indigenous studies bibliography (since updated to the Mura® collections catalogue)⁷⁰ were undertaken in following the threads of identified issues.

2.3 Indigenous knowledge and health research

Mason Durie—a Maori Elder, politician, and psychiatrist—gave a succinct and compelling view of indigenous knowledge, its scope, and its potential interaction with scientific knowledge in a review for the Higher Education Policy journal in 2005. This opinion piece took up the dominant themes that he had consistently and clearly expressed in multiple arenas, including the World Congress of Epidemiology and the Asia-Pacific Economic Cooperation Research and Development Leaders Forum.^{71,72} According to Durie, who worked from New Zealand, indigenous knowledge is the worldview of an indigenous people, which categorises life experiences, thereby shaping attitudes and patterns of thinking. It is based on a long history and a long forward view; the relationship of people to land and to society; sustainability of resources, and aspiring for the good of the group. It tends towards over-viewing a system as an ecology, a complex geography incorporating relationships over a wide sphere, where multiple (sometimes disparate or conflicting) strands come together to make a whole. Examples include the holistic view of health and

wellbeing, and the system of people and environment. Durie also stated that health research may use this distinct but complementary knowledge system alongside the scientific method to enable new insights.⁷¹ A compatible, holistic view of health was defined and practically articulated in Australia by Aboriginal people in the National Aboriginal Health Strategy, 1989.⁸

Laycock et al. (2011) wrote that Australian indigenous knowledge systems are based on a tradition where knowledge belongs to people and is held by right, this right governed by ancestral laws still strong in many communities. It is often held by respected Elders and can only be transmitted in accordance with customary rules, laws and responsibilities. In their practical guide to researching Indigenous health, the authors refer to the importance of indigenous knowledge and to sources of Indigenous cultural materials held in collections, including oral histories. They further emphasise the need for awareness of the process of Western and indigenous research traditions coming together.⁷³

Indigenous scholars have provided moral leadership for the research agenda on social justice. Maori researcher Linda Tuhiwai Smith (2012) in *Decolonising Methodologies* pointed out that research was associated with the worst excesses of colonisers and explained that indigenous peoples' 'collective memory of Imperialism' coloured their response to research and researchers. Smith maintained that indigenous peoples were valued less than the colonisers, and were *othered*, referring to Edward Said and his analysis of the *Orientalism* of certain Western nations. This negative and separating assessment was conveyed back to indigenous people and to some extent internalised by them, a situation that needed to be challenged. In relation to the research process, Smith pointed out that there were multiple ways of being an insider and an outsider in indigenous contexts, that reflexivity was critical, and that a support network within the community was necessary both to ground research and to deal with its consequences. Her focus was on indigenous researchers as actors in spaces she described as 'on shifting ground' in relation to research institutions, and therefore contentious.⁷⁴

Marie Battiste (2005), an indigenous Canadian educational scholar who has studied impacts of and impacts on the Mi'kmaq language and people, referred to *cognitive imperialism* affecting indigenous peoples.⁷⁵ Battiste referenced Ruth Frankenberg (1993), who examined the concept of *whiteness* as a social construction from the point of view of white women, where there was an unconscious assumption of separation between groups.⁷⁶ Battiste described the social construction of *whiteness* or Eurocentrism in

relation to indigenous peoples, and the *whitestream*, a term that identifies whites as the privileged in the mainstream.⁷⁵

Denzin and Lincoln (in collaboration with Smith), in the introduction to the edited collection *Handbook of Critical and Indigenous Methodologies* (2008) took up Smith's premise, that the use of indigenous methodology in the setting of Western scientific tradition is inherently contentious, and that it is a critical approach. The authors viewed indigenous knowledge as a resource for social change, the basis of their critical theory.⁷⁷ They referenced Freire's *Pedagogy of the Oppressed*, which focused on recognising a 'culture of silence' where a stance in education is internalised, and linking education to social action through posing social problems, a process termed "conscientization".⁷⁸ Denzin and colleagues advised that collaboration between the 'coloniser and indigene' for research was problematic due to a persistent power differential. However where guided by a set of ethical principles, they advised, it could be 'learning *from* difference rather than learning *about* the Other'.⁷⁷

Martin Nakata, a Torres Strait Islander, who like Smith has written primarily for indigenous scholars, examined the Torres Strait Islander/ Western cultural interface. He found it to be more complex and layered than can be conveyed by a binary framework, such as coloniser-indigene, while acknowledging that the elements of this and other frameworks are influences to be understood as part of the whole.⁷⁹ On the problems associated with indigenous studies, also relevant to this work, Professor Nakata has pointed out that:

One of the problems that Indigenous studies faces (is) resisting the tendency to perpetuate an enclave within the academy whose purpose is to reflect back an impoverished and codified representation of Indigenous culture to the communities that are its source... My suggestion is that we see ourselves mapping our understanding of our particular Indigenous experiences upon a terrain intersected by the pathways, both of other Indigenous experiences, and of the non-Indigenous academic disciplines.⁸⁰ (Nakata M., 2006)

This acceptance of different experiences and disciplines helped me to have confidence, as a non-Indigenous researcher, that with as much conscious awareness of difference as possible, I could find a way to contribute to a topic concerning Indigenous people.

Further, these writers have helped me to understand the negative effects of the pervasive 'deficit model' that we apply to the epidemiology of health. While 'the gap' may be quantified to identify potential health gain, it is also a negative representation of the population experiencing the gap, often untempered by an assessment of positive attributes. Its message may be internalised by Indigenous people in a fatalistic way, and may influence health professionals to have low expectations. 'Risk factors' also are negative and sometimes stigmatising attributes, presented without assessment of 'protective factors'. Bond challenged public health on this issue:

The perception of Aboriginality as nothing more than a label, a health risk, and predictor of unhealthy behaviours within Indigenous public health practice reinforces stereotypical ideas of Aboriginality, demonises those who possess it, and disconnects Aboriginal people from their own identities in a manner similar to past oppressive policies of colonisation, assimilation, segregation and integration.⁸¹
(Bond, C.J, 2005)

Another indigenous scholar and health professional who influenced my early thinking about the PIPCGP study topic has been Irihapeti Ramsden, a Maori midwife who recognised institutional racism and led the move in New Zealand towards cultural safety in midwifery care, where safe service is defined by those who receive the service. Ramsden developed an educational framework for the analysis of power relationships between health professionals and their patients.² Her ideas have been acknowledged in Australian scholarship and practice in cultural safety, for example in Binan Goonj.⁸²

The qualitative research of Professor Bronwyn Fredericks, examining many aspects of the delivery of healthcare to Australian Indigenous people, has both explained and illustrated social barriers to care, and influenced my approach. In a book chapter on Aboriginal community control and decolonising health policy, Fredericks pointed out that prior to colonisation Aboriginal people lived in a complex society, self-determining many aspects of their own and their communities' lives, and that this is what today's Aboriginal people strive to maintain and restore.⁸³ This suggests that given a conducive environment within a mainstream health service, Indigenous people may seek to be very actively involved in decision making about their health, about their health service, and about their local area.

In approaching a case study of a rural health service, Fredericks referred to De Certeau's notion of belonging as a sentiment which develops over time through both knowledge and everyday experience, and Memmott & Long's exposition of Place Theory which included

examination of emotion associated with place, that it can be maintained by groups of people and reinforced through feedback and ongoing experience.⁸⁴ Fredericks referred to Professor Moreton-Robinson's explanation that non-Indigenous connections to place over time have been possible only through dispossession and territorialisation. Symbols of that belonging, therefore, actively either include or exclude Indigenous people.⁸⁵ Fredericks then analysed the Indigenous experience of a rural health centre using a sociological lens, and clearly highlighted how health environments are embedded in politics. She described how a rural health-service waiting room's d'Arcy Doyle prints and mounted foundation stone conveyed a social message of exclusion and domination. She examined interview data that further detailed active and passive roles of exclusion and non-involvement being played out.⁸⁶ This gave me greater understanding of how a lack of Indigenous artwork or other Indigenous symbols, inflexibility of the appointments system, and intolerance of children's behaviour might keep Indigenous people away from a mainstream health service. These were specific concerns brought forward in the initial Indigenous community consultations at Inala, recorded by Hayman, an Aboriginal doctor, in his report describing the establishment of a successful Indigenous-specific service within a large, mainstream community-health centre.⁸⁷

In this particular project, for me as a non-Indigenous researcher of an Indigenous health topic, awareness of Indigenous knowledge, frameworks and protocols has been essential. Both inclusiveness and flexibility were important as learning proceeded and advice was sought and received. Interviews with Indigenous people are an important part of the PIPCGP study, and guidance given by Indigenous individuals has been important both to project development, to analysis and to success in providing local benefit.

2.4 Health effects of colonisation

Throughout the world, colonisation has affected the colonised, and is reflected in their health status. In Australia, the initial effects for Aboriginal people were introduction of infectious disease, displacement and poor living conditions, warfare and violence. The long-term consequences have been loss of land, forced assimilation, social marginalisation, and political disempowerment. Direct effects have been loss of language, loss of cohesion of some groups, impaired transference of culture, and profound disruption of families through separation of children. Further, Anderson (2004) reminds us that Aboriginal people were excluded from accessing welfare benefits such as unemployment and sickness benefits in rural and remote areas until 1944, from voting until 1962 and from the Census until 1967.⁸⁸ Acknowledgement of injustice finally came with recognition of the

Stolen Generation in 1997⁸⁹ and a National Apology in 2008.⁹⁰ The population decline over 200 years has now been reversed, exceeding the estimate of around 500,000 at British settlement, a recent estimate being 700,000 people.^{91,92}

Another consequence of this lack of recognition has been a lack of health data about Indigenous Australians. Freemantle et al. reported that although able to self-identify and counted in the national Census following the 1967 referendum, no state or territory identified Indigenous people separately in hospital data or vital statistics until 1976. Systematic collection of these data across all jurisdictions was finally established just 20 years ago, in 1997. Under-ascertainment has been a continuing feature of these counts.⁹³ now lessening as the proportion of Indigenous-identifying people has increased successively from one Census to the next. The Australian Bureau of Statistics has developed methods of compensating for the undercount, such as extrapolating back from the most recent estimates and standardising small age groups, particularly in relation to the Northern Territory population, and estimating the proportion who do not answer the Indigenous identification question. These have continued in one form or another up to the most recent Census.⁹⁴

The size of the life expectancy gap in Australia between Indigenous people and other Australians far exceeds that of most other countries. It was assessed by Anderson et al., based on 2010–12 figures, as the second highest disparity amongst indigenous populations of ten high-income countries, exceeded only by a small population of Inuit in northern Canada.⁹⁵ On best ascertainment of available mortality data by the Australian Institute for Health and Welfare (2011), there has been only a small significant change in that disparity over the last quarter century.⁹⁶

Between 1970 and 2000, the death rate for cardiovascular disease fell precipitously in the general population of Australia.⁹⁷ This was in keeping with a trend in high-income countries that was attributed to a focus on integrated population-level strategies and individual care related to risk factors common to chronic diseases.⁹⁸ More specifically, the change in cardiovascular disease has been attributed to a diet lower in saturated fats, a decrease in smoking, treatment of hypertension, and the development of coronary care services that actively manage heart attacks.⁹⁷

Procedure-based management of heart attack is associated with better long term outcomes. Patients admitted to private hospitals for heart attack have a higher rate of intervention than others. In the public hospital system, non-Indigenous patients have a

higher rate of intervention than do Indigenous patients. Nationally, in 2002-3, the rate of intervention was 40% less on hospital statistics.⁹⁹ Coory & Walsh(2005) studied a state wide public hospital cohort in Queensland, and when controlling for age, gender, socioeconomic status, hospital type and co-morbidities (which make the procedures more risky), the rate was still 22% lower.¹⁰⁰ A Western Australian study highlighted under-management of Indigenous people aged 55 years and older.¹⁰¹ In South Australia, Tavella et al. (2016) examined the range of documented reasons for more non-intervention. There was no clear reason in a large proportion of Indigenous patients (36%) and there was more misdiagnosis. Discharge against medical advice was more common (11%) and co-morbidities made a small contribution. The authors of the study, who included Aboriginal cardiologist Alex Brown, concluded that 'improved consideration of the hospital experience of Aboriginal patients must be a priority for reducing health care disparities'.¹⁰²

In summary, rapid change in health-risk factors and chronic-disease outcomes has already happened in Australia for most of the community, but not for the Indigenous population. Given the right conditions in Australia, rapid health improvement for Indigenous people should be possible, as the means for acting are largely in place. It is imperative that barriers to appropriate population level support and individual care are understood and eliminated.

2.5 Social determinants of Indigenous health

Social epidemiology suggests that behavioral health-risk factors and material circumstances lead to ill health not as isolated causes, but rather as the final common pathway for a web of health determinants. These are predominantly social, and to some extent economic, which some would argue is itself ultimately social. The World Health Organisation (WHO) stated that

These inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces. (WHO Commission on Social Determinants of Health, 2008)¹⁰³

In relation to the health system contribution to health equity in the UK, Marmot has argued for preventive healthcare to specifically target disadvantaged groups, as generally targeted programs would most likely not reach them, increasing health inequality.¹⁰⁴

The process of domination by groups in society, external power relationships, and absolute quantity of accessible resources were the factors considered by Pierre Bourdieu, a French sociologist, termed a political economist, who became prominent in the 1990s. Bourdieu's frameworks for analysis of social equity have been frequently cited. At a systems level, these approaches have been applied to class or race relations, and socio-economic conditions. Bourdieu extended the ideas of financial capital as a commodity, to social capital, cultural capital, and symbolic capital. Working initially in Algeria in a colonial period, then in France, Bourdieu (1992) analysed the behaviour of cohesive social groups as *fields*—such as applying to members of a cultural group, or later in the academic, economic, or creative field—and developed field theory.¹⁰⁵

The sociologist's perspective has improved understanding of factors influencing health. There is now a health agenda for social change. In our high-income country with a well-developed health system, the question often raised amongst health professionals is whether poverty, its direct and indirect effects, is solely to blame for differences in Indigenous health. Shepherd, Li and Zubrick (2012) in their review of studies of social gradients and health of Indigenous Australians, found a less consistent patterning of socioeconomic status and health in comparison with most other populations, in the small number of available contributory studies. This suggests there are other factors at work.¹⁰⁶ Analysis of the Western Australian Aboriginal Child Health Survey showed consistent patterning for some conditions such as but not all health conditions. Less associated with socioeconomic status were asthma, injury and oral health problems.¹⁰⁷ Analysis of National Aboriginal and Torres Strait Islander Health Survey data (self-assessed health and chronic disease risk factors) by Andrews showed self-identified removal from family as a child to be a major influence on these outcomes.¹⁰⁸

A factor highlighted in recent social research in Australia is racism as a social determinant of health. Racism has been shown to influence mental health and, to some extent, physical health of Indigenous people in Australia. A meta-analysis of international studies by Paradies (2006) quantifying the effects of racism on both mental and physical health found a strong effect on the first and a weaker effect on the second, including some evidence in relation to obesity.¹⁰⁹ A Darwin based survey by Paradies and Cunningham assessed experience of racism and self-assessed health of 164 Indigenous Australian people with diabetes. Racism was correlated with mental, but not physical, health. It has been described as a direct effect in daily interactions between people. As a pathway to personal stress and mental illness, racism was considered a quantifiable social

determinant amenable to direct action by individuals and groups.¹¹⁰ Urban studies have reported a higher level of racism, associated anger and stress experienced in everyday life, than have studies in remote areas. Discussion of the different context has centred on urban experience of Indigenous people as an 'invisible minority' in these areas.^{111,112} Day to day experience of racism, then, must be considered an influence on Indigenous identification and the willingness of Indigenous people to take up preventive care in mainstream urban practices.

Institutional racism refers to societal systems or patterns that have the net effect of imposing oppressive or otherwise negative conditions against identifiable groups based on race or ethnicity. The influence of racism in health care often remains unsought and unacknowledged. Henry, Houston and Mooney (2004), on the basis of a range of local studies of pattern of hospitalisation, editorialised on the theme of institutionalised racism in healthcare in Australia. In addition to differences in treatment and cultural barriers to care, systemic issues including a lack of funding for appropriate service, different performance criteria for Indigenous specific service, a lower level of funding in fragmented bundles for Indigenous specific service, and inequitable distribution of Medicare and Pharmaceutical benefits were also identified.¹¹³ Durey & Thompson (2012) in a qualitative study documented views of experienced health professionals on the many aspects of racism in healthcare, describing institutional, interpersonal and internalised racism. This presents a more complex aspect of healthcare accessibility that can be reflected upon in regard to general practice.¹¹⁴ Zambas & Wright (2016), in a discussion paper which reviewed available studies and reports, examined the connections between colonisation and healthcare access in Australia and New Zealand. They described the connections between health determinants and access: socioeconomic factors limiting resources to pay for travel, care service and medicines, and the induction of personal stress. This last effect was related to forced assimilation practices such as forced removal of children.¹¹⁵

Beyond individual risk and protective factors for health are community-risk and resilience factors. Social capital is a concept that commodifies the social cohesion of a group or social network that serves to provide extra resources to individuals. Political scientist Robert Putnam (1993) applied notions of social capital to American society. He considered the problem of 'urban decay' to be in part due to loss of 'social cohesion'. His theories emphasise trust as a precondition for bonding, social norms and reciprocity. Social mechanisms that produce health include social support for day-to-day life; social leverage for access to opportunity, social control to maintain order, and participation in

neighbourhood organisations. Social networks are a conduit for practical support: information, advice, cash loans, and can buffer stress or support stress. In a socially cohesive group, there is collective socialisation of children, and adults are socially controlled.¹¹⁶

Kawachi et al. (2008) succinctly summarised a decade of research findings in the first chapter of their book on social capital and health. *Bonding social capital* links individuals within the group of similar people, and *bridging social capital* enables individuals to access resources across boundaries of class and identity. Research suggests that bonding helps survival in a disadvantaged community, but there is a high cost for mutual responsibility on some individuals, and there are other negative effects such as down levelling of norms. Bridging capital may counteract these negative effects. Further, clustering of like people in neighbourhoods exposes them to a specific physical environment that may or may not promote health.¹¹⁷ Chelsea Bond, in her 2007 thesis examining urban Indigenous identity, has reflected on the inward pull of a tightknit group being a strength but also a potential vulnerability, which may draw the group member away from other general community groups.¹¹⁸

The failure to recognise Aboriginal and Torres Strait Islander people as citizens with the right to vote suggests conditions were not conducive to the establishment of trust and reciprocity between Aboriginal and Torres Strait Islander people and white Australians for many years. It was not until 1962 that the Commonwealth Electoral Act was passed, enabling Indigenous people to vote in federal elections. Even at this point voting was compulsory for all Australian adults except for Indigenous people of the Northern Territory. Queensland was the last state to establish this right for its state elections, in 1965.¹¹⁹ Indigenous Queenslanders over the age of seventy remember when they, personally, were not entitled to vote.

2.6 Diversity and mobility of urban Indigenous people

Mobility of Indigenous people to and from urban areas was described in detail by demographer and Indigenous policy researcher John Taylor (2006) to consist of overall in-migration of individuals and families to regional and urban centres from rural and remote areas, which has continued since the post war period. Movement into cities was documented over three censuses. For those aged 15 to 29 years, city in-migration was associated with education, training and employment search. For older people, there was more city out-migration, associated with family presence and the reliance on rental

accommodation. The proportion of Indigenous Australians resident in urban areas in 1971 was 44%, a figure that increased to 74% by 2001 and was possibly augmented by an increasing propensity of urban people to identify as Indigenous. In the same paper, small-area urban-Indigenous data was analysed for socioeconomic status, describing movement around those areas. Unlike the pattern for non-Indigenous people, Indigenous identified people continued to concentrate in areas of low socioeconomic status (around 40% in the lowest quintile neighbourhoods). Further, these people were consistently more disadvantaged than the rest of the community residing in those same areas. An example presented was that of Inala, where the non-Indigenous unemployment rate was 19% while the Indigenous unemployment rate was 35%.³²

2.7 Urban connections

Many Indigenous representative groups in urban areas tend to be neighbourhood groups rather than wide-area groups, and the history and concerns of these groups often differ, so local knowledge and local relationships are important. Brough, Bond & Hunt (2004) conducted a health promotion project in Brisbane, *Strong in the City*, commencing by collecting views of local Indigenous people about community and community building. They found that the communities in the city were, with very little support, actively working towards health improvement goals. They noted that an unhealthy 'denial of the urban identity of Indigenous people' was experienced, which goes unquestioned, and they found evidence of key strengths of urban Indigenous people in relation to health promotion: extended family, commitment to community, neighbourhood networks, community organisations and community events.¹²⁰

Brand, Bond & Shannon (2016), in a review of urban Indigenous health issues in South East Queensland, stated that some Aboriginal and Torres Strait Islander people in Brisbane have traditional connection with that area, and for some, where they live now is their country. Further, many Aboriginal and Torres Strait Islander people living in the region maintain close cultural and kinship ties with their community of origin.¹²¹ Diversity of Indigenous communities in urban areas thus in part comes from differences in language and cultural groups. Also, urban Indigenous identities themselves are diverse and for example, not the dichotomous Aboriginal or non-Aboriginal. Brough et al., based on the initial focus groups and interviews carried out for the Strong in the City project, concluded that identity is important to Indigenous people in the city, is complex, and influences a range of social connections across both Indigenous and non-Indigenous Australia.

Regarding the mainstream, there was a predominant sense of needing to 'prove oneself', to disprove the stereotype.¹²²

2.8 Quantification of Health outcomes in urban areas

In 2001, the Commonwealth Grants Commission Review of Indigenous Programs examined the question of linking need to resource allocation, recognising the need for a summary index of health. Establishment of partnerships between Indigenous groups, federal and state governments, to influence and coordinate service development, was recommended, as was improving mainstream services to eliminate barriers to access for Indigenous people through reform of Medicare. Indigenous-specific programs were viewed mainly as remote-area programs. One administrative outcome was the establishment of Burden of Disease Studies (BOD) in Australia, methodology adopted from the World Health Organisation. BOD provides a single quantitative measure of health status, the Disability Adjusted Life Year (DALY). DALY represents the number of life years within a population that are affected by ill health, disability or early death. This data has been used as a measure of the impact of disease-based health programs that can be linked with their impact and cost-effectiveness.¹²³ An Australian national report was prepared using 2003 data,¹²⁴ and has been repeated using 2011 data.¹²⁵

Separate analysis of 2003 data for Indigenous people was undertaken by Vos et al., steered by a group including two Indigenous academics¹²⁶ and was likewise repeated later by the AIHW.¹²⁷ In the initial study, the DALY rate (per 1000 Indigenous people) in major cities was 380, compared with the highest rate in remote areas (such as Cairns) of 523, and in very remote areas (such as Cape York) of 440. It can be seen, therefore, that healthcare of Indigenous people in cities can address a large proportion of illness. More than half of the health gap (or potential health gain) experienced by Indigenous people was associated with chronic disease, and a small amount of the burden was associated with infectious disease. Chronic disease was related to 11 defined health risk factors.¹²⁶ Promotion of a healthy lifestyle, provision of medical treatment for chronic disease and its antecedents, and immunisation were therefore recognised as health service-related activities in all geographic areas that would potentially provide measurable health gain.

BOD risk factor identification looks only at 'proximate causes',¹²³ and is problematic in that there is no accounting for social determinants in the analysis. As Taylor discussed in 2008, this is a 'mainstream' approach with no consideration of health priorities of the subpopulation described.¹²⁸ Further, as discussed by Brough and others since, the

identification of 'risk groups' which have 'deficits' in health can be seen as a construct that promotes negative stereotypes, screening out positive and healthful aspects of the population.¹²⁹

Geographic reporting in most other studies, including the latest Indigenous burden of disease study,¹²⁷ focuses on results distributed by state, which can be related to the indicator reporting required of state-based framework agreements for Aboriginal and Torres Strait Islander health. Urban Indigenous health remains a neglected area in both reporting and research.

2.9 A positive policy context

The 1989 National Aboriginal Health Strategy was established with Indigenous leadership arising from urban ACCHOs. These leaders gained traction as the result of the finding of the Royal Commission into Aboriginal Deaths in Custody, released in 1991, that the health of Aboriginal prisoners was poor—30% of deaths being due to disease, and that there was insufficient data available to understand or act upon health problems in the community.⁸ Anderson et al. summarised the ensuing health governance developments: The federal government assumed responsibility for a national Aboriginal health program in 1995 and has since driven an agenda of reform in collaboration with the states through the Council of Australian Governments (COAG). Aboriginal and Torres Strait Islander Health Framework Agreements were negotiated between the Aboriginal and Torres Strait Islander Commission (ATSIC), state and territory representatives of ACCHSs, and state and territory health ministers. The principles outlined in these agreements are implemented in Australian Health Care Agreements, which determine state funding for healthcare.¹³⁰

Since the mid-2000s, there has been the political will and the gradual development of intersectoral policies across government, to address the needs of Aboriginal and Torres Strait Islander peoples. This political history is important to understanding the role of different health agencies influencing the primary care sector and mainstream general practices, and to understanding the best next actions that will achieve sustainable improvement in access to primary healthcare for Indigenous people.

Tom Calma, an Aboriginal man and an academic, as Human Rights and Equal Opportunities Commissioner in 2005, called for 'Health as a Human Right' of Indigenous peoples in Australia.¹³¹ The campaign to Close the Gap in health equity was then taken up by the National Aboriginal and Torres Strait Islander Community Health Organisation (NACCHO) and the ACCHOs it represents. This and other representative Indigenous

health groups joined with national health organisations in a partnership to promote and critique efforts to achieve health equity for Aboriginal and Torres Strait Islander people.¹³² The governmental initiative of Closing the Gap in Indigenous disadvantage, agreed in 2007, has a range of aims across sectors, including health aims of closing the gap in life expectancy in a generation and halving the gap in mortality of children under five years of age in a decade.¹³³ Progress is presented in an annual report to parliament and the public from the Prime Minister's office.³⁸ This example illustrates how ACCHOs give Indigenous people agency in the health system, and their status as spokespersons for the community.

The Prime Minister's reports have illustrated that the very slow upward trajectory in life expectancy of the past two decades, offset by improvements in non-Indigenous life expectancy. Approaching ten years, there has been more improvement in other indicators such as child mortality and educational outcomes.³⁸ While many influencing factors may be outside the health system, the high prevalence and death rates of Indigenous people from chronic disease continue to require Indigenous chronic-disease prevention and early intervention within the health system. The critique by the Close the Gap Steering Committee affirms this and points out a need for more service, particularly through ACCHOs, and the need for full funding of the 2015 National Aboriginal and Torres Strait Islander Health Implementation Plan.¹³⁴

The Australian Government's intersectoral approach through changes in health, education, and welfare policy attempts to influence both structural determinants of health, which affect social position, and intermediate determinants of health, which affect the conditions of daily life. This agenda is reflected in integrated Overcoming Indigenous Disadvantage reporting to inform policy, undertaken by the Productivity Commission, for the Steering Committee for the Review of Government Service Provision. This (roughly bi-annual) report highlights factors in the arena of government related to health, education, and employment. The strategic areas for action highlighted as worsening most recently are those that are challenging in the primary healthcare setting: mental health, suicide and self-harm, and drug and other substance use and harm.³⁵

The agenda is actioned in health sector planning through continuation of the National Partnership Agreement, and a series of Australian state-based Framework Agreements on Aboriginal and Torres Strait Islander Health. Queensland's current funded strategy spans 2015–18 and funds Indigenous targeted health promotion efforts towards chronic disease prevention. Planning is underpinned by the principles of partnership between government, Indigenous communities, and service providers: cultural respect in service delivery;

prioritising Indigenous health across the whole of the health sector; a holistic view of health with attention to all aspects; community control of primary healthcare services; and accountability for consultation and outcomes. Primary healthcare access is a focus, and health checks and immunisation are featured as effective interventions to be promoted at all ages.^{135, 136} Federal government budgetary processes put the states in competition with one another for funding of government programs, and a higher prevalence of prioritised factors attract more funding. Remote health services have been an Indigenous health priority for many years, which has meant that urban health issues and services have not been high on the government's agenda.

2.10 Mainstreaming

Although most widely used in Special Education, *mainstreaming* is a term that has gained wider currency. It is a contentious area for Aboriginal and Torres Strait Islander people, as it has been aligned with a return to assimilation and denial of difference. Taylor's 2008 critique explained the difficulty for all indigenous peoples of international Millennium Development Goals, pointing out that the same applies to Australia's Overcoming Indigenous Disadvantage targets. He explained that Indigenous diversity, and priorities arising from the concept of wellbeing, can be unconsidered, or in conflict with, high-level targets developed by governments. An example given was the view of the father of a remote area Indigenous man employed in the mining industry. The father's view was that employment diminishes his son's opportunity to undertake his cultural practice, including caring for country, and diminishes his capacity to pass cultural knowledge and practice on to his children.¹²⁸ Indigenous protocols feature local decision making, which allows for diversity. The process of government promulgation of targets from the top down is in itself at odds with Indigenous peoples' diversity. Brand (2016) has suggested this may particularly apply to urban areas.¹²¹

The government's response in regard to Indigenous health has been described as alternating between support of Indigenous-specific services and mainstream services: one often in competition with the other for funding. Mainstreaming has been seen by some as resulting in the absorption by White bureaucracy of a large proportion of funds allocated for Indigenous services, with diminishing trickle down to Indigenous people. There have been sudden changes in direction, resulting in defunding of some successful, Indigenous-run programs, which served to heighten tensions within those programs that continued to operate.

According to an issues brief for parliamentarians by Pratt & Bennett, the Australian Government, with bipartisan support, abolished the Aboriginal and Torres Strait Islander Commission (ATSIC) in 2004, heralding a swing back to mainstreaming of Indigenous services within government. ATSIC was a representative body established in 1989 aiming to empower Indigenous people within government, combining policy and program administration roles. It was the third and last of a line of three government-sponsored Aboriginal representative structures that had marked a shift in policy from assimilation to self-determination, commencing in 1973 with the formation of the National Aboriginal Consultative Committee.¹³⁷ ATSIC was the body that related directly to the COAG, and their intersectoral agendas. Anderson wrote at the time of the tumultuous and public deterioration of the relationship between Indigenous people and the Australian Government, noting that there might be 'significant negative consequences for the partnership processes specific to the health sector'.⁸⁸ Jon Altman interpreted this mainstreaming simply as assimilationist and 'a reallocation of (Indigenous-run) Indigenous-specific Commonwealth programs to Government Departments'. Altman argued for Indigenous political input, with mainstreaming working alongside Indigenous-specific programs, to meet the needs of a diverse population in a complex environment.¹³⁸

The shift towards mainstreaming delivery of Indigenous-specific programs in 2004 potentially weakened the funding base for ACCHSs. Indeed, in 2008 the Hospital Health and Reform Commission recommended establishment of an authority to act as a purchaser of services for Indigenous people across all health sectors from both community-controlled and mainstream services.¹³⁹ Although this did not happen, ACCHOs have needed to focus squarely on embedding their clinical activities within the Medicare framework of remuneration to better ensure their viability. In this real sense, ACCHOs and mainstream general practices are in competition with one another for patients.

Over the period 2009 to 2012, COAG, by means of the 2009 National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (NPA), allocated \$1.6 billion to specifically address the life expectancy target.³⁴ In 2009–10 the Australian Government started implementing the Indigenous Chronic Disease Package (ICDP) as part of this strategy. The package included improved chronic disease management and follow-up care through Medicare and the Pharmaceutical Benefits Scheme (PBS), and a Close the Gap prescription medicine supplement which commenced in July 2010. In the first 18 months, the PBS reported, more than 181,700 Aboriginal and Torres Strait Islander patients had accessed cheaper medicines under the scheme, and a review determined

that while there was a shift in prescriptions from other categories to Close the Gap, there was also an absolute increase in medicines provided to Indigenous people.¹⁴⁰ The ICDP continues at present. Maternal and child health services have also been supported using this mechanism, mainly through the Healthy for Life Program, where the majority of centres funded have been ACCHOs and demonstrable improvements in parameters such as antenatal care attendance and follow-up care of hypertension have increased.

Australian Government reporting has summarised the healthcare access of Aboriginal and Torres Strait Islander people, indicating some slow improvement. Based on data from successive National Aboriginal and Torres Strait Islander Social Surveys presented in *Overcoming Indigenous Disadvantage*, the proportion of Aboriginal and Torres Strait Islander adults reporting not seeing a GP/specialist in the previous 12 months fell by 5% over 10 years to 14% in 2012–13; health services usually used by Aboriginal and Torres Strait Islander children in major cities showed a 10% shift in 7 years towards Aboriginal Medical Services, which provided 19% of the billed occasions of service in 2015.³⁵ Access to the Pharmaceutical benefits system was substantially less, 44% per capita, compared with non-indigenous people in 2010-11.³⁰

2.11 Summary

Well-functioning Indigenous societies in Australia were impacted by exclusion and domination consequent to colonisation two centuries ago, creating adverse physical and social environments for Australian Indigenous people and resulting in differential access to power and resources. Depopulation, family disruption through separation, and high levels of personal stress experienced in everyday life have been the legacy of colonisation for Indigenous people, and this has been evident in urban-based studies. These effects on communities and individuals often go unacknowledged in health care. The conceptualised mechanisms of social capital and bonding, based on trust and reciprocity, may provide insight into ways to improve health care relationships in this post-colonial period. Indigenous knowledge conveys a holistic, system-oriented, long-term view of life and health, and aspiration for good which can potentially transcend these difficulties.

Although a major change in Australian society and government policy was evident around 50 years ago and has gained momentum over the past ten years, the change is insufficient. Funding of Indigenous-specific programs has provided more service access, however initiatives applied within general community programs have not sufficiently influenced mainstream practice.

The persistent experience of racism reported in daily life is an indicator that Aboriginal and Torres Strait Islander people are unlikely to be comfortable, appreciated and well engaged in mainstream settings. Perhaps mobility is in part a reflection of this discomfort, lack of appreciation and lack of mainstream engagement. This unfortunately is very evident in the health system and in health services as, for example, documented by the research of Coory, of Mathur, of Lopez and of Tavella on coronary procedures in Australian hospitals.^{99,100,101,102} Instability of funding and instability of support for models of primary care and other services speak to the lack of commitment over time to work with Indigenous people to address inequities. The (frequently acknowledged) low number of Aboriginal and Torres Strait Islander doctors, nurses and managers practicing within health services is persisting evidence of health system inequity compounding adversity. This suggests that across the board in health services, the needs of Indigenous people are not being met, and there is a pervasive avoidance of active discussion about these shortcomings in the mainstream setting.

Indigenous people have declared their aim to seek societal and health improvement as a human right through re-establishment of self-determination and active participation in the current society of Australia. The knowledge and opinions held by Aboriginal and Torres Strait Islander community members about health, wellbeing, their local area and their community must influence adoption of any new strategy for Indigenous healthcare. Health service research, to make a useful contribution in this area, must consider this history and reflect this Indigenous perspective. Literature suggests that a supportive environment for preventive care within urban mainstream general practice may be provided where cultural safety is addressed by practitioners and by the organisation; where there is acknowledgement of diversity, local knowledge, local links, good communication, respect, trust and attention to power differentials.

Chapter 3 **Immediate context: establishing preventive healthcare with and for Indigenous people**

3.1 Overview

In this chapter, the internal context, or the more proximate influences on general practices, are reviewed based on available literature. The focus is on the specific aspects of primary health service delivery for Indigenous people in Australia, including the main barriers and enablers relevant to preventive care.

3.2 Role of support organisations for primary healthcare

A policy review by Gardner et al. considered that over the last 20 years, Australian Government health policy has increasingly focused not only on efficiency but also on driving quality assurance processes in primary healthcare as a means of increasing integration of care and improving health outcomes. GPs are the established gatekeepers for secondary and other health services through Medicare. Policy measures have included strengthening accreditation of general practices, providing financial incentives for adherence to best practice (the Practice Incentives Program) and establishment in 2011 of the Australian Commission on Safety and Quality in Health Care, which has provided a framework for improving practice. An overarching influence has been establishment of the National Health Performance Framework to improve accountability, elements being adopted in a range of health plans.¹⁴¹ The framework has been enhanced by development of a performance accountability framework for use at the level of area-based GP support organisations, and at health-service unit level for benchmarking. Equity indicators for local use, such as various forms of health care access, are not yet developed. All the local level indicators are required to be reported each for Indigenous and non-Indigenous populations.¹⁴² An example is PHN level data provided by the AIHW in MyHealthyCommunities reports, available on line in a format allowing integrated local area presentation, targeted to health professionals. Indigenous and non-Indigenous immunisation rates are reported, however only whole of community figures are provided in the most recent report of GP attendances.^{143,144}

Support organisations were undergoing rapid change over the period, to embed them in governmental strategic planning at various levels, and to better promote effective and efficient and equitable care. One of the models that embodied integration of primary care functions was the Medicare Local. Nicholson et al. (2012) reviewed the model in this way:

Divisions of General Practice (numbering 112 in 2010) focused primarily on support of GPs and were further developed into larger Medicare Locals (numbering 61 in 2012).¹⁴⁵ These were a collective, professional, local voice, focusing on practice accreditation, quality improvement, information technology adoption, expansion of multidisciplinary teams in general practice and improving access to care. A national survey of Medicare Local staff found that their organisational styles and effectiveness varied to a great degree.¹⁴⁶ A comprehensive report by Horvath to the federal government highlighted these aspects as well as disengagement of GPs and fragmentation of activities in some areas. More national coordination, greater geographic and functional alignment with other health organisations and a move to facilitation and commissioning rather than service provision was recommended.¹⁴⁷

The further transformation of Medicare Locals into 31 PHNs from July 2015 has been with the stated aims of increasing efficiency and effectiveness of local services including those to disadvantaged groups, and improving coordination of care according to government documents. Boundaries have been aligned with regional Hospital and Health Service bodies, and there has been a higher level of national priority setting, monitoring, and public reporting. The role of commissioning has been considered, with renewed editorial interest in the experience of other countries in health service commissioning.^{148,149}

Commissioning and equity were considered in a qualitative study of PHN stakeholders, by Henderson et al. in 2018. Facilitators of equity, engendered by commissioning based on local need, were considered to be objectivity in decision-making, reduced conflict of interest, and control of service specifications. The barriers recognised were lack of flexibility of funding, tension in relationships with local service providers, lack of understanding of the local context where services were brought in from elsewhere, a lack of local services available to tender, and importantly a recognition that the process is at odds with the way that ACCHOs function. The range of potential impacts on ACCHOs highlighted included competition with ACCHOs for funding, loss of employment in ACCHOs, and bureaucratisation of relationships.¹⁵⁰ As health equity for Indigenous people is a priority, commissioning in this area should be congruent with their values and protocols.

Couzos et al. (2016) set out proposals for collaboration between PHNs and ACCHOs based on formal participatory structures, such as via an Aboriginal and Torres Strait Islander steering committee within the PHN led by local ACCHO organisation representatives and inclusive of those from other Indigenous health organisations. An

example of pre-PHN collaboration given by Couzos was the Metro North Medicare Local, which coordinated the South East Queensland group of Medicare Locals to subcontract their ICDP-funded care coordination and supplementary care service to the UIH, which delivered a higher level of service than the national average. Implementation of reporting able be disaggregated by Indigenous status across all services was recommended. Enhancing the cultural competence of primary healthcare staff was envisaged as another situation that might be contracted to the local ACCHO.¹⁵¹

While integration between hospital and general practice has been a focus of government change strategy, synergies between primary care and public health units (PHUs) at the primary care level can also enhance quality of care through emphasis on prevention activity. These services are part of local area Hospital and Health Services. PHUs and primary care services have overlapping aims, roles, and complementary actions. Levesque et al. (2013) mapped functions of primary care and public health according to the international literature, finding overlap in health service planning and community impact evaluation, advocacy for equity and access, organisation of immunisation campaigns, promotion of healthy lifestyle, clinical screening, and early preventive intervention.¹⁵²

Federally funded PHNs and state funded PHUs in Australia sit at the interface between primary health carers and others in the health system. These are well positioned, because of the geographic focus of responsibility, to facilitate performance improvement, translation of research into practice, and service-based research and evaluation in collaboration with service providers.

3.3 General practice accreditation

The RACGP has established standards for accreditation of practices that meet the following definition:

General practice provides person-centred, continuing, comprehensive and coordinated whole-person healthcare to individuals and families in their communities. General practice must be the predominant nature of service provided and there must be organisational capacity to meet the standards [for general practice].¹⁵³ (RACGP, 2017)

There are eight core standards, which cover the rights and needs of patients, practice governance and management, health promotion and prevention activities, clinical management, information management, content of patient health records, and education

and management of non-clinical staff. The standards include processes of goal setting, monitoring and evaluation.¹⁵³ Details of the relevant standards follow.

The patient identification criterion for clinical records specifies that a minimum of three identifiers must be used, such as name, date of birth, and address. There is no requirement for Indigenous status identification. Respectful and culturally appropriate care is described as core, but does not mention Indigenous status identification. A systematic approach to preventive care is required. Although a holistic approach considering *heritage*, such as considering Indigenous status, is suggested, there is no requirement for Indigenous status identification for preventive care in the 2017 standards. Added to the core indicators are two additional modules, so placed for separate revision but both also required of general practices. Module two, quality improvement, entails having a continuous quality improvement (CQI) process, which includes patient feedback, monitoring clinical indicators (clinical audit) and undertaking risk management activities. Module three, General Practice, covers considerations specific to that setting such as home visiting and after hours care, comprehensiveness of care including preventive care, recall (e.g. for review of abnormal pathology results, where defined follow up is required and non-response should be documented) and reminder (e.g. invitation to preventive care, where follow up of non-response is not required).¹⁵³

General practice accreditation based on the RACGP standards is voluntary, is current for a three year period, and is assessed by one of several RACGP-specified organisations. Appleyard et al. (2008) made an assessment of costs of accreditation by interviewing stakeholders and practitioners. The report advised that around twelve months is needed for a practice to prepare for initial accreditation, engaging with an accreditation team which includes a GP over that time, prior to the assessment. Costs of accreditation varied. The practice's labour cost of preparing for first accreditation was around 200 hours, a cost of around \$6,000. Additional to that was the accreditor's fee of several thousand dollars, and in some practices, a one off cost for altering the building or the record system. Benefits of accreditation, according to practitioners, were recognition of the practice, risk minimisation, establishment of quality and safety procedure review on an ongoing basis, and eligibility for Medicare incentive payments to practices, which could offset the costs of accreditation.¹⁵⁴

A recent consultation paper from the Australian Commission on Safety and Quality in Health Care states that in May 2016, the Australian Government Minister for Health endorsed implementation of the National General Practice Accreditation Scheme. The

scheme commenced on 1 January 2017 to support the consistent assessment of Australian general practices to the RACGP *Standards for general practices*. The Commission began a consultation with primary care providers in late 2017. A discussion paper details a series of developments and proposed developments. A stated aim is to review the Commission's practice-level indicators for primary care to support service improvement through performance monitoring and benchmarking to further develop the National Safety and Quality Health Service Standards, which have been trialled in some ambulatory care and general practice settings. A practice incentive payment for Quality Improvement is planned for introduction in the near future.¹⁵⁵

3.3.1 Local uptake of accreditation

The Productivity Commission's Government Service Reports for 2011 and 2012 quoted Australian General Practice Accreditation Limited's figures indicating that in Queensland, the percentage of general practices accredited varied from 75% in 2007 to 78% in 2012, and this was comparable with PIP enrolment.^{156,30} (As was mentioned in Chapter 1, accreditation was a pre-requisite for participation in the federal government's practice incentive programs.) There were several established Incentive programs, including one for immunisation and one for eHealth—the Indigenous Health Incentive being the latest at that time.³⁰ According to DGP Practice Incentive Program (PIP) statistics reports 142 Inner North practices (71%) and 42 Outer North practices (66%) participate in a PIP in 2012.¹⁵⁷

3.3.2 Local use of electronic information systems

The eHealth PIP was used in government reporting as a proxy for practices using electronic information systems and reporting. This incentive commenced in August 2009 and data are accessible via Medicare Local from 2011. For Metro North Medicare Local (the amalgamated Inner North and Outer North DGPs), there were 177 practices (66%) receiving this payment in 2011, and about the same number the following year.^{157,158}

3.4 Influence of Aboriginal people on primary healthcare

The ACCHO movement, a community response to the failure of mainstream health services to meet the needs of Indigenous people, has become a major force of change influencing health services for Indigenous people. Aboriginal community volunteers commenced the first health service in 1971 in Redfern, and a service on the southside of Brisbane was established in 1973. A national umbrella organisation for the services, the National Aboriginal and Islander Health Organisation, (NAIHO) was established in 1974. A National Aboriginal Health Strategy was developed by a government working party chaired by NAIHO representatives and was tabled in the national parliament in 1989. Panaretto et

al. (2014) explained that the model of community governance and comprehensive primary healthcare, as articulated in this document, led ACCHOs to develop a patient-centred care approach in advance of mainstream primary care services in Australia.¹⁵⁹

3.4.1 Recommendations for health screening specific to Indigenous people

In 1999, Ten years after the establishment of preventive health guidelines for the general community, Aboriginal health checks entered the Australian literature when the Kimberley area ACCHS published a review of evidence-based practice in Aboriginal primary healthcare. This work was successively revised and refined through to a third edition in 2007. The chapter on health screening, by Couzos & Murray last updated in 2008,¹⁶⁰ formed the basis of a national guide to preventive health assessment in Aboriginal and Torres Strait Islander people, updated in 2018.¹⁶¹ This approach was endorsed and supported by Medicare first in 2004, when a new health check item for Indigenous Australians was introduced. Initially, Indigenous Australians aged 15 to 59 years of age were eligible for a check each two years, with the aim of early diagnosis and intervention for common treatable conditions. A long list of specific activities carried out directly by the doctor or within their direct supervision was specified. With little uptake, the item was revised and simplified in 2006, becoming an annual check for all ages, appropriate to the age-related disease profile.¹⁶² Specific content of the check has been since added for children, adults and those aged 55 years and over, within the same Medicare billable item. The current value of the item is \$212.25.¹⁶³

3.4.2 A focus on CQI for Indigenous primary health care

From 2002 to 2009, the Audit and Best Practice for Chronic Disease (ABCD) Project and Extension Project (ABCDE) brought together ACCHOs and researchers in a large-scale project to implement CQI at practice level for better care, associated with the development of electronic data management tools. Initially 12 centres in the Northern Territory were involved, and by 2009, 62 sites across four states participated, and all government-funded centres in the Northern Territory took up the developed system. The project utilised annual cycles of system assessment and audit of clinical records to assess the quality of care, feedback workshops, goal setting and action planning, and implementation of system changes over an extended period (see figure 3.1).⁵⁰

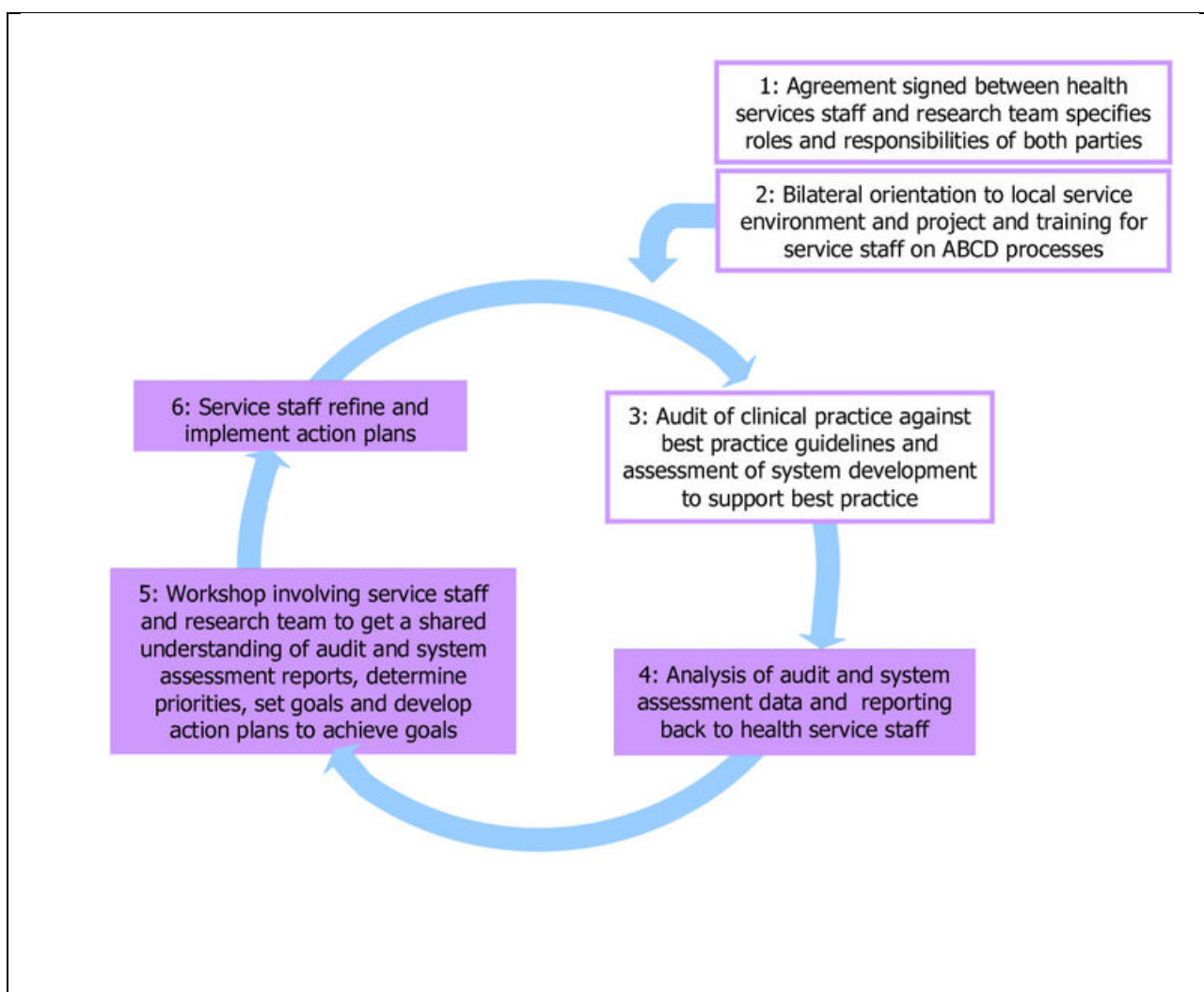


Figure 3-1 The ABCD Project's annual cycles of system assessment and audits of clinical records to assess the quality of care, feedback workshops, goal setting and action planning, and implementation of system changes

Source: R. Bailie (2010).⁵⁰

Bailie et al. reported that a feature of this project was structured assessment of health centre systems, and defined activities based on the Assessment of Chronic Illness Care scale. This enabled measurement of key aspects of primary care service—systems. These included design of workflow and staff roles and responsibilities, arrangements for working with other agencies and community members, information systems, support measures for clinical best practice (such as availability of guidelines and access to specialist advice).¹⁶⁴ Outcomes achieved by the initial Northern Territory project group after two cycles (around two years) were improved coverage of care processes, such as scheduled diabetes care (52% from baseline 30%), and a higher level of satisfactory patient results, such as HbA1C indicating good diabetes control (28% from baseline 19%). Coverage of scheduled preventive services for well adults, however, changed little (21% from a baseline of 19%).¹⁶⁵

A later review of the further developed system—funded by the federal government’s Healthy for Life program, additionally taking in the maternal and child health service—showed a greater change in outcomes over a more prolonged time period when child-health activity was analysed. Fifty-nine centres that had completed three or more audit cycles over six years were included. Statistically significant improvement in coverage for large numbers of children occurred in the third and later cycles, and was attributed to CQI participation (see figure 3.1) by the authors, albeit acknowledging the greater focus on staff training.⁵¹

The variable degree of success between (largely remote area) centres was studied through audit of participation in the six-step CQI process of the project and interviews with health unit participants, their regional administering body, and key health bureaucrats. They found that at the unit (organisation) level, commitment at the top, leadership at all levels and resources for implementation were required. At the broader system level, it was suggested, governance arrangements that could foster links between CQI and regulatory, financing, and performance frameworks would assist. The views on the active dissemination process showed that presentation of research findings at forums and conferences, and direct engagement with stakeholders was successful in influencing senior managers to support the project. In addition to conferences and for associated training, providers such as Aboriginal health workers and nurses were engaged directly in the project—and clearly saw the benefits of participation. Clinic doctors were more difficult to engage and least likely to participate in feedback sessions. An exception was one particular champion who actively used peer networks to influence colleagues.¹⁶⁶ Views of patients were not considered in this study.

In 2007, implementation of a similar system in an urban Indigenous clinic (Inala Community Health Service), with pre-existing well-functioning information systems, showed good results. Inala received federal government Healthy for Life funding. Spurling et al. (2013) reported that after two years and two CQI cycles, coverage of Diabetics with HbA1C measured within six months was 90% (national average 44%), average HbA1C for diabetics was 7.9% (down from baseline of 9.6%) and target blood pressure was achieved in 50% of Diabetics (up from baseline of 25.3%).¹⁶⁷

3.5 Primary care services used by Indigenous people

Currently available information about Indigenous peoples’ usage of mainstream urban general practice is inconsistent regarding proportion of mainstream versus Indigenous-

specific services accessed by Indigenous people. BEACH studies were a cornerstone of activity-related research in Australian general practice from the late 1990s until 2016, collecting GP activity at sentinel practices using an encounter record, but have been unable to provide detailed information about Indigenous patient activity. Analysis suggested under-recording in major cities. Fahridin's 2009 review of Indigenous patient data over 10 years showed higher rates of service delivery for diabetes, asthma, pregnancy, drug use, chronic alcohol use, and renal failure, and lower service delivery rates of cardiovascular diseases including high blood pressure management, relative to the general practice population. Infections, such as skin and ear infections, were more commonly managed. Cardiovascular check-ups and immunisations were less often provided at Indigenous encounters, than at non-Indigenous encounters.³⁹ Much of this is difficult to interpret, however the lack of cardiovascular checks is notable, given the high prevalence of a disease that is silent in the early stages but detectable on a check.

Deeble's (2009) national report, based on 2006–07 Medicare remunerated service figures, distinguished those of ACCHOs (exempt from exclusion as publicly supported organisations under Section 19.2) and found the relative proportion of Indigenous people who used ACCHS and mainstream general practices to be about equal. Further, there was a degree of mixed usage of either type of service by individuals, not able to be further quantified. In 2009, based on the Voluntary Indigenous Identifier within Medicare, Deeble estimated around 40.5% of the Indigenous population identified themselves using this route, and non-ACCHO doctors provided 36% of services for this group.¹⁶⁸

3.6 Enablers and barriers to health service for urban Indigenous people

Levesque, Harris & Russell (2013) synthesised the published literature to describe a multi-dimensional patient-centred model for access to healthcare. Levesque conceptualised patient access on a broad continuum that emphasises the relationship between the service and its users (see figure 3.2). The continuum stretched from the perception of needing care through to the benefits of receiving care (at the patient level, or demand side) and incorporated dimensions including approachability, availability and appropriateness (at the service level, or supply side).¹⁶⁹

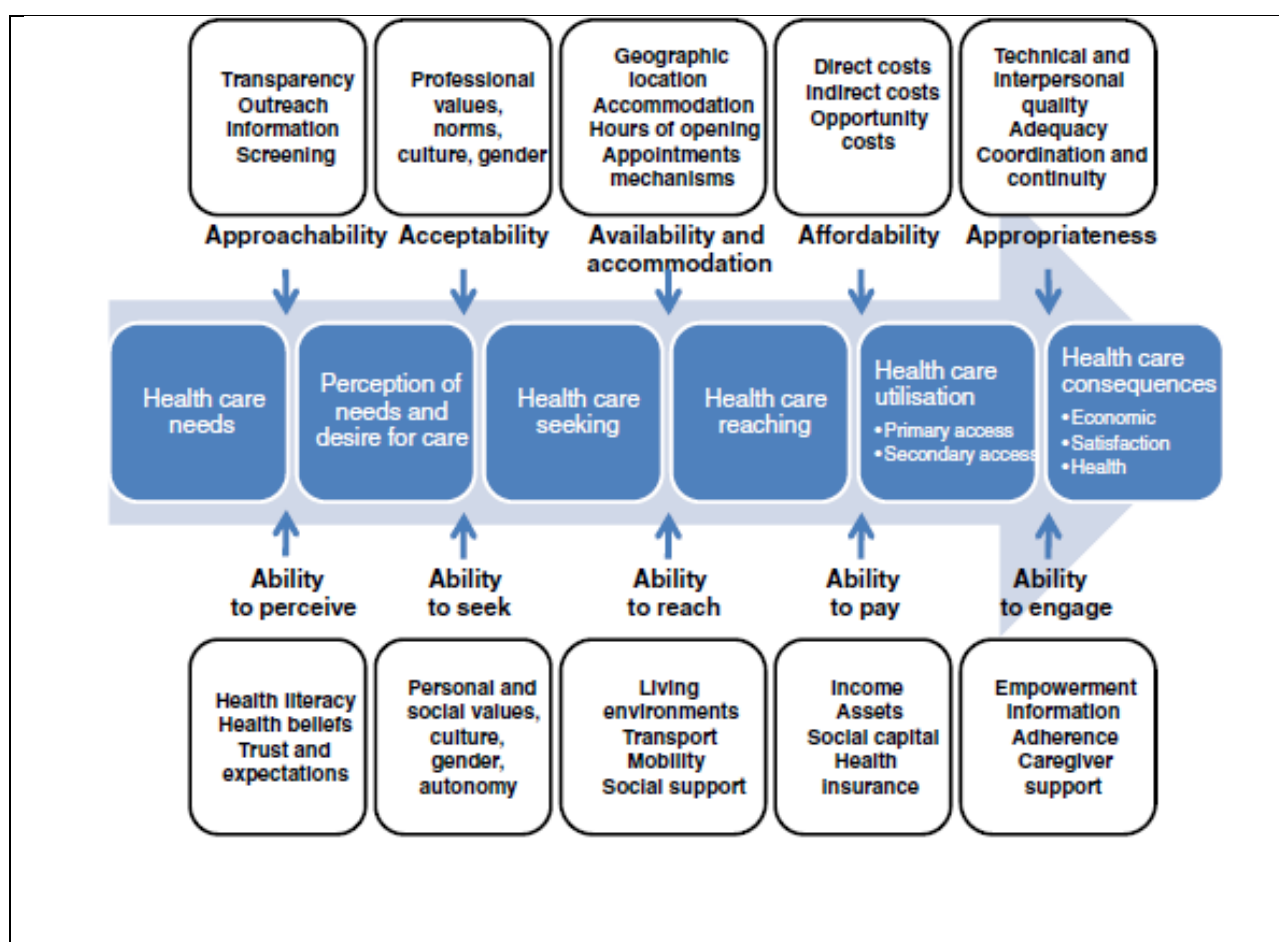


Figure 3-2 A conceptual framework for access to healthcare

Source: Levesque et al. (2013).¹⁶⁹

Davy et al. (2016) performed a further synthesis adding the literature related to Indigenous-specific services, considered highly accessible to Indigenous people. Added considerations were social and cultural determinants, and systems issues such as variable adequacy of funding. Indigenous service responses included additional patient support, such as provision of transport, and home visiting. Employment of local Indigenous people within the service improved access by promoting community ownership and cultural safety. In representing the new model, an ecological model of concentric circles was thought to better represent alignment of issues, and “appropriateness” of the provider was replaced by “Ability to Engage”.¹⁷⁰ This change in terminology applied to the provider or service expresses a fundamental shift from a passive to an active relationship, where the patient’s perspective must be considered by the practitioner.

A recent government commissioned and detailed evaluation by Bailie (2015) of the Australian government’s Indigenous Chronic Disease Package (ICDP), previously described in section 1.17, provides valuable information and insights into the complexities,

challenges, and potential for innovation of re-orienting health service delivery to address chronic disease in a way that benefits Aboriginal and Torres Strait Islander people. The Sentinel Sites Evaluation of the Indigenous Chronic Disease Package 2010–2014 was a place-based evaluation designed to understand local factors that made the program work. Mixed methods were used to collect a range of clinical and key informant data across 24 sites. Eight of these were urban, and these were either community controlled and/or Indigenous-specific services. The proportion of Indigenous population in the local urban communities was 0.5 to 2.7%. There were many participants, including, for example, 670 community members who participated in focus groups.

The evaluation examined both clinical processes within sites and outcomes for the local Indigenous community as a geographic unit. Administrative data such as use of the Pharmaceutical Benefit System (PBS) co-payment, Medicare benefit claims, and use of the Indigenous Health Program incentive were collected. In some sites, interviews were conducted with key informants in an annual review, and in some sites, intensive case studies were undertaken, which involved interviews with key informants and community focus groups. Notable achievements for the sites overall were documented, and wide variation between local areas in ICDP uptake was recognised. Success of delivery of the PBS co-payment, which improved Indigenous peoples' access to low cost medicines, 'exceeded expectations', and the increase in health-check delivery by sentinel sites was twice that of other areas of Australia.

The ICDP focused funding and program activity directly on providers, and overall, the data suggested that supply side strategies had been successfully carried out. Examples were removal of cost barriers and the creation of welcoming, culturally safe spaces. There was less evidence of change to demand side strategies to promote care seeking, and a gap was identified: the lack of complementary programs in non-health sectors to support health improvement and address the social determinants of health. Practice Incentive Program–Indigenous Health Incentive (PIP IHI) billing, health check billing and PBS co-payment distribution data showed increasing uptake in urban sentinel sites participating in the PIP-IHI relative to other urban sites. Sustained activity related to individuals, did not show a clear increase, suggesting there was still fragmentation of care.^{164,171}

A review of available studies about barriers to accessing mainstream urban general practice for Indigenous Australians was carried out by Scrimgeour & Scrimgeour (2008), and few were found. Craig's (2002), unpublished work produced for the Macarthur DGP was featured in this paper.¹⁷² In Craig's work, receptionists, Indigenous people and

doctors were interviewed (in separate, consecutive phases of the study) about barriers to access for Indigenous people. Communication issues, cross-cultural misunderstandings, and practical barriers were highlighted. *Shame* related to the patient's health problems and lack of progress following treatment was discussed, and doctors mentioned difficulty establishing trust. An important role for receptionists, as first in contact with the patient, was a finding of Craig's study.¹⁷³

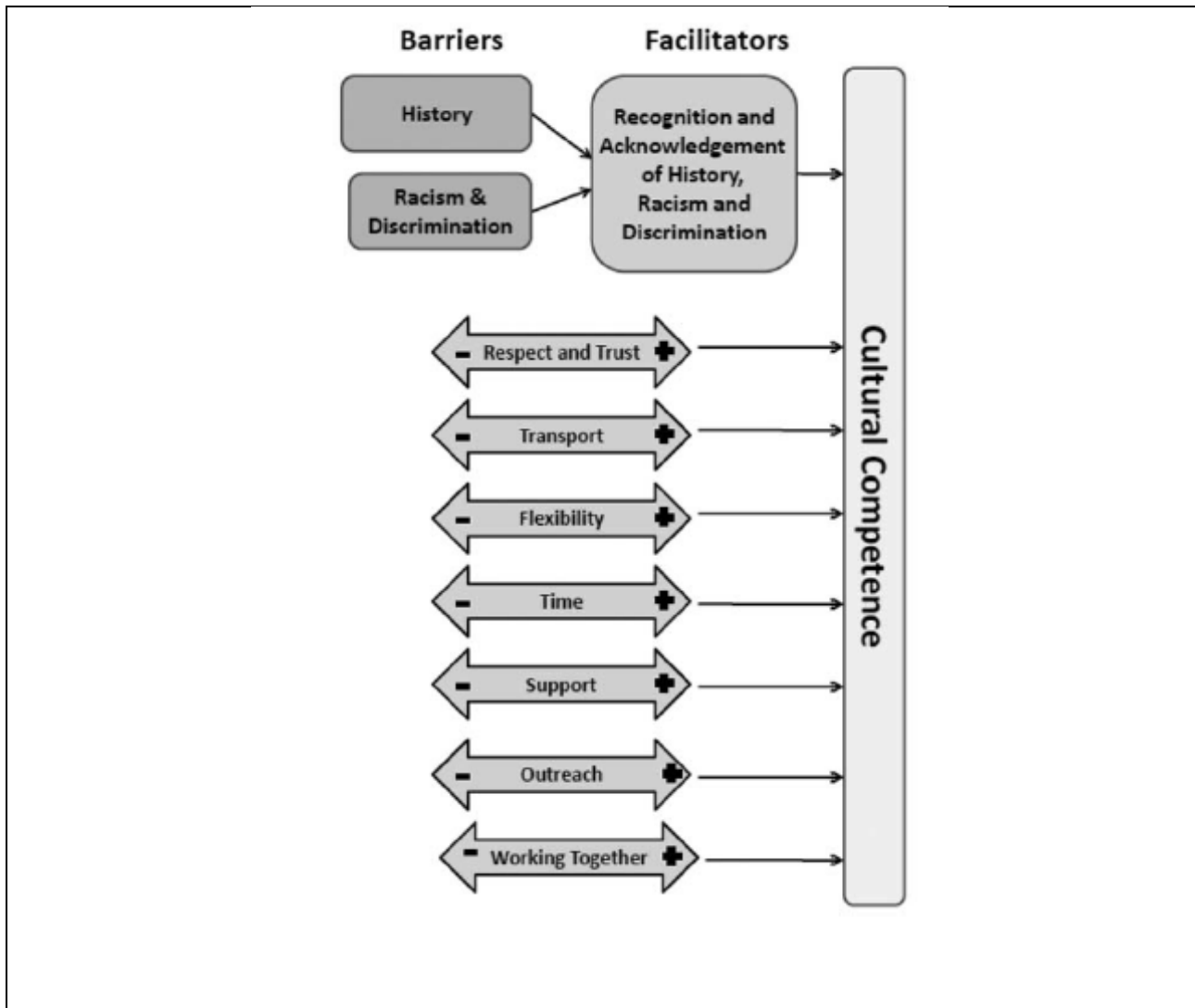


Figure 3-3 Barriers and Facilitators to accessing mainstream urban general practice and healthcare services by Aboriginal people with chronic illness

Source: Lau P, Pyett P, Burchill M, Furler J, Tynan M, Kelaher M and Liaw S-T (2012)⁴⁰

Later, Lau et al. (2012) published a qualitative study of factors influencing access to urban mainstream general practice by Aboriginal Australians with chronic disease. Forty policy makers, service providers, and community members in Victoria participated in an interview or focus group where practical experiences in relation to diabetes management was discussed. Thematic analysis produced a useful schema of two overarching themes of

history and racism, and seven influencing factors including 'respect and trust, 'working together', and practical barriers such as time (see figure 3.3).⁴⁰

A study by Liaw et al. (2015) conducted in South Western Sydney in 2012–13 examined the effect of an audit and cultural workshop and intervention on general practices, the Ways of Thinking, Ways of Doing Project. Intervention commenced with an audit and cultural-quotient questionnaire completed by staff; results of which were brought to a three hour cultural respect workshop. Findings were discussed and a toolkit was provided for ongoing cultural-respect activities within the practice, with the assistance of a cultural mentor. The toolkit included practical information and ten example case studies that had been developed with input from Indigenous patients. The audit was repeated after six months, and practice staff, mentors and patients were interviewed at that point. Audit results showed an increase in Indigenous identified patients and some increases in care activities. The staff questionnaire showed an increase in cultural strategic thinking. Participants emphasised the success of cultural mentors in facilitating change. From the patient perspective, increased "friendliness" of practices and a lack of information amongst clinicians about Indigenous-specific services persisted. The authors recommended wider trialling of the package.¹⁷⁴

An additional element not often featured in the literature is the degree of community engagement of the practitioner/practice. Hayman and colleagues documented the success of the Inala Indigenous Health Service, following consultations with the Inala Elders group (see also section 1.10).^{175,176} This type of activity, which is seen as appropriate to Indigenous-specific services, may apply in some way to mainstream general practice.

It has often been observed by practitioners in urban areas that Indigenous people may use multiple providers—an ACCHS and a mainstream general practice—sometimes for different types of problems. The engagement of mainstream general practices with the community including Indigenous health organisations, helps to provide an appropriate range of options for Indigenous people, to complement the work of ACCHOs. It is important that practitioners are aware of this usage pattern so that care is not fragmented or duplicated.

3.6.1 Indigenous identification for healthcare

Indigenous identification in hospital and community health services for the purpose of offering appropriate care and assessing the effectiveness of that care is a priority for both Queensland and federal governments. The Health Insurance Commission began

implementing an ongoing Indigenous Access Program in 2000, a component of which is promotion of voluntary Indigenous identification. Medicare liaison officers connect with ACCHOs and other health service providers to promote and support the use of the Medicare Australia program and a range of Medicare benefits. Recently a specific telephone helpline has also been established. The Indigenous status reported to Medicare by patients is not accessible to GPs and other healthcare providers who bill Medicare.¹⁷⁷ A separate process is required to identify patients within a practice.

A study of general practice staff attitudes likely to influence Indigenous identification and health check uptake was conducted by Kehoe & Lovett 2006–07, based in the Australian Capital Territory DGP. A survey and a series of semi-structured interviews were used. Findings were that there were concerns about introducing routine identification activities for all patients, that there were low levels of identification, and significant barriers to change. These included apprehension and fear of offence by office staff in relation to the Indigenous identification procedure; clinicians' lack of awareness of Indigenous peoples' health need in an urban setting and lack of support for specialised health assessment in that setting, and practice software not suitable to recording Indigenous identification and health checks.¹⁷⁸ Subsequent work by Kelaher et al. (2010) for the AIHW identified practical issues similarly to Kehoe, based on both practitioner and patient views. These included lack of awareness and training of staff about Indigenous status and its identification, little follow-up of missing data, inadequate data systems, staff reluctance to ask the question because of a perception that the person would not want to disclose their status and might refuse, and also a lack of privacy when questioned in the setting. Kelaher suggested a way forward for practices, making action relevant to the whole community by recommending a focus on ethnicity generally, and emphasising that quality of care for all includes cultural and interpersonal aspects.¹⁷⁹

Kelaher's main aim was to define best practice for identification of Aboriginal and Torres Strait Islander peoples in health datasets, based on the views of Indigenous people.

This question has been framed as:

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

With response options of

No; Yes, Aboriginal; and Yes, Torres Strait Islander, where both Aboriginal and Torres Strait Islander may be selected, or alternatively a fourth option of **yes, both Aboriginal and Torres Strait Islander** is included.¹⁸⁰

More recently, an ABS (2014) review of the Indigenous status standard—for example as used on the Census, worded as above—garnered feedback from Indigenous stakeholders that *origin* was not the same as identity. While an Aboriginal or Torres Strait Islander person will always have one or more Aboriginal or Torres Strait Islander ancestors, they may or may not identify as an Aboriginal or Torres Strait Islander person. Cultural identity was seen as the quality to be captured, being fluid and capable of change over the course of a lifetime and within specific situations. The preferred wording of the question was

Are you [is the person] an Aboriginal or Torres Strait Islander person?¹⁸¹

3.7 Implementation of Medicare Indigenous health checks

Systematic health checks tailored to age and health behavioural risk have been a relatively new development in the Australian health system, with evidence-based guidelines for practice first established by the Royal Australian College of General Practitioners (RACGP) in 1989. Good practice is considered to be offering this service at the appropriate age, for example, when aged three to five years and when aged 75 years.¹⁸² These activities are specially remunerated under Medicare at a higher level than simple consultations to provide compensation for the extra time required, and are defined for that purpose as having the following features: history and examination, an assessment, recommending appropriate intervention, providing information and advice to the patient, producing and retaining a written report and providing the report to the patient.¹⁸³ Templates for the age-related checks are a feature of most general practice electronic patient records, for example a 'healthy kids check'.¹⁸⁴ Prompts at the point of care (to indicate to the person opening the record that the check is due) and ability to generate a list for reminder of patients for preventive care, are a feature of many practice information systems.

More frequent checks for Indigenous people were recommended by the RACGP from 2005.¹⁶¹ Annual health checks for Indigenous people of all ages have been supported by Medicare remuneration for general practice since 2010, a schedule varying by age supported in earlier years.¹⁸⁵ The majority of Indigenous health checks are undertaken by Aboriginal and Torres Strait Islander Community Controlled Health Services (ACCHSs). For example, in 2015, 33% of children from birth to four years old, who were regular

clients, received a health check within a federally funded Indigenous primary care service.¹⁸⁶

A review by Urbis Keys & Young (2006) concluded that 'Providing EPC services requires GPs with the necessary time and commitment, responsive patients willing to make the time available, and good administrative/IT systems'.¹⁸⁷ Inala Indigenous Health Service in Southern Brisbane, a Queensland Health run service, has both implemented and studied the checks. Spurling's 2009 review of Indigenous health check activity indicated that there was a high level of resulting investigation, intervention and referral as the result of screening, and that new diagnoses were established. Vaccinations were given to 42% of the people checked.¹⁷⁶ In 2013 Spurling described in more detail the process of transferring health-check documentation from a paper-based to an electronic system. Advantages of the electronic system were increased health-check activity, high staff satisfaction with the system, and better access to data which began to be used in research.¹⁶⁷

Initially there was a high rejection rate of claims to Medicare for the various Indigenous health-check items, according to DGP staff. After claiming was simplified in May 2010, by combining all ages as the single check Medicare item no. 715, there was a simple means of claiming and a simple means of reporting. A national increase in uptake was seen at this time (see Figure 3.4). Contributors to the rise were thought to be increased federal government investment in the Indigenous health workforce associated with the 2009 National Partnership Agreement on Closing the Gap, the introduction of the Close the Gap pharmaceutical benefit available to Indigenous patients, and the introduction of the Indigenous Health Practice incentive, which rewarded increasing delivery of Indigenous health checks.¹⁸⁸ The jump coincided with the beginning of the study intervention period.

3.7.1 Indigenous health check national targets and coverage

The Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan has set age-related targets for health-check coverage of between 42% for young adults aged 15 to 24 years, and 74% for adults aged 55 years and over by 2023.¹⁸⁹ Indigenous health-check coverage for adults (over 15 years of age) rose from 9% in 2010 to 28% in 2016, and was highest for those aged 65 years and over, an age where all general community adults are recommended and funded for a check.¹⁹⁰

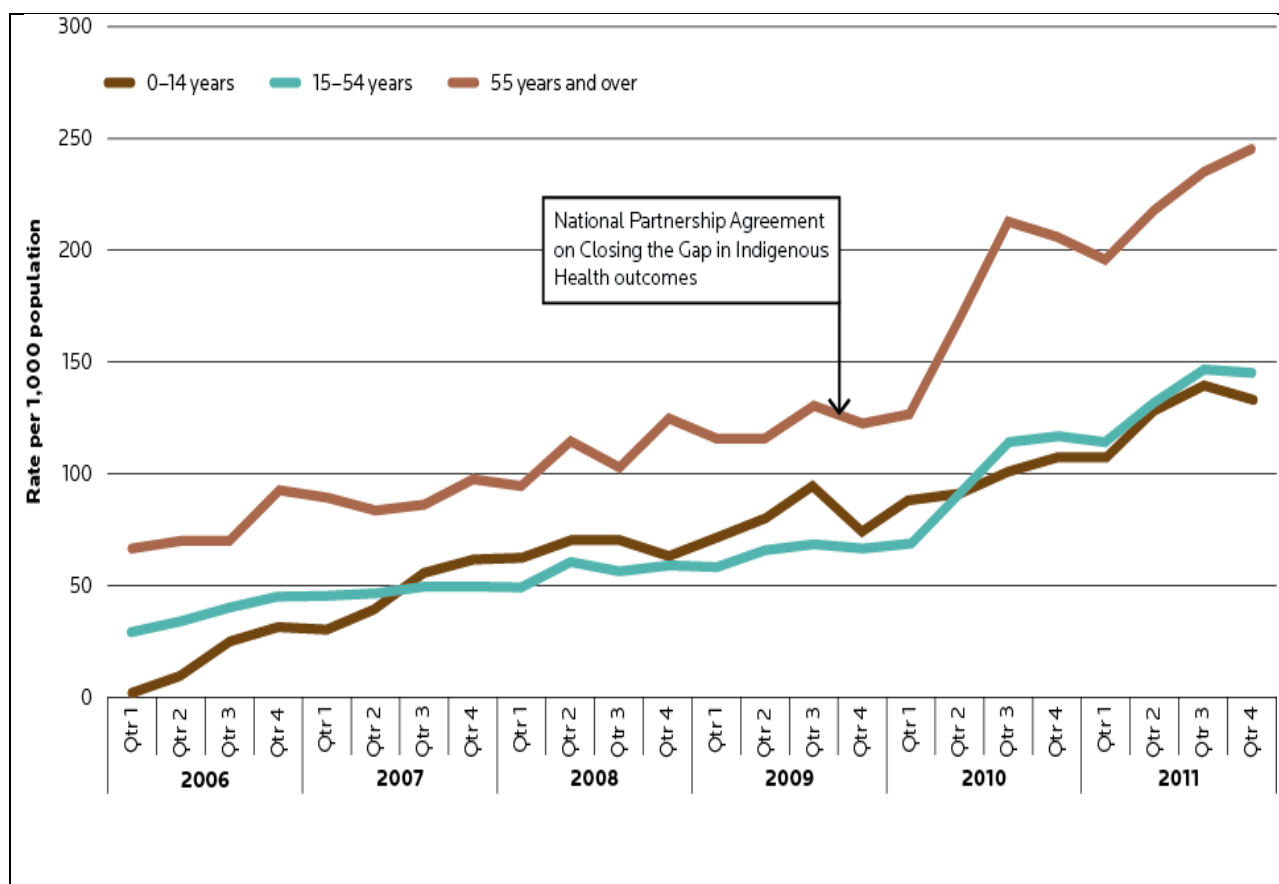


Figure 3-3 Rate per 1000 persons receiving Medicare Benefits Schedule Health Assessments, by age group, Indigenous Australians, January–March 2006 to October– December 2011

Source: AHMAC, Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report.¹⁸⁸

Queensland has delivered around one-third of the national total of checks. Medicare statistics indicated early on that Queensland provided the highest numbers of child and young adult checks per year, that the numbers had been increasing steadily, and that these were yet reaching only a small proportion of the eligible populations. For most checks, females slightly outnumbered males in the service counts. In 2008 in Queensland, around 8% of the total Indigenous population of 126,000 were screened (see table 3-1).¹⁹¹

Table 3-1 Medicare activity statistics, service counts for Queensland

Period	Child health Item 708	Young adult Check 15 to 54 Item 710	Older adult check 55+ Item 704	Qld total (Qld % of National count)	National total
Calendar year 2008	3955 (93 per 100,000 Medicare enrolled)	5151 (121 per 100,000 Medicare enrolled)	1212 (28 per 100,000 Medicare enrolled)	10,318 (30%)	34,688
Quarter 1 and 2, 2009	2435	3096	758	6289 (32%)	19,659

Source: Medicare Australia, 2009.¹⁹¹

3.8 Implementation of Immunisation programs

Immunisation has been implemented in Australia since the 1930s and is intrinsic to general practice activities. A national childhood immunisation schedule was established in the 1950s, and regularly updated by the National Health and Medical Research Council (NHMRC). The schedule has since been extended to all age groups.^{192,193} Vaccine preventable disease still causes death. A Queensland report of child deaths based on the state's death register reported that in the three years 2014 to 2016, 11 children died from (notifiable) vaccine preventable conditions including invasive pneumococcal disease, invasive meningococcal disease, and influenza.¹⁹⁴

The most recent epidemiological review of vaccine preventable disease in Aboriginal and Torres Strait Islander people reported that many vaccine preventable infections had decreased in incidence in recent years, and most recently, there has been a reduction in child hospitalisation for hepatitis A and for the types of pneumococcal disease covered by vaccines, since commencing use of these vaccines. Concern was expressed about an increasing rate of influenza and pneumococcal disease in adults, and a continuing higher rate of some severe childhood infections³⁷, as mentioned in section 1.2.1. These are meningococcal type B (where there is a new vaccine available) and *Haemophilus influenzae* and rotavirus, which are part of the infant schedule. Severe pertussis is occurring in young infants across all populations of the country, the vaccine now part of the

schedule for infants and their mothers at the end of pregnancy, for the purpose of protection in early life.

3.8.1 Additional vaccines for Indigenous people

Additional vaccines are recommended for Indigenous people in Queensland and in other parts of Australia, excluding New South Wales and Victoria. These are state-based schedules with a small degree of variation from one jurisdiction to another. They provide extra protection against hepatitis A, pneumococcal disease, and influenza.¹⁹⁵

Indigenous identification is a specified component of preparation for each immunisation, according to the National Immunisation Handbook, section 2.1.4.¹⁹⁶ As an RACGP standard of clinical practice improvement, Q I2.1, patient records and summaries should include an immunisation history.¹⁵³ Schedule vaccines are provided at no cost to primary care services and other immunisation service providers.¹⁹⁷ Many services deliver the vaccines at no cost to the patient while some charge a service-related fee. Child immunisation-register reporting indicates that general practices provide 85% of child immunisations in Queensland, and the figure is similar in most other states.¹⁹⁵

3.8.2 The immunisation schedule

Immunisation on time and according to schedule is important to achieve both the individual and the public health benefit.¹⁹⁷ Immunisation is concentrated in the early years, with vaccines being recommended at birth and at seven age points up to the age of four years (see figure 3-4). The childhood immunisation schedule for Queensland underwent several changes immediately before and during the PIPCGP study period. Oral rotavirus vaccine was introduced in 2007, and over the next three years, the combinations of vaccines used in the primary schedule were frequently updated. There were changes to the schedule in most years.¹⁹⁸ This has meant that primary providers required frequent communication and education about immunisation. Primary health providers deliver most young-child vaccines and those for adults, while older children are vaccinated in primary school. At the time of the PIPCGP intervention, there were two extra recommended and funded immunisation age points in Queensland for Aboriginal and Torres Strait Islander children: at 18 months and at two years of age.¹⁹⁵ Additional age-related visits present practical difficulties, requiring awareness and pre-planning for additional reminders.

Age		Vaccine									
Childhood vaccines											
Birth	Hep B										
2 months	Hep B	DTPa	Hib	Polio				13vPCV		Rotavirus	
4 months	Hep B	DTPa	Hib	Polio				13vPCV		Rotavirus	
6 months	Hep B	DTPa	Hib	Polio				13vPCV		Rotavirus*	
12 months			Hib		MMR				Men C		
18 months						VZV	Hep A†				
24 months							Hep A††	23vPPV†			
48 months							Hep A‡	23vPPV‡			
48 months		DTPa		Polio	MMR						
Adolescent vaccines											
12 years	Hep B§	dTpa				VZV§					HPV
15 years		dTpa								Flu¶,**	23vPPV††
Adult vaccines											
≥ 50 years										Flu¶,**	23vPPV¶
65 years										Flu**	23vPPV

* 3rd dose of rotavirus vaccine at 6 months is dependent on vaccine brand used in state or territory

† Aboriginal and Torres Strait Islander children in Western Australia and the Northern Territory

‡ Aboriginal and Torres Strait Islander children in Queensland and South Australia

§ Catch-up only

|| Females only

¶ For Aboriginal people only

** Annual vaccination, all aged ≥6 months with medical risk factors, non-Aboriginal adults ≥65 years

†† Aboriginal adults with medical risk factors

Figure 3-4 Australian National Immunisation Schedule in 2011

Source: Hull, BP, Dey, A, Menzies, RI, Brotherton, JM & McIntyre, PB 2013, p. E292.¹⁹⁵

3.8.3 Immunisation coverage, reporting and incentives

Promotion and monitoring of the general schedule and the Indigenous-specific schedule are handled differently in some ways. Childhood immunisation coverage is monitored nationally using Australian Immunisation Register (previously the Australian Childhood Immunisation Register) records of immunisation status at the first-, second-, and fifth-year birthday. The main vaccines due prior to each of the three birthdays are used to assess coverage status in national and state reports. This assessment includes general schedule vaccines only. The other use of this measure has been as one of the criteria to confer parental eligibility for family tax benefit, from July 2012.¹⁹⁹

In 2009, Australian immunisation coverage for the general schedule at 12 months of age was 85% for Indigenous children, and 92% for non-Indigenous children. Coverage of Indigenous-specific vaccines for Indigenous children was lower, at three years of age being 55%.²⁰⁰ By 2014 Indigenous child general schedule coverage at 12 months of age rose to 88%, and Indigenous-specific vaccine coverage also was increased. Coverage of 3 year old Indigenous children for hepatitis A vaccine rose to 62.9%, and for pneumococcal

booster vaccine rose to 66.9%. In relation to the PIPCGP study period in Queensland, Indigenous child coverage for the age milestones up to five years was between 85 and 90%.¹⁹⁹ On retrospective analysis, it was confirmed that coverage for Indigenous-specific vaccines was much lower; for example, in Queensland in 2009, coverage for the two-dose course of Hepatitis A which was to be completed by three years of age was 49.3%, up to 62.8% by 2011. Coverage for the pneumococcal booster due at 2 years of age in Queensland in 2009 was 47.5%.^{199,200}

Childhood immunisation timeliness is also monitored. A vaccine is considered *on time* when given on the day, or within a month of, the scheduled age being reached. Timeliness of immunisation can be shown by reporting the time beyond the due age, at which a vaccine is received. For Australian children born in 2007, around 88% received a third dose of pertussis containing vaccine on time, at six months of age. For the Indigenous children of the same group, less than 70% received the vaccine on time, and for the remainder the delay was up to 6 months.²⁰⁰ This relative lack of timeliness is thought to contribute to the higher proportion of pertussis illness and death suffered by Indigenous infants.³⁷

Immunisation coverage of Indigenous adults is currently measurable only from national surveys on self-report. Adult vaccination levels are estimated to be generally low and less reliably estimated because of the lack of central collection of data. In the 2009 national adult vaccination survey, 27.5 % Indigenous people aged 18 or older said they had been vaccinated for influenza during the past year.²⁰¹ In the National Aboriginal and Torres Strait Islander Health Survey of 2012-3, only 8% of Indigenous adults over age 15 in urban areas reported receiving pneumococcal vaccine in the past 5 years.²⁰² National surveys and a recent comparison of surveillance systems in Victoria by Coghlan et al. (2016) indicated that influenza-vaccine coverage of people over age 65 years in the general community was higher, at around 80%. There was no determination, however, of Indigenous status.²⁰³

3.8.4 National targets and local performance reporting

The current “aspirational” national target for childhood immunisation coverage is 95% at one, two and five years of age, for general schedule vaccines.¹⁹⁷ Immunisation of Indigenous people is a stated priority for Queensland, where the Queensland target for 2022 for Indigenous children is to halve the disparity in coverage for the general schedule vaccines.²⁰⁴ Performance reporting relating to child immunisation coverage (for the general schedule at 1, 2 and 5 years of age) has been successfully applied to mainstream

general practice, raising the coverage of general practice patients through the incentive payments to practices.¹⁹⁵ Some reporting by locality is available on the My Healthy Communities website. For example, based on national immunisation register records, 2/31 PHN areas had Indigenous 5 year old child general schedule coverage over 95% in 2012, rising to 22/31 PHN areas in 2017.¹⁴³

It is interesting to note that in contrast, performance reporting has been more extensively applied to Indigenous health check coverage than health check coverage for other community members. Health check and chronic disease service activity coverage are reported on only within Indigenous community-controlled and Indigenous-specific services, related to direct funding by the federal government and through specific reporting agreements.²⁰⁵

3.9 Enablers and barriers to immunisation

Immunisation and health checks both require patients to visit a general practice when they are well, and are relatively time critical. This means that both providers and patients must be aware of, and motivated to undertake, the activity. Overall, evidence suggests that strategies, such as recall/reminder, facilitated by electronic databases, can enhance coverage. A Cochrane review of recall for immunisation was recently updated by Jacobson Vann et al. (2018). Individual studies reported increases in immunisation rates due to reminders in the range of 1 to 20 percentage points. A few studies involving repeated follow-up produced a greater change in coverage. In comparing methods in the review, telephone calls and letters were more effective than text messaging; and communications where serial reminders were given, both prior to an immunisation being due and when overdue, were more effective than a single reminder. Reminders to providers of patients due or overdue (for example by a support agency) in addition to patient recall or reminder was shown to be more effective than patient recall alone. The number of studies including both, however, was small.²⁰⁶

In 2011 it was estimated that only around 2% of Australian children were unvaccinated due to parental objection.¹⁹⁵ Parents of Indigenous two year old children who voluntarily participated in a cluster randomised survey in Queensland in 2002, included in the state's need assessment, indicated willingness to identify their children as Indigenous for the purpose of immunisation, and a very low rate of objection to immunisation.^{207,208} A national review of Indigenous infants identified on the Australian Childhood Immunisation Register by Rank & Menzies in 2005 (via parental registration of the infant on Medicare),

indicated that 95% of the Census-estimated population was included.²⁰⁹ However, immunisation data suggested a lack of identification by providers and consequent lack of appropriate service in mainstream general practice.

The Queensland immunisation database, VIVAS, relies on a single report of Indigenous identification by the immunisation provider, which is then maintained on the individual's record. Shannon et al. at Northside PHU analysed VIVAS data for South East Queensland (i.e. Northern Brisbane, Southern Brisbane and the adjacent Sunshine Coast and Gold Coast areas) from 2006 to 2009. Their analysis showed around 42% of the estimated population of Indigenous children aged 0 to 6 years were identified on the database. Immunisation providers to Indigenous people were categorised according to provider type by data officers who were in communication with the local services. The timeliness of vaccine administration for children was analysed by provider type. GPs consistently delivered general schedule vaccines in a timely fashion (e.g. 78% of childhood pneumococcal vaccine dose 3, due at 6 months, were delivered within a month of the schedule-recommended date), but were less timely than other provider types in delivering extra Indigenous schedule vaccines. While general practice staff may have had low awareness of the Indigenous schedule for Queensland or gave the additional vaccines lower priority, it was most likely that lack of identification was the main factor, given the variable reporting of Indigenous status on register records.²¹⁰

Delivery of the Indigenous schedule by providers requires awareness of the recommendations, and Indigenous status identification. Where recall is required at a different age to that of general schedule vaccines, then extra practice organisation must be in place. Variations of the Indigenous schedule from one state to another have been based on risk assessment of the local environments. This variation has been an adaptive challenge, one that was not taken up within electronic records packages provided for General Practice, at the time of the study. Cashman et al. (2016) reported that in Hunter New England (New South Wales), Indigenous infant-vaccination coverage and timeliness improved at a significantly faster rate than elsewhere in the state. Associated with this was employment of Indigenous immunisation officers in the PHU. These officers pre-called Indigenous parents with a reminder prior to the infant's due date and facilitated contact, where necessary, with culturally safe immunisation services, such as those within general practices.²¹¹

Within practices, special measures can be taken. Spurling (2009) documented immunisation was given at 42% of adult health checks at an Indigenous health service.¹⁷⁶

This would most often have been seasonal influenza vaccination. There are few other published articles about projects that have successfully targeted Indigenous adult vaccination in general practice. Thomsen et al. (2012) documented increased numbers of Indigenous adults vaccinated for influenza at community health service—clinics, run by nurse immunisers and Indigenous health workers, when a Townsville Centrelink office was included as a (non-traditional) immunisation clinic site.²¹² Abbott et al. (2013) reported an impressive increase in timeliness of Indigenous child immunisation at an ACCHS for children where a personalised calendar was provided to the parent at immunisation. Calendars featuring an indication of the next due date, a photo of the child and Aboriginal artwork, were printed for the parent at the consultation.²¹³

Coordinated effort—between agencies working with the community (such as the PHU and PHN) and the general practice immuniser—have been a feature of immunisation programs in regional areas where timeliness is better than in urban areas for Indigenous children.^{37,214} Provider reminders may be one part of that coordination. An intervention in New South Wales to promote uptake of the pneumococcal vaccine for Indigenous infants (prior to the vaccine becoming part of the general schedule) used active strategies focused on parents, and on providers including staff from the maternity unit, council, and the community health centre. The local ACCHS was actively involved, and a mail-out of promotional material to other GPs in the area was included. An evaluation of the program after 12 months by Thomas, Joseph and Menzies showed moderate impact, including a 10% rise in vaccination coverage and, according to staff interviewed, high awareness of parents attending the ACCHS. There was a lack of change in general practices, only 4% of GPs being known to have vaccinated an Indigenous infant over the study period.²¹⁵

Pearce et al. (2015) examined barriers to immunisation, using data from a 2004 face-to-face survey of parents of children up to the age of 19 months from the longitudinal study of Australian children. The participants were drawn from Medicare, 94% were from non-remote areas and 3% identified as Indigenous. Excluding those with a mother who disagreed with immunisation, four parental situations were associated with parent-identified barriers: lone parent, mobile family with good support; low social contact and service information, psychological distress; larger family not using formal childcare; and child health issue or concern.²¹⁶ All of these situations are experienced by Indigenous families in urban areas. A cohort study of Indigenous children living in an outer urban area by Harris et al. showed that Indigenous children of younger mothers and those living within larger families were at higher risk of delay.²¹⁷ These are examples of situations that can be

identified and flagged for extra support in the mainstream general practice setting. Home visiting, often termed 'outreach', has been a mainstay of community health programs, and in some localities, targeted home visiting for immunisation is available, should it not be available through general practices.

It is possible that non-traditional approaches may assist to increase access for hard-to-reach groups within the local Indigenous community, however there is as yet very little research literature to support this approach for Indigenous parents in Australian urban areas. An arts-based intervention run by an Aboriginal Health Worker at a community health service in outer Sydney sought to improve empowerment, connectedness and wellbeing of young Indigenous parents. A mixed methods study of the program by Jersky et al. (2015) included measures of personal empowerment of parents, and use of health and support services for their children. Referrals and attendance for child healthcare were recorded (but not immunisation coverage). Improvements in the measures, and increased engagement with health services, was demonstrated over a two year period, particularly for regular attenders of the program.²¹⁸

An international review of interventions to reduce inequalities in vaccine uptake of children and adolescents in high-income countries was conducted by Crocker-Buque, Edelstein & Mournier-Jack (2016). It included multi-component interventions, outreach programs, computer-based projects and recall/reminder projects. The evidence available for change in coverage was variable. They concluded that locally developed, multi-component interventions had been successful in urban, ethnically diverse and socially deprived populations. Multi-component interventions included some of these strategies: promotional materials, parent or child education, provider education, outreach, patient reminder, healthcare worker prompt, standing orders, and in some cases, community involvement.²¹⁹

3.10 Summary

A range of factors drawn from the literature contribute to a more detailed understanding of the mainstream urban general practice context of preventive healthcare for Indigenous people. This care should be culturally safe, as suggested in chapter 2. Care also must be specifically tailored to this group, where it has not in the past in mainstream practices, and of low or no cost. Tailored care starts with Indigenous identification, which has been lacking in this setting. More regular and more comprehensive health checks, and additional immunisation are required to meet national targets. Care guidelines and additional resources to support this activity for Indigenous patients in mainstream general

practice are available, through Medicare and through the national and state immunisation programs.

Research suggests, however, that mainstream GPs for the most part have not improved their practice routines and their electronic information systems to appropriately and efficiently undertake these tasks. Mainstream general practice continues to largely exclude the specific concerns of Indigenous people. Incompleteness of reporting of Indigenous status in general practice ten years after Australia's commitment to improving health outcomes of Indigenous people is a glaring short coming, with no immediate prospect of change given that the RACGP accreditation framework does not require mandatory Indigenous status identification for all general practices.

This knowledge is totally necessary to be able to provide appropriate patient-centred care. One simple and tangible example illustrating the need for this measure is that, given the specific schedule of immunisation for Indigenous people, general practitioners have a duty of care to seek this information at each and every immunisation encounter. Establishing Indigenous status is a procedural step for every vaccination encounter specified in the NHMRC's Australian Immunisation Handbook. General practitioners and other vaccinators potentially bear responsibility for occurrence of certain vaccine preventable infections in their Indigenous patients, where the offer of scheduled Indigenous schedule vaccines has been omitted.

The lack of equity indicator reporting in our national health performance reports is a problem that is taking too long to resolve. Had there been a clear development of this requirement in health policy, program management, standards and guideline development, electronic record systems would have fallen into line, or surely would have attracted funded projects for rectification. The need for change is urgent.

Many of these challenges have already been resolved within ACCHSs, which can serve as examples. Patient-centred care for Indigenous people is evident in ACCHSs and some of the strategies used there may apply to mainstream services or be offered to patients of mainstream practices in co-operation. It is evident that well established, internal quality improvement processes help to drive change in the general practice setting. These processes are emphasised as a component of practice accreditation, and in the external monitoring of quality in general practice service, which is an evolving aspect of governmental management of the primary care sector.

An evidence-base about care for Indigenous patients has been accumulating in recent years. Coordination of community agencies working together for Indigenous patients has been shown to be successful. PHNs have a role in fostering change, as supporters of general practice—positioned between the government and clinical services, and public health services have a complementary role that has been well developed in relation to immunisation. ACCHO staff have mentored mainstream practitioners towards appropriate practice change.

Consistent implementation of current health policy and evidence-based practice for Indigenous people is required in mainstream settings. Innovative, coordinated patient-centred approaches should contribute to improved access and uptake of preventive care in mainstream practices. Support agencies and community-controlled services may be best placed to facilitate innovative approaches that are complementary to this fundamental change. Having provided the context for the study, the next chapter presents the methods used to develop, implement, and evaluate an intervention aiming to improve access to preventive care.

Chapter 4 Research methods

4.1 Overview

This chapter details the mixed methods evaluation process used in the Promoting Indigenous Preventive Care in General Practice (PIPCGP) study. It highlights some of the challenges of implementing and evaluating complex interventions in healthcare settings and outlines the application of a framework, influenced by realist evaluation (RE) in the study. Ethical considerations, and my role and positioning as a researcher, are then addressed before presenting details of data collection and analysis processes.

The PIPCGP study sites were self-selected. Data collection and analysis were theory-driven, based on a conceptual framework of operation within the practices. Quantitative evidence of effectiveness was derived from clinical audit processes gathered within practices. Interviews with practice staff occurred during the intervention, and Aboriginal and Torres Strait Islander patients were interviewed after the intervention. Qualitative data was analysed and related to community and practice conditions.

4.2 Evaluation framework

Realistic Evaluation, which was later referred to as Realist Evaluation (RE) by the authors, is a theory-based approach to evaluation that is concerned with contexts, and how different interventions or programs may have different effects on different groups in different settings. This approach to evaluation is explicitly concerned with understanding how, for whom, and under what conditions an intervention works (in addition to asking whether an intervention works). Pawson (1997) regarded programs to be limited activities aimed at influencing and changing the trajectory of *regularities* of action leading to usual outcomes that take place in open systems which are affected by wider social setting. Figure 4-1 shows the essential elements, which are the broad or system context (K), the local contexts (C) the interventions or measures (M) the changing actions (R) and the Outcome (O).

Central to RE is the investigation of what are referred to as context-mechanism-outcomes configurations (CMOCs).^{58,220}

Adopting this approach, Tilley advised, involves asking questions the following questions:

Mechanism: what is it about a measure which may lead it to have a particular outcome pattern in a given context?

Context: what conditions are needed for a measure to trigger mechanisms to produce particular outcome patterns?

Outcome pattern: what are the practical effects produced by causal mechanisms being triggered in a given context? and

CMOCs: how are changes in regularity (outcomes) produced by measures introduced to modify the context and balance of mechanisms triggered. (Tilley, 2000).²²¹

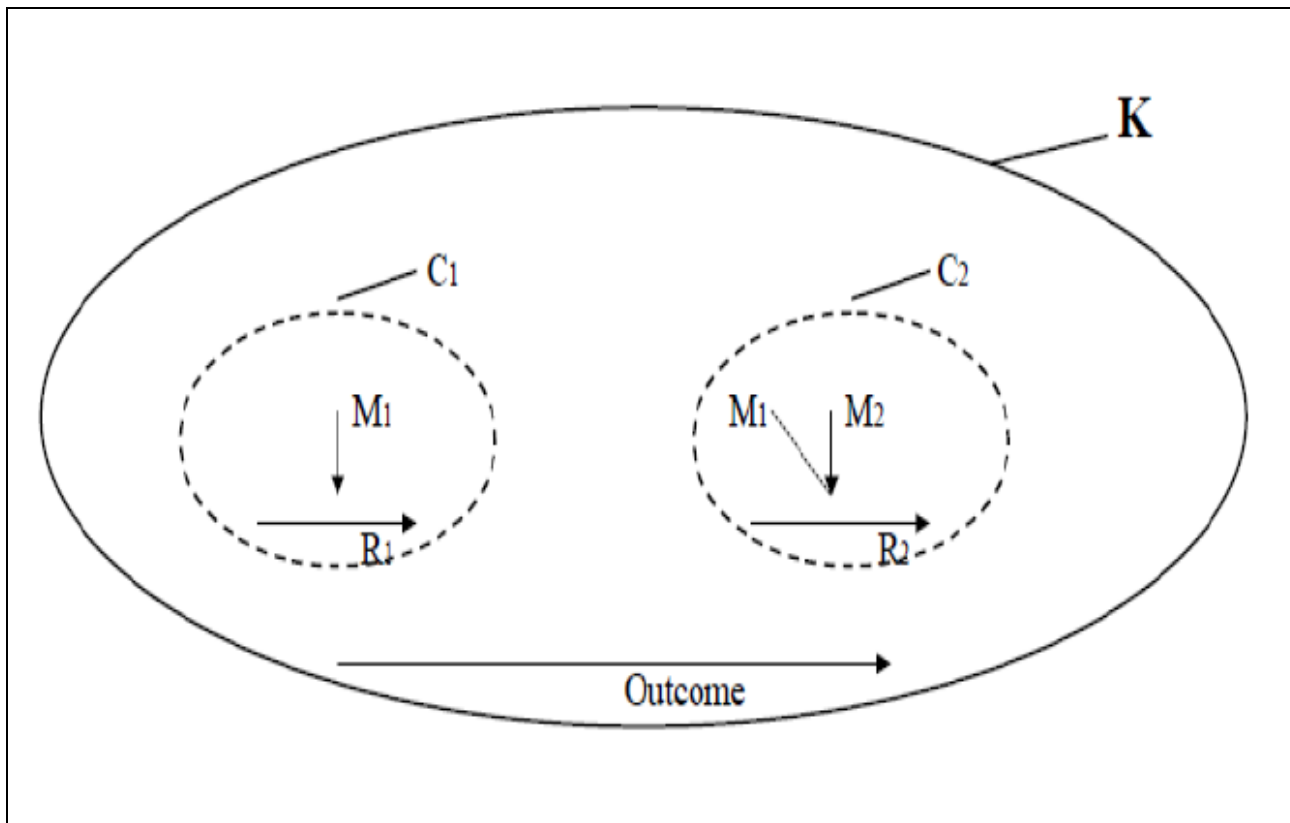


Figure 4-1 Elements of RE. This illustrates the relationship between regularities of action (R1, R2) which are modified by mechanisms (M1, M2) within internal contexts (C1, C2) and an external context (K). In this example, multiple mechanisms are recognised and two CMOCs affect a single outcome.

Source: Pawson, R & Tilley, N 1997, 'Realistic evaluation', Ch 4 in Sage Publications⁵⁸

Starting, for example, with multiple If/Then statements that describe conditions under which an outcome is likely to occur, the researcher may develop potential CMOCs. CMOCs may be applied to different levels in a system, such as that of the policy maker, the practitioner and the participant. Looked at another way, both “outer” and “inner” workings of a program may need to be explored. CMOCs are developed based on current knowledge and practice, then some are selected to include in evaluation based on a rationale, and finally tested using appropriate and usually mixed methods. This is the

beginning of a cycle involving periodic improvement of the program theory through repeated, modified evaluation (see figure 4.2).⁵⁸

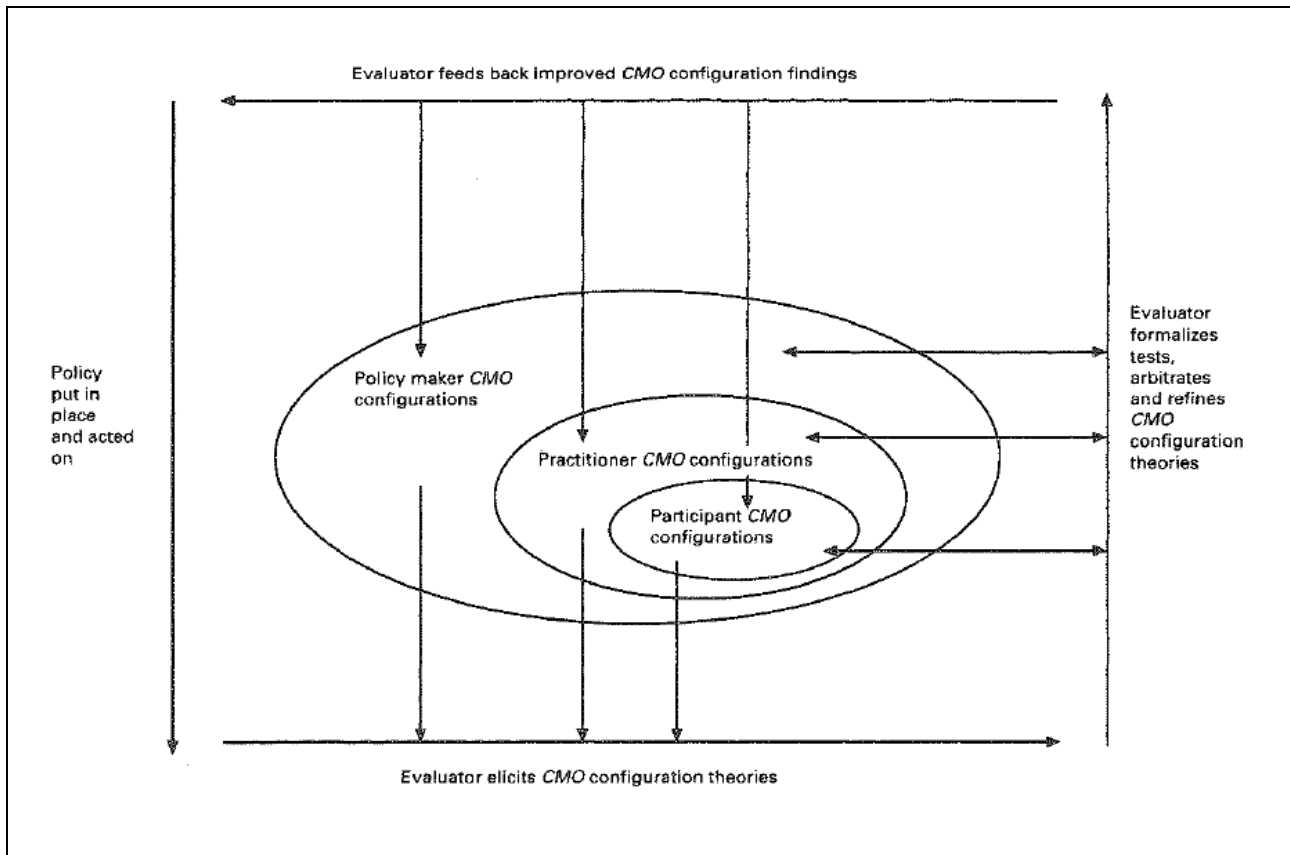


Figure 4-2 The realistic evaluation and policy making cycle

Source: Pawson R, Tilley N. Realistic evaluation. Sage Publications; 1997, p 208⁵⁸

4.2.1 A realist-inspired approach to evaluation

The methodology was discussed in relation to a wider range of practical examples in later work. Pawson (2013) has advised that RE is most appropriately applied to ‘mid-range factors’ in the context including policy, funding, and health system levers. Concepts that describe interventions at a level between the big policy ideas and the day-to-day realities of implementation are used. There is a degree of abstraction towards social theory. This helps to create theory that may be applicable to a range of different types of programs, a ‘middle range theory’. Generic program domains suggested by Pawson are to do with incentivisation, target setting, behaviour change and legal restrictions. ²²²

A realist study commences with a theory describing an array of “context/mechanism/ outcome configurations”. Based on a rationale, some of these are selected to explore in an evaluation. In a discussion article, de Souza (2013) listed a schema for considering CMOCs based on social theory. A range of aspects of context such as structure, culture,

agency and relations may be acted upon by mechanisms such as role, practice, resource, process, idea, belief, duty, right or power, to result in change.²²³ Like any complex evaluation, RE is labour- and resource-intensive and no single formula exists for its application. However, key hallmarks of the approach according to Salter & Kothari (2014) are: a) an explanatory focus; b) investigation of linked configurations of context(s), mechanism(s), and outcome(s); and c) use of multiple, mixed methods of data collection.²²⁴

The realist approach or 'realist science' of evaluation, as it is now described, has provided a lens for me to view the framework for the study. I have chosen to apply this approach to identify the basic questions to be answered, 'What is it about a measure which may lead it to have a particular outcome pattern in a given context?' and have applied the question to the actors within the internal environment of the general practice, excluding views of external influencers, with the exception of patients in the community.

Our intervention development group was inspired by Realist Evaluation, however took a more targeted, applied and pragmatic approach, focusing only on the practice environment, and a loose configuration of elements. In this way we were able to gain practical understanding appropriate to the main audience for the study. I have intentionally focused on a broad description of action that health practitioners relate to. I did not undertake a detailed exercise of examining an array of propositions and underlying social mechanisms. In this way I have deviated from the methodology. This seemed appropriate to the main audience for the study, health professionals and community members, and allowed me to focus on the understudied aspects of the problem.

In defining contextual scope, boundaries needed to be set. In the PIPCGP study, unlike the most comprehensive realist approach, I have excluded the study of government influencers or broad system factors (K) shown in Figure 4.1. I have assumed that most broad factors (K) were the same for all urban general practices in Australia (and all services in Brisbane). For instance, policy environment and the remuneration system for services were the same for all general practices. Other broad contextual factors include the socioeconomic status of the local community, the socioeconomic status of Indigenous patients, and the Indigenous population density. These are known to vary from one area to another, as did the urban infrastructure, such as availability of public transport.

While there was no external description or quantitative accounting of these factors within the PIPCGP study, it could be expected that difficulties associated with these broad factors

may be raised by either staff or the patients interviewed. Patients interviewed were users of mainstream general practice who lived in the study area, some in the practice localities, but not necessarily patients of the practices. My pragmatic approach was to study the practice environment and patients and to examine intensively some of the mechanisms operating, to produce new knowledge that could be acted upon at practice level.

I constructed a schema based on the literature and experience, using a single CMOC that focused on activity rather than on motivation (table 4.1). The main outcomes were increased Indigenous identification, increased Indigenous immunisation coverage, and increased delivery of Indigenous health checks. The mainstream practice environment features impeding service delivery were identified as low levels of Indigenous identification, no focus on Indigenous culture, poor knowledge of the specific Indigenous immunisation recommendations and of health check guidelines. Additionally, there seemed to be a low level of demand for these extra services by Indigenous patients. In improving the level of target activities, practices and conditions likely to be important related to a number of inputs. These included staff education about recommended best practice of Indigenous identification, and knowledge of the recommendations for immunisation and the guidelines for delivery of Indigenous health checks. Skills in use of the practice electronic-information system to maintain a record of Indigenous identification and to generate lists of Indigenous patients for targeted activity were required. Information about practice performance might be used to trigger internal quality improvement processes within a practice. For example, opportunities for cultural awareness training and linking with local Indigenous community members and organisations might provide motivation. Additionally, specific resources for updating details and for promotion of immunisation and health checks to Indigenous community members might reinforce the focus.

Table 4-1 Elements of the intervention for study, based on the literature and experience (Source: the Author)

Context: Current practice environment	Mechanism 1 (intervention)	→	Mechanism 2 (practice staff act)	→	Outcome (patient acts)
RESEARCH QUESTIONS	1. Investigate SUITABILITY of intervention		2. Investigate EFFECTS of intervention		3. Identify factors that ENHANCE effects within the practice
Practices identifying Indigenous status on patient record to varying degree	Audit highlights areas for improvement		Practice team develop strategies to systematise Indigenous identification within the practice		Increased Indigenous identification
Practices identifying Indigenous status on immunisation data to varying degree	Staff education re identification, health, immunisation, and screening issues		Staff interest generated for catering to current Indigenous patients		↓
Practice environment has no focus on indigenous culture	Indigenous artwork on posters provided		Increased comfort of indigenous patients in practice		More family members and other community members attend the practice
	Staff given cultural orientation and are familiar with local Indigenous organisations				↓
Patient data-management system not conducive to appropriate alert and recall of Indigenous patients	Written Instructions and on-site support for modifying data-management system		Alerts re immunisation and screening at each patient presentation, capacity to generate lists for patient recall		Increased immunisation, possibly increased screening if practice has the capacity to carry out screening
Indigenous patients unaware of recommended immunisation	Postcards detailing Indigenous immunisation schedule available in waiting room		Patients request service		
Indigenous patients unaware of recommended screening	Adult record card detailing immunisation and screening recommendations and dates undertaken provided by the practice				

In thinking through the questions, it became clear that the process of ascertainment of Indigenous status in general practice was a key feature of implementation to be fostered and examined, so I have linked the Indigenous status ascertainment to health-check activity and to immunisation in the PIPCGP study. I needed data about performance in Indigenous identification as well as health checks and immunisation, including qualitative data to understand the change and some quantitative data (audit indicators) to help assess the change (see table 4.3).

4.3 Consideration of the appropriate study type

In evaluation, we seek information about the nature, direction and size of effects that are attributable to an intervention. Intervening in a complex situation in the community requires a number of strategies, which address a range of factors. Information about the situation or context is thus a necessary part of the research.

Pawson (2013) made some salient points that underline the importance of social and physical context in evaluation. In summary, society, programs and interventions influence and are shaped by the choices that people make. Pre-existing structures, institutions and opportunities condition choices. Change is constant, and much of the change is unplanned and unintended. Interventions modify change (rather than modifying a constant situation).²²⁵

Mixed methods are needed in order to obtain both outcomes and their explanations. This is gathered from different sources and a variety of stakeholders^{77,226} The Cochrane Handbook for Systematic Review of Interventions has examined public health evidence appropriate to broadly defined interventions. Considering the diversity of activities that often characterise public health interventions, they advised that no single method could be used to answer the range of questions arising. A range of study designs must be considered that may be appropriate to the questions posed.²²⁶ Sanson-Fisher et al.(2014) advised that non-randomised trialling in varying situations may be needed to inform generalisability or external validity. Quasi-experimental, quantitative study designs that may provide public health evidence include controlled before and after studies where there is an intervention and non-intervention group, and an interrupted time series design where the intervention is the interruption and there is comparison with historical controls or national trends.²²⁷ In consideration of the third option, where there is a relatively large degree of externally influenced change, however a small intervention effect may be masked.

In the PIPCGP study, knowing that the level of Indigenous identification was probably low and the number of health checks being carried out in local general practices was very small, it was likely that a larger change in practice arrangements would be required for improvement in the uptake of health checks than for immunisation, where there was a higher level of pre-existing activity. Enabling Indigenous patients to identify, convincing current Indigenous patients to have a health check, and attracting additional Indigenous patients for this purpose, would depend on a range of sociocultural factors. Thus in addition to counting the activities undertaken, it would be necessary to understand the factors influencing outcomes from the point of view of both the providers and the consumers. Their views could be considered in a later, more developed realist study, to demonstrate more clearly the key motivators and organisational factors of influence.

4.3.1 Audit of preventive activity to demonstrate outcomes

Quantitative data was collected using clinical audit. The purpose of this quantitative phase of the study was to provide a focus in the practice for quality improvement activity. In retrospect, the upward trend in performance across the state meant that any change in local area health-check activity over the period was unlikely to be attributable to the intervention. In the PIPCGP study, only local data was analysed. Evidence of effect was obtained through the gathering of audit data. Audit and feedback was undertaken as a trigger for quality improvement in practices, associated with multiple support strategies to give an evidence-based push towards change. Quantitative evaluation was a simple comparison with the historical control: the practices were compared with themselves before and after intervention.

The audit monitored three related activities: Indigenous identification, which was a prerequisite for Item 715, health-check activity, and child immunisation, which was in part related to identification.

The preventive care activities reported on were:

- Number of Indigenous people identified (total) and number of Indigenous children aged two to five years identified
- Number of Indigenous health checks claimed over the preceding quarter
- Number of Indigenous children aged two to five years who were up-to-date for immunisation (all recommended vaccines for age and for Indigenous status)
- Number of Indigenous children aged two to five years who had immunisation data missing from the practice record (a factor of importance identified at the first audit).

While I initially envisaged implementation of the intervention in a single group of practices (the Inner North group), on request of the Inner North DGP, a second group (the Outer North group) was included, commencing three months after the first. The two practice groups were determined by geographic area and supporting DGP. Audit data was collected at the beginning and end of the intervention period for both groups of practices, and in two intervening periods for the first group. Comparison of the two groups of practices, with slightly different environment and support strategies, was also possible.

4.3.2 Qualitative data to study the processes

The detailed knowledge necessary for transplanting a complex intervention is often prioritised less by evaluators in reporting than is quantitative data. In RE, the opposite holds. As the aim is to provide practical information that can inform further implementation, specifically why the intervention works is a main product of the evaluation. One should understand the choices that participants have within the intervention, and what influences their choices. Whether behaviour changes because of monitoring rather than program action may be a consideration. The significance of measured outcomes to various stakeholders may be important. Which other programs, policies, or interventions may be affecting outcomes should be considered, and what might be the long-term adaptations.

As well as evaluating the core intended outcomes of immunisation and health-check delivery, this research sought to gain deeper insights into contextual aspects of the intervention. It explored how the intervention was experienced by patients and by practice staff, and how uptake of these activities in mainstream general practice can be further enhanced, from both the *demand side* and the *supply side*, in reference to Levesque's model of access described in section 3.6.¹⁶⁹

4.3.3 My positioning as a researcher

Awareness of my positioning as the researcher was required. Cresswell (2013) advised that reflexivity involves a process of acknowledging and reflecting on the researcher's involvement in the research process. How this involvement shapes the approach to the research and its outcomes must be considered.²²⁸ Through reflexivity, the researcher seeks to make explicit the assumptions, biases, and perspectives that may influence the findings and their interpretation. The professional role, relationships with Aboriginal and Torres Strait Islander people, and my experience as a researcher have shaped the approach taken to the PIPCGP study. As a doctor I am both consciously and unconsciously influenced by the negative framing of disease in Indigenous people, aiming to 'close the gap' by identifying and eliminating disease or problems in Indigenous people.

Most approaches have little regard for positive strengths, as discussed in section 2.8. This is pervasive in the literature and public health discourse, This means I must question each 'professional' interpretation, and be open to the views of non-professional people.

Working relationships were used to accomplish research that draws on simple outcome indicators of day-to-day practice, and on personal views. There has been an attempt to make the voices of Aboriginal and Torres Strait Islander people central while integrating a broad, systemic context, reflecting a public health perspective.

As a non-Indigenous female medical practitioner, I worked in general practice and clinical teaching settings where the main clientele were Indigenous people, gaining the benefit of advice and active mentorship by Indigenous people in urban, rural and remote settings over a 25-year period. During the study period, I practised as a public health physician in the local area. This afforded access to data about the local area over time, which provided support for assumptions of lack of Indigenous identification and a concentration of Indigenous patients amongst certain practices. The working role involved professional relationships with, and obligation to, GPs and people of the area. The community role involved personal relationships, support, and advocacy for Aboriginal and Torres Strait Islander peoples. These obligations were drivers for the intervention project, able to be actioned through work-related, established, collaborative, professional relationships with staff of the DGPs prior to the project. Reflections on the process of conducting interviews within the PIPCGP study are provided in the discussion section of Chapter 6.

4.3.4 Ethical considerations

The NHMRC through a process of consultation with Aboriginal and Torres Strait Islander groups have provided guidance on important considerations for Indigenous health research. At the heart of these guidelines, which are intended to provide guidance to researchers in the conception, design, and conduct of research, are six core values that apply to all stages of research:

Reciprocity refers to inclusion and acknowledgement of contribution. Respect implies respecting people and their contribution, minimising difference blindness and seeking to recognise and act on consequences of the research. Equality means the valuing of knowledge and wisdom, equality of partners and the distribution of benefit. Survival and protection is upheld by valuing the solidarity of Aboriginal and Torres Strait Islander peoples, respecting their social cohesion and maintaining the right of Aboriginal and Torres Strait Islander peoples to distinctiveness. Responsibility means doing no harm and

being accountable for the results of the research to the community. The sixth value of spirit and integrity links and overarches the other five. Spirit is about awareness of the continuity between past, current, and future generations, and integrity is acting in a way that maintains the coherence of Aboriginal and Torres Strait Islander values and cultures.²²⁹ These values and their inter-relationships are depicted in Figure 4-2.

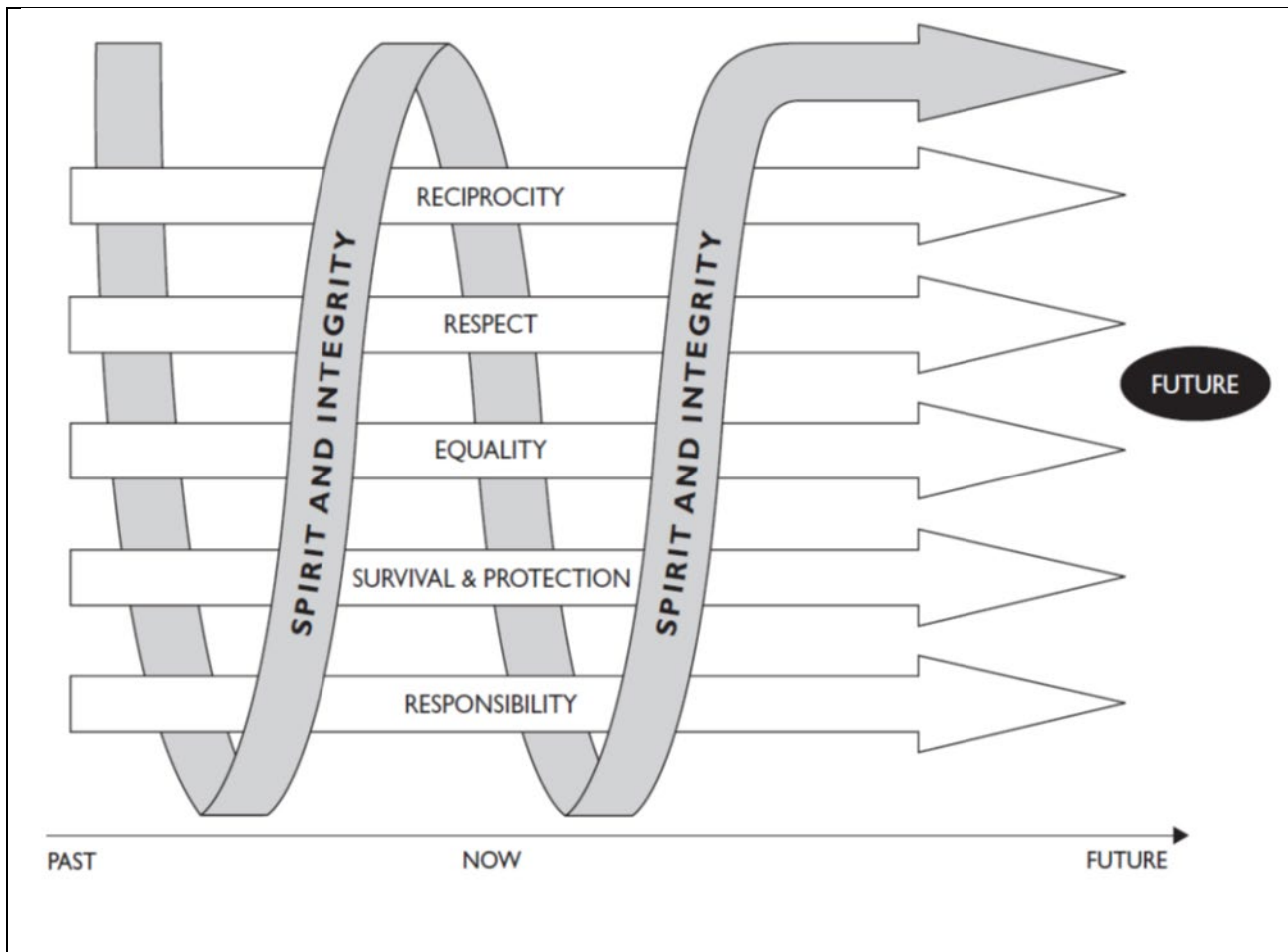


Figure 4-3 Values and Ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander Health Research

Source: National Health and Medical Research Council (2003)²²⁹

Meaningful engagement with Aboriginal and Torres Strait Islander communities is essential for research that benefits Indigenous people and that respects their values, needs, and aspirations (NHMRC). This has been a key priority at all stages of the study presented in this thesis. There was no formal consultation of an Elders group in the local communities. Consultation occurred through the community controlled health service organisation, IUIH. I was advised by that organisation's Executive Officer that the Brisbane Elders group had delegated health matters, and particularly health research, to IUIH.

Several members of local elders groups were interviewed within the project, and were comfortable with this arrangement.

A number of formal and informal reporting and feedback mechanisms were used within the study. These included

- Presentation of findings and discussion with staff of the IUIH. I met with the chief executive officer in the planning phase prior to PIPCGP study commencement, and at the end of the intervention period to present a report.
- Periodic discussion with the IUIH Director of Research
- Presentation of audit findings at a regional research workshop.
- Quarterly reporting and discussion at the 'Prickle on Time' local area Indigenous Immunisation Advisory Group associated with the PHU, which includes Indigenous members.
- Consultation with IUIH Integrated Care Team Manager and staff regarding qualitative findings of the study.

In a less formal sense, certain Aboriginal and Torres Strait Islander people advised and mentored me in progressing the work. Professor Cindy Shannon advised on collaboration and was an early supervisor, Kym Kilroy, a researcher and board member of Link-Up, an organisation dedicated to enabling Aboriginal and Torres Strait Islander people to reconnect with family, advised about many aspects of community functioning and Indigenous Identification. Nancy Collins worked to support the project within the DGPs and advised in relation to general practice and community networks. Brett Shannon shared my immunisation service research interest, particularly in relation to CCHSs. These colleagues have all given generously of time and advice.

The protocol was ethically reviewed primarily by Queensland Health. I was a staff member of Metro North PHU before and during the intervention period. The study was approved by the Queensland Health Central Office Human Research Ethics Committee (HREC) on 23 June 2010, and endorsed by the University of Queensland Behavioural and Social Sciences Ethical Review Committee. A site-specific assessment for Moreton Bay PHU was requested by the Metro North Hospital and Health Service manager (a standard request) and approved two months after the study approval. Ethical approval was also gained from the Human Ethics Unit, University of Queensland. A General Practice ethics committee was not specifically engaged nor thought necessary at the time. I left the employment of Queensland Health after data collection had been completed, and the

Queensland Health approval expired before the final report was completed. The QH Central Office HREC advised that an extension of approval from the University of Queensland Ethical Review Committee would be appropriate, and this was granted (see appendix 1).

Informed consent was obtained from individuals and participant organisations. Their principal doctor or practice manager represented participating practices. Many of these attended the intervention workshop so had detailed information about the study. All were provided with a printed information sheet about the study and gave written consent for the practice's participation. Interview participants, both patients and healthcare providers, were provided with an information sheet about the study that was then further discussed prior to written consent being given. The few interview participants who were unable to read or to sign their name were assisted by an Indigenous health professional or by their accompanying supporter. It was made clear to the patient participants that the researcher had no connection with their own general practice or their individual healthcare. No incentives were used other than morning tea or other food brought along and shared as part of the introductory process. All interview participants were given assurance that they could withdraw at any time, and were given the contact details of an independent university officer, should there be a concern regarding the study (see appendix 2).

Individual interviews were always offered first, and groups were interviewed together only at the participants' suggestion and with the group members' mutual verbal agreement at the time of interview. Permission was specifically obtained to digitally record interviews, and the interview participant was made aware of commencement and ceasing of recording. The recorder was paused when there were other conversations or phone calls in the room.

While the initial, approved plan was to recruit Indigenous patients for interview within the intervention practice settings and during the intervention period, practice staff were not comfortable with this approach. Indigenous workers, and the research director from IUIH, then advised approaching the Indigenous users of general practice in the community, through personal connections and through other organisations, starting with a small number of direct referrals to Elders who were active in community health organisations, and follow a process of snowballing. A modification to the original patient recruitment plan was formally requested by me, and approved, along with a request for inclusion of the evaluation of PHU-based community outreach for immunisation in cooperation with local general practices (see Appendix 1). This patient recruitment process was then able to

commence at the end of the second intervention period, after the variation to the ethics application had been approved.

A range of data types were managed within the study. Identified audit responses were recorded on paper and numbered by each participating practice. These were held securely by the DGP support workers during the intervention period and progressively passed on to the researcher in de-identified form. The identified data was destroyed by the support worker at the end of the intervention period and an identifying list of names of practice and practice participant number was provided to the researcher. The researcher has retained the de-identified paper copies of audit information separately to the identifying list.

Typed interview transcripts and other print material offered at interview, such as patient information sheets about some of the practices, were also included as data with permission of the owner of that material. All information, including voice recordings, was stored securely, available only to the research team, except for audit data as described above, and will be destroyed seven years after thesis submission and final publication.

Maintaining privacy of individuals and of practice organisations was necessary. Practices were informed that practice-level identity, description and performance information was required by DGP staff to carry out support work within the intervention. Every effort has been made to ensure that individuals are not identifiable in written reports of the study. Several Elders interviewed said that they would have preferred to have their names included as informants, but agreed to give unattributed statements because of the undertaking about de-identification of data relating to individuals made to the Ethics Committee. General practice data were grouped in reporting to protect the identity of specific practices.

Reporting back in multiple ways was a feature of the study. Feedback and suggested action were discussed individually after each audit with the practice manager or principal doctor, and individualised audit reports providing a comparison with the group were returned to each practice principal in writing at nine months for Inner North practices and at the conclusion of the intervention period for all practices.

The Chief Executive Officer of the IUIH in Brisbane received a progress report on the project at the conclusion of the intervention period, and audit findings have been presented at an IUIH research seminar. The researcher also completed and distributed progress and final audit reports to the supporting Divisions of General Practice. Further reports or publications to do with the study will be relayed to stakeholders, namely the CEOs or

directors of IUIH, the Metro North Primary Care Network (formerly Metro North Brisbane Medicare Local) and the Metro North PHU.

4.4 Data sources used in the study

The forms of data collection chosen for the PIPCGP study covered implementation factors, the local environment surrounding the intervention, the views of the actors, and of course the planned and unintended outcomes. Discussion of the findings considered systemic factors of the wider context such as physician practices, health organisations, and community groups. In the PIPCGP study, this part of the story is told through the literature review and the history of the intervention, rather than through data collection. Different methods of sourcing data have been used to provide a comprehensive picture. In this way, they are a means of documenting and understanding the varied factors that are likely to influence transfer of a program from one locality or setting to another.

Seven data sources were used. These included:

1. *History of the intervention* was recorded in minutes of meetings, administrative documents, progressive reports provided to the PHU for the local population, newspaper articles, and my diary and journal.
2. *Workshop discussion* notes were recorded by me at the time, and comments were gathered using the DGP's standard workshop evaluation survey, as a third source of data.
3. *A series of conversations with support staff*, that I journalled over the course of the intervention, was the third source. In addition, a final review discussion was undertaken with the Indigenous support worker and recorded as an interview. This worker conveyed comments from the other support staff and reflected on what was found at audit and on the support given.
4. *Practice descriptions* were the fourth source, gained from an initial and final audit survey, observations and reflections recorded by me and by co-interviewers who attended practices, and occasionally from practice documents that were provided. Information gathered by me consisted of practice-produced pamphlets providing information about the practice for new patients, content from the practice website (in the case of large clinics), and a journal article about a model of care for Indigenous patients in general practice. Informal observations on the practice environment were a part of the process of visiting practices to conduct interviews. Impressions of the waiting room and public communications in the waiting room were noted. These helped inform some of the

vignettes prepared about different types of practices as part of the process of analysis. Formal, unobtrusive waiting room observation, enabled by formal consent of the practice and conducted by an Indigenous observer, was attempted. One observation record was made, on an hour-long visit; however, further attempts were problematic because of the discomfort of the observer in interacting with staff members. Although observation had been with consent and the session had been pre-arranged, the reception given was less than supportive, staff members expressing the view that they felt 'monitored'. The second Indigenous observer preferred to use photographs to document the observations, which were undertaken in a short time but potentially could provide rich information, particularly in discussion. It was decided not to use these, as there was no specific consent and no pre-approval by the Ethics Committee.

The audit data comprised the fifth data source. The working group in preparation for intervention initially developed the audit data collection form and question guide. The audit form and interview guides are provided as appendix 2, along with study information sheets and consent forms.

5. *Audit data* was gathered by DGP support workers during a visit to practices. A count of Indigenous patients and Indigenous-identified patients aged less than five years was made, and the number of health checks billed was taken from the practice's Medicare-related records. Immunisation records of Indigenous children were individually checked to derive coverage. Occasionally two visits were required to complete the audit, if there were difficulties with the information system. The Pen Computer Systems Clinical Audit Tool (PenCAT),²³⁰ which has been adapted for use with Australian systems and is now introduced to practices via PHNs nationally, was used to derive a list of patients where the information system was not able to be used directly to obtain the data. The DGP and the practice retained the identified audits, and, after each round of audits, the DGP provided me with a compilation of audit reports identified by number.

Supplementary to the practice activity data, the initial and final audit questions covered demographics and relevant aspects of the practice, such as opening hours and bulk billing, promotion of cultural identification, recording of cultural identity; and systems to support immunisation and health checks. Support requested and follow-up arranged were also recorded on the audit form. Intermediate audits covered the preventive care activities and support plan only.

6. *Interviews with general practice staff—doctors, nurses, receptionists and managers—*were the sixth data source. Staff other than doctors had to be actively recruited to provide a group of interviews that covered the full range of practice issues. The question guide for the interviews was used in addition to an open invitation to contribute information on the preventive healthcare measures taken by the mainstream general practices. These were trigger questions, and, while the interviewer pursued answers to these specific issues, interview participants digressed to areas they felt were important to the topic, and these lines of discussion were pursued.

7. *Interviews with Indigenous community members who had been patients of mainstream general practices* were the seventh data source. Where common concepts relevant to patients had been identified from previous interviews, these were specifically raised and explored with patients when opportune. A similar set of questions was used with both staff and patients, with some supplementary questions to patients based on issues raised by staff, as illustrated in table 4.2.

4.5 Recruitment

4.5.1 Recruitment to the intervention

Following usual practice, an invitation to participate in an educational workshop was included in the Inner North DGP newsletter. It was made clear that the workshop was for both clinicians and administrative staff. The invitation stated that those who attended would be further asked to consider participating in a 12-month project, and that project participation required involvement of both clinical and non-clinical staff. In addition, practices that provided the highest number of immunisations to Indigenous children, according to register data, were contacted by letter by me. These practices were informed of the number of Indigenous children recorded as immunised by the practice in the previous five years, and specifically invited to attend the workshop and participate in the project. DGP staff members directly approached practices that had already expressed an interest in a continuing professional development session on Indigenous health. Around one quarter of the Inner North workshop participants reported on the workshop evaluation that they responded based on the newsletter invitation or a direct approach from DGP staff. Two-thirds of the Inner North practices contacted by letter participated in the workshops.

After completing the development process and initial workshop with the Inner North DGP (see appendix 3), Inner North divisional staff requested that we repeat the workshop and

intervention in the Outer North DGP (See PIPCGP Challenges, 'preparation' and 'mid intervention'). The Outer North DGP worker stimulated extra interest in the project by arranging practice visits to discuss potential remuneration under Medicare and the benefit to Indigenous families of the Close the Gap pharmaceutical benefit. In this way, despite a shorter introduction time and lack of involvement of local GPs and staff in development, GP interest could be ascertained. An invitation was also placed in the Divisional newsletter.

At the end of the workshops, the representatives of practices were offered participation in the PIPCGP study, and if they agreed, completed a consent form for practice participation to be signed by the practice's principal doctor or manager. This was either completed at the workshop or taken away for discussion and return within two weeks. One additional, newly established, large Inner North practice received on-site instruction within the practice, along similar lines to the workshop, and was recruited.

4.5.2 Recruitment for interview

In-depth interviews were undertaken to gain a rich understanding of the issues from a wide range of participants. In all, thirty-five people, including 18 Indigenous and 17 non-Indigenous, were interviewed (see table 6-1). Staff interviews were conducted first, during the second half of their practice's intervention period, and patient interviews were conducted after the staff interviews, delayed because of difficulty with the initial recruitment process (see section 4.3.4, Ethical Considerations).

Phone calls were made to the practice manager or principal doctor to invite participation, and, on acceptance, arrangements were made for interviews to be conducted at the practice during working hours. A purposive sampling method for practice staff members was used, with recruitment directed to capture the views of doctors, nurses, receptionists and practice managers. About half the staff interviews were conducted individually, the others were group interviews with two or three staff members of a practice. Looked at in retrospect, these participants were drawn from both high- and low-activity practices, and from both study groups. Practice managers are highly represented, along with doctors. Many practice managers also worked on reception within the practice. These were designated simply as practice manager.

Approaching recommended community members, invitation by letter to participate was ineffective. Some people returned the letters to sender unopened; others did not acknowledge receiving a letter that they had opened, but responded well to a direct

approach. Letters were seen not to be 'the community way'. Patients preferred requests for an interview verbally from a known person and then with face-to-face contact with me. Visits were made to organisations and to peoples' homes, and often there were several brief conversations or visits before an interview would be considered. I was anxious not to harass or apply unwanted social pressure by repeated visiting, but it was a fine balance. Reticence to be recruited did not equate with reticence to participate once agreed. Conversations with Indigenous staff members suggested that there simply needed to be a period for the potential participant to gain trust from the interaction or seek outside confirmation of the bona fide nature of the request, and fit it in to their schedule. Older people, most of whom were referred to as 'Elders' by themselves or by others, are highly represented in this sample. This was in keeping with local protocols, where Elders are regarded as spokespersons for all age groups in their local community. The Elders then referred me to others.

4.6 Question guides

This *snowballing* method of recruitment proved to be appropriate for recruiting Indigenous community members. A range of participants, who were mostly adults in the oldest age group, agreed to take part in an interview. Because of the low number of young people contacted in this way, additional purposive recruitment was undertaken to seek out young interview participants through an Indigenous Youth welfare organisation, through personal connections, and through IUIH directly—allowing me to invite a group of new cadets starting work at IUIH for interview, a few of whom agreed to participate. I was able to interview staff but not clients at the youth agency. IUIH then offered that I come into their central office to interview two new cadets who had just commenced work. In this way, a combination of snowballing and purposive sampling was used to recruit Indigenous people of the area who were all mainstream general practice patients, but not necessarily of intervention practices.

In interviews, I used the question guide, and pursued additional issues raised by the participant. The change to recruitment meant that the initial plan of conducting patient interviews prior to staff interviews was reversed. This had consequences for the iterative process of analysing content of interviews and further investigating new issues as they presented, with subsequent interview participants. Practitioners suggested topics they thought needed better understanding, which I followed up, such as parallel use of mainstream general practices and community-controlled services by patients; however, I was not able to follow up issues such as communication style raised by the patients.

Table 4-2 Interview question guide

Practice staff members	Indigenous community members
What has been your experience of caring for Aboriginal and Torres Strait Islander patients?	What has been your experience of being a patient at mainstream general practice? Do you attend more than one practice? (Explain)
Do you think Indigenous patients are comfortable in the practice? (Expand) Why/ why not?	Do you think Indigenous patients are comfortable in the general practice? (Expand) Why/ why not?
How can the practice work better or smarter to: - identify Indigenous patients? - deliver all immunisations recommended for all Indigenous age groups?	How can the practice work better or smarter to: - be a comfortable place for Indigenous patients? - identify Indigenous patients for their records? - deliver all immunisations recommended for all Indigenous age groups? Did you identify as an Indigenous person at your first visit?*
	Please tell me about your experience identifying
Is the practice geared up to offer Indigenous health checks for children and adults?	Have you or a family member (child or adult) ever come in when not sick, and had a health check at this practice or another mainstream general practice. What do you think about these health checks? (Expand)
How could Health checks activities be better supported? (Expand)	How could health checks be better offered to men?*
Which records system does your practice use?	
Invite further feedback about the PIPCGP intervention.	Invite further feedback about health screening and immunisation in general practice

Source: developed by the author

A question guide was initially developed for staff and another for patients—worded differently but with the aim of, for the most part, asking similar questions. An iterative approach was undertaken so that additional issues raised at one interview were asked about at subsequent interviews. In this way, a number of questions were added to the patient interview guide (See table 4-2).

4.7 Sequencing of data collection

In evaluating mixed methods studies in primary care, Creswell, Fetters & Ivankova (2004) recommended a model where quantitative and qualitative methods were integrated, with information gained from one form being used to develop further enquiry using the other form. Instrument building, triangulation, and data transformation models were found to add rigour.²³¹ Onwuegbuzie & Leech (2004) examined the nature of evaluation and its use of commonly available data or locally structured performance definitions. He discussed common problems in establishing usable evaluation criteria as 'significant' in both quantitative and qualitative work, and described means of using mixed methods to enhance the interpretation of significant findings. He found that each gave extra dimensions to the other, and sequential rather than parallel mixed collection and analysis was more useful.²³²

In the PIPCGP study, quantitative data relevant to individual practices (i.e. the audit) was established based on current reporting formats, priorities, and local clinician advice. Issues for practices were first collected and understood through the workshop process, then through the audits by the group of support workers. Issues for practices were also understood in parallel to the audits through observation and in sequence by interviewing a range of staff of different disciplines after their initial and progressive audit results were known. By necessity but not by plan, there was a disconnection in sequencing patient interviews. The gathering of information on the patient's perspective lagged behind this process, so there was less opportunity to cross check issues between patients and providers in a formal way. Although some additional questions raised by staff could be asked of patients, patient issues could not be taken to the staff interviews.

4.8 Analytic strategy

4.8.1 Data sources and their related research questions

Data relevant to each of the research questions was drawn from multiple sources to present different types of information about the same issue, and to seek to triangulate findings.

Table 4-3 PIPCGP data sources and their relevance to the research questions (Source: the Author)

	Data sources	Research question 1 Suitability	Research question 2 Effects and consequences	Research question 3 Enhancement
1	History of the intervention			
2	Workshop discussion			
3	Discussion / final review with support workers			
4	Practice descriptions gained from audit and observation			
5	Audit outcomes			
6	Interviews with providers			
7	Interviews with patients		*	

*Limited relevance only some of the patients interviewed attended an intervention practice

4.8.2 Data management and initial analysis

Audit data received from the DGP was kept in hard copy and entered into Microsoft Excel[®] 2010 spreadsheet software for description and analysis (see table 6-4). QSR International's NVivo[®]9 qualitative data analysis software was used mainly as an organising tool to sift and cross-reference pieces of text while maintaining the integrity of the original data so that codes and themes could be developed.

All interviews were digitally recorded and the transcripts typed verbatim in Microsoft Word[®] (Microsoft Office Professional Plus 2010). In one case a relevant journal article by Johanson & Hill (2011)²³³ and several patient information leaflets about the practices were offered at interview, and these were collected. Interview voice recordings, typed transcripts, and electronic copies of print media were entered into NVivo[®] 9 software for the purpose of storage and analysis, as described below.

NVivo[®]9 is a relational database set up to facilitate thematic analysis. Datasets can be linked under a system of nodes that allow the identification of themes. By pre-naming a

node as a specific theme under which to collect text as codes, each piece of text retains its link to the original transcript or other document. One node can be linked to many sources. Nodes can be utilised by pre-naming them as a specific theme under which to collect text as codes, each piece of text retaining its link to the original source (interview file), and to a range of attributes recorded for each source. In addition, nodes can be created as they emerge during the process of coding, and be built up in that way. Words or word groups can also be searched for throughout the sources to aid the process of collecting relevant codes.

Individual interviews collected for the study were saved in NVivo®9 as sources, and initial codes were derived from the interviews, line by line, collected as a set of nodes. After careful reading of the transcripts, I commenced coding of early provider interviews on a line-by-line basis to derive an initial set of open codes based on the questions and ideas introduced by participants, grouping relevant text under each node. The assistant interviewer completed this coding independently on paper and in parallel for the first few interviews so that findings could be compared and discussed. Concepts or themes were then deduced based on more selective coding. My ongoing analysis of the material progressively informed the interviews. Where text was relevant to more than one code or theme, it was included in both. Analysis also involved reflection on various information sources and, where possible, the triangulation of information. Interviews continued until there was saturation of themes.

Several passes through the data were made over the course of the project and afterwards to arrange data as codes and add new codes and themes. Although the program has node-hierarchy (tree) arrangements, and memo-writing capability, these were not used within the program. Rather I worked on paper to derive categories or themes while manipulating the data on screen, and I also wrote memos. The software enabled access to the totality of data, enabling easy exploration of content by moving between the interview and nodes I had created, and by performing text searches. To complete the first stage, I derived a set of themes, and was struck by the disparity in focus of patients and providers: patients concentrated on people, communication and relationship, and providers concentrated on practice functions. The exception was that providers experienced in Indigenous health aligned with patients. As I identified quite strongly with participants who were providers experienced in Indigenous health, I needed to test these notions further, in a way that would eliminate any unconscious bias on my part.

In the second stage of data analysis, interviews were also entered into Leximancer Pty Ltd.'s Leximancer® Desktop Academic²³⁴ qualitative data analysis software for the purpose of automatic content analysis. Leximancer® processes text files by identifying common concepts within the text, based on the occurrence of words together. A thesaurus of equivalent and related words is derived which can be checked by the user. A *seed word*, the most common central word, is used as a label for the concept. The frequency of co-occurrence between concepts is then analysed and depicted statistically and as a concept map.²³⁵ The Leximancer® program automatically analyses text to derive high-level concepts. . A key word represents each two sentences of text, grouping other words around it and identifying synonyms that fit within the group of words. A single word on the concept map thus denotes a concept, which may be understood by checking the quotes grouped within that concept by the program. .As the focus is on individual words and how they link to other words, some of the contextual meaning conveyed by sentence structures is lost. The extraction processes that derive links, however, are based on semantics and word relations. An evaluation by Smith & Humphreys (2006) found these underpinnings to be logical and the outputs to be reproducible. Analysis can be carried out in a number of ways, for example removing *stop words* (functional words with low semantic content, such as 'and' or 'but') or expansion or contraction of the range of concepts.²³⁶ Analysis of sentiment may be derived from the text. Subsets of data may also be used. Automatic analysis could provide an alternative look at the data, for comparison with the researcher-developed analysis as a form of validation.

Using both Leximancer® and NVivo® 9 to analyze the same data offered further insight into differentiation between the two groups of interview participants. Once the alignment of views was evident from coding facilitated by NVivo 9, the groupings could be mapped — for the two groups of participants asked similar questions— which showed divergence with a small degree of overlap. The results were striking and gave further strength to my initial analysis (see figure 7.1).

This type of result has been evident in a number of studies analysed using Leximancer®, where two or more contrasting or interacting groups of people have been studied. An example was a study by Baker et al. (2011) of doctors and patients' perspectives of communication with each other about the management of musculoskeletal disorders, where a separation of main concepts was evident between patients and specialists.²³⁷ Another example was a study by Freeman et al. (2012) of the views of pharmacists, GPs, healthcare consumers, and practice managers about integration of a pharmacist into the

general practice environment. In this study, the views of practice staff were similar: however, those of pharmacists were quite different, and this was evident from the concept map.²³⁸

To check this interpretation (as a means of triangulation), rather than compare with the interpretation by practice staff, on advice of the UIH research director I met with staff members undertaking the Integrated Team Care at UIH. These staff members were involved in supporting Indigenous patients of both mainstream practices, and CCHSs. Using the Leximancer® illustration, I discussed the main themes of the PIPCGP study, and asked if these were in common with their experience in the community. There was agreement on the point of the people/ communication focus of patients, the lack of it in the practices, the need for cultural safety training of practice staff, and the strengthening of links with Indigenous community organisations and resources. I was referred also to their senior Indigenous cultural safety mentor.

4.8.3 Integrated analysis

In the third stage, I took the conceptual framework used at the outset of the project to examine results of the quantitative and qualitative data together, recording confirmatory and new information related to the context, mechanism, and outcome factors that had been originally identified. This also allowed me to place the overall themes I had derived into the microsystem of the practice and the mesosystem of the community.

On considering audit findings and views related to practice activities and the effectiveness and consequences of the intervention, it was useful to re-analyse the material, along with the audit information about practices, based on the concepts and terms used in the preliminary schema. In this way context, mechanisms, and the patterns of linkage between them were highlighted (see table 7-2). A Context/Mechanism/Outcome configuration (CMOC) was developed to capture the linkages (see figure 8-1). This re-analysis was facilitated by use of NVivo® 9 to store and manage interview transcripts, which enabled targeted searching for relevant interview material. The audit and interview data built on the connections and complexities of the model, providing a rich understanding of the dynamics of a complex situation.

In the fourth stage, I reviewed again my field notes, memos, audit results, and interview transcripts to ensure that I had the best interpretation of the data that I could present. The themes were then further analysed by applying various lenses. Given the data consisted of participants' history and lived experience, it was appropriate to use an indigenous

knowledge framework for analysis, as was discussed in the literature review and summary of context presented in Chapter 2. The commonly used report structure for studies of this type would be to document provider views and supplement with those of patients, or to compare and contrast the views of the two groups in text or tables of short narrative. This report gives central focus to the patient interviews (albeit as interpreted by the researcher) and arranges provider views around them. This is in keeping with indigenous knowledge principles, and the ‘decolonising methodologies’ of research championed by Linda Tuhiwai Smith (2012) about human rights, power, and the central positioning of indigenous voices.⁷⁴

4.9 Summary

Evaluation was integral to my research intervention, and was conducted by the team who had previously implemented the intervention. Mixed methods were used to complement a theory-driven enquiry structured according to the Realist Evaluation paradigm, which focused on changing specific patterns of practice. The internal environment of the practice was the focus of the study. An introductory workshop was provided and feedback gained. Periodic support was given and the types of requests noted. Audit information was collected periodically and was shared by the audited practice and its supporters. Data about features of the participating practices were collected at the time of the audit, and practice environments were observed. In-depth interviews were conducted with practice staff and patients to further understand issues relevant to the practice environment.

The next three chapters present the findings based on analysis of these data. Findings include analysis according to a framework developed for the study (table 7.2), and exploration of a key mechanism that was recognised and developed primarily from the Indigenous patient’s perspective—the staff-patient relationship.

Chapter 5 **Study Setting and Intervention**

5.1 Overview

This chapter primarily addresses the first research question: Based on the best evidence, what intervention by PHU and DGP staff was appropriate and feasible to promote increased coverage of Indigenous immunisation and health checks in mainstream urban general practices? It does this by providing the details of study setting, intervention, and feedback about the intervention from practitioners. Through this data the chapter also begins to address the second question: What were the effects of the intervention?

First, the chapter provides evidence from the literature that informed the type of intervention as one employing multiple strategies, then examines the setting in detail. The geography, relevant history, Indigenous population, general practice workforce and stakeholders are described. A description is then given of the intervention development, and implementation. Decisions about the intervention were based on the literature, experience, and consultation with a multidisciplinary development group. A workshop bringing together staff of general practices was followed by a twelve-month period of audit, feedback, and extra support for the target activities in participating practices. The study phases, challenges faced, and their resolution are documented.

Appropriateness of the intervention—the remaining part of the first question—can be judged from retention of recruited practices and the outcomes achieved, which are discussed in the next chapter.

5.2 Justification for the type of intervention used

In addition to understanding the nature of the change to practice that was needed, it was important to understand how best to work with practitioners.

5.2.1 Influencing professional practice in primary care

Development of the intervention began by reviewing proven implementation strategies. The Cochrane library, including outputs of the Effective Practice and Organisation of Care (EPOC) Review group, was searched for reviews relevant to ways of influencing professional practice. The EPOC Review group generated a series of reviews of interest about general practice. EPOC Convenor Jeremy Grimshaw conducted a workshop on evidence-based practice on Fraser Island for staff of Queensland Public Health Units, and gave the following assessment of EPOC measures that had been evaluated using

Cochrane reviews: “While the strength of evidence is lacking in many of the available studies, the evidence presents a consistent pattern across a range of issues” (pers. communication Grimshaw, 2009). Establishing clinical guidelines does not in itself change practice. Individual measures such as printed education materials (Farmer et al. 2008), educational outreach visits to practices (O’Brien et al. 2007), and on-screen clinical activity prompts (Shojania et al. 2009) have small effects on clinical practice in the community, of the order of 10% or less improvement in process outcomes.²³⁹⁻⁴¹ Continuing education meetings including courses, conferences, workshops, and seminars were evaluated based on review of 81 randomised controlled trials by Forsetlund et al. in 2009. An objective measure showed practice improvement of around 6%, with or without an intervention. Education that mixed interactive and didactic sessions was more effective than either one alone. Effects on practice were less for less serious outcomes and less for complex behaviours.²⁴² Larger changes have been associated with multifaceted interventions that may use a combination of these measures. Grimshaw used a review of efforts to change antibiotic prescribing practice by Arnold et al. 2005 to illustrate this. Single interventions were associated with similar change to the above. In a range of studies, multi-faceted interventions that combined practitioner, patient and public education in a variety of formats were able to reduce inappropriate antibiotic prescribing by roughly between 7 and 74% less prescribing. Success of the multi-faceted intervention was dependent on the pre-intervention practice starting point, and was more likely to be effective where barriers to change were identified and addressed.²⁴³

In Australia, coordinated care trial results showed clinics with predominantly Aboriginal and Torres Strait Islander patients that received intensive support to change practice achieved between 10 and 20% improvement over 12 months, most sustaining more modest change over three years. Bailie et al. concluded that a process of CQI had been a key feature of the sustained change achieved in the ongoing ABCD programs at these clinics.^{165, 244} A qualitative study of practitioners and other stakeholders regarding mainstream Australian primary care information needs to guide practice improvement was included in a review of information sources in 2008. The factors influencing adherence to best practice recognised were described in four domains: Community (community health profile, rurality, cost, availability of services); Practice (support for change, cost, workforce capacity, medical and technological advances); Practitioner (faith in evidence); and Patient (health beliefs, adherence, cost).²⁴⁵

5.2.2 Dealing with barriers to implementation of practice

The gap between guideline establishment and clinical practice has been examined in more detail in the literature. In the United States, Cabana et al. (1999), on synthesising this literature, offered a schema for understanding barriers to implementation of guidelines by doctors in relation to knowledge (K), attitudes (A), and practice (P). Cabana's model emphasises the following variables of interest: for K, awareness, agreement, motivation, and confidence in performing the procedure; for A, match between guideline and patient, outcome expected, self-efficacy and inertia; for P, patient preference, time, resources, organizational constraints, reimbursement, and exposure to risk of litigation (see figure 5-1).²⁴⁶

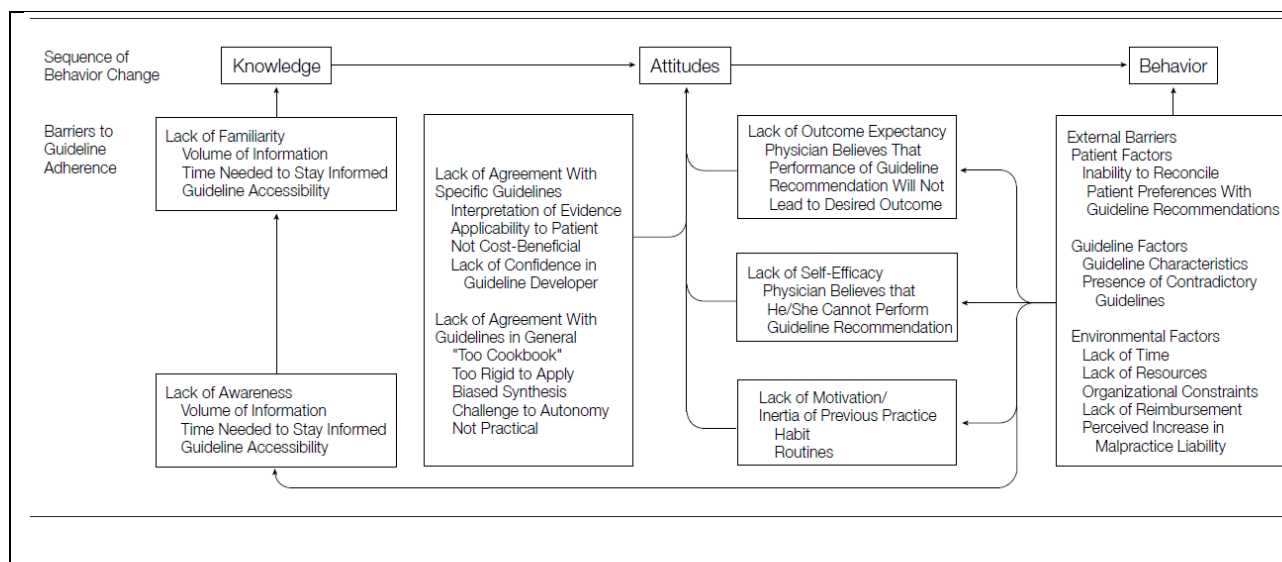


Figure 5-1 Barriers to Physician Adherence to Practice guidelines in Relation to Behaviour Change

Source: Cabana (1999)²⁴⁶

My approach to implementation was guided by awareness of these different types of barriers and influenced by an implementation model presented by Moulding, Silagy & Weller (1999), which was based on social and behavioural theories, which could potentially address these practitioner barriers, and was broad enough to include a wide range of patient barriers. Five steps were recommended by Moulding as follows: assess practitioner readiness for change; assess barriers to guideline use; determine the appropriate level of intervention; design dissemination and implementation strategies; and evaluate implementation. These were advised to be gradual (to accommodate varying readiness for change), with planning including practitioners, assessing practitioner readiness, using multiple methods of dissemination, identifying and addressing barriers to change, providing participatory education and providing a support over time.²⁴⁷

5.3 Study setting

Northern Brisbane is the PIPCGP study area, around half of the urban centre of Brisbane, consisting of about 4,000 square kilometres. This area is bounded by Moreton Bay to the east and the Brisbane River to the south. The northern boundary takes in the satellite city of Caboolture and extends to meet the Sunshine Coast. The boundary extends west to take in the town of Kilcoy (see figure 5-2). This is also the geographical area of the Metro North Hospital and Health Service, which was established in July 2012, and of the Brisbane North Primary Health Network (PHN). The PHN was the most recent iteration of a federally funded community-health professional-support agency and community-program manager. At the time of the study, general practice support for the area was provided by two separate Divisions of General Practice: the Moreton Bay General Practice Network (Outer North) and GP Partners (Inner North). These two amalgamated in mid-2012 to form the Metro North Brisbane Medicare Local which (with the same boundaries) then became the PHN in July 2015.

Northern Brisbane was home to around 18,000 Aboriginal and Torres Strait Islander people, who in 2009 still had limited physical access to an ACCHS.²⁴⁸ Few local general practices were known to provide targeted care for Indigenous people: one small, part time satellite clinic of an ACCHS, one new, private Indigenous-owned clinic, and two established mainstream general practices, which provided limited hours Indigenous clinic times, and were part of a 'collaboratives project' for quality improvement²⁴⁹ aiming to improve chronic-disease care for Indigenous people. These two practices, which were among the recruits to the PIPCGP study, also had state health service support in the form of an Indigenous Health Worker to visit the clinic, and patient transport to the clinic, as described in an article by Johanson.²³³

5.3.1 Geography

Brisbane is the capital of the state of Queensland, Australia. The urban area of Greater Brisbane, which is a Greater Capital City statistical area of the Australian Geographical Classification System²⁵⁰ spans the meandering Brisbane River as it travels towards the coastline. The area is narrow at the coast, being bounded by the Gold Coast and Sunshine Coast regions, and wide in its inland extension. The Brisbane River naturally divides Brisbane to the north and to the south into two main segments of about equal land area. The central business district surrounds the river, situated for the most part on the north side. For neighbourhood service in general, it could be said that *Northsiders* stay north and *Southsiders* stay south.

This is a smaller area than the 'Indigenous region of Brisbane' designated originally by the Aboriginal and Torres Strait Islander Commission and described within an ABS Indigenous area classification, and which includes the Sunshine Coast and the Gold Coast, north and south of the Greater Brisbane area.²⁵¹ These more distant coastal areas have their own regional hospitals, health service districts, primary care networks, and ACCHSs. It is important to remember that, for Aboriginal and Torres Strait Islander people, there are strong pathways of movement and family and cultural links between Brisbane and the adjacent coastal areas, as reflected in the wide borders of the "Indigenous region". As well, there are family links to the rural Indigenous community of Cherbourg, further north.

According to Professor Raymond Evans, a local historian, the Brisbane River Valley prior to colonisation was a neutral and hospitable meeting place for many different groups of Aboriginal people who visited or were travelling through from other areas.²⁵² *Aboriginal pathways in Southeast Queensland and the Richmond River* is a book that is passed around by local health service providers and Indigenous people. Steele (1983) used ethnographic literature, archaeology, and museum collections to provide a picture of the land and its people.²⁵³ This collection of archival and recent photographs, vocabulary lists, and mud maps is an important supplementary resource for conveying local Aboriginal history and the current significance of special sites in South East Queensland. Although (according to an ethnographer's review) it does not present a critical or analytical account,²⁵⁴ it lists intact sites of cultural significance and their connecting pathways known to the general community, including several in northern Brisbane. The locations of other covered-over cultural sites are also documented. Hunting and fishing sites are described and the methods used discussed. Some of the early colonial history of the Redcliffe area (in the Outer North), which became a white settlement prior to the establishment of Brisbane, is documented, and this area's strong Aboriginal connections with the Sunshine Coast is discussed. Taken for what it is, a personal interpretation by an outsider, Steele's book has proved to be a useful shared resource—an adjunct to learning from local people.

To confer understanding, this knowledge of landmarks must be connected with people. For example, the location of Bora rings in northern Brisbane, both evident and covered over, are documented by Steele in Samford and Nudgee (Inner North), Strathpine, and near Caboolture (Outer North). Their emotional significance has been succinctly and beautifully conveyed in a poem, *Bora Ring*, written in 1946 by Oodgeroo Nunuccal (also known as Judith Wright).²⁵⁵ Diversity, ceremony, remembrance, fear, the settler's ignorance, and, in an academic assessment by Kohn (2006), an overarching 'grief for the unseen presence'

are conveyed.²⁵⁶ Several Indigenous interview participants of the PIPCGP study referred to these places as sites of significance that a non-Indigenous person should be informed about, as they still play a role in community life.

There is another, more hidden geography, that some local Indigenous people mark and discuss, the sites of past massacres. Artist Judy Watson has developed an on-line map site, 'the names of places', which collects anecdotes and records referring to the massacre of Aboriginal people. In northern Brisbane, places of the Inner North featured include Petrie, Breakfast Creek, Nundah, and Victoria Park in Spring Hill. Multiple attacks of Aboriginal camps in these places were reported between 1840 and 1881. An account of a punitive expedition to Caboolture in 1862 was described in detail.²⁵⁷ Information about events in and around Brisbane described by this map was provided by Dr Ray Kirkhove, a local historian whose interest is the early history and material culture of Aboriginal South East Queensland.²⁵⁸

5.3.2 Relevant history

Disease cannot be divorced from history, either natural or social. The indigenous people can be seen as patients as well as colonised races. The system of Aboriginal administration, including government protectors, magistrates and police, along with doctors, hospital health workers, pastoralists and missionaries, was crucial in shaping both indigenous and non-indigenous responses to disease and health. (Briscoe, 2003)²⁵⁹

Briscoe's words apply directly to the history of northern Brisbane and surrounding areas, which is one of displacement, violence, exploitation, a lack of human rights, and extreme control by the administration. Doctors and the police were indeed part of the same administration, as shown in the following summary, taken from *The history of Queensland Indigenous missions and reserves*, available on the State Library website. Featured is an account prepared by Kathy Frankland (1994), here summarised:

In the 1800s Indigenous people were 'managed' (dispersed, killed, imprisoned) by a native police force (recruited from outside the area, most from southern tribes) under the Crown Lands administration of Queensland. A single surgeon was appointed, later two, then three (as a sideline to their main work) by Crown Lands Commissioner. One of these was based at Ipswich adjacent to southern Brisbane.

Reserves were first established in 1875, under the Department of Public Lands and then the Colonial Secretary.

The Queensland *Aboriginals Protection and Restriction of the Sale of Opium Act 1897* resulted in Aboriginal and Torres Strait Islander peoples losing their legal status as British citizens and effectively becoming wards of the state. The police commissioner became also the 'protector' of Aboriginals. A 'government resident' and later the shipping master became the controller of Torres Strait Islander people, and then a local protector.²⁶⁰

The Act applied to people who were described as:

4. Every person who is

(a) An aboriginal inhabitant of Queensland; or

(b) A half-caste who, at the commencement of this Act is living with an aboriginal as wife, husband, or child; or

(c) A half-caste who, otherwise than as wife, husband, or child, habitually lives or associates with aboriginals

(Legislative Council and Legislative Assembly of Queensland., 1897)²⁶¹

The definition of 'half-caste' was variable and open to interpretation. Protectors administered Aboriginal employment, wages, and savings bank accounts. They controlled where Aboriginal people lived and whom they were able to marry, frequently practicing removal to a reserve, which became part of the administration. This aspect of Queensland history, the extreme degree of control of Indigenous peoples exercised by government, was further detailed by Dr Rosalind Kidd, in a locally published book, based on her doctoral thesis.²⁶²

Based on archives, Frankland (1994) gave an account of local missions, here summarised:

The Nundah Lutheran Mission ('Zion Hill') situated in Inner North Brisbane, operated from 1838 to 1845 and was associated with large farms. A Catholic orphanage was also established nearby at Nudgee in 1869, housing children moved from other parts of Inner North Brisbane such as Diamantina Orphanage (near the Fever Hospital of Victoria Barracks, Paddington), and from New Farm. Many removed Aboriginal children were housed at Nudgee, and this facility operated until 1971. (Frankland, 1994)

In conducting the study, I was told that several Indigenous Health Workers and health administrators of the local area had grown up at this orphanage.

Bribie Island, very close to the coast north of Brisbane and East of Caboolture was a place away from initial colonial settlement where Aboriginal people gathered for fishing. In 1892, all Aboriginal people were removed from a mission in the area, taken to Peel Island, and then later to Stradbroke Island further south. Both Stradbroke and Peel were used as quarantine stations for incoming ships, which often carried infectious disease. Peel Island, for a time, became a Lazaret. Myora mission for Aboriginal people on Stradbroke Island operated until 1942.²⁶⁰

Indigenous communities have remained strong and active in these localities, despite this history of adversity. Visiting Stradbroke with a group of Indigenous students, I found that Indigenous organisations are prominent in the local community, for example running an aged care facility for all local residents. Indeed the Land Council of the area is prominent in the media and in action, as custodians of the Island and surrounding bay and its wildlife. In undertaking the study I found that the Local Aboriginal family networks of Caboolture and Bribie are strong and provide welfare support both to local people and visitors to Northern Brisbane. One example is a group of women I talked with who visited, interpreted for and otherwise supported patients at Royal Brisbane Hospital, on request of the hospital's Indigenous Health Workers.

Frankland provided information about Cherbourg: Barambah Mission (later called Cherbourg) in the South Burnett district, around 200 kilometres further north, was established around 1900 as a repository for Aboriginal people who survived settler incursion in the wider area, including from Woodford (near Caboolture) and Kilkevan, 47 kilometres east from where the mission was shut down: 176 people were shifted by train and on foot to the mission. Food was in short supply and epidemics were frequent: whooping cough, dengue, malaria, pneumonia, and influenza. There was also tuberculosis. By 1938, there were around 1000 residents, including people from 28 different language groups. Dormitories separating males and females, including those married or in family groups, were established. Some cottages were built in the 1920s and many more in the 1950s. Removal of Aboriginal people to Cherbourg was documented through to 1971.²⁶⁰

The Ration Shed Museum presents this description of life as part of its online introduction to Cherbourg:

On the settlement, the government administration controlled almost every aspect of Aboriginal peoples' lives; the language they spoke, what they ate, what they wore, where they went, for whom they worked and, in some cases, whom they would marry. Aboriginal people, removed to Cherbourg were either placed in dormitories or lived in camps. Large numbers of boys and girls, men and women were brought up away from families in the dormitories. Anyone breaking the strict laws were severely punished – locked up in jail or sent away to other reserves like Palm Island and Woorabinda.²⁶³ (Ration Shed Museum, 2018)

This history is in living memory of the local Aboriginal people of South East Queensland and other areas of Queensland. The Ration Shed Museum website has recorded text of the following speech: At the launch of *On the Banks of the Barambah: a history of Cherbourg* in 2003, Sandra Morgan's speech (2014) included the following:

We never heard our grandmother complain and she was always very strict and we always thought she was grumpy but actually it was her way of protecting us. She took us kids everywhere, not our mum – Granny wanted to watch over us...

She was taken away as a young girl from country to Woolawin Girls Home and then taken to Fraser Island and then shipped to Yarrabah and then back to Barambah.... Taken here and then taken there... We used to think she got around a lot... but actually she was part of the stolen generation moved by the authorities from place to place... Every night she told us stories yarning us to sleep – dreamtime stories, fairy tales, bible stories – But she never complained, never told us about the past... through fear that they would move her again, fear that she would be separated from family again...

One can understand – I only really found out about her and my grandfather's pasts later in life... One can say that survival in a place like Barambah-Cherbourg meant keeping quiet, holding your tongue...

But, while one can understand this, we also have to say it is in itself part of the problem because to never talk about the past served to cover-up much of our history and to cut us off from our ancestral pasts²⁶⁴ (Sandra Morgan, 2014)

In Brisbane, as in other areas of the country, there is still an active process of reconnection between families and the children who were removed from their care, who form part of the

Stolen Generation, as described in a landmark report by the Human Rights and Equal Opportunities Commission in 1997.²⁶⁵ The Link-Up organisation continues to support family tracing, reunification and support, and also promotes understanding in the wider community through engagement with volunteers.²⁶⁶ Many Indigenous people who grew up in the orphanage at Nudgee in the Inner North have engaged with Linkup. I and several medical students were able to participate in a Link-Up reunion weekend at Cherbourg, visit the Ration Shed Museum and hear its speakers. We have benefitted from this Indigenous community resource that is available to many local health and education professionals. On Sorry Day in Brisbane, my experience has been that conversations turn to Cherbourg and to the orphanages, their persistent legacy of emotional pain, and positive aspects such as the familial nature of bonds between the children who shared years in an orphanage. This is an example of an issue that may strongly influence mental health of the Indigenous people of the local area.

5.4 Indigenous Population

Greater Brisbane's population at the 2011 Census was 2,065,996, the northern segment population being almost half at 900,000. The outer northern area's general population has been continuing to expand rapidly as new areas of housing have become established, replacing farmland and state-owned forest. The Indigenous population of northern Brisbane had been rapidly growing, partly due to increasing Indigenous identification, and at the time of the 2011 Census, comprised 2% of the total population of the area.²⁶⁷ According to a study by Hal Pawson & Herath (2015) of the Australian Housing and Urban Research Institute, as with most capital cities of Australia, there has been an increasing concentration of disadvantage evident over time in outer areas of Brisbane (see figure 5.2). In northern Brisbane, a lesser concentration of very disadvantaged areas has existed in comparison with the southside.²⁶⁸

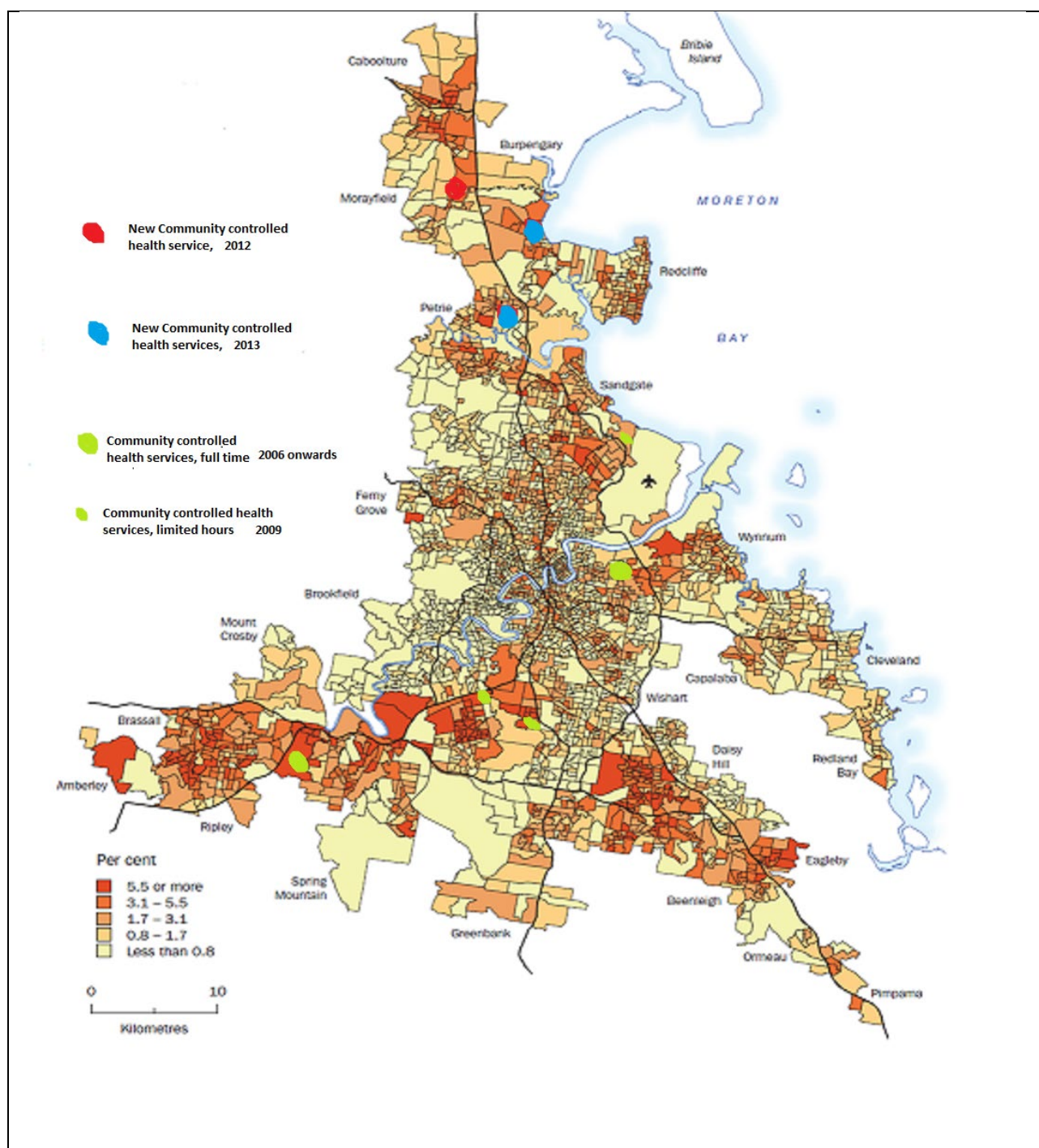


Figure 5-2 Map of Brisbane indicating Aboriginal and Torres Strait Islander people as a proportion of local population, based on 2006 Census

Note: Location of community controlled health services has been added by the author.

Source: Social Atlas of Brisbane, 2008 page 16 (Greig, 2008) ²⁷¹

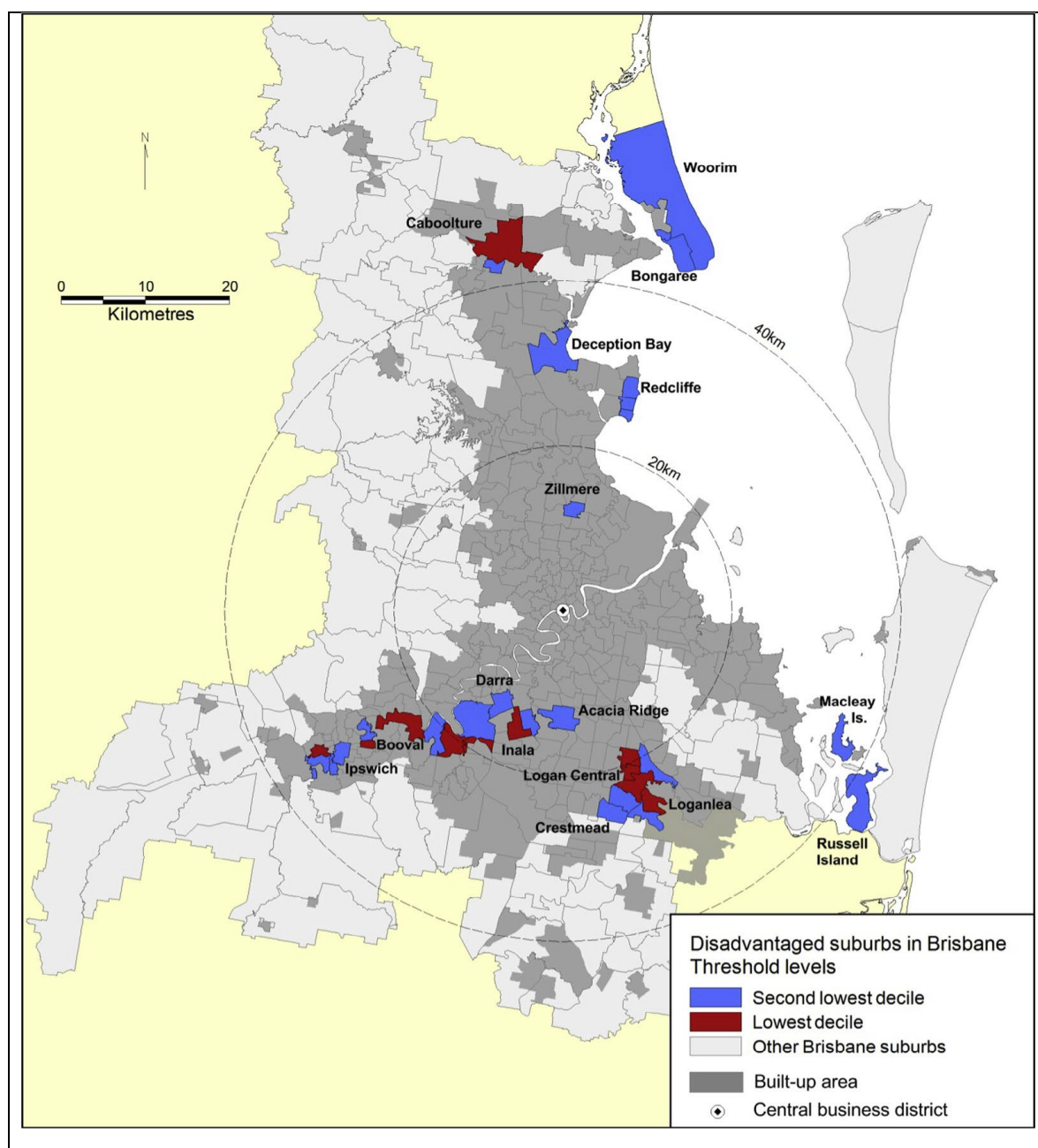


Figure 5-3 Disadvantaged suburbs in Brisbane, lowest and second lowest decile

Source: ABS 2006 SEIFA, IRSD figures and ABS digital boundaries (H. Pawson & Herath, 2015).²⁶⁸

The Index of Relative Socio-economic Disadvantage is a measure derived from an average of indices reported to the Census for the households in a small area (collector district) and compiled for larger aggregations. The Index of Relative Socio-economic Disadvantage is one of the four Socio-economic Indexes for Areas, which is most sensitive to disadvantage across population age groups. For the 2006 Census data, the Index of Relative Socio-economic Disadvantage was calculated from 17 indicator variables of low income, low education, high unemployment and unskilled occupations, one of which was Indigenous status.²⁶⁹ After a review and for the 2011 census, this index was modified to

exclude Indigenous status as a contributing variable, which was thought to inappropriately assign a lower ranking.²⁷⁰ Pawson's analysis used the 2006 census data and categorisation to derive disadvantaged suburbs of Brisbane. The map produced (see figure 5.3)²⁶⁸ showed two lowest-decile areas in the Outer North, one in the Inner North, and three in and about the Brisbane satellite city of Caboolture. Lowest decile and second lowest decile areas of northern Brisbane contained concentrations of Indigenous people (see figure 5.2).²⁷¹

5.5 General practice workforce

In 2011, the northern half of Greater Brisbane had around 270 general practices, employing around 1000 GPs and 340 practice nurses, according to the Divisional survey of the time. There was no reporting of Indigenous status. (See table 5.1). The GP to population ratio was lower in the Outer North, where there was also a lower proportion of female GPs and fewer practice nurses.²⁷² My experience of working with practices in the Outer North was of more corporatisation of practices, associated with amalgamation or sudden demise of smaller practices, often with loss of records. There was easy access to bulk billing in the Outer North, except for one geographically distinct area (the Redcliffe Peninsula) where most practices required a co-payment.

The first DGP involved in the study, covering the Inner North, was a very large Division in terms of population served and staff numbers. It had successfully taken on a number of projects in the local area. One third the size of the Inner North Division, was the Outer North DGP, later involved in the study. It served a smaller population in the outer suburban area, with one satellite town, Caboolture. The two Divisions, administered by the Australian Department of Health, merged to form a single entity towards the end of the study's intervention period. The pending restructure had an unsettling effect on staff and on forward planning of activities in the Outer North. Once restructuring occurred activity was very limited for a period of months in the Outer North area.

During the intervention period, these two DGPs included Department of Health funded Aboriginal and Torres Strait Islander Project Officers, whose role was to support implementation of the Indigenous Chronic Disease Package in general practices, such as the Practice Incentive for Indigenous Health,²⁷³ and these workers, plus the Divisional immunisation support officer, participated in the intervention.

Table 5-1 Key characteristics of two DGPs

Study area Divisions of General Practice	Inner North	Outer North
Population	657,646	218,175
Number of practising GPs	853	215
% female GPs	49.9%	29.8%
Practice nurses*	280	60
Number of practices	201	66
Proportion of accredited practices	70%	66%
Number of solo practices	47	16
Estimated number of Indigenous people	7,087 (1%)	4,119 (2%)
Estimated number people aged 65+	72,211	33,389

*This information separately sourced from Minister N Roxon's statement to Parliament Feb 10, 2011¹⁰³

Source: Primary Health Care Research and Information Service 2011 Annual Survey of Divisions of General Practice (Petousis-Harris, 2012)²⁷⁴

5.6 Stakeholders

The stakeholders were two Divisions of General Practice, the Northside and Moreton Bay Public Health Unit, the Institute for Urban Indigenous Health, the general practices and the Indigenous communities of the area. Anecdotally, it was evident from meetings with support workers from the DGPs that there was a desire to improve uptake amongst GPs. They understood from their work that there was a lack of knowledge of how to implement appropriate changes-in-care procedures and Medicare claiming at practice level. Support workers from the PHU understood that there was a more fundamental lack of knowledge of how to improve the low rate of identification of Indigenous people. Working with members of the public and with general practice immunisers had shown PHU staff that many of the Indigenous-identified children on the immunisation database were not receiving the extra vaccines from their general practice immuniser due to lack of Indigenous identification at the practice level.

During the study period, there were few local, established Indigenous-specific services. A small, limited-hours satellite clinic of the main southside ACCHS had been running for a year, and a limited-hours state-run Indigenous primary care clinic in the Inner North closed early in the period. A new private Indigenous-owned clinic in Caboolture (Outer North) was established during the intervention period. Some local Indigenous people attended one of the two large, well-established ACCHSs on the southside, or the large, state government supported–Indigenous primary care clinic on the southside at Inala. The Institute for Urban Indigenous Health (IUIH) was established in July 2009 to represent the ACCHSs of South East Queensland. Its strategic plan for 2011 to 2014 outlined its rationale and plan to expand service delivery based on service mapping, with the initial focus of activity being northern Brisbane.²⁷⁵ The first new IUIH clinic was set up in the second half of 2011 within a large state government–run community health service at North Lakes. IUIH has since become a driver of rapid ACCHS development in the area.

The state health service managed hospitals, community health services and PHUs. This local area health authority became Queensland’s largest Hospital and Health Service (HHS) early in 2012 as part of a health service regionalisation process. The HHS at that point became a single entity separate to the state health department by legislation. There were two large tertiary hospitals in the Inner North and three smaller local public hospitals in the Outer North.

The PHU provided a number of services to the area. Relevant activities included monitoring of local immunisation coverage and incidence of vaccine-preventable infection, providing immunisation register information to general practice staff, and professional support with regard to immunisation practice. The PHU was a subunit of the state Public Health Service with local responsibility for the same northern segment of Greater Brisbane. There were two local offices: one in the Inner North and another, newly established office, in the Outer North, which was subsumed by the Inner North office upon regionalisation of the service within the HHS.

The project was undertaken at an opportune time and place, with a group of stakeholders who had already begun to work collaboratively. The local primary healthcare environment had been undergoing rapid change and seemed conducive to further change, based on the success of previous local projects undertaken by the inner north DGP. The study sought to address a recognised gap in service that was a priority for the DGPs, the local Public Health Service (PHS). These two organisations cooperated with the aim of maximising mainstream provider change. Support and guidance of the newly established

Institute for Urban Indigenous Health (IUIH) enabled Indigenous guidance and direct community engagement.

5.7 Indigenous preventive care activity of the study area

By comparison with southern Brisbane, the health check rate was lower and the immunisation coverage for general schedule vaccines was higher at each milestone. The study area was remarkable in that at the time of intervention, it had the lowest Indigenous health check coverage for the state. According to locally available Medicare reporting available at the time, during the 12 months to June 30, 2009 when discussions began, only 79 Indigenous health checks had been billed in northern Brisbane (personal communication, Cindy Shannon, 2009).

In June 2008, immunisation coverage was 87.3% for one-year-old Indigenous children, 93.8% for Indigenous two-year-olds and 81.5% for Indigenous five-year-olds, according to ACIR periodic internal (unpublished) reporting to Queensland Health. A local review of immunisation data of South East Queensland on VIVAS 2006 to 2009 by Brett Shannon et al. showed Indigenous-specific vaccine coverage in children to be 50% or less for each dose. Further, Shannon's analysis showed that relatively fewer Indigenous children immunised by GPs received the additional vaccines recommended only for Indigenous children.²⁷⁶ There was a very low level of Indigenous identification on the immunisation data that VIVAS received from GPs, in comparison with other provider groups such as community health and Indigenous-specific services. This suggested that Indigenous identification might be very low in the local general practice setting.

5.8 Initiating the intervention

Applied to local-level change, my strategy was to build on available opportunities in this way:

1. Attract the practitioners most ready to change
2. Focus on changes that would reduce barriers for patients to access care and barriers to change in practices
3. Take advice of a local development group on how much was needed to support change, bearing in mind that there was a new available practice incentive
4. Design and develop implementation strategies with the development group within the limits available
5. Develop an integrated evaluation plan.

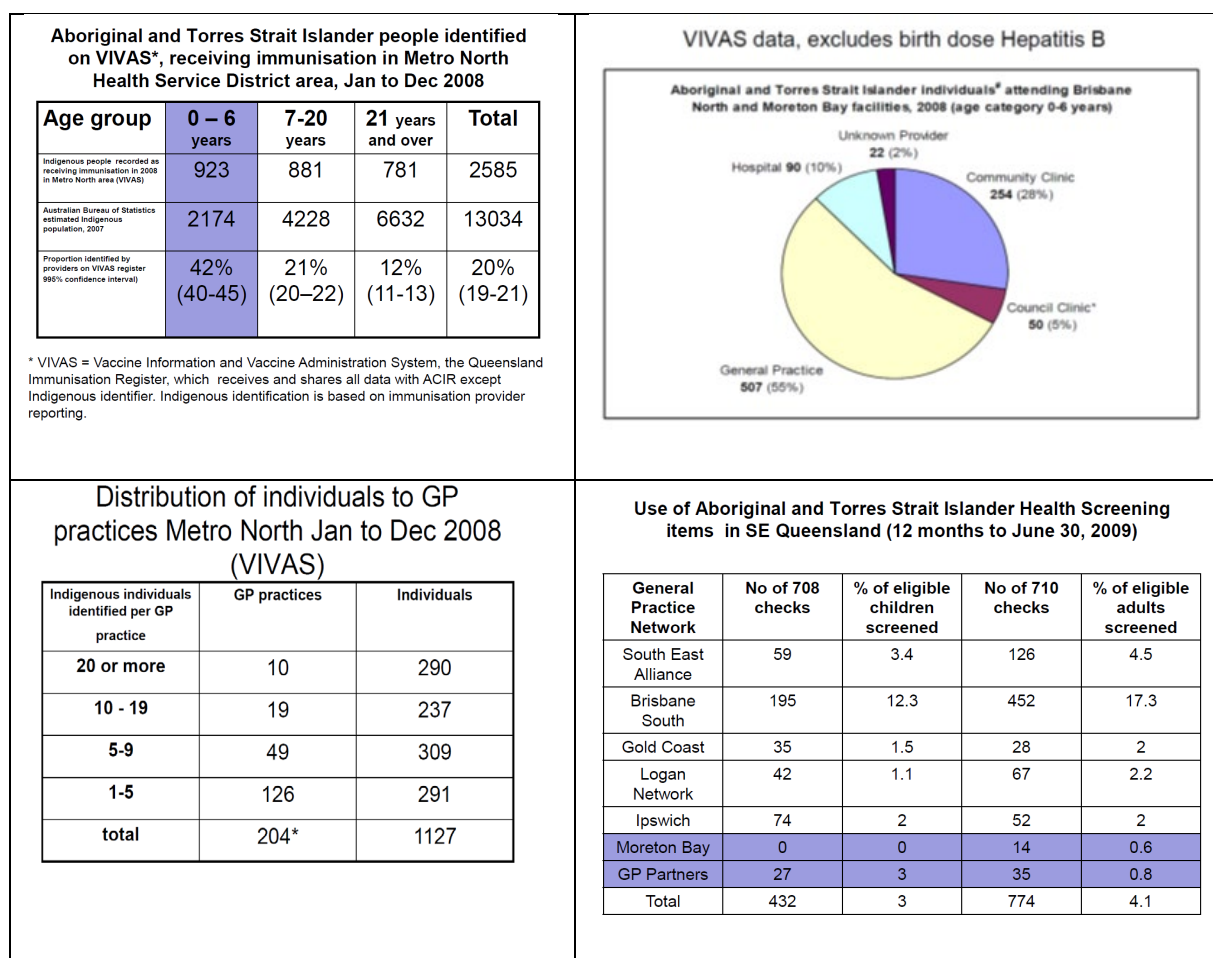


Figure 5-4 Extract from presentation to executive officers of two DGPs, November 2009

Source: developed by the author based on reports cited in the slides.

I initially approached the immunisation support officers of the two Divisions of General Practice (DGP) within the PHU (PHU) study area to check their interest, as their knowledge and possibly their work time would be needed. Given a positive response, I then met with the executive officers of the DGPs to discuss the low billing rate of Indigenous Health Checks (evident from data provided to me by an Indigenous colleague, Professor Cindy Shannon), the low Indigenous-specific child immunisation coverage, and my information about Indigenous peoples' use of mainstream general practice for immunisation. I provided a presentation (see figure 5-4), a report, and a proposition. The executive officers were well aware of the Health Check figures. It was on their agenda, having just gained funding for an Indigenous support officer for practices.

I offered help in organising an educational program that could precede DGP- and PHU-supported activity by a small group of practices that could be evaluated. The offer was taken up by the Inner North DGP, and not by the Outer North DGP. Over a six-month period, two GPs, two Division practice support officers (one assigned immunisation, the

other Indigenous health), and I formed a development group and determined the intervention plan. This was based on the literature regarding barriers to Indigenous people accessing healthcare, on evidence for measures to support practice change, and on the development group's knowledge of the information needs of clinicians regarding Indigenous health, the new opportunities for GP remuneration, and a new patient benefit. A workshop program, practice support kit, and audit process were established by the development group.

5.8.1 Shaping the local intervention

Based on my reading of the literature of barriers to change in practice and barriers to access in 2010, my professional clinical experience, and my consultation with the intervention development group, a list of desired elements of the practice environment was generated (see table 5-2) Working backwards from the desired outcomes, the intervention development group discussed how an intervention might help to bring about the necessary conditions within local general practices. This also then contributed to the analytic framework for the evaluation (see table 4-1)

The review of barriers to access helped us to have confidence in the topics to be covered and the range of staff types to be included at the launch workshop, which at that stage we thought of as a very brief opportunity to interest staff and motivate them for change. We understood that the support activities must be tailored to the local practices and must utilise multiple strategies, including reinforcement of efforts for CQI. We realised that the major resource was the practice support visits and other forms of advice that would be available as the need arose in the practices. We factored in that doctors of PIPCGP study practices would soon be undertaking RACGP online cultural competence training, to be eligible for the Indigenous PIP. Our cultural sessions included a range of practice staff and focused on asking the Indigenous-identification question and getting to know local people and organisations.

Evaluation was integrated with the planned support activities. The audit was planned to provide information both for the practices (the activity data) and for the PIPCGP study (practice details and activity data). As the development group were of the opinion that the audit procedure would be better sustained if conducted by support staff outside the practices, it was designed for that purpose. The intervention actions needed to be understood through documentation of the history of the intervention and the experiences of the actors involved (practice staff, patients, and support workers).

5.8.2 Preconditions and assumptions

Intervention activities needed to be of a style and extent able to be implemented within the limits of the support organisations at the time, and in future audits within the practices. It was decided to invite participation in the workshop first and then in the study. In this way, the workshop formed part of the educational program, accessible to all practice staff of the area, and attracted those most interested and more likely to already have Indigenous patients. We reasoned that these were also the most likely to sustain the activity into the future. We assumed that Indigenous people were under-identified within the practices, and that practices may have some interest in adopting a higher level of health-check activity, which although time consuming for the practice to implement was potentially well remunerated under Indigenous Health Check items, chronic disease care planning, and the PIP IHI. We also assumed that practices undertook quality improvement as part of their general functioning, and that audits would be utilised by practices using these avenues.

Table 5-2 Context and mechanism for Indigenous preventive care within the practice

Context: Desired practice environment leading to better preventive care	Possible mechanism within the practice
Outcome 1: increase identification of Indigenous patients in the practice	
Cost to Indigenous patients minimised	Bulk billing
	Transport to practice available
Staff motivated and interested	Staff comfortable to enquire about identity through cultural orientation
Indigenous patients comfortable in the practice	Indigenous artwork present
	Child area or toys available in waiting area
	Short waiting time
	Female doctor available
Standard process for identification by reception staff	Patient management system records Indigenous status
	Appropriate recording form available
Outcome 2: increase Indigenous patients' immunisation on time and for all recommended vaccines	
Staff motivated and interested	Information included in education session attended by staff
Staff aware of schedule	Patient management system prompts for all vaccines due or overdue
Patients aware of schedule	Patient educational resources available
	Patients request vaccine
Capacity to offer vaccines in practice setting	Stock all relevant vaccines
	Nurse immuniser in the practice
Outcome 3: increase the number of Indigenous patients receiving a health check	
Staff motivated and interested	Information included in education session attended by staff
Staff aware of schedule	Patient management system prompts for all checks due or overdue
Patients aware of schedule	Patient educational resources available
	Patients request check
Capacity to offer check in practice setting	Practice nurse or Indigenous health worker available to assist
	Practice able to manage extra-long appointments
	Tools to record check available in practice
Practice remuneration sufficient	Relevant Medicare items claimed

Source: developed by the author

5.8.3 PIPCGP intervention materials and activities developed by the team

The intervention aimed to facilitate increased Indigenous immunisation and health-check activity within an interested group of general practices in northern Brisbane over a 12-month period. By consensus of the development group, this was to be facilitated by:

1. Conducting a workshop for the staff of interested practices within the DGP to provide interested general practice clinicians and administrative staff with local cultural orientation, knowledge of Indigenous health issues in urban areas, and logistic information needed to implement Indigenous immunisation and health checks in their practice
2. Providing support materials for the practices in the study and in the local area of the DGP
3. Recruiting practices to participate in a 12-month project
4. Working with the DGP to provide quarterly audits and summaries of activity, based on information obtained at the practice site by a DGP officer, and provide regular support for the target activities to study practices from both the DGP and the PHU.

5.8.4 Workshop content

Based on the literature and perceived needs, the intent of sessions was outlined in general terms by the public health physician, a GP, and support officers from the Inner North DGP. It was an opportunity to introduce practices to both existing and new government initiatives. Most recent were Medicare's Indigenous Health Practice incentive (May 2010)⁵⁶ and the Pharmaceutical Benefit System's Close the Gap pharmaceutical benefit for Indigenous patients (July 2010).¹⁷⁷

The time allotted to the workshop was three hours on a Thursday evening, recommended by DGP staff as the best time to attract participation. A light meal was provided prior to the educational sessions. Entitled "Don't meet difference with Indifference!" the workshop sessions were:

- A. Overview of Indigenous health in urban areas and PIPCGP study details
 - B. Cultural awareness and local cultural connections
 - C. Indigenous identification within the practice; Indigenous patient communication in the practice, with parallel sessions for
 - i) Clinicians and
 - ii) Non-clinical staff
 - D. Workshop evaluation.
- (See appendix 3.)

5.8.5 Toolkit content

A package of materials for practice was compiled, which included both collected materials and new resources developed for local use. This was supplemented by information on Indigenous health and preventive care, and details of the PIPCGP study. One member of each practice in attendance was provided with the materials. A complete list of items found in the practice toolkit is included in appendix 3.

5.9 Intervention challenges and their resolution

Challenges occurred at each stage of implementation. Most were able to be resolved. These are summarised in the following tables (5-3 and 5-4).

Table 5-3 PIPCGP Study timeline

Activities ↓	Phases →	Preparation	Development	Early intervention	Mid intervention	Late intervention	Community	Analysis and formal reporting
Prepare								
Develop intervention								
Workshop then audits, intervention area 1								
Provider interviews intervention area 1 then intervention area 2								
Workshop then audits, intervention area 2								
Indigenous community interviews								
Reporting back								
		Jul 09	Jan 10	Jul 10	Jan 11	Jul 11	Jan12	Jul 12

Source: developed by the author

Table 5-4 PIPCGP study challenges and their resolution over time (Source: developed by the Author)

Phases	Activities	Actors additional to the researcher	Issues	Resolutions
Preparation	First literature review Prepared brief local report Met with DGP directors (2) within PHU area	Inner North DGP director Outer North DGP director	Outer North DGP winding down as to be amalgamated with Inner North DGP the following year	Decision to work only with Inner North DGP and Inner North practices
Development	Development committee worked on introductory workshop, audit form, and practice reporting plan Plan developed and presented for review/ advice from IUIH and ethical review District health service overview of plan through establishment of site-specific agreement at PHU	2 support workers and 2 GPs from Inner North DGP worked with me on the plan over three months Plan presented to IUIH CEO who provided support and link with IUIH research director.	Practice sensitivity about patient and management data sharing IUIH main focus was establishing community-controlled clinics in the area Hospital and Health Service permission for the project to be conducted in organisational and community venues outside HHs facilities Multiple Medicare changes being introduced	Audits to be undertaken by DGP support staff only, and audits provided to me in de-identified form I plan to progressively present findings to IUIH Production of a site specific assessment and establishment of main study site of Moreton Bay PHU ,with agreement of the Hospital and Health Service following ethical clearance from Queensland Health Central Office committee Detailed toolkit compiled to cover changes—reliant on detailed knowledge of DGP staff
Early intervention	Workshop well subscribed and recruitment successful	DGP immunisation support worker and DGP Indigenous project support	Combining disciplines for training was new to staff.	Nurses and doctors attended all workshop sessions together, receptionists and practice managers had extra time with Indigenous

	First audits took longer than anticipated because of varying state of practice electronic records.	worker hosted and contributed to workshop delivery, PHU funded meal, and kit production. Indigenous community Elders, hospital board member, IUIH clinical director, child health nurses, practice nurses, and PHU staff of Indigenous Immunisation Network hosted by PHU.	Indigenous presenters with local links needed for workshop, however, only one Indigenous staff member at DGP and none at PHU.;RACGP online cultural safety training package anticipated, but was delayed by 9 months Practice data for Indigenous child immunisation often incomplete	presenters while clinical issues covered by researcher Centrelink Indigenous project officer promoting birth certification engaged, and PHU Indigenous Master of Applied Epidemiology student engaged to present own report on immunisation timeliness and related issues PHU staff consulted local Indigenous immunisation network about Indigenous child immunisation data, sharing issues to develop guidelines. Queensland Health Immunisation Unit facilitated agreement with NCIRS Indigenous Committee regarding ACIR child immunisation data sharing by Queensland PHUs with general practitioners who may not already know of child's Indigenous status, for purpose of provider immunisation prompts by PHU (see figure 5-5)
Mid intervention	Practice staff Interviews completed for Inner North DGP. Inner North DGP Director requested project be extended to Outer North DGP	Outer North support staff engaged to refine workshop and toolkit for Outer North practices, based on feedback	Outer North area missing out on collaborative activity Increased volume of work for project Indigenous officer uncomfortable with conducting observation in practices' waiting room	Second intervention group established Director Communicable Diseases provided support funds for temporary project officer to assist with practice observation and interviews, using immunisation project funds. I made observations using informal route when attending for interviews

	Audit 3 formal report returned to each practice with group comparison, and summary report provided to DGP directors and CEO IUIH by the researcher. Audit findings presentation to IUIH internal research group	Outer North DGP support worker visits practices, detailing financial incentive through Medicare and undertakes initial audits Inner north DGP continues support	GPs request toolkit in electronic format Inner north practices not willing to recruit Indigenous patients or refer them for recruitment.	Health check templates obtained from another DGP, multiple web links added for electronic version toolkit, produced at the PHU with DGP/PHU authorship IUIH research director advised referral to community Elders for interview then snowballing; so variation to ethics submission requested, approved, and actioned
Late intervention	Outer north practice audits and support Inner North 12 mths Audit findings: National Immunisation conference poster presented by DGP staff General Practice Queensland National workshop presentation in Brisbane; and IUIH Community Research Day presentation by researcher.	Single Outer North DGP support worker National DGP staff National Immunisation workers SEQ ACCHO workers	Outer North DGP staff do not have capacity to complete multiple audits Outer north practices take up the project but some do not continue as unaccredited and therefore ineligible for Indigenous Health Incentive Child immunisation data incomplete and DGP officer not skilled to assess immunisation coverage	Frequency of audits for Outer North DGP reduced No resolution for Outer North practice-retention issue. Immunisation data sharing protocol used by PHU to provide update of immunisation records of register—identified Indigenous children immunised by the Outer North study practices, and to contribute to audit.
Community	Indigenous Community member interviews undertaken, initially with Indigenous project officer and then by the researcher alone, most via invitation to home visit.	Indigenous project officer, local Elders and Indigenous health worker	Few young people interviewed using the snowballing method commencing with Elders	Researcher successfully approached local youth welfare agency drop-in centre. Not given permission to interview clients; however, did interview young staff

		Facilitate community contact.	Immunisation coverage at 12-months of age for the area's Indigenous children remains behind general community coverage rate.	IUIH arrange for interviews with new young cadets entering the organisation PHU undertake three-month Indigenous Immunisation Outreach project with referral to 'Indigenous friendly' general practices where possible
Analysis and formal reporting	Qualitative findings analysed, including staff patient relationship model Contextual mechanisms within the practices analysed	Intensive work with supervisors Consultation with academic familiar with automatic text analysis IUIH chronic disease outreach team involving mainstream GP patients consulted to review qualitative findings Qualitative research writing masterclass with Kathy Charmaz	Interpretation of qualitative data suggests divergence of views about importance of staff-patient relationships. Literature and informal feedback from IUIH suggests possible next steps in supporting sustained Indigenous service development support for mainstream practices; however, study data does not encompass policy or upper level local managerial perspective	Importance of staff-patient relationship model supported by textual analysis and by IUIH staff consultation Working towards publication of findings Short term mentorship by Professor Justin Jagosh (RE methods expert) offered by employer at School of Public Health, UQ, with aim of developing further project in collaboration with IUIH and Primary Care Networks.

5.10 Conducting the workshops

5.10.1 Workshop delivery

There were two workshops, one for each of the intervention groups. The venue was the usual education venue, Inner North DGP meeting room and a local hospital meeting room in the Outer North DGP area. Sessions were delivered similarly at each workshop. A local Indigenous community member presented a short talk on Indigenous cultures, and three Indigenous professionals gave presentations as follows: an epidemiologist discussed immunisation and timeliness, a health administrator presented on Closing the Gap initiatives outside practices and local community resources, and a Centrelink officer discussed Indigenous identification and welfare issues. The DGP worker presented Medicare items and incentives, and I as the local public health physician presented on health issues and treatment outcomes. Presenters determined the content details of sessions, and all presenters were aware of the materials in the PIPCGP Toolkit.

The two intervention groups were launched in a staggered fashion, the second five months after the first (see PIPCGP timeline). In transferring the intervention to the second area, it was agreed that the same package of materials would be used, that a local Indigenous person who already has some association with the DGP present Indigenous cultural orientation, and that Outer North DGP staff would complete audits in the recruited intervention practices of their area. Improvements were made to the package for the second workshop, and electronic copies of materials included. The electronic copies were also distributed to the first intervention group on request of the DGP support officer.

5.10.2 Feedback from the workshops

Administrative staff were generally happy to be offered education with clinical staff and found the sessions useful. Workshop evaluations returned by participants were generally positive for each of the sessions. Cultural communication sessions devised and delivered by local Indigenous people were regarded as useful by both clinical and administrative staff. Participants reported improved confidence to ask the Indigenous-identity question at the immediate evaluation, and this was a topic brought up frequently at interview, where staff discussed a successful change in their approach and positive responses from patients. Secondly, the information gained about local Indigenous organisations from the speakers was valued.

The idea that identification, additional immunisation and screening, and in some situations subsidised medicines could help existing patients of the practice was a frequent positive

point of discussion raised by the participants. It was confirmed that for some of the practices, the number of Indigenous children immunised by the practice, according to Queensland VIVAS data, was higher than anticipated by practice staff from practice records.

VIVAS had no parental registration process. Indigenous identity, when reported by one provider, was applied to the whole record. Most children had multiple providers who may or may not have reported Indigenous status. Infants had often been identified at the birth hospital or at an Indigenous-specific service that was attended for immunisation, but had not been identified by the general practice immuniser. It was therefore likely that the number of families to whom the practices were providing medical care, and potentially providing health checks, was higher than evident from practice records.

Concerns of non-clinical staff centred on *asking the question* to determine Indigenous status, and time management within the practice for health checks. Clinicians discussed difficulty with recording Indigenous status in their records, and in using practice software to record the assessment and prompt follow-up.

Some clinicians were surprised about the prevalence of reported Indigenous health problems in reports that were discussed. These included the high burden of disease in non-remote areas,³³ a high rate of pertussis hospitalisation in infants,²⁷⁷ middle ear disease in urban schoolchildren,²⁷⁸ and adult obesity and depression in an urban group.¹⁷⁶ Studies about the mental health effects of racism amongst Indigenous people^{111,279} seemed to be new information to the clinicians. Urban social determinants of Indigenous people²⁸⁰ and recommended positive strategies to recognise capacity and promote resilience based on the Australian Medical Association national 'Report Card' of 2009²⁸¹ were also discussed in a presentation. Discussion of studies that suggested the possibility of racism in hospital settings manifest as lower rates of procedural care^{282,283} were challenged by clinicians, and one vocal participant in the discussion about racism in healthcare decided not to proceed to PIPCGP study participation.

A particular concern raised at the Outer North workshop was the requirement for practice accreditation, as a pre-requisite for access to Medicare practice incentives such as chronic disease care-planning items for patient billing. Unlike the Inner North group, there were several unaccredited practices represented at the Outer North workshop. DGP staff later confirmed that practices were more often opened and closed down in the Outer North, and

that they were aware of a lower level of practice accreditation in this area of rapid population growth.

Points of confusion discussed by clinical staff were how best to share health-check activity components between staff of different disciplines, and the criteria conferring eligibility for Close the Gap notation of prescriptions to enable access to low-cost prescribed medicine. Of further concern to clinicians was the lack of accredited, accessible cultural training, to fulfil conditions of the Indigenous Practice Incentive under Medicare. Support officers took up issues raised at the workshop in practice visits and in the Divisional newsletters. Examples were the sourcing and distribution of a software template for health checks produced by a DGP from another state, and a newsletter feature on Close the Gap prescribing. At interview and on support visits, there were several requests for the DGP to include more information on Indigenous organisations in their online directory of services, which was done. The issues were also further explored in interviews with practice staff (see Chapter 7).

5.10.3.1 Feedback on the toolkit

My visits to practice staff members for arranged interviews were an opportunity to observe usage of the toolkit. Often the package box (containing parts 1, 2 and 4) was sitting on a shelf in a private space, which was sometimes accessible to other staff, and sometimes not. Usually but not always, the patient promotion materials (part 3) had been removed for use. The principal doctor, or sometimes a nurse, often had the disc at their computer, suggesting that electronic format materials can more easily be used and shared, even within the practice setting.

Examples of demand and observed use of each part of the toolkit are as follows:

Part 1: A GP from the first workshop asked for two extra print copies of the compiled readings, one for his personal use and one for his son, a medical student. Three GPs from the second workshop (who received electronic rather than print copies) asked for print copies of the reading book. Other than these specific cases, the readings about Indigenous health were used mainly by the workshop participants and not shared with other staff in printed form. There was some sharing of electronic copies.

Part 2: Practice guidelines and tools were asked for in electronic format by those who had received them in hard copy and were actively shared with other practice staff.

Part 3: Much of the promotional material was actively used by the practices, including:

- Three-flag lapel pins were valued and often worn by staff members in their workplace. Interviews indicated these were a point of conversation and connection between the staff member and Indigenous patients.
- ‘Update your details’ tear-off pads were used by about half of the intervention practices. Others adapted the questions for their own practice stationery including the new patient registration form.
- ‘Prickle on Time’ Indigenous immunisation schedule posters were often displayed in the waiting room or a consulting room, and the associated postcards were left out in waiting rooms. Several practices asked for repeat supply from the PHU. The Outer North DGP and an associated Indigenous community group used the artwork to produce similar postcards promoting the Indigenous immunisation schedule.
- The patient-held record card was used by few practices and by those only temporarily. However, its use was taken up by some Indigenous-specific services in the area (e.g. promoted by the community health worker who worked with *Indigenous-friendly* practices).

Part 4: The research tools were accepted and used with few additional questions.

The Division’s Close the Gap worker for intervention practices devised an additional promotional resource. This was a small, laminated sign for the practice entrance displaying the three flags symbol (Australian, Aboriginal, and Torres Strait Islander), similar to that on the lapel pin. The sign announced that the practice was part of a project to improve preventive care for Aboriginal and Torres Strait Islander people attending the practice through immunisation, health checks, and follow-up care. Staff members interviewed valued this sign, and almost all practices displayed it throughout the intervention period.

5.11 Audit process and support

5.11.1 DGP support

Practices recruited to the PIPCGP study agreed to aim to improve their Indigenous preventive-care procedures over the coming 12 months. On receipt of consent to participate in PIPCGP after the workshop, audit visit times were negotiated, with the aim of completing the first audit within a four-week period.

A typical practice visit and audit took between one and two hours. Some audits had to be completed over two visits to allow for resolution of practice software issues and the editing and resending of immunisation data that had failed to transmit prior to the practice immunisation report being generated from Medicare. Because of the high amount of missing data from Indigenous children’s immunisation records, practice overdue reports for the Indigenous children could not be relied upon. Each identified child’s record needed to

be printed out and deemed up to date or overdue. Children aged two to five years were scheduled to receive a common list of vaccines; however, often these were recorded by vaccine formulation rather than antigen in practice records, making this a task that required specialised knowledge.

The needs of practice staff for knowledge regarding data-transmission monitoring, establishing the data item of Indigenous status in the practice electronic information system, and other issues to do with instituting review and recall/reminder were recognised by DGP staff. The need was met by more practice visits, telephone advice, and the production of a booklet on immunisation data management in practices, which was distributed widely. The result of each audit was given back to the practice at the time and discussed with their representative. I produced feedback reports comparing individual practices with group results—twice for Inner North practices and once for Outer North practices. Audits coincided with support visits, and there was further contact for support by telephone, as workers fielded calls from the practices for help, mainly with practice software issues. A summary report of audits was produced for each DGP and for the IUIH.

5.11.2 PHU support

As practice immunisation data was ascertained to be incomplete, PHU staff worked with practices in the group who wished to update their Indigenous child-immunisation data. Requested missing data was provided. Immunisation records of children listed on the VIVAS database as Indigenous, who had most recently been immunised at the practice, were also provided. This was thought to be important as these Indigenous children may otherwise miss recommended Indigenous-specific vaccines. This provision of Indigenous-identified information to the practices was a new step. It was preceded by discussion with and approval of the local Indigenous immunisation reference group that advised the PHU, which produced a guideline for public health staff on sharing of Indigenous identification of children with the parent's preferred immuniser (see figure 5.3). This guideline was further developed to apply to the state as a whole and elevated to and approved by the National Indigenous Immunisation Advisory Group of the National Centre for Immunisation Research and Surveillance in Sydney in 2010, to be used in a state-wide project of follow-up of overdue Indigenous children, based on national register data. Follow-up could potentially have an impact, as the Indigenous-identified younger age groups of children on the national register were now of similar size to that of the estimated population.

5.12 After the intervention

The end of the intervention period coincided with the Outer North DGP being subsumed by the Inner North DGP as a newly formed Medicare Local. Soon after, local practice-support work for Indigenous issues was contracted to the IUIH, who sought to work initially with the general practices that had higher numbers of Indigenous patients. The IUIH later went on to develop a group of chronic disease care coordinators, clinical nurses who worked for individual patients both in the community and directly with practice staff, across practices and across secondary and tertiary health services in the local area.

Principles for Public Health Unit Follow up of overdue Indigenous children identified monthly from ACIR

Developed by Queensland Health Indigenous Immunisation Advisory Committee, and endorsed by the National Aboriginal and Torres Strait Islander Immunisation Group, 2010.

Public Health Unit staff in following up the list should:

- Determine follow up method locally through public health unit initiated consultation with key stakeholders including the local Community Controlled Health Service (CCHS), the Health Service District, the local Division of General Practice, and the local government immunisation service. Where a local CCHS does not exist, other local Indigenous community organisation or representatives should be involved.
- If possible, first contact with the family should be by an Indigenous Health Worker.
- The initial contact should be made by phone, and if unsuccessful, consider sending a letter.
- Parents/carers should understand that, no matter who contacts them, they have the option to immunise their child at any service they choose including their local CCHS.
- Parents/carers should have the opportunity to opt out (i.e. not have their child vaccinated).
- Where Outreach Services are available, this should be an option presented to the parent/carer. Identification of neutral locations for immunisation may be necessary if the child's home is not appropriate.

Figure 5-5 Principles for PHU follow-up of overdue Indigenous children identified from ACIR

Source: Queensland Health Immunisation Unit, 2011, Internal document.

5.13 Summary

There were many challenges in conducting the intervention by collaboration across organisations in a time of rapid administrative change in the support organisations themselves and in the desired practice and remuneration scheme. Within practices, the audit-collection process showed that data management was not keeping pace with new requirements.

Workshops and support were an effective means of communicating procedural change in relation to Indigenous identification, and of establishing the study. Some clinicians lacked knowledge of health problems of Indigenous people and some seemed blind to racism within healthcare; however, most were eager to discuss Indigenous-identification processes with Indigenous people and to hear more about the local Indigenous community. All practice team roles were effectively engaged in the discussion. The doctors anticipated availability of on-line training from the RACGP to supplement their workshop activity.

Staff-information resources provided in electronic format were best utilised by practices. In addition, a three-flag practice-entrance sign, three-flag lapel pins, and Indigenous immunisation posters and postcards were popular resources utilised for promotion of the study and of services to Indigenous patients. Support mainly took the form of advice on software issues and data management. These were ongoing issues. Practices sought more contact with Indigenous organisations and resources than was available. The workshop and information resources only partly met these needs.

An unanticipated and positive outcome was that the intervention helped to draw attention to the PHU-support role in Indigenous immunisation, and the ethics of Indigenous-status disclosure between providers. Resolution of this issue occurred in that Indigenous community representatives and mainstream supporters agreed on a protocol for sharing information for the benefit of Indigenous children. Another outcome of the intervention, which underlined its appropriateness, was that the knowledge gained by the DGP about local practices enhanced their planning of further support. Commissioning of support to an Indigenous organisation (IUIH) was undertaken, targeting practices with a high number of Indigenous patients.

Chapter 6 **Audit findings**

6.1 Overview

This chapter primarily addresses the second research question: What were the effects of the intervention in mainstream general practices on Indigenous identification, immunisation, and health checks? In describing retention of recruited participants and activities changed, it also provides evidence of the appropriateness of the intervention, to complete the answer to the first research question.

The chapter sets out the results of audits undertaken within the two groups of practices. Inner North practices had a high level of support, received the results of four audits and had high retention of participating practices. Outer North practices received a lower level of support, received the results of pre and post intervention audits, and half the practices dropped out of the study. Change in Indigenous identification, health-check coverage, and Indigenous child-immunisation for the two groups are described and analysed. There was a large increase in Indigenous identification, associated with change to routine practice procedures: current patients were identified as Indigenous and new Indigenous patients attended the practices. There was a varying smaller change in health-check activity and no discernible change in immunisation activity. A group of “high activity” practices was recognised that commenced with a higher number of Indigenous identified patients and had already commenced offering checks. Most of these were able to achieve a higher number of health checks during the intervention period. A complicating factor for the Outer North group was lack of eligibility for the Indigenous Health Practice incentive. Intervention using progressive audit and support was successful in engaging practices over time.

6.2 Recruitment and retention within the PIPCGP study

As previously described, practices self-selected based on interest to attend a workshop that, while offering education, also offered participation in an intervention study. There was a high rate of recruitment of practices from the workshop (table 6-1). Following the first audit, a small proportion of practices withdrew in the Inner North group. There was a high rate of attrition in the second, Outer North group after a few months.

Table 6-1 Recruitment and attrition in the two PIPCGP study groups

Group	Start time	Attended workshop	Consented to participation	Withdrew during intervention	Completed 12-month intervention
Inner North	July 2010	18	14 + 1	2 (13%)	13 (87%)
Outer North	December 2010	12	8	4 (50%)	4 (50%)

Source: developed by the author

Fourteen Inner North practices were recruited to the first intervention group at the workshop, and one afterwards (see section 5.7.3). One of the practices withdrew after the first audit, giving the reason that the number of Indigenous patients was low. A second withdrew at this time, as their patient-information system (Monet Clinic[®] - now no longer available)²⁸⁴ could not be utilised to derive the audit information. There were no further withdrawals from this group. Eight Outer North practices were recruited to the second group. Two practices withdrew, giving the reason that their Indigenous patient numbers were low, and two others withdrew, giving the reason that their practice was ineligible for the Medicare Indigenous Health Practice Incentive payment scheme (PIP IHI) as their practice was unaccredited. The recruited practices, staffed by 90 doctors, varied from a solo GP practice to very large practices with extended opening hours. The groups on completion consisted of 6.5% and 6.1% of their respective DGP total practices, and 8.5% and 11.2% of their respective DGP number of doctors. (See section 5.3 for a description of the DGP practices.)

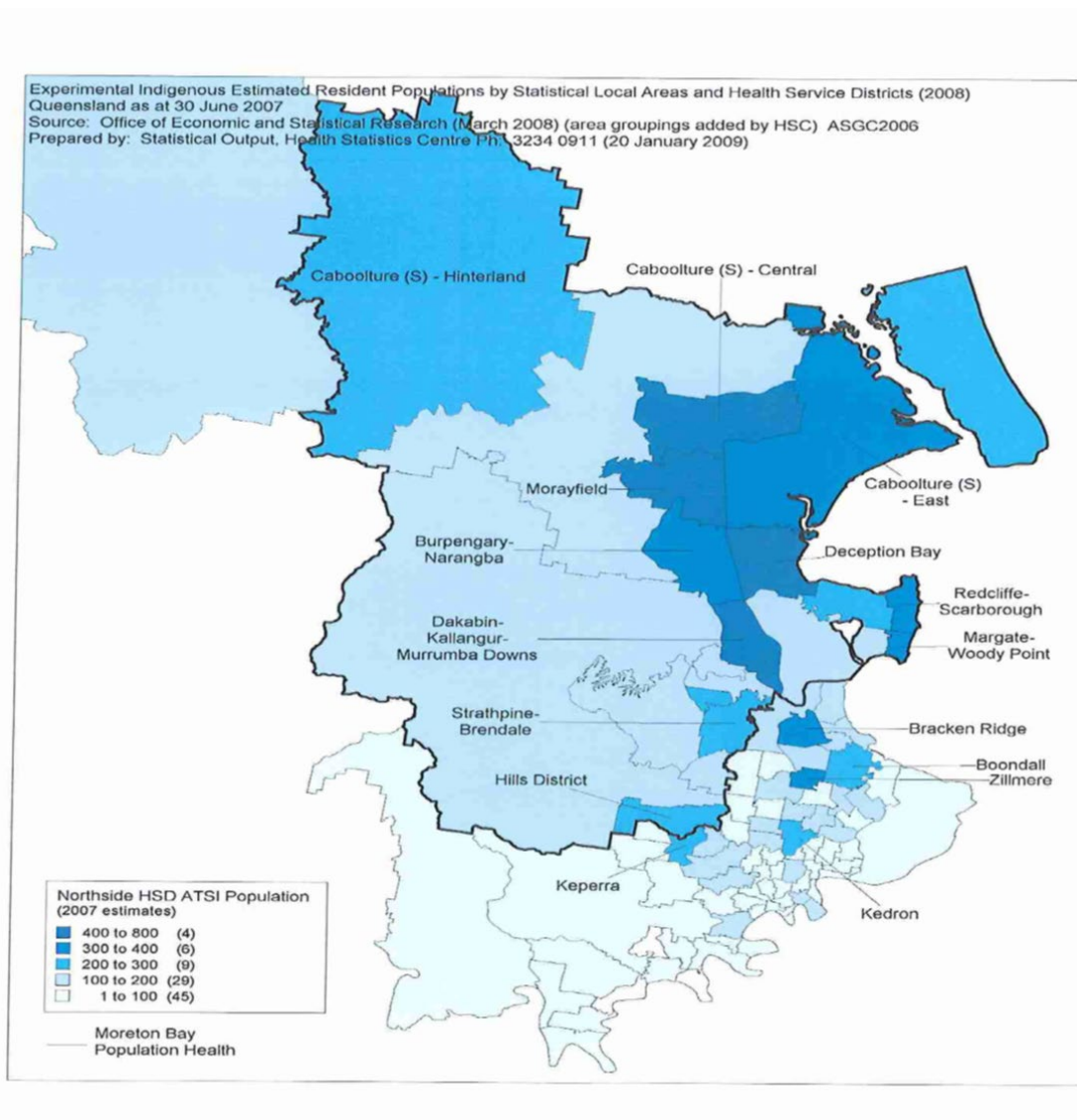


Figure 6-1 Population density of Indigenous people in the Northside Health Service District

Source: ABS. Metro North Hospital and Health Service District internal report, 2009.

Table 6-2 Distribution of study practices by estimated local numbers of Indigenous residents

Areas by population density		400-800	300-400	200-300	100-200	All areas
Practices completed intervention	Inner North	2	2	9	0	13
	Outer North	3	0	1	0	4
Practices withdrew before completion of intervention	Inner North	0	1	0	1	2
	Outer North	4	0	0	0	4

Source: developed by the author

6.2.1 Indigenous population of the local area relative to recruited practices

While not all of a practice's population comes from their local area, geographic studies show that most patients, and particularly patients with low incomes, are likely to use primary healthcare services close to home.²⁸⁵ A map of the study area describes Indigenous people by count, for statistical local areas (See figure 6-1). Recruited practices were predominantly from local areas with higher Indigenous populations. One of the two practices that withdrew from the Inner North group was from an area with the lowest concentration of Indigenous people. All of the practices in the Outer North were in areas of higher Indigenous population with 200 or more Indigenous residents.

6.3 Indigenous identification became routine within the practices

Prior to the intervention, most practices in the area would have had access to posters featuring Indigenous artwork, including immunisation and healthy lifestyle promotion, provided by the Queensland and federal governments. More than half of the study practices already displayed Indigenous images prior to intervention, usually in the form of posters. Less than half, however, promoted Indigenous status identification and/or included Indigenous identification on their new patient form. Relatively modest changes to the model of practice were able to be implemented quickly in the practices. By the end of the intervention, all study practices displayed Indigenous images, all promoted Indigenous identification through the use of specific educational brochures and/or posters available in the waiting room, and most practices had included Indigenous identification on their new patient form.

Table 6-3 Changes in Indigenous identification procedures in the study practices

Group	Displayed Indigenous images in the practice	Promoted Indigenous identification	Included indigenous identification on their new patient form	Total
Inner North before	9	6	6	13
Inner North after	13	13	10	13
Outer North before	3	0	0	4
Outer north after	3	4	4	4
All practices before	12 (71%)	6 (35%)	6 (35%)	17
All practices after	16 (94%)	17 (100%)	16 (94%)	17

Source: developed by the author

Table 6-4 Audit of Indigenous-patient identification and health checks for the practices by intervention group

	Inner North	Outer North	Total
Number of practices	13	4	17
Pre-intervention number of Indigenous patients identified on practice records	883	397	1280
Post-intervention number of Indigenous patients identified on practice records	1571	787	2358
Percentage change in Indigenous patients identified	78%	98%	84%
Indigenous health checks claimed in four months pre-intervention (% initial patient group)	49 (6%)	48 (12%)	97 (8%)
Indigenous health checks claimed over the intervention period (% final patient group)	298 (6%)	N/A	N/A
Indigenous health checks claimed in four months at end of intervention	72	21	93

Source: developed by the author

There was a large change in Indigenous-patient numbers identified within the practices—an 84% increase. For the first group of practices, progressive audits showed the increase occurred steadily throughout the period. The number of patients identified represented 31% of the estimated Indigenous population of the DGP at the time.

The Indigenous-identified group of patients in the PIPCGP study practices at the end of intervention numbered 2358. Although some patients would have had records with more than one practice, there was no way to determine this. In addition, many practices had not removed inactive patients from their database, so the total Indigenous-patient number at the beginning of the period may have included inactive patients

All practices, with the exception of one in the first study group, increased their number of Indigenous patients. At the end of the intervention period, the highest number of Indigenous-identified patients in a single practice was around 500, and there were six practices with 100 or more Indigenous-identified patients. The overall increase was 78% in the Inner North and 98% in the Outer North. The increase was more marked in the second intervention group, where there was a larger change in specific promotion of Indigenous identification within practices. The final patient population of the Inner North practice group represented around 31% of the estimated Indigenous population served by the DGP.

6.4 Health-check activity increased at a slower rate than identification

For the Inner North group, 52 health checks were conducted in the three months before intervention, and 326 checks were conducted during the 12-month intervention period. Progressive audits showed a steady increase in the number of patients, and a rise then fall in health-check billing. The regular audits allowed an estimate of checks billed over the 12-month period for the Inner North practice group

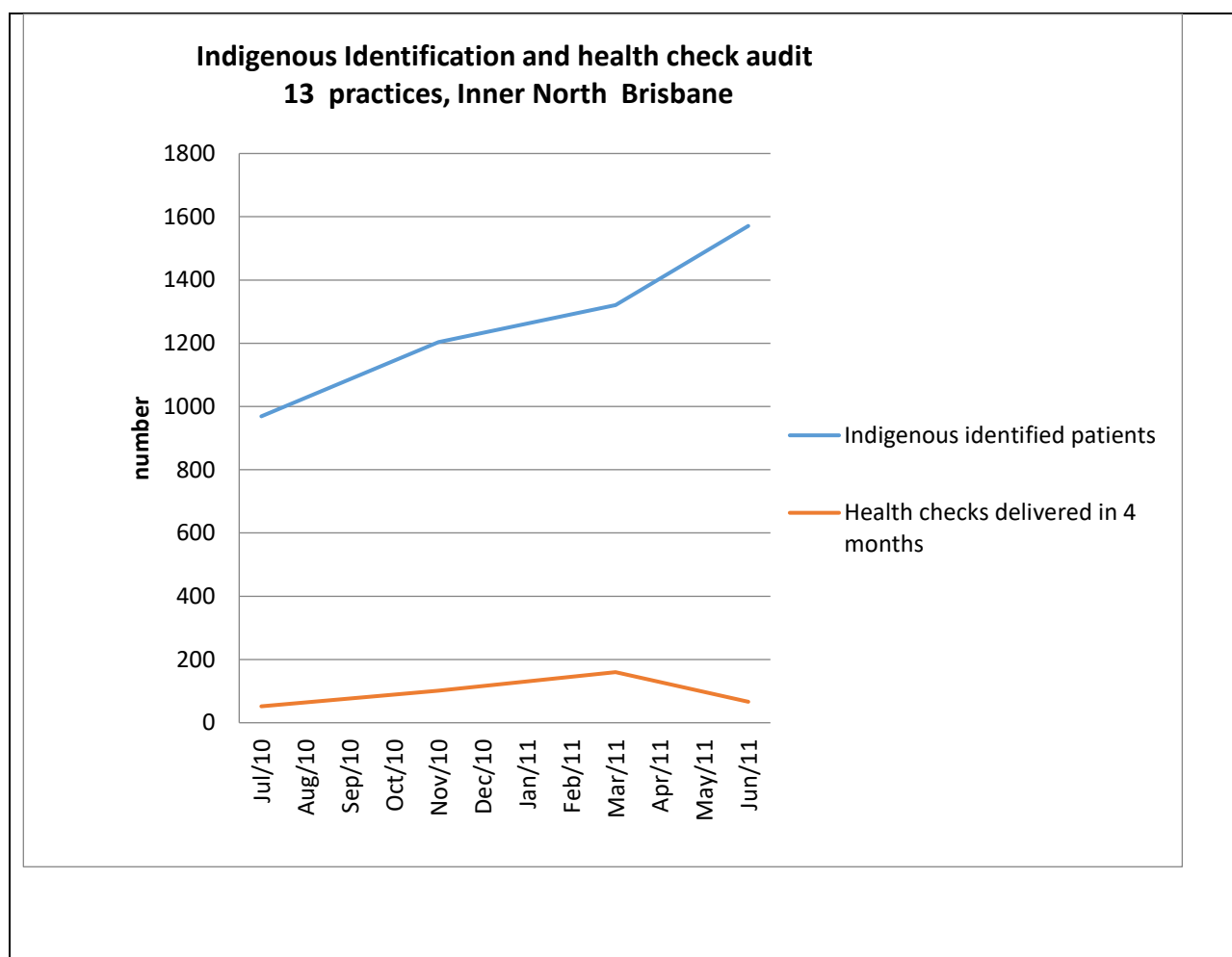


Figure 6-2 Audit results of the Inner North group of practices

Source: developed by the author

In comparison with the local area, during the immediate pre-intervention period the intervention practices of the Inner North billed 30% of the Division's Indigenous health checks. Over the intervention period, the proportion delivered increased to 47% of the total, indicating that this group was improving at a faster rate. These numbers are also indicative of a below average level of health-check activity for the study area. The national average health check coverage was 10% on reporting at the time, and 11% in retrospect.¹⁸⁸ For the Inner North's estimated Indigenous population, 177 checks per quarter would have reflected the national average, a level that was surpassed in the third quarter of the Inner North study period (see figure 6-3). Only one of the Outer North practices was shown to have billed health checks prior to the intervention, and the discontinuous gathering of audit data did not allow reporting on health checks billed over the 12-month period.

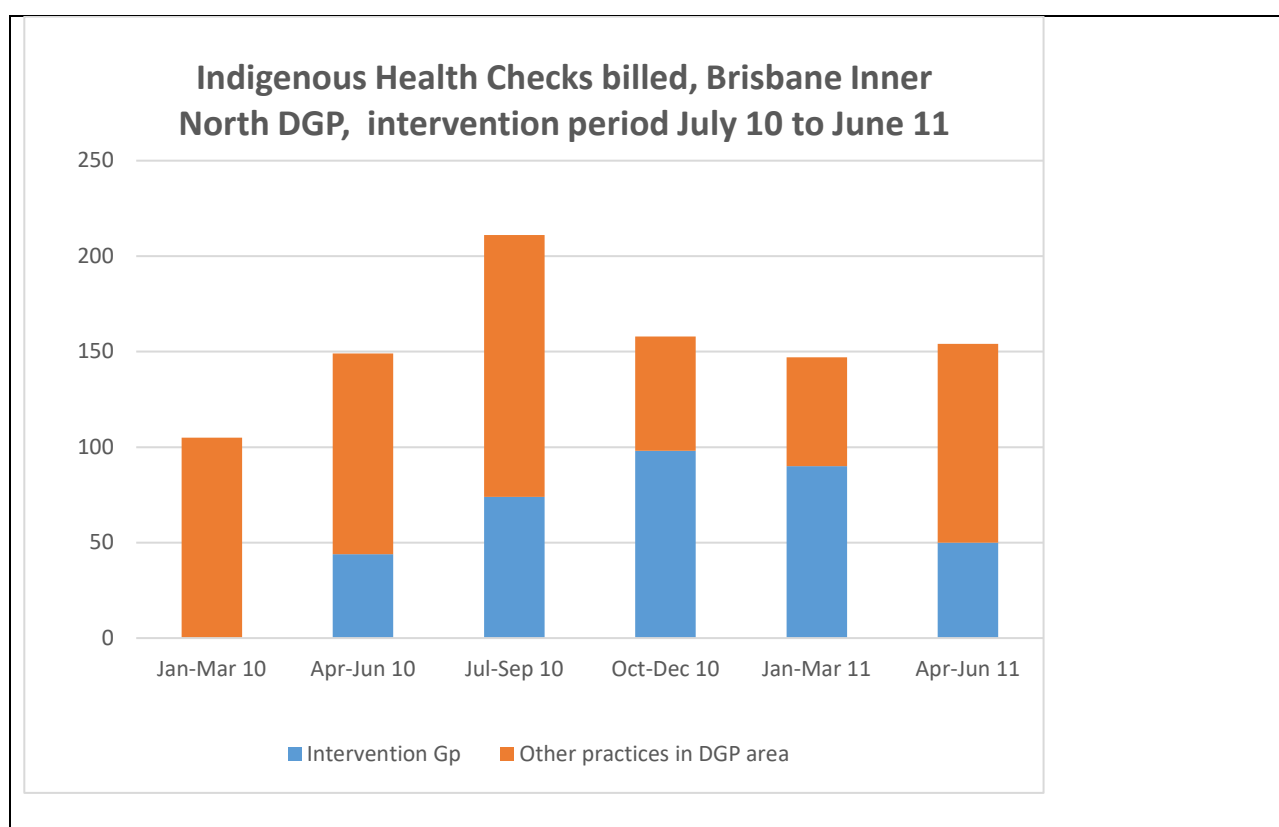


Figure 6-3 Number of health-check claims to Medicare by practices of the Inner North study group, and by other practices of the Inner North DGP, Jan 2010

Source: developed by the author

6.5 Comparison of high-activity and low-activity practices

High-activity practices were defined as those that had identified 150 or more Indigenous patients at the end of the intervention period. There were five practices that met this criterion. With the exception of one that was a newly established practice, these high-activity practices were the group that started with more than 120 Indigenous patients. High-activity practices included medium and large practices. Three were in localities with 400 to 800 Indigenous residents, the remainder in localities with 200 to 300 Indigenous residents (see table 6-2). Two of the practices had an Indigenous staff member and two others had a doctor who had previously worked in an ACCHS. Two had specific injection of funds or resources to support the tailoring of service for Indigenous people, and these two joined an Indigenous health General Practice Collaborative Group at the beginning of the study period. (See further discussion of General Practice Collaboratives in section 8.2).

Table 6-5 Audit of Indigenous-patient identification and health checks for the practices by outcome group

	Low Activity	High Activity	Total
Number of practices	12	5	17
Pre-intervention number of Indigenous patients identified on practice records	517	763	1280
Post-intervention number of Indigenous patients identified on practice records	695	1663	2358
Percentage change in Indigenous patients identified	34%	118%	84%
Indigenous health checks claimed in four months pre-intervention	54	76	97
Indigenous health checks claimed in four months at end of intervention	9	84	93
Percentage change in number of checks claimed	- 83%	11%	- 4%

Source: developed by the author

At the initial audit, all five of the high-activity practices already displayed Indigenous images in the waiting or clinic room, and three promoted Indigenous identification using printed material, however only two included Indigenous status as a data item on their new patient information form. Four had been undertaking health checks. Those of the Inner North group (whose health check numbers were accumulated over the study period) provided 20% or more health check coverage over the 12 months for their end-of-intervention Indigenous-identified patient number. The exception within this group was one bulk billing practice that actively identified and welcomed new Indigenous patients, but did not undertake delivery of health checks at all during the study period.

Of the low-activity practice group, around half commenced with 50 to 99 Indigenous-identified patients, and the rest with a smaller number. These practices were at the outset less familiar with the intervention's methods. Only two had provided any checks in the months before intervention and these were few. The majority of this group commenced or continued health check activity during the intervention, increasing activity towards the end and providing 10% or less coverage for their patient group, with the exception of one

practice with a very small number of Indigenous-identified patients, that did not commence offering health checks during the study period.

A standout, high-activity practice had a large Indigenous-identified patient group at the outset, was already engaged generally with the community, and received Indigenous Health Worker support and community transport as the result of negotiation with Queensland Health. The principal doctor had previously worked in an ACCHS, and the practice had already developed a model of care in partnership with a local Elders group, which had been documented in a published article.²³³ This practice undertook twice as many health checks as any other practice over the study period. At interview, comment was made that the clinic had completed health checks on most of the patients who had been willing to have them, so a decrease in activity was anticipated by them over the intervention period. Compared with other practices, this practice's activity increased at a greater rate. To explore the effect of the GP Collaborative intervention and resources in addition to PIPCGP in two practices, their audit results were compared with the other study practices. The effect of additional intervention plus additional resources together was certainly greater than PIPCGP alone. (See table 6-6).

In summary, these varied conditions meant that audit findings did not only reflect the effect of the PIPCGP intervention. It could be said that overall there was a steady and substantial rise in Indigenous identification associated with implementation of an appropriate procedure within practices, and that there was a minor increase seen in health check activity, most marked around six months after intervention,. There was some evidence in one study group that health check activity increased at a faster rate than for other local practices in one study area. Further, practices with additional intervention together with additional resources were more successful in delivering health checks.

Table 6-6 Audit of Indigenous-patient identification and health checks for the practices with and without additional measures

	PIPC	PIPC + additional measures	Total
Number of practices	15	2	17
Pre-intervention number of Indigenous patients identified on practice records	931	349	1280
Post-intervention number of Indigenous patients identified on practice records	1442	916	2358
Percentage change in Indigenous patients identified	55%	162%	84%
Indigenous health checks claimed in four months pre-intervention	47	50	97
Indigenous health checks claimed in four months at end of intervention	36	57	93
Percentage change in number of checks claimed	-23%	14%	-4%

Source: developed by the author

6.6 Incomplete immunisation records made catch-up difficult

In the Inner North group, immunisation records within the general practices were determined to be incomplete for 61% of two- to five-year-old children at the beginning of the project. It was unclear from the audit data whether positive change in coverage occurred.

The planned audit procedure used ACIR reporting of children overdue at practice level with coverage of additional Indigenous schedule vaccines to be added. On detailed review of child records and initial audit results for inner north practices, it was discovered that the ACIR report was based on completeness indicated by four doses of Hib vaccine, whereas

at the time in Queensland, generally three doses completed the schedule. A different vaccine was in use in Queensland, an Hib PROMP-type that required fewer doses to be given. This report was used at the time as the basis for immunisation practice-incentive assessment. Queensland later reverted to the more commonly used type of vaccine. This meant that ACIR reporting could not be utilised for the audits. Individual records had to be reviewed, which was time consuming. The support officer in the Inner North was able to compare the practice record and ACIR record, highlighting missing data.

At the time of each audit, where incomplete records of children were identified, on request PHU staff retrieved data from the Australian Childhood Immunisation Register (ACIR) and the Queensland database, to provide a complete record to the practices so that any missing data could be added to practice records. A small number of doses, recorded at the practices but unregistered, were identified and added to the national register. At the end of the project, only 8% of the identified children had immunisation data missing. The practice-based up-to-date count therefore largely reflected the updating of missing data (See table 6.7).

Table 6-7 Audit of number of Indigenous-identified children aged two to five years and immunisation record completeness, Inner North group of practices

	Pre- intervention	Post- intervention
Number of Indigenous children identified on practice records	100	182
Number of Indigenous children with no immunisation data missing from the practice record (%with no immunisation data missing)	39 (39%)	167 (92%)
Number of Indigenous children with all immunisations up to date on practice records (%)	26 (26%)	84* (46%)

*Immunisation records verified and updated based on register check

Source: developed by the author

The immunisation records of the outer north practices were similarly assessed in an initial audit, however remained unaudited at the end of the PIPCGP study period, because of lack of divisional staff capacity. The DGP office's funding base was in doubt at that time, and project work could be only minimally supported. The PHU was able to provide a report

based on the practice and register records of identified children, with specific permission of the practices, and provide missing dose administration–information to practices.

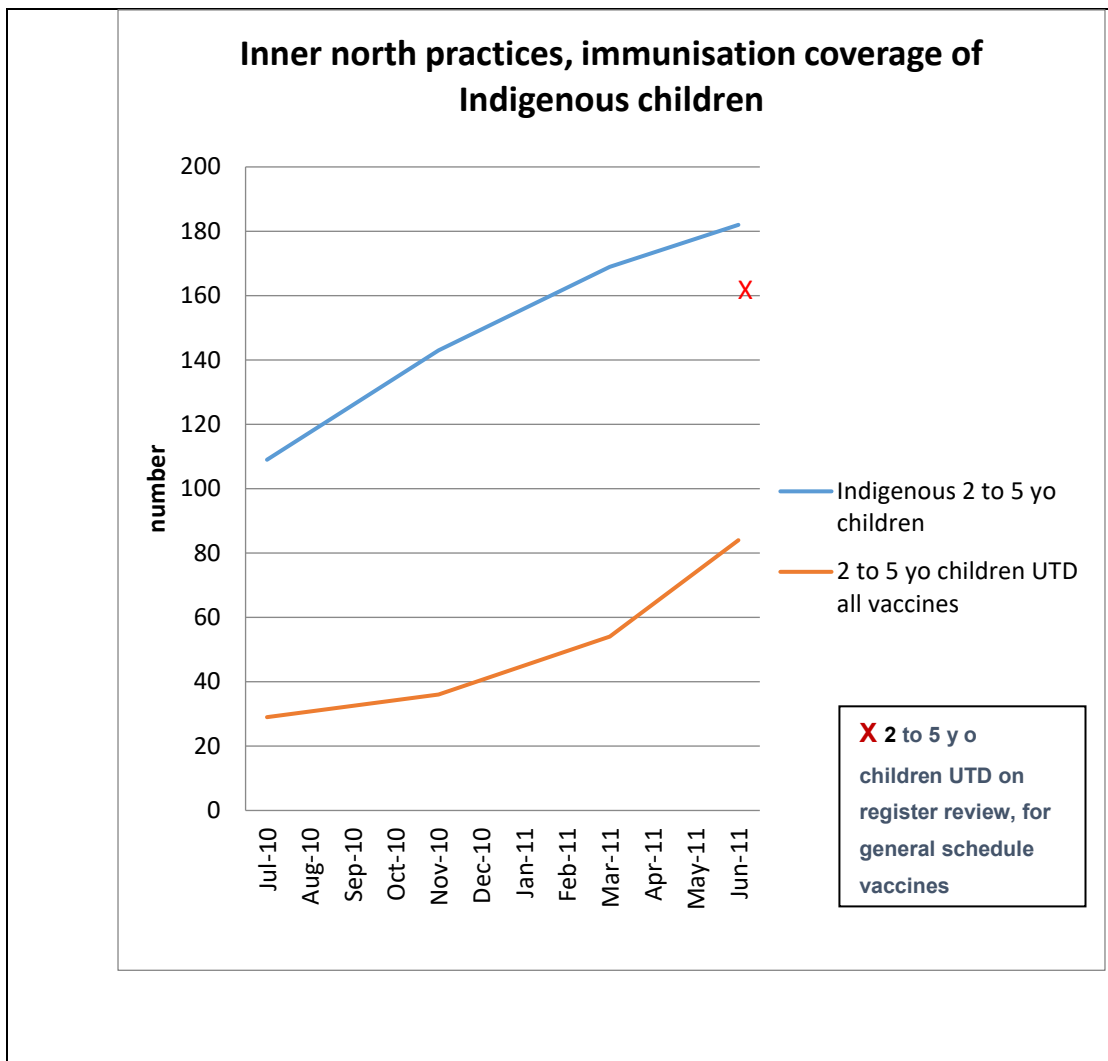


Figure 6-4 Immunisation audit results for the Inner North group: Number of Indigenous identified children aged two to five years, and number of those children up to date for all vaccines, including both general and Indigenous-specific scheduled vaccines

Note: Comparison with register review of general schedule vaccines for these children is included. UTD = up to date for scheduled immunisations.

Source: developed by the author

The immunisation records of the outer north practices were similarly assessed in an initial audit, however remained unaudited at the end of the PIPCGP study period, because of lack of divisional staff capacity. The DGP office’s funding base was in doubt at that time, and project work could be only minimally supported. The PHU was able to provide a report based on the practice and register records of identified children, with specific permission of the practices, and provide missing dose administration–information to practices.

6.7 Immunisation coverage was low for Indigenous-specific vaccines

A review of individual immunisation records of children of the Inner North group was undertaken at the time of the last audit by the PHU, and this confirmed that many children were in fact up-to-date. Of 175 children, 155 (89%) were up-to-date for the universal schedule vaccines by age included on ACIR reporting (i.e. DTP three or four years, polio three or four years and MMR one or two years). This represents coverage similar to that achieved nationally for general schedule vaccines. However, only 40% of children had received two doses of hepatitis A vaccine and 50% had received pneumococcal 23 vaccine, the vaccines recommended in Queensland for 18 month and two-year-old children. This was similar to the state wide-coverage level.²⁰² For the four Outer North practices, 43% of two- to five-year-old children had missing data at the beginning of the project. No further practice-based immunisation data is available for this group.

Practice software varied in its functionality. Indigenous schedule vaccines often had to be entered as “other” vaccines, with no specific inbuilt recommended age or schedule or prompts for further activity. Data issues associated with effective transmission from practices to ACIR and of ACIR reporting made the immunisation audit process complex. Few divisional support officers had the expertise to deal with the more unusual situations. Individual audit reports were returned to GPs midway through the intervention period, highlighting the need to check electronic transmission to the register.

General practice staff were able to gain direct access to ACIR immunisation histories of their patients, but often did not undertake this search for information. Register record searches were offered by the PHU, to fill gaps in practice data. This offer was taken up by many practices.

6.7.1 Little change in immunisation coverage in northern Brisbane

The state's trend in Indigenous childhood immunisation coverage was increasing for children at two and five years, but static for children at one year (see figure 6-5). This was partly due to with frequent change in the infant schedule. There was an unusually large and sustained increase in five-year-old coverage of around 10%, to 85%, first evident at the beginning of the intervention period. NCIRS data analysis at the time of the 2010 national coverage report was presented for both five- and six-year-old children to describe this jump, which was thought to be related to introduction of a requirement for immunisation completion by the age of 60 months as part of the GP Immunisation Incentive Program.²⁸⁶

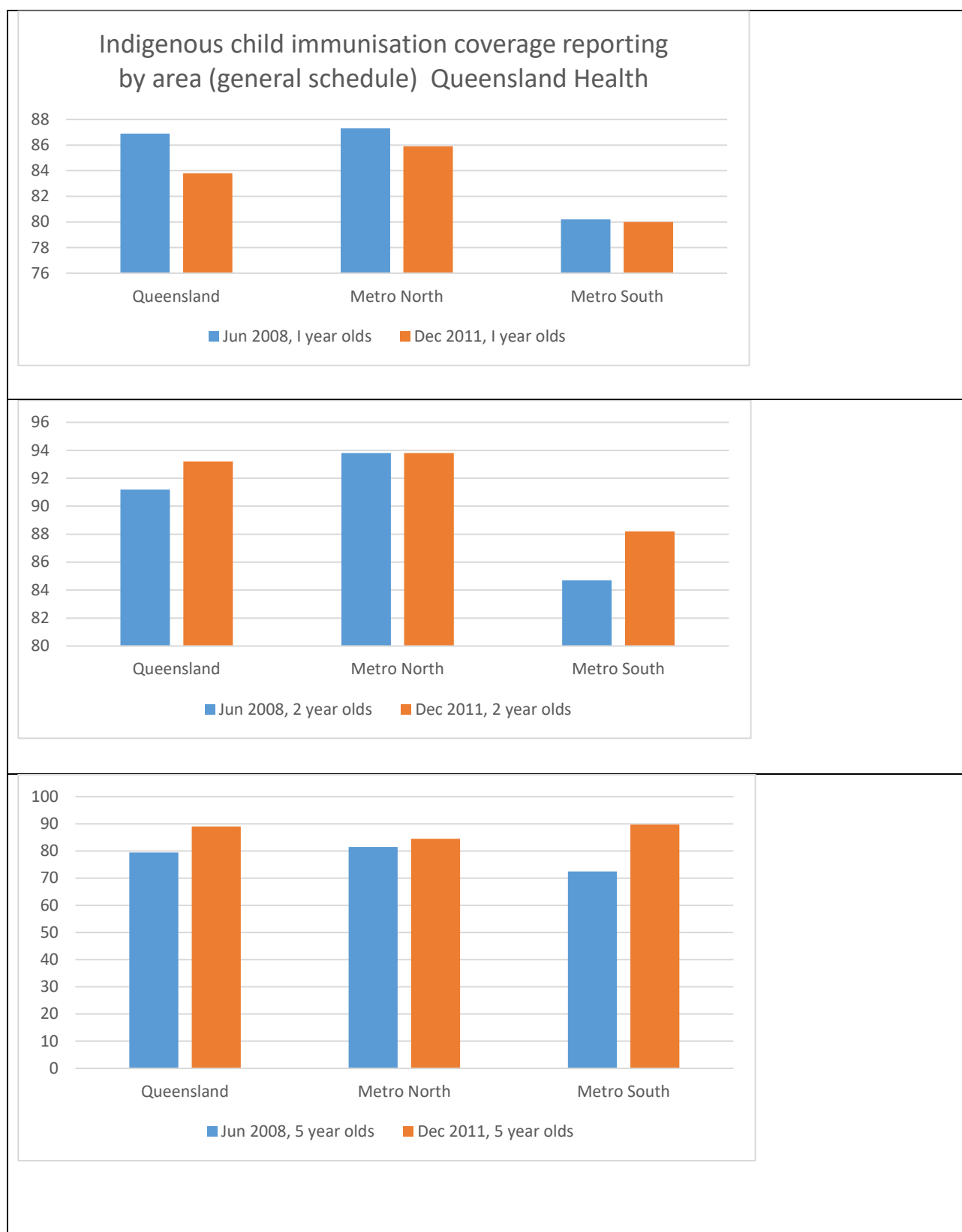


Figure 6-5 Immunisation coverage of Indigenous children by age milestone, June 2008 and December 2011

Source: Queensland Health, based on data provided for periodic reporting from ACIR to Queensland Health.²⁸⁶

In Metro North Health Service District, Indigenous five-year-old children had immunisation coverage higher than the state average prior to the intervention period, and the change

was smaller. Trend data for the Metro North Health Service District (equivalent to both study areas) between 2010 and 2012 for coverage of universal vaccines at age milestones up to five years showed small variations from one period to the next, as could be expected with small numbers of children. There was no specific effect evident from the intervention.²⁸⁶

6.8 Summary of findings

6.8.1 Successful aspects of the intervention recognised by participants

To answer the first research question, the PIPCGP intervention and study design were for the most part appropriate to the setting, and the collection methods were acceptable to the participants. The PIPC study has provided useful information for boosting implementation in motivated practices. The workshop, audit, and other data collections were relevant to PIPCGP participation. The multidisciplinary nature of the workshop fostered interdisciplinary discussion of practice objectives at the workshop and in later follow-up. Relevance of the intervention was attained by undertaking intervention development with local practitioners (doctors, a nurse, and administrators), and data collection by a practitioner experienced in general practice work.

Amongst the low-activity practices who undertook the intervention, few had previously undertaken health checks, and all improved their Indigenous-identification procedures. The increase in Indigenous identification was a positive reinforcement for these practices who remained enthusiastic in the second six months of the study. Around half of these practices newly implemented health-check activity in their practice during the second six months, with small numbers of patients. This suggests that there was a sustainable change in care offered.

6.8.2 Audit outcomes

To answer the second research question, the audits have documented some of the effects of the intervention, however interpretation is limited by other concurrent enabling factors whose effects cannot be fully separated. These include additional resources, another intervention with the same aim (a General Practice Collaboratives project) and community promotion. The effects were examined in two urban areas with differing characteristics. The first area was larger, well established and had a stable population size, with a high proportion of accredited practices and relatively more practice nurses. The second area was growing in population and had both a higher concentration of disadvantaged suburbs and a higher proportion of Indigenous people. Accreditation and eligibility for the PIPHI, as

well as a current recognised cohort of Indigenous patients, was necessary for mainstream general practice participation in Indigenous preventive care improvement within the study. Through the intervention which directly influenced Indigenous status ascertainment procedures, Indigenous status identification was able to be markedly improved, and more Indigenous patients attended the practices. Improvement in health check activity occurred at a slower pace, less slowly where health check practice was already established, where there were additional measures supporting quality improvement and where extra resources were available. The study design did not allow clear comparison between interventions, or comparison with non-intervention practices, as is often the case in evaluation in a natural setting.

Supporting data can be found from another source. The northern half of the study area was included in the Sentinel Site Evaluation (SSE) of The Indigenous Chronic Disease Package during this time period, as a sentinel site case study: “North Lakes/ Caboolture Tracking site”. The SSE area took in the PIPCGP Outer North area plus localities of a few of the more northern Inner North study practices. The outer north DGP boundaries were used to report on clinical indicator data compared with the estimated local Indigenous population for the period 2009 to 2012. The PIPCGP study period was associated with a rise in the rate of health-check payments and Indigenous health incentive payments over the period of PIPCGP intervention, including the period prior to the opening of an ACCHO in the area in August 2011, from around 1 per 100 Indigenous people to around 3 per 100 Indigenous people. During this time, in addition to the DGP Indigenous health project officers and outreach workers, there were two tobacco control workers and four healthy lifestyle officers working in the area from IUIH and later from the ACCHO clinic.

The SSE showed there was a rapid rise over the six months following PIPC, of a different order of magnitude for health assessments, to around 15 per 100 Indigenous people. This coincided closely with the establishment of the ACCHS. This data illustrates the major benefits of a local Indigenous service, which provided direct services and promotion of checks and healthy lifestyle, raising community awareness to enhance attendance at a large range of health services, through the Indigenous Chronic Disease Program.²⁸⁷

6.9 Comparison with another study showed similar findings

There was one similar intervention study in the literature, which achieved similar results: Liaw (2015) reported on the Ways of Thinking, Ways of Doing Cultural Respect Program, previously mentioned in section 3.6. This study linked Indigenous identification and health

checks, but not immunisation, and had more emphasis on cultural learning through engagement with a mentor. The intervention was conducted in the year following completion of the PIPCGP intervention, 2012–13, engaging a group of ten general practices, all of which were already undertaking Indigenous health checks and most of which were already enrolled in the PIP IHI. Outcome measures included chronic disease planning–billing and health check coverage which rose from 16% at baseline to around 22% six months later, in a total final group of 197 Indigenous-identified patients.¹⁷⁴ Liaw's intervention audit results showed similar increase in Indigenous identification from both existing and new patients, and more increase in health check activity, on a smaller scale for each practice. There was an average of 20 Indigenous patients per practice in Liaw's study, and the average number of Indigenous patients identified per practice in the PIPCGP study was 139.

6.10 Limitations regarding the audit and its interpretation

Lack of data availability was a limitation. Practice data for Indigenous child immunisation was found often to be incomplete at the first audit. The lack of a valid patient denominator for practices, where all patients over time were kept on the reporting list of their information system, was an additional issue. This was real-world research and limitations do exist. These data issues may have been better managed were I to have piloted the data collection.

If the audit results are regarded as a trial of intervention, there are a number of limitations to consider. First of all and as discussed above, conditions were not uniform for the study practices. With detailed examination locally relevant factors may be understood, however the intervention may not be generally applicable. Experience shows that commonly a single, uncontrolled intervention cannot be applied with the same success elsewhere. This intervention was applied to a self-selected group of practices, so the results may not be indicative of application in every urban general practice. The non-randomised nature of the PIPCGP study means that selection bias is unable to be avoided, and there may be unrecognised confounders operating. This was an issue brought forward by Deeks et al (2003) in a systematic review of assessment tools for the evaluation of non-randomised intervention studies.²⁸⁸

As an intervention in the community, there were additional aspects that were uncontrolled that could be identified, that might have affected the results. Examples were functionality of the patient-information system for those particular users, and Indigenous-identification

practice and health-check activity prior to the intervention. It could be seen that most high-activity practices were already actively providing tailored care to Indigenous patients, in that they had performed health checks prior to the intervention. It was evident, however, that identification procedures were not consistently applied in these practices and that the intervention was associated with more systematic recording and use of Indigenous-status information in these and the other intervention practices. Although this may have happened in the practices without workshop attendance and support, given the new incentive and patient benefit, the workshop did facilitate networking and resource sharing amongst the group (as in use of the new patient form, and use of the 'Update your details' form), so these changes are likely to have occurred more quickly than otherwise.

As a before-and-after study, there was the potential for two groups to be compared, however, the implementation in both groups was quite different. The incomplete implementation of audits with the second group of practices, due to challenges faced in implementation, limited quantitative analysis. Participation was a second issue that should be considered about the results of the study. The participation rate over 12 months was high for the first group of practices, but low enough in the second group to dismiss the audit results from analysis as a group. In a randomised trial, often 70% participation is a criterion used to keep an intervention study in or out of consideration in a review.²⁸⁹ Aside from audit results, the context and progress of the Outer North group, and the data gathered on observation and at interview are informative. Formal exit interviews may have been more informative about barriers to change of practice; however, these were not part of the study.

The length of the study period may not have captured all the effects. The Inner North group continued to increase Indigenous identification over the period, and only some commenced health checks. It is possible that there were effects of the intervention over a longer period. More of the practice group may later have commenced health checks. The 13 Inner North study practices claimed 45% of Indigenous health checks claimed for the Inner North area of approximately 200 practices over 12 months (see figure 6-3). The Australian Institute of Health and Welfare's health-check tool shows that the Metro North Medicare Local (Inner North and Outer North Brisbane areas combined, approximately 267 practices) billed 3,126 checks the following year. This is a fivefold increase; however as previously mentioned, it coincides with the establishment of a new ACCHO clinic near Caboolture, which, from my experience as one of the service providers of that clinic, far outstripped the mainstream practices in health-check activity. It is not possible, then, from

this history to say what the longer-term effect of the intervention may have been on the practices, particularly in performance information of the practice was available.

6.11 Conclusions

The general environment of change associated with increasing incentives and strategic focus on Aboriginal and Torres Strait Islander health had provided resources for improvement in preventive care delivery. Additional local intervention had positive effects on participating practices, including increased Indigenous identification and increased Indigenous health-check activity. At a population level, the activity of ACCHOS and general upward trends in health check and immunisation coverage have occurred in parallel. Barriers additional to Indigenous identification are evident in relation to Indigenous preventive care in accredited mainstream practices. Barriers and facilitators are explored in the following chapter.

7 Qualitative findings: perspectives of Aboriginal and Torres Strait Islander patients and providers

7.1 Overview

This chapter addresses the third research question: How can the existing barriers to immunisation and health checks in mainstream general practice be overcome? The qualitative data presented are derived from the views and firsthand experiences of Aboriginal and Torres Strait Islander patients and those who provide Indigenous preventive care in mainstream general practice settings. The chapter begins by describing the sample of 35 interview participants, comprising 19 practice staff members and 16 patients. Themes from the interviews that relate to the delivery of primary care in general practice are then presented. The second part of the chapter focuses on information collected about technical and clinical processes within participating general practices. This includes data collected through formal observation in waiting rooms, as well as reflections on interview data. The final part of the chapter makes connections between the qualitative findings and the findings presented in the previous chapter focusing on the key issues addressed in the study: identification, health checks and immunisation. The chapter concludes with a re-examination of the conceptual framework with new knowledge derived from the study added to the framework.

7.2 Description of participants

Provider interviews were conducted within the practices of those who gave consent to interview. All staff groups were represented. Some Interviews were conducted singly, others in multidisciplinary groups. A range of practice types were included from both intervention groups. Patient interviews commenced with older Indigenous people of the local area who were nominated by Indigenous Health Workers as speaking for the community, and interested to help by contributing to the research. A process of snowballing then occurred, seeking advice for nominations from those interviewed, regarding who else to contact. It was also necessary to purposively sample younger adults at an Indigenous social support agency and an Indigenous organisation's administrative centre. (See section 4.5.2, recruitment for interview.)

Table 7-1 Profile of participants

Indigenous status		Indigenous		Non-indigenous		Total
Gender		Female	Male	Female	Male	
Indigenous Patients	Young adult (18 to 29 years)	3	1			4
	Older adult (30 to 49 years)	4				4
	Oldest adults (50 years and over)	3	4		1	8
Provider group	Practice manager	1		6		7
	Receptionist			1		1
	Nurse	1		2		3
	Doctor			1	5	6
	DGP support worker	1		1		2
Total		13	5	11	6	35

Source: developed by the author

7.3 Interview analysis

My view, as explained by Given (2008) is that social reality is modified by experience of an individual and is embedded in a social setting.²⁹⁰ I attempted to analyse the data by providing an account that reconciles the interpretations of various participants, to “make sense” of their accounts. Further, I used different methods to test what I thought were the main themes. The content of the interviews focused around several areas suggested by

the question guide, such as Indigenous identification, health checks, and immunisation. However, the most numerous references and most detailed discussion related to an area not immediately suggested by the questions: the nature of desired staff-patient relationships in general practice. This was a major focus for patients, and featured in discussions with staff who were Indigenous themselves or experienced in Indigenous health. Staff-patient relationships were not often discussed in detail by the other staff.

In addition to using NVivo to manage and analyse the interview data, I also entered all the transcripts into the qualitative analysis program, Leximancer®, which would provide an automatic and more objective text analysis, plotting codes from the patient transcripts and the staff transcripts together on one chart (see section 4.7.2). The program identifies a key word, or *seed word* for each two sentences of text, then grouping other words around it, identifying synonyms that fit within the group of words. A single word on the concept map thus denotes the concept, and it may be understood by checking the quotes grouped within that concept by the program.²³⁶

Using Leximancer®, a visual concept map of the interview data was derived using standard pre-set word definitions and analysis settings.²³⁵ There were three major themes identified, represented by the seed words 'health', 'people' and 'doctor'. Three participants were identified as having high connectivity (i.e. covering the highest range of themes: an Indigenous nurse working in general practice, a doctor who was experienced in indigenous health and worked in general practice with a personal focus on Indigenous health, and myself (who participated in almost all of the interviews). The striking difference between patient and (the majority of) providers was well illustrated by this concept map, figure 7.1. The focus of the patients was on people and the quality of their relationships, while for staff the focus was health activities and health as a system. Convergence of the discussion of the two groups did occur and was often demonstrated in conversations about community. The Leximancer® map's succinct visual depiction of concepts proved useful in my discussion of results with UIH staff.

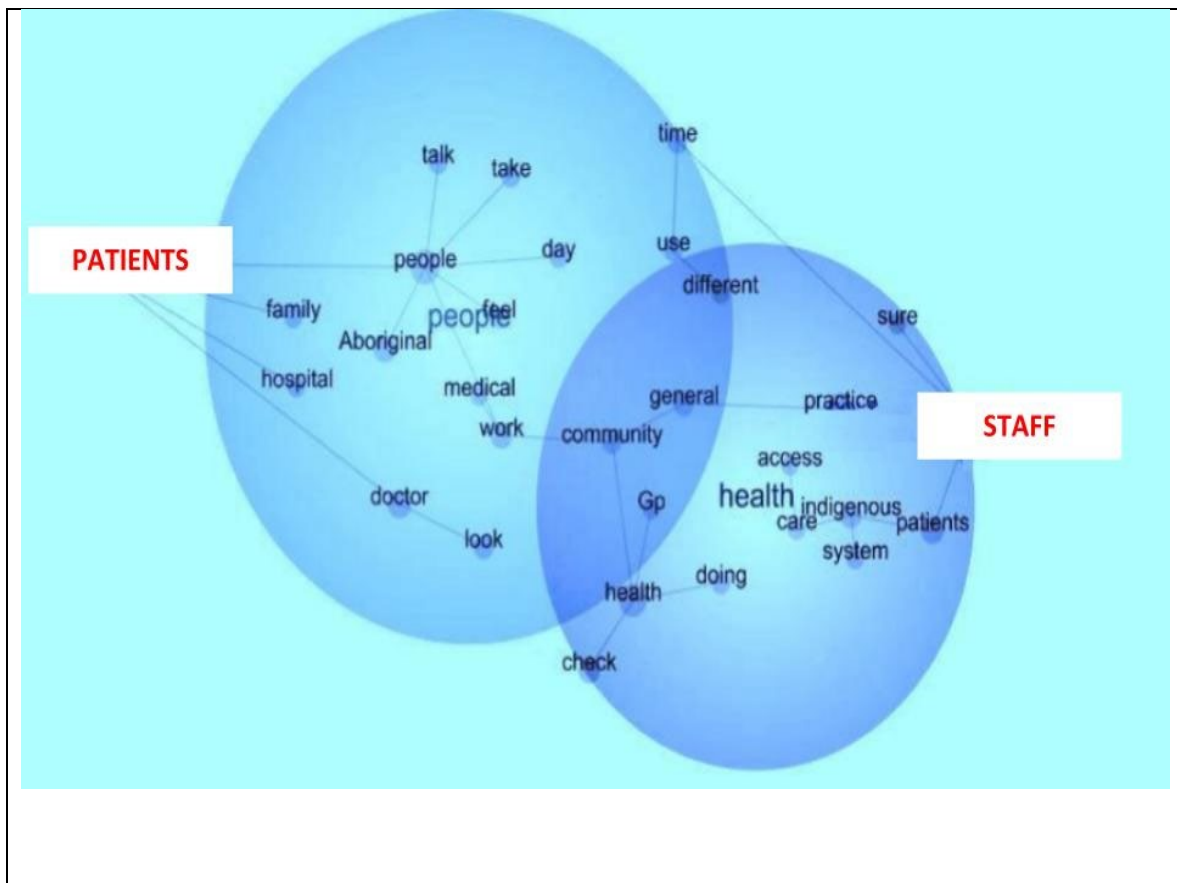


Figure 7-1 Concept map of text analysis by Leximancer® for concepts used by providers and patients

Source: developed by the author

7.4 Barriers to care for patients

An anecdote provided by an Aboriginal nurse about a patient of the practice offered an extreme but compelling example of the complex and deeply entrenched barriers to mainstream general practice attendance that may exist, and highlighted the importance of healthcare providers with the skills, understanding, and preparedness to address these barriers. This was discussed prior to tape recording an interview with her, so I have summarised the discussion between us:

The patient, a middle-aged Aboriginal woman, had chest pain and was short of breath, but could not be persuaded by her family to get out of their car and enter a new, mainstream general practice in suburban Brisbane, for fear of what may happen there. She had also refused to go to hospital. The practice nurse came out to the carpark, and was also unable to persuade her. The nurse then sat in the car and talked, later retrieved her equipment to assess the woman in the car. After 40 minutes, the woman was able to relax enough to go inside. Over a series of visits, her heart condition was assessed and treated, and specialist referral

arranged. She is now a regular visitor to the practice and her heart condition is improving. (Summary of discussion, Indigenous nurse, large general practice).

The Indigenous nurse unhesitatingly reached out to the Aboriginal woman in the carpark in a clear act of creating cultural safety for this woman, within what was to the woman an unsafe space, the clinic. This is a graphic example, a metaphor, for the action needed in general practice, to emphatically and actively focus on 'welcoming' Indigenous people.

Patients cited instances of frustration and sometimes anger, over the issue of communication with doctors. They were aware of simple failures of communication resulting in acute problems not being addressed, and sometimes a time pressure that stopped them from bringing forward the main problem for which they were seeking care. One patient described being angry because he was given a pamphlet to read about a health condition rather than being able to discuss it within the doctor's consultation:

Just lacking in professionalism in some ways a lot of these places but ... [the impact on a patient is] well, you get sent away without anyone really getting to the bottom of what you're trying to tell them or, you know, [without] trying too hard to communicate with people. (Indigenous man, 40 to 50 years)

That's the most important thing that a patient—all patients, whether they're black or white, is for the doctors to say you've got this wrong with you, what's happened, why you've got it and how long you're going to have it for (Indigenous Elder and health professional, female)

The danger in failure of communication sensed by Indigenous patients is tangible, and a key issue for clinicians in relation to clinically safe practice.

An Indigenous woman described a situation where respect was lacking in a hospital clinic encounter for specialist follow-up. This episode resulted in her avoiding the hospital near her home for many years, and also avoiding the local general practice that had made the referral that resulted in this incident. She regarded hospital practitioners and general practitioners as being part of the same group:

Only thing was that I felt uncomfortable with the doctor that told me that I had cancer. She just said—she's a lot younger than me of course—she said, oh you've got cancer, you don't have to come back to me anymore. You don't have to come back for a visit to me, see me anymore. And I was thinking to myself—oh. So right, I got up and walked out. She said hooray sort of—you know ... it was just that one

doctor, I felt that she could spoken better—a bit different to me, you know? I think she could have said, oh listen Mrs [Surname] I've got something to tell you and I don't want you to get upset or anything ... she could have spoke different, you know? (Indigenous woman, older age group)

This well illustrates the importance of sensitivity in conveying important news, which would apply to any patient. Respect and compassion should have been communicated in this situation. The emotional intensity of the experience had a lasting, negative effect on engagement with another doctor in a different setting, in relation to this problem. There was a sense the patient had that she was an object to all doctors. This further underlined the relationship as being central.

7.5 Breaking down barriers

A dominant and complex theme about long-term relationships for healthcare was common to patients and to practitioners experienced in Indigenous health. This was relatively absent from the interviews with staff who had little experience of Indigenous health. I provide evidence of the different aspects and then a construct, which integrates these subthemes.

7.5.1 Overt respect

Most simply put, respect was 'being treated like a human being, not a number'. Respect was linked with civility, clear communication, awareness of cultural and gender issues, sufficient time taken, and friendliness. Both younger and older Indigenous people emphasised this aspect.

An Aboriginal Elder advised how to start conversations with Indigenous patients, conveying respect:

I suppose the best way to start is ask them about their—maybe their family and where they come from, and what people do you belong to, that's what Aboriginal—that's how the yarning starts right, they sit there and they start—what tribe do you belong to, who is your mob and all that stuff, that's just about—then the Aboriginal people, they sort of relax and open up, and they get fully into a conversation.
(Indigenous man, 50 to 60 years)

An overseas-trained doctor remarked that,

'We are made to treat people (of other cultures) or greet them in a certain manner but [Indigenous people] they're not included in that, so it's funny isn't it? (Doctor, male)

These excerpts emphasise the habitual absence of cultural protocols experienced, in situations requiring them.

Gender sensitivity was an issue for some, but not all, patients in this urban group of people. Some women preferred a female doctor, particularly in relation to women's' health issues, and a young male patient preferred a male doctor for a male health issue.

7.5.2 Mutual investment

Concern for the person is necessary, and the practitioner should be open to receiving feedback about the practice from the Indigenous patient. Older Indigenous people that I interviewed saw this as a natural part of the process in general practice. An older person talked about past healthcare and the valued concern shown by their doctor:

He [the doctor where I grew up] was so good to my mum—had 12 kids in the family and every time anything came around we had to be there and got our needles—anything going on, he was there ready, waiting for the Aboriginal people. He was so good to us. (Indigenous woman, older age group)

Practice staff sometimes reflected a very caring attitude to Indigenous and other patients. In summing up, a practice manager used these words:

We are only a small practice but the patients we do have stay with us, love us. They walk in the door, we know them. We know who's got an appointment in two days' time, you know. It's just a knack we have here where we know our patients and every single thing we can get for them, we try. Because it is a big issue. (Indigenous Practice Manager of a mainstream general practice, female)

These quotes well show the positive emotions associated with care from these non-Indigenous doctors conveyed both by Indigenous patients and Indigenous staff.

'Elder' is a role arising from cultural practice. In the general community, the role describes Aboriginal and Torres Strait Islander people who are respected and can (or have permission to) speak for the community. Elders explained their role as problem solvers and advisers for Indigenous people of their community. Interview participants said they would, as an Elder, give advice on where to access healthcare, while others said that they would seek the advice of an Elder about this issue. Elders frequently accompanied a sick

person to the doctor or arranged for someone else to help in this way. Elders provided transport, acted as interpreters, provided needed goods such as food and clothing, and provided a place to stay for those in difficulty. This helping function was prominent in their life, taking large amounts of time, and part of their income. This function extended well outside their own family. Elders saw a link to a specific general practice as enhancing this role.

Elders expressed the view that there needed to be a direct connection between their particular group or at least some Indigenous community group (such as the IHWs of Community Health) and a general practice providing services to Indigenous people. An example was given where this had occurred in the form of a consultation with a local Elders group by the practice principal before a clinic was established, in a situation where special funding for Indigenous programs was sought. At the time of the intervention, there were regular meetings of the community group held in a room provided by the general practice.

A few practice staff members were aware of local Indigenous groups of their area. The project commencement workshop did include local Indigenous people so there was some new knowledge within these practices. In one case, a GP regularly attended an Indigenous men's group on their invitation as a resource person. Where there was an Indigenous staff member, this person was regarded by staff as the main liaison with the community. An Indigenous staff member of a general practice talked about consulting an Elder or the Elders group where possible, about contentious issues such as refusal of service to an Indigenous person. Indigenous staff members also discussed their membership of mainstream community groups such as school committees, where they acted as leaders of their community and were able to educate the non-Indigenous people of the group about Indigenous protocols and sensitivities.

As community leaders, the Elders attempted to advocate for and gain funding to establish projects and organisations to benefit their community. Discussed in relation to this role were advocacy for the local arts community, establishment of an Indigenous child care centre, an established men's group, a series of leadership camps for young people, a proposed aged care program, and Indigenous parent and student activities that had included health screening.

7.5.3 Good communication

As was presented in section 7.4, the conversation about communication applied most directly to doctors. Other health staff were regarded differently, which emphasised the communication barrier with doctors. Nurses and other health workers were seen in general as good communicators who regularly showed their concern for the patient, communicated more easily, checked the patient's understanding of the clinical issues identified, and their agreement with the care plan. One Indigenous woman suggested that Indigenous patients would benefit from having a nurse accompany the Indigenous patient to every consultation with the doctor for this reason. A secondary reason only, in the view of the woman, was that where the nurse and patient were female, the comfort of the patient would be increased in a gender sensitive situation, such as pelvic examination by a male doctor.

Reception staff were seen as an important part of the care team, as keepers of information and organisers. A welcoming receptionist who talks with patients on entering, rather than only addressing the person at the head of the queue, was viewed positively.

7.5.4 Good practice

A patient appreciated prioritising a sensitive but necessary test, despite reluctance, by a trusted and engaged health provider. Humour was also appreciated in this sensitive situation:

I started off with him and then went towards Dr M. because she's female, because I'm on the cancer register for pap smears ... The alarm goes off like I robbed a bank somewhere or something. It's like they lock me down in their office—they won't let me out until I've had it done. So I stick with Dr M. because of that reason.

(Indigenous woman, 40 to 50 years)

Being unhurried and being clinically competent are desired qualities, as expressed by this patient:

I mean, I couldn't even talk without bursting into coughing and everything and she's really taken the time with me and sent me off and did my 'deadly choices' and got to the bottom of what's causing all this and we've been to physios and all sorts of things and we're on top of it now, so I feel I can trust the doctor with a lot of my stuff. It's good. (Indigenous woman, oldest age group)

7.5.5 A long-term relationship built on trust

The theme of a long-term relationship built on trust was at the centre of discussion and an overarching theme for patients. Preventive care activities were seen as part of life and healthcare over time, supported by staff in whom the patient had trust and confidence.

Preventive care was seen as desirable when linked with an established practitioner-patient long-term relationship, rather than as a disconnected service. The participants' expectation of care extended to preventive care, particularly immunisation but also health checks. The various aspects of this desired relationship revealed through the interviews are summarised in the following diagram. This applies specifically to the doctor-patient relationship, and to the practice setting.

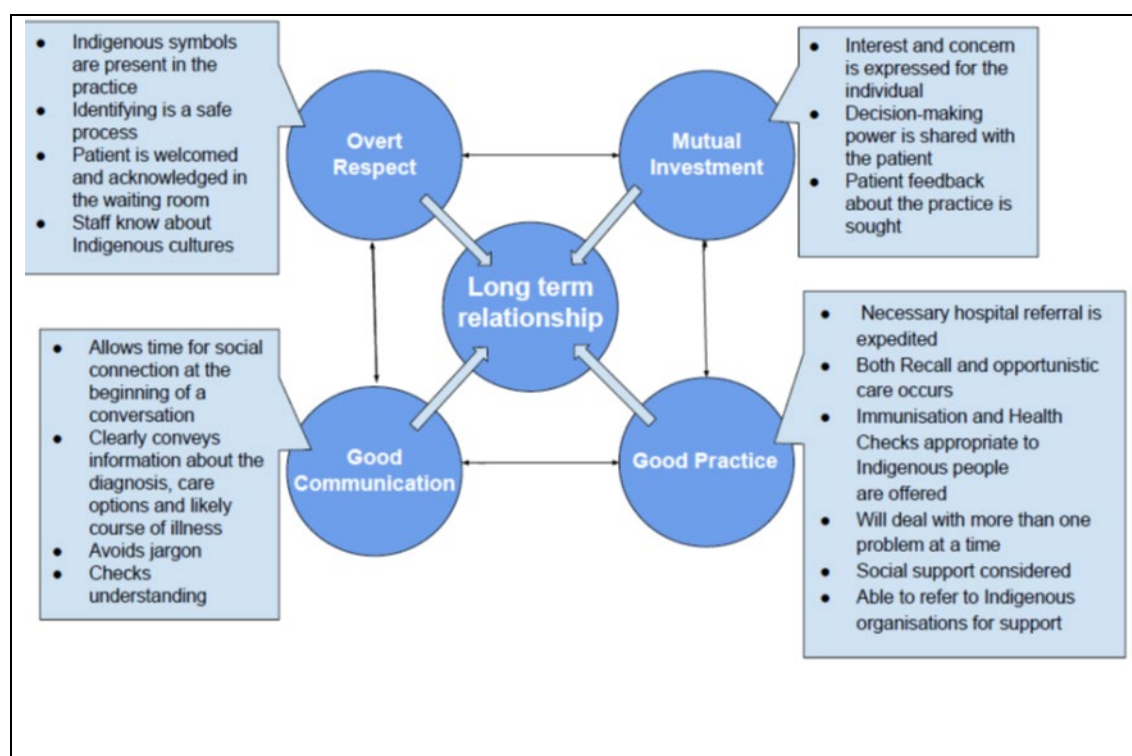


Figure 7-2 A long-term relationship for healthcare: analysis of a main theme and sub themes

Source: developed by the author

Trust in the doctor-patient relationship was conveyed to be based on a firm belief in the clinical competence of the clinician, along with sensitivity, respect, and concern. These were the recurring topics of discussion. One participant illustrated the strong link between many of these aspects in describing the handling of a gender-sensitive clinical problem, managed over a long period, with a good outcome as follows:

Obviously because I'm male it's just natural to feel more comfortable around a male doctor ... It was pretty personal when I went there, but like I said, the start was a bit uncomfortable but once I sort of like, I trusted [the female doctor]—you know, she knew what she was doing and you know ... It was okay then, I just relaxed—and her personality was good too, you know. She was very friendly to me, she was like a male doctor, because she treated me no different to any other doctor and she made me feel comfortable and then that was all right (Indigenous man, younger age group)

7.6 Looking at the practice environment

This section, focusing on the practice environment, integrates observation and interview data. Views of practice staff members about clinical activities within the practice and its technical support, views of patients on the same topics, formal observation in waiting rooms, and my reflections on the environment gleaned throughout the process of undertaking the interviews, have been drawn upon in this section. Further, integrating both qualitative and quantitative methods, the practice environment framework has been annotated with relevant qualitative and audit findings (See table 7.2 bold and italic type) and their relative importance as key mechanisms has been indicated by shading, based on interview data.

7.6.1 Staff commitment

Interviews with staff indicated that a protocol of bulk billing at the practice for Indigenous people and purchase and display in the practice of artworks by local Indigenous artists were strategies regarded by staff as indicative of their commitment to local Indigenous people. Staff saw practice staff engagement with the Indigenous Health Collaborative group, the Indigenous Practice Incentive Program and involvement in the PIPCGP study in a similar way. The provision of health checks and follow-up care was seen as a service to the community. There was little emphasis on the remuneration available at that time. Lack of time-efficient practice systems for undertaking such complex care created challenges for the practice staff, which some acknowledged may affect patient comfort.

Both clinical and non-clinical staff gave examples of an Indigenous patient who they had helped and who had helped them to understand the importance of respectful or tailored care. Further, there were examples of learning from other staff. Two clinical staff emphasised the positive impacts of their involvement in the GP Collaboratives project. These included responding to the high level of motivation displayed by colleagues in the

community controlled sector, who were their discussion partners, and the sharing of practice procedures that was possible through that project. While other staff within the practice may not understand the importance of respect shown by symbols, communication style and processes that accommodated Indigenous patient needs, colleagues attending the monthly collaborative meeting shared their concerns and fuelled the participants' commitment to follow through on actions to create change. Further, the monthly internal staff meetings required by the collaboratives project provided a formal opportunity for discussing change which would otherwise be de-prioritised in their crowded meeting schedule.

7.6.2 A welcoming entry

Observation was undertaken by an Indigenous person in the waiting room of two of the large clinics, one in an old building, the other in a new, purpose-built space. A range of factors was identified that were considered to have an effect on the Indigenous patient's comfort in attending the waiting room of the practice. Some of these factors were recognised by staff.

Positive factors observed in the clinic entry and waiting area included:

- the receptionist greeting a patient by name
- the receptionist smiling and speaking respectfully to an elderly patient
- the receptionist arranging for a chair to be placed in a location to suit the patient
- a supply of tissues in the waiting room
- short waiting times for patients
- health promotion posters nicely displayed on the wall and featuring Indigenous artwork
- the presence of health education material in the waiting room
- an absence of dated or torn magazines.

Negative factors included:

- a grille or high counter in front of the receptionist
- queueing in front of the receptionist to await attention
- loud voices discussing personal details at the reception desk
- stressed/ possibly unfriendly interactions where the reception area was busy
- frequent interruptions of discussion with a patient before them to take a phone call
- crowded waiting room particularly where children needed to wait (and might be considered noisy by other patients in the waiting area)
- chairs placed very close together
- absence of soft furnishings
- absence of decorative objects, and in particular no objects or illustrations with an Indigenous theme.

Both the clinics had many of these features. The older clinic, however, had two waiting areas, and one of these was set-up to be used by families with children, away from the main reception area and with toys supplied. This was the space Indigenous people preferred. Many of these points apply to any patient's comfort, regardless of Indigenous status. The emphasis in both the observation exercise and in Indigenous patient interviews was on personal warmth, how it effectively counteracted many of the alienating effects of the physical environment and the disempowering aspects of being a patient: being patient, and waiting on clinical staff. Attention to a sense of welcome that is tangible to Indigenous people, however, cannot be over-emphasised. Fredericks described the waiting room as a "charged" space, potentially damaging of relationships⁸⁶. What may be considered an over-reaction of reception staff to lateness for appointments, and the sense of disapproval (in fact imposition of physical separation to another waiting area) consequent to noisiness of children, can be interpreted as symbolic violence that may ensue when, in Bourdieu's terminology¹⁰⁵, the habitus of general practice is at odds with the habitus of Aboriginal and Torres Strait Islander people.

A culturally sensitive routine for Indigenous identification helped to set the tone in the Indigenous person's view. The emphasised negative effects were to do with a busy environment, when one felt ignored, and where the risk was that handling would be less civil. (People of all age groups concurred on this). Discomfort was associated with waiting chairs placed close together, because there might be close contact with others waiting, and marked sensitivity about one's noisy children was explained as likely to disturb others and to negative judgement of the parent/carer.

Qualitative and quantitative findings are in agreement in the PIPCGP study in relation to Indigenous identification. The numbers suggest that general display of Indigenous images (as was prevalent in the study group prior to the intervention) is insufficient to induce many Indigenous patients to identify; however, specific promotion as was introduced via the intervention, was more effective. Specific promotion has been shown in the PIPCGP study to increase Indigenous identification in settings where some of the practice staff, including administration staff, have undertaken Indigenous cultural education. The importance of culturally appropriate communication was emphasised by patients at interview.

Communicating a benefit of identification available within the practice (in this case 'improved preventive care' as announced on PIPCGP study practice front doors) may also be of benefit. Whether or not there was to be some outcome from Indigenous identification

was another issue identified by patients being interviewed as influencing their decision to identify their Indigenous status.

Most practice staff members thought that ascertainment of Indigenous status should be a routine associated with new patient registration. Receptionists reported this field was often left blank by the new patient (Indigenous or non-Indigenous) on the new patient form, and a prompt from the receptionist would encourage completion in most but not all cases. Several staff members discussed Indigenous patients, who initially refused to identify as being Indigenous, or who consistently identified only to clinicians and not the receptionist. Most staff members had an appreciation of Indigenous identification as a personal choice that may be situational, and could easily work with the patient on that basis. One practice manager described her approach of encouraging identification, pointing out the preventive care offerings and making enquiry of other family members where some members identified and others of the family who were patients of the practice did not. She recounted an explanation given to her that was similar to that conveyed by many of the Indigenous interview participants, that an older family member's past negative experiences of identification in a hospital setting led her not to identify in the general practice. Another explanation often given at patient interviews was that some Indigenous people choose to identify only when there is a perceived outcome dependent on this information.

The issue of new opportunities for ascertainment of status in existing patients was recognised and handled in some practices by utilising an 'Update your Details' single sheet for patients to fill in, provided to project practices in a tear-off pad. The details asked for were name, date of birth, address, phone number, and Indigenous status. Staff saw this as avoiding a potentially awkward situation. Many reported that their patients were newly aware of benefits such as low-cost prescriptions and funding for allied health visits as part of care plans, and identified with the specific purpose of accessing these benefits. Stories of improved follow-up and improved health were told in relation to the Indigenous associated benefits, a strong motivator for staff to feel good about the care they were able to provide, which led them to actively promote Indigenous identification.

7.6.3 Staff who attract Indigenous patients

The intervention practices with the highest numbers of Indigenous patients (the high-activity practices) varied in structure and style from a 1.5 doctor practice with few extra staff housed in very plain rooms with no display of Indigenous symbols except for the three-flag sign indicating study involvement, to a large and stylishly appointed medical centre with artwork on the walls produced by local Indigenous artists. The common

denominator seemed to be trusted staff, most of whom had previously worked in a CCHS or in another setting with many Aboriginal and Torres Strait Islander people.

Interviews with patients reinforced the idea that trust is needed (see 7.5.5) and that Indigenous staff of any discipline attracted Indigenous patients to a practice. Above their professional role, patients valued staff that identified as Aboriginal or Torres Strait Islander. They were trusted to deal with patients appropriately, to make every effort for the patient. The presence of Indigenous staff in a mainstream general practice was often said to relax new Indigenous patients and help them to gain a sense of connection with the practice. Patients referred others to the practice via the Indigenous staff member, confident that the referred person would be respected and would have an advocate. Indigenous health professionals were known to carry their responsibilities with them into the community, which was seen as an effective way to work. They were obligated to look after *their mob*. Indigenous staff members were knowledgeable about Indigenous community resources, such as an Indigenous hostel, an Indigenous legal service, and a drop-in centre for Indigenous people with welfare support. The Indigenous staff member would know their locations and route of access. Indigenous staff members were described also as a link to Elders of the area:

Too many white people! See, we have our witch doctors, right? They will rather go to a witch doctor than go to a white man medicine. And that is now, I call them down here 'urbanised' Aboriginals, because they're living in a white man's world. They've had a white man's education, but deep down, they're still Aboriginal. The culture is born in them. You hear that all the time. They've got that feeling in them that something's not right and I have a lot of people come to me. A lot of people come to me and I say, 'See C. D.' [Aboriginal nurse]. She sorts things out.

(Elder from Aboriginal family, aged over 60 years)

This illustrates the strong feelings Indigenous patients described in their interactions with Indigenous staff. Indigenous workers in general practice described their role in a similar way. They also experienced times where high community expectations of a general practice could not be met, and found this to be a source of personal stress.

Although none of the intervention practices or other mainstream general practices of the area had an AHW on staff, one practice received AHW-visits from the local community health service once per week, on Indigenous clinic days, to support patients as part of the community health service's Indigenous Friendly Practices initiative. In this community, AHWs worked at a newly opened Indigenous-owned private general practice in the area, and there were AHWs at the one ACCHS clinic. AHWs were seen as excellent supporters in the practical sense, able to understand the patient's situation and anticipate need for social and practical support, and having greater power of persuasion with Indigenous patients than did the clinician in some instances. Some patients also saw them as interpreters of the doctor's advice. Two doctors regarded AHWs as a key resource for improving primary healthcare for Indigenous people, both because of the understanding and practical support they provide, and because of the cultural advice they are able to give to the other health staff, lessening barriers to relationship and to care.

Table 7-2 Summary of evidence from audits, observation, and interviews (Shading indicates importance.)

Pre-intervention situation	Mechanism 1: Intervention by support staff	Mechanism 2: Practice improvement	Mechanism 3: Patient engagement
RESEARCH QUESTIONS	1. Investigate SUITABILITY of intervention	2. Investigate EFFECTS of intervention	3. Identify factors that ENHANCE effects within the practice
Practices identifying Indigenous status on patient record to varying degree Most practices under-identified Indigenous people and 14/15 improved identification following a workshop.	Audit highlights areas for improvement 1/15 patient record systems without indigenous status capture; missing immunisation data precluded coverage reporting	Practice team develop strategies to systematise Indigenous identification within the practice Procedures systematised. Information system issues included: no dedicated field separate from ethnicity or field not linked across screens and not linked to activity prompts	Increased Indigenous identification Success: Large increase in identification within the practice group. Patients viewed being asked about identity positively.
Practices identifying Indigenous status on immunisation data to varying degree Most practices under-identified Indigenous people for immunisation. IT systems may not display both identity and immunisation record on one screen 61% of Indigenous children had incomplete immunisation records at the beginning of the intervention, 1% at end of intervention, with PHU support.	Staff education re identification, health checks, immunisation, and screening issues Positive feedback about workshop. Contact with Indigenous people valued. More information about patient expectations and importance of relationship required.	Staff interest generated for catering to current Indigenous patients Positive response to discussion with local Indigenous person. Bulk billing, flexible appointment arrangements desired by patients	More family and community members attend the practice Success: Patients already within the practice identified Indigenous status, and new patients came in. Elders have a role in recommending practices.
	Indigenous artwork on posters provided 9/15 displayed Indigenous symbols prior to intervention, afterwards all did. A personal welcome to the waiting room is important to Indigenous patients	Increased comfort of indigenous patients in practice Patients commented on project sign. Staff who wore three-flag badges said they generated positive conversation with Indigenous patients. Patient comfort is influenced by factors both inside and outside the practice: friendly staff; family or Elder advice; negative experiences in hospital; experience of discrimination in the community. INDIGENOUS STAFF attracted Indigenous patients to the practice, improved communication and were patient advocates.	Practices seek more engagement with the local Indigenous community
Practice environment has no focus on indigenous culture 4/15 practices had “no Indigenous focus”. All practices displayed Indigenous symbols and targeted information in waiting room during intervention. Some focus is necessary according to patients. The workshop did help establish a focus.	Staff given cultural orientation and are familiar with local Indigenous organisations Three staff of practices attended orientation. Request for additional team member training made. More information about Indigenous organisations requested by practices. Doctors waiting for online training to meet PIP IHI requirements.		Patients request service Patients expect provider to advise when due, or offer opportunistic immunisation or screening on attendance On invitation, many patients are reluctant to undergo a health check. Reasons given are the long-time taken and perceived intrusiveness of questioning and examination in mainstream setting.
Patient data management system not conducive to appropriate alert and recall of Indigenous patients Some staff thought recall was too time consuming. Some unable to use their	Written Instructions and on-site support for modifying data management system Technical support from the software companies and resources provided within the study were useful for	Alerts re immunisation and screening at each patient presentation, capacity to generate lists for patient recall	Patients seek a good, trusting relationship with the provider before

<i>records system to organise it. The PenCAT tool was easily adaptable to most but not all systems</i> <i>Some practices had little success with both Indigenous and non-Indigenous patient's response to recall.</i>	<i>some but were insufficient for a few practices.</i> <i>Electronic files of health-check template and new-patient form recommended by accreditation organisation shared around practices.</i>	<i>Capacity for recalling adult patients for programmed activity lacking for some.</i> <i>Indigenous-specific vaccination reliant on recall as patients often unaware. Software little help.</i> <i>62% immunisation records of children aged 2 to 5 years were incomplete, improved over intervention period</i>	undertaking screening, with a view to chronic disease care
Indigenous patients unaware of recommended immunisation <i>Indigenous patients not aware of Indigenous-specific immunisation recommendations for children, were aware of yearly adult influenza immunisation recommendation</i>	Postcards detailing Indigenous immunisation-schedule available in waiting room <i>Popular, reproduced by Indigenous community group</i>	Increased immunisation, possibly increased screening if practice has the capacity to carry out screening <i>Audit did not effectively assess immunisation activity because of data issue related to the chosen indicator</i>	
Indigenous patients unaware of recommended screening <i>All patients aware of screening through the CCHS Deadly Choices Campaign.</i> <i>Some patients aware of Close the Gap Prescription benefit — informed by friends or family.</i>	Adult record card detailing immunisation and screening recommendations and dates undertaken provided by the practice <i>Not appropriate for many practices.</i>	<i>11/15 practices demonstrated capacity to undertake screening</i> <i>Change hard to implement where quality improvement activities not well established as a team activity.</i> <i>Health checks regarded as time consuming.</i> <i>Unaccredited practices not eligible for incentive payments</i>	

Source: developed by the author

7.6.4 Practice software issues to be addressed

Some practices using Health Communications Ltd MedicalDirector® patient information system software²⁹¹ were unable to easily include Indigenous-status information as a demographic field in their electronic records. They required advice of external IT support and found this difficult to obtain. Other users of later versions of MedicalDirector® had received Indigenous health-check templates. Clinicians who used Best Practice Software Pty Ltd's Best Practice® patient information system²⁹² were able to modify the new patient information screen and complete the Indigenous ascertainment field where this had not already been recorded for the patient. The Monet Clinic® software system²⁸⁴ used by a large chain of practices was not able to record Indigenous status at the time of the project, resulting in one inner north and two outer north practices withdrawing from the project. Indigenous status often did not carry across to other fields such as to the health check, particularly where an external template was adopted, and usually was not carried across to

the immunisation record. Some practices had a template 'coming' from their software provider. Best Practice® software had just made available integrated templates for the yearly registration required by Medicare for patients participating in chronic disease care-planning activities. The linking of the template to a summary of the check for the patient, and to follow-up schedules, was variable. State-based immunisation schedule variations were not accommodated, such as Queensland's, which recommends extra vaccines for Indigenous children. This lack of visibility of Indigenous status at these points of care and in the standard consult screen is a persistent and current issue in patient management software in Australia. It is of note that many practice staff, even after the training workshop, viewed Aboriginal or Torres Strait Islander as a form of ethnicity that should be included in a list of nationalities. They were not accepting of Indigenous status as a separate attribute, which is the best practice advocated in regard to health data collections.¹⁸⁰

7.6.5 Staff collaboration and practice reorganisation for health check delivery

Health checks require an unusual pattern of cooperative activity between the nurse and doctor in general practice. They have the potential to cause increased workload, particularly if activity is not well integrated. Within some of the study practices there was uncertainty about which of the many elements of the check could be completed by different staff members, how long should be spent in a single session, and how best to negotiate this with Indigenous patients. Another cause of anxiety was whether remuneration could go directly to the nurse or nurse practitioner rather than to the doctor. Many GPs were unused to working with nurses as independent clinicians, and one expressed the view that his own assessment was necessary for all aspects of the check.

Each adult health check required a long time spent with the patient, 45 minutes to several hours in complex cases, often with input of two staff members, according to most informants. This could disrupt the usual pattern of activity of practice staff and of patients. Some staff emphasised the need to negotiate choice by the patient ahead of time. Others had a preferred way that suited the practice staff, depending in part on the patient flow possible between doctor and nurse within that practice given the layout of clinical spaces. Practice nurses could complete the patient history component and some elements of examination, including urine testing, prior to the doctor reviewing the patient. One nurse preferred to explicitly negotiate and where necessary offer to draw blood samples for testing, to minimise loss to follow-up of testing requests via an additional visit to a pathology service. Some doctors undertook all elements of the examination and

documented it separately, whether or not a nurse had examined the patient. (This is a hospital-based tradition.) Others worked together from the same template.

In some practices, nurses organised and completed the first part of the check, the doctor then completing the review and discussing it with the patient. Two examples follow:

An Indigenous nurse working in a general practice considered that she had a workable and patient-friendly approach organised at her practice. A nurse would conduct the initial part of the history and physical check in about an hour, then perhaps half an hour was spent with the doctor reviewing the assessment and conducting extra examinations. This would be followed most often by both blood tests taken (at the pathology service in the building) and immunisation. The nurse would initially inform patients that the check would take two hours or more and offer the option of a check now or alternatively at another appointment within a week. This seemed to be accepted (and indeed was described as a good service by patients interviewed).

Another nurse, specifically employed to conduct chronic disease care, preferred to split the activities across two sessions, felt that her patients were more accepting of that approach, and that it seemed to work in her local area. The health education aspect of the check was important to the nurses. One described the many issues that might need discussion and would develop a staged plan for the health education:

Depending on the person, we try not to bombard them with too much at once because there are a lot of issues that need to be dealt with. I will sit there and say 'Let's pick the top two and deal with them, and then we'll work our way down the list'. Then they don't feel so overwhelmed. (Non-Indigenous nurse)

Indeed, "too many issues" was a frequent comment from general practice staff, who often felt ill equipped to handle social, drug and alcohol and mental health issues in their Indigenous patients. This nurse's approach was that nurse and patient worked together on each issue, a patient-centred approach which could apply in many situations of complexity.

A few doctors were ambivalent about offering checks to young people who appeared healthy, regarding checks to be unnecessary. This type of interaction with young people, however, could potentially have a positive effect on their health by, for example, providing the opportunity for support to quit smoking. There was also anxiety about recommending people for the Close the Gap medicine benefit, except where the need was obvious (pension holder or large family) for fear of being accused of inappropriate use of the

benefit for patients by a pharmacist or monitoring body. Both these measures were new and quite different from these practitioners' usual care. The concern about transgressing guidelines did seem genuine. The notion of inappropriately privileging Aboriginal and Torres Strait Islander people with extra care or special entitlements was expressed and discussed at the workshop (by a participant who declined study participation). To a large extent the study recruitment process would have excluded practitioners with conscious, strong feelings about privilege. This notion was partly reflected in the examples above, but seemed mixed with fear of censure by the funder, Medicare. The notion of inappropriate privileging may yet have been an unacknowledged factor influencing provider attitudes, perhaps hidden because of the social influence of the researcher.

In contrast, Indigenous preventive and chronic disease care was simply conveyed by some staff as being an extension of general community chronic disease care, and similar to chronic disease care for veterans. Armed forces veteran care is also incentivised, and requires a similar level of organisation, excluding Indigenous identification.

7.6.6 Patient reminder/recall for health checks

Most practices offered checks in an opportunistic way, when the patient before them was due according to their record, and when a new patient came to the practice that was identified as Indigenous. Indigenous staff, both clinical and non-clinical, were particularly motivated to look for opportunities as patients presented, and suggested health checks for other family members. This more opportunistic approach was a contrast to the voiced expectation of Indigenous patients that a good doctor or nurse would keep track and contact them when they were due for a check or some other follow-up care, and persist in their contacts.

Only a few of the practices had a systematic approach to reminders for health checks, where the practice manager or nurse (including a nurse specifically employed to follow-up chronic disease patients) would identify Indigenous patients from their records, based on a generic follow-up schedule or the doctor's advice, phone them and where unsuccessful, send a letter. Some practices used the Pen Clinical Audit Tool[®], a software application adaptable to a variety of patient management systems that can extract lists of eligible patients based on user-specified criteria.²³⁰ Medical Director[®] could be trawled in this way and individual follow-ups entered. Indigenous Practice Incentive reports from Medicare, which list the patients registered for care plans, sometimes prompted this review. The

managers saw this as part of their service to the patient once they had registered with the practice for ongoing care. Doctors were more motivated to formally carry out a health check and regular review where they saw it as providing eligibility for healthcare benefit to the patient. Some practice managers reviewed patient records and entered recalls/reminders for immunisation. This activity had been prompted in some cases by Immunisation Practice Incentive reports (aiming for a level of coverage at the practice) which had recently been discontinued by Medicare.

Success of recall efforts (by letter or by direct contact) varied between practices. Some success factors recognised by staff included patients being longer term and in stable accommodation, use of direct contact with family members to get the message to the patient, and Indigenous status of the staff member who undertook recall/reminder by telephone or text message. Patient suggestions about recall involved Indigenous workers liaising in the community (e.g. attending community events to establish contact with people needing recall or visiting the home).

7.6.7 Patient registration for chronic care planning

Patient registration with a specific practice using a Medicare process available to all in the community with chronic disease, was required to confer eligibility for extended care items. Concern was expressed that Indigenous patients sometimes attended multiple practices and may have already registered with another practice for this purpose, 'without being aware of it'. Concerns included: knowing whether a patient registration was to be accepted by Medicare (two months wait according to one doctor); knowing if their patient who had not returned had moved on to another doctor; whether the patient that came to them and was already registered with another practice could be referred to allied health services on the benefit. At the time, there was much waiting for medical records from other practices, to enable further care under the chronic care benefit. This seemed to be a large paperwork headache for some. A further frustration was the lack of availability of allied health professionals to refer their Indigenous patients to, for example psychologists and physiotherapists who would bulk bill, and dentists who could be accessed at low cost, with or without the assistance of supplementation using Medicare chronic care planning.

Whether or not there was any initial intent, Close the Gap prescribing was erroneously caught up with this idea that only one practice could confer the benefit to a patient. The DGP support worker liaised to clarify this. Later, Close the Gap prescribing was clearly unlinked from the patient's registration with that particular practice, but restricted to

prescription by doctors who worked in a practice which was registered for the PIP Indigenous Health Incentive, or in an ACCHS, in public communications by Medicare.

7.6.8 Immunisation practice

Often the nurse within the practice had the job of administering vaccines and individually entering recalls for child vaccination. The records, however, were incomplete for most Indigenous children. There was some frustration regarding delay in obtaining vaccination records from the local ACCHS clinic, by contrast with other general practices. This was particularly a concern to providers for babies on a two-monthly schedule, as they thought information might not yet have made it to the immunisation register. It was confirmed in interviews that practice staff and patients were often unaware of the extra schedule vaccines for Indigenous children. Some practice staff appreciated, and displayed in their treatment room, a recently updated Queensland Health schedule poster that depicted this extra Indigenous schedule alongside the general schedule.

Incomplete records had the effect of decreasing staff confidence to undertake recall and would have made it less likely that vaccines were offered opportunistically when a patient presented for another reason, as providers were concerned about over-vaccinating their Indigenous patients. Some providers did not refer to patient held records of immunisation, and when asked about this said they thought these too might be incomplete. Practice staff who arranged immunisation recall said that there was often a lack of response to the recall by patients. A few staff used phone calls and SMS to young parents with good effect.

Recall was rarely undertaken for adults receiving annual influenza vaccination. Often staff felt that if the instruction had been given at a consultation regarding the next time the vaccine was due in an adult, then that was enough. Indigenous patients, by contrast, often expected their practice to recall them for an influenza vaccine, and certainly expected a recall when children were due. Patients thought letters were appropriate for this purpose and appreciated local flyers and word-of-mouth for seasonal influenza vaccination.

7.6.9 Indigenous community-member suggestions regarding immunisation

The patients interviewed were supportive of immunisation. They favoured general practice-based promotion and recall, and convenient availability. The Elders interviewed received influenza vaccination themselves and recommended it to others. Older family members guided younger ones and felt all the community needed to know about immunisation recommendations. Child immunisation was supported and there was concern about whooping cough in the general community. Mothers' distress when their

children are upset by needles was raised, but the upset was regarded as necessary for protection. The importance of immunisation for families with many children was discussed several times. Visits of rural and remote family members to urban households for long stays were discussed in terms of everyone needing the protection of vaccination. Lack of easy availability of influenza immunisation for non-Indigenous members of Indigenous households was raised as a concern, because they had the same risk of acquiring infection. Interview participants also raised with me the importance of vaccinating younger family members to protect older and more vulnerable members:

I'm not anti-immunisation. I see them as having a benefit to our health. I mean, I've just this year got the flu injection. He [the doctor] has been pushing that at me for a while but I've not felt that I needed it. I thought I should have it this year because of my elderly mother and other people in my life who are not as well as I am. I might be passing things on to them, you know? (Indigenous woman, 40 to 50 years)

Many patients said their GP did not review their immunisation status when they attended the practice, although there were exceptions. One participant, a young woman, said that was the reason she did not know her own immunisation status, and she did not feel that she could ask. Some people attended an ACCHO for immunisation rather than a mainstream general practice, as it was actively promoted, free, and conveniently available, rather than on prescription. Immunisation was well accepted as part of a health check.

Community-based promotion was suggested, for example, promotion of influenza vaccination linked to the football season and football teams, as a means of improving coverage. NAIDOC Week (the name originating from the National Aboriginals and Islanders Day Observance Committee) is held from the first to the second Sunday of July each year. This annual celebratory week is associated with a festival in Musgrave Park and similar community events in a number of suburbs around Brisbane. These events were thought to be appropriate for distribution of immunisation promotion material, a time when people gathered in large numbers in the city and suburbs, and whole families were together. Community agencies often run stalls at these events.

To target young people, schools were thought to be an appropriate setting. Suggestions were sessions with young people, promotion via an Indigenous community group's social newsletter distributed at school to Indigenous families and an immunisation day for the families at a local school with an active Indigenous parent group. Person-to-person

contact, rather than distribution of pamphlets or booklets, was thought to be the best way to provide information to the community:

You've got to have a day in the school and say 'Okay, this is immunisation day. We need you to bring all your families along because this is very important that if you don't, you can be sick. This could happen and this could happen.' And, you need to talk to them about why it's important, because you give them a book and they'll just go 'Yeah' and chuck it away because it don't matter what it means then. Aboriginal people learn that way, they look, they listen and they talk. (Indigenous man, over 60 years)

Provision of vaccination at the school as part of Immunisation Day was thought to be appropriate and the main reason for bringing family members in to the school. Provision of vaccination in the workplace or near the workplace, and in association with social events was also suggested. A flu vaccination session conducted for a local men's group, outreach to those vulnerable, such as *parkies*, (homeless people who frequent public parks) and to households where children were known to be overdue was also suggested.

While this type of promotional activity was beyond most general practices, GP support organisations were able to act. The PHU undertook outreach, and—for a piece in the national Indigenous newspaper, the *Koorie Mail*—the DGP arranged for a local GP to visit an Indigenous kindergarten to promote on-time immunisation for young children.

7.7 Discussion

7.7.1 Strengths and limitations

The audit process demonstrated good flow of the intervention through to Indigenous status identification, and reduced flow into health-check completion. This highlighted the importance of this same point in the configuration as did the interviews, that the relationship between the clinician and patient must be well established to enable preventive care. This is one illustration of the strength of mixed methods in unpacking complexity. The interview-associated visits to general practices, homes, and Indigenous organisations allowed me to gain a good sense of the essential features of environments of function for initiating preventive care. My experience as a provider and the visits both contributed to the practical relevance of the findings to practice.

The limited number of questions and the consistency of questions for both groups of interview participants enabled me to arrive at the point of repetition of those main themes pertaining to my focus, from person to person within those settings. I am confident of the

validity of those main findings on four counts. First, I reached saturation of themes pertaining to the focal issues. Second, I analysed the data in two different ways to produce findings that were compatible. Third, I have been able to triangulate the main point from both the quantitative and qualitative data. Fourth and most importantly, I received confirmation from consulting UIH chronic disease staff who currently practice community outreach to mainstream practice patients, and from the Indigenous mentors who guided my work.

A more extensive interview process may have raised a wider range of issues to do with patients and practices. In such diverse settings, there is no doubt that I was unable to capture the full range of elements operating. A further limitation, of course, is that I am a privileged white doctor. I have tried to compensate by being reflexive throughout the process, thinking critically about my impressions throughout the study, by reading about similar studies and underlying issues, and reviewing interpretations with my Indigenous colleagues.

7.7.2 Comparison with other studies

A peer reviewed publication about urban access to healthcare by Lau (2012), described a series of focus groups with Indigenous people recruited via metropolitan hospitals in Melbourne, and provider interviews. Barriers to care were identified, as previously discussed in section 3.6. Further findings were that cultural competence of staff could overcome barriers through their awareness of history, racism, and discrimination. Respect and trust, flexibility of practice, time and support, transport and outreach were highlighted as the means of enabling access to health services in general.⁴⁰ Issues described and conclusions of this study have much in common with the explanatory findings of PIPCGP study.

Schutze (2017) undertook a mixed methods case study of factors contributing to Indigenous identification in mainstream general practices, in Eastern Sydney in 2012. This was a collaboration with an Indigenous group that conducted focus groups with Indigenous community members and documented the experience of unannounced patients in general practice. Seven practices were self-selected, using the same method as was used in the PIPCGP study. Findings included a lack of practitioner/staff understanding of the need to identify Indigenous status or that there is under-identification in general practice; practice information systems that poorly record Indigenous status; and lack of promotion of Indigenous status identification in practices. Conclusions were that because there had been a lack of change between 2010 and 2012, the established method of identification

(which were acceptable to Indigenous people in practice) and the PIP IHI were insufficient to improve the level of identification in these practices. While Indigenous status identification became a required item within general practice standards from 2014, it was recommended that Indigenous identification be made mandatory as a matter of national policy, which could lead to, for example, Indigenous status recording on all Medicare claims. Another suggestion was again reformulating the Medicare Indigenous Health Check item to enable checks to be billed over a number of discrete sessions rather than as a single activity.⁴² Findings of the PIPCGP study show that available means can be used to prioritise Indigenous identification in practices where there is motivation to do so, and that, a range of practical arrangements can be made to deliver health checks in a comfortable way. At the time of implementation, for motivated practitioners at least, billing arrangements did not seem to be the main limiting factor. Interpersonal factors were more important.

In the intervention study by Liaw et al. (2015), described in sections 3.6 and 6.8, eighteen practice staff, three mentors and ten Indigenous patients were interviewed, the patients interviewed by telephone. Most of the reported qualitative findings related to practice staff and their interactions with the mentors, which is understandable. Cultural mentors worked well with the practice and advised that practitioners needed more knowledge of Aboriginal history. Staff noted increased liaison with Aboriginal organisations. Patients confirmed an increase in friendliness of the practice staff and availability of more information of relevance to Indigenous people.¹⁷⁴ The cultural mentorship process was later described in more detail by Liaw et al. (2016) as implemented in a group of practices in both Sydney and Melbourne, which were to be part of a larger intervention trial. Honesty, respect and trust were the qualities recognised as being necessary to facilitate relationships between the Indigenous mentor and the practice staff member who was the mentee.²⁹³ In Liaw's studies, practitioners had ease of access to a group with specialised knowledge of the local Indigenous community. Indigenous people, Indigenous experience and good relationships seem to be key elements in both these and the PIPCGP studies.

7.7.3 What my findings add

My study has focused on the patient provider interface for preventive care in two areas, one (immunisation delivery) being systemically well developed in mainstream general practice and the other (Indigenous health checks) relatively new. The study has been able to show some of the differences in expectation between patient and mainstream practitioner. According to practice staff interviews, the uptake of health checks in the study

practices was mostly limited by lack of demand from patients, or reluctance of patients on invitation. Community members discussed preventive care as desirable, however they were reluctant to engage with practitioners with whom there was not a bond of trust in a setting of comfort and cultural safety. They also remarked on the lack of offer of health checks. Practitioners saw their role as offering “reminders” for health checks and immunisation whereas patients expected continuing or persistent communication as “recall” for both. There was a lack of awareness on both sides of the recommended specific Indigenous immunisation schedule, compounded by information system incompatibilities.

The staff–patient interaction is a formal encounter between people who have the specific roles of doctor, nurse, or receptionist (as part of the clinical team), and patient. ‘Patient’, the term most used in medical literature and the term used by Indigenous community members, is not a waiting recipient of care, rather an active partner in care. The elements of respect, investment, communication and appropriate practice are integral to effective clinical work. They must be understood at a deep level by practitioners. Indigenous people attending urban general practice are much more focused on the development of a relationship with their primary health carer than are doctors of mainstream practices. Most doctors failed to acknowledge that the lived experience of racism in other spheres often colours an Indigenous person’s expectations of their general practice experience. The Indigenous people interviewed were acutely aware of negative elements in their social interactions within a general practice and expected more engagement than was offered in most instances. One of the main findings of the PIPCGP study concerns the desired doctor-patient relationship. Deficiencies of this area may help to explain the slow rate of uptake of health checks despite improved Indigenous status identification.

The study has shown deficiencies also in the well-developed system of immunisation delivery in relation to Indigenous people. These seem to be related to failure of communication about the schedule and immunisation history of individuals, coupled with low expectations of success of recall by practice staff, resulting in incomplete records and a low level of reminders.

Overall, there was a big change in style of practice for some of the practices that enrolled in the PIPCGP intervention, and by the end of the 12-month period, ‘high activity’ practices and some ‘low activity’ practices continued on the path of change. In the next phase of divisional activity, support for Indigenous health screening in general practice was transferred to the IUIH, who focused mainly on engaging with the high-activity practices,

continuing its community awareness campaign, and dramatically expanding the ACCHO services available in northern Brisbane. This area now has ACCHO service access comparable with those of other major cities, and population coverage of Indigenous health checks in Queensland is better than the national average.

7.7.4 Reflection on the ‘Eurocentric’ mainstream and cultural safety

The message that Indigenous patients want to take control of their health in general practice bears reflection. The aspirational relationships and difficult situations described can be viewed as situations where the power is very unequal. The context can be viewed as ‘whitestream’ or ‘Eurocentric’ in the view of indigenous writers such as Battiste²⁹⁴, which makes white privilege explicit. Many of the learnings from the PIPCGP study have an underlying theme of movement towards more equitable power in the relationship of patient to provider. Respect implies the sharing of power. The desire is for a doctor who is a respectful friend, one who shares power. A more educated patient gains power in the relationship. Nurses AHWs, lower in the practice hierarchy than the doctor, become allies. The unpredictable receptionist/gatekeeper is tamed.

Acknowledgement of culture, local references, and respectful interchanges help redress the very unequal balance of power. The desire of patients for their feedback about the practice environment to be heard was strongly evident from study interviews. The inclusion of a third party—an Indigenous organisation that is supportive of patients’ rights and active involvement, or an Indigenous support person—could further move the situation towards balance, lessening the ‘Eurocentric’ nature of the practice.

There are various approaches to professional training termed “cultural orientation”, “cultural awareness”, “cultural sensitivity” or similar. It is essential that awareness and a knowledge of colonial and contemporary history is imparted, however further steps must be taken in self-reflection and examination of power relationships. Most relevant to this setting is a body of work undertaken in New Zealand by Irihapeti Ramsden, a Maori midwife who with colleagues developed the concept of cultural safety in healthcare and steered its implementation in nursing training and nursing practice at a national level in New Zealand. This is applicable to all situations of cultural difference in healthcare, not only in relation to Indigenous people.

In the initial work, Ramsden and Papps assume each healthcare relationship between a professional and a consumer is unique, power-laden, and involves the convergence of two cultures. The nurse is tasked with making the health space safe for the patient’s culture.

This task requires self-examination of attitudes and awareness of the power element of the relationship. It empowers the service user to express degrees of felt risk or safety.² This approach has had longevity and is credited with engendering change in the profession.³

A review of cultural training for health professionals in Australia by Downing, Kowal and Paradies (2011) described six models, the most commonly used being cultural awareness, which risks stereotyping and lacks the extra elements described in the cultural safety approach. They found little evidence of good effect in Australia and, on the basis of scholarship, recommended the cultural safety model as holding promise as a change agent for use in Australia.⁵⁷ On-line training for mainstream general practice staff can deliver only part of the required skill and resources. Direct engagement with local Indigenous people is asked for by practitioners, and would seem to be an essential part of the exposure, self-reflection and community engagement needed to bring about change in the approach of mainstream health professionals.

Beyond individual training, the cultural safety of organisations and systems also needs to be examined. On a practical level, “cultural audits” for organisations have been developed, adapted to organisational type, which present practical examples for organisations of ways to adapt. A relevant example is a cultural safety evaluation tool developed by the Western New South Wales Primary Care Network (2016), based on the ‘cultural responsiveness framework’ of the Indigenous Allied Health Australia,²⁹⁵ ‘Standards’ are set out, covering six organisational functions. These include culturally responsive culture within the organisation at management level, culturally responsive models of clinical care, cultural safety of the workplace, a cultural audit of policy and procedures, cultural community engagement, and cultural workforce planning and management. Examples are provided of how an organisation demonstrates evidence of meeting the standard. There is a strong emphasis on involving Aboriginal families in designing and updating models of care and clinic procedures, providing avenues for patient feedback on treatment, and acting on feedback.²⁹⁶ This preceded the release of standards by the Australian Commission for Safety and Quality in Health Care, which have emphasised governance but also an even more practical approach in standard setting, specifically adding improvement of Indigenous identification rate, creating a safe and welcoming environment, and effective and safe communication.²⁹⁷

Evidence-based medicine has incorporated aspects of patient centred care, for example evaluating various ‘tools’ for working with patients on clinical problems,²⁹⁸ with standards set by an international research group²⁹⁹, and growing interest from Australians.³⁰⁰

Consideration of presentation of information, 'clarifying values' and 'health literacy' are features, however the evidence-based literature has been devoid of formal consideration of cultural safety, another example of the Eurocentric mainstream.

8 Discussion

8.1 Overview

This chapter begins with an overall review of the study. Firstly, the study methods are revisited, to define their alignment with realist methods and future realist enquiry. The successes and challenges of implementation of this realist-inspired evaluation, and limitations of the study are then discussed. Understandings from the wider literature, and the study's contribution to the Indigenous health literature are then considered. Finally, recommendations are made for improving Indigenous preventive care in mainstream general practice.

The PIPCGP study set out to better understand the processes of Indigenous preventive care in mainstream general practices, and how to improve them through practice level intervention using existing resources. Using an analysis framework and a mix of data collection methods has confirmed that rapid improvements in rates of Indigenous identification can be achieved in mainstream general practices, that more concerted effort is needed for immunisation and health checks. Improving Indigenous access in mainstream general practice is critical to improving health outcomes and addressing inequities in urban areas, a complement to community controlled health service activity. The findings of this study make an important contribution to this under-developed area of health services research by highlighting the range of practical and social issues to be addressed in increasing access to Indigenous preventive care.

These findings include system, practice and individual provider factors, studied in a group of practices who were motivated to undertake specific care for Indigenous patients. Indigenous identification is improved when it becomes systematised in the practice. Staff were able to adopt best practice with some training. Information system deficits exist in Indigenous identification recording, on-screen activity prompt and recall/ reminder. Completeness of immunisation record keeping and knowledge of the Indigenous immunisation schedule, prerequisites to immunisation practice, required attention. Further, the quality of engagement with Indigenous patients seemed to be an important factor influencing willingness of Indigenous patients to go forward with a health check. The success factor of staff experienced in Indigenous health enabled a patient relationship-building focus and influenced team work for Indigenous patients in the practice.

8.2 A Realist-inspired study

Formulating a program theory using realist methodology requires a detailed analysis of actions and reactions, and their possible underlying motivators. Often managers with or without practitioners are the main evaluation participants. When working with a group of providers to develop our theory of action, the concerns were about dynamics in the clinic setting and the voice of Indigenous patients, which was largely missing from our knowledge base. For these reasons we maintained a simple framework of enquiry for the study, taking in both patients and general practice staff as our informants, while we implemented the intervention. In this way, the uniqueness of service delivery to Indigenous patients in the mainstream would be well captured, a good basis for a thorough elucidation of Context-Mechanism-Outcome Configurations (CMOC). The PIPCGP study suggests that relationship building with Indigenous patients should be a focus, and that further theory building could also usefully be informed by cultural safety frameworks. After the study was completed, I had the opportunity to present the work to Justin Jagosh, one of the investigators of the RAMSES II project which set reporting standards for RE.³⁰¹ On discussing the methods used, he concurred, advising that the study was 'realist inspired', contributing useful findings for further study using realist methods.

Realist evaluations in Indigenous health are few. Schierhout, Bailie and colleagues (2013), well into the ABCD Project, with a group of twelve quality improvement workshop facilitators working within the project considered underlying mechanisms behind the wide variation of success in quality improvement between ABCD sites. The study was based on interviews with the workshop facilitators. They determined that collective valuing of clinical data for performance improvement, collective change efficacy and organisational change towards a population health orientation was associated with success in ABCD study sites.³⁰² These influences could well apply to the mainstream general practice setting, with an added layer of complexity being efficacy in relationship building with Indigenous patients, and Indigenous community engagement.

8.3 Review of the study phases

Salter and Kothari (2014), in a review of the use of RE in the assessment of knowledge translation interventions implemented within healthcare environments, presented four phases of the realist evaluation cycle, as applied to knowledge translation to practice²²⁴. These phases are based on Pawson's 'Realist Evaluation Cycle', outlined in Chapter 4 of his original book⁵⁸ and a later workshop. Adapting Salter and Kohari's description, I discuss the four phases of development:

- Phase 1: formulating an initial program theory based on available sources (which may include interviews with practitioners and study designers)—this was carried out to some extent, however detailed “if...then...” statements were not developed into CMOCs that comprehensively covered the situation I summarised the literature and experience of a group of practitioners and their support organisations, and formulating research questions based on evidence for effect on practice. Underlying drivers were not fully considered in this first stage, in contrast to the RE process. Thus the initial framework was too general to focus a deep level of enquiry, and it took a long time for the data to indicate specific directions. This is a trap described by both Pawson & Manzano-Santaella in a 2012 article³⁰³, and by Salter & Kothari²²⁴. A more detailed mapping of Indigenous perspectives at the outset may have generated a framework for a more focused, deeper level of enquiry.
- Phase 2: data collection, which is recommended to be a pragmatic, mixed methods approach—this was achieved through a mix of quantitative and qualitative data collection methods that included audit, observation, and interviews.
- Phase 3: data analysis and hypothesis testing, using the CMOC configurations. One main CMOC was considered, rather than the multiple configurations that would more completely unpack a complex situation, in a non-linear fashion.
- Phase 4: refinement of the CMOC configurations (which may contribute to a generalizable theory). My single framework did yield some focused issues at individual and practice level, so the framework could be further refined, as shown in the italicised text in table 7-2. This could be considered as a starting point for further elaboration of CMOCs to be tested.

In further comparison with the range of reported challenges to implementation, the PIPCGP study did have some advantages. RE is inevitably time and resource intensive. Time and resources were a major challenge for me, addressed by limiting scope of interview-participant types (i.e. policy officers and external managers were not interviewed). There was less time pressure for an outcome as my practice partners saw their main deliverable as the audit results, linked to the 12-month intervention period, and this could be reported on soon afterwards. I would have liked more resources to work more intensively with the practices to gather information on internal quality improvement processes. Although included in the audit data collection form, this feedback was not provided by the practices. The fact that there was just one phase of data collection, as is often the case in RE studies, meant that there has been limited refinement of the

framework. Pawson, in a later text, has advised that each study should be built upon over time.²²²

Defining contextual factors and mechanisms, and the confusion between them, is a reported challenge. After much consideration, I decided on a somewhat pragmatic approach. Longer discussion may have brought more complexity into the initial formulation, incorporating more insight into behavioural motivations and behavioural control. I could have made the framework more detailed by focusing on factors identifiable in the literature and, for example, broadly aligned with quality improvement literature Kaplan et al. (2012) provided a useful model for the study of quality improvement, which describes contextual factors at various levels. Within the microsystem, these include leadership, motivation, capability and culture. Including these aspects in questions to staff might have provided useful information.^{304, 305} However, my exploration of personal interaction factors did highlight their importance in the mainstream environment, and this could now be augmented in future study.

In general, the lack of previous information on identifiable CMOCs was a challenge, although the cultural safety model and quality improvement models could have been applied. Regarding health outcomes, I was able to consider the performance indicators developed within the ABCDE projects as a guide;⁵⁰ however, without any specific software change within the practices, I was limited to collectable items. The PenCAT tool²³⁰, which became widely known around that time, might have been used to obtain additional information. Information collected also needed to be balanced against general practices' perceived need for privacy when working with their colleagues, which may have been a factor in reluctance to report periodically on measures taken within practices (see appendix 3, Research tools).

Distinguishing the effects of simultaneously functioning mechanisms is a reported issue. In this study, two of the high-activity practices of the Inner North group were part of an Indigenous health collaborative project²⁴⁹ focused on chronic disease management, of which health checks were a part, which started soon after the PIPCGP intervention. A Plan-Do-Study-Act model³⁰⁶ was used in this quality improvement project. This would have to be considered as one of a range of quality improvement mechanisms that could have been detailed as an additional CMOC for study, and could have had independent effects on those practices.

The final group of challenges discussed by Salter (2014) was defining and assessing outcomes, as the demand for assessment (from stakeholders, for example) can be complex.²²⁴ I did not have this pressure and included a defined set of outcomes.

8.4 Limitations of the study

Methodological limitations and other study constraints have been described in previous chapters (Chapter 5, 6 and 7) and are briefly summarised here. Audit data reflected not only the PIPCGP intervention, but also other interventions and variations in resourcing, so study question2 could not be fully addressed. The audit frequency could not be maintained in the second (Outer North) group, which limited the use of the data related to that group. The methods used to collect audit information generally provided data that was not high quality, relying on billing rather than clinical record review to count health checks. The final audit format might have been varied to provide an actual count of health checks delivered over 12 months. This single change would have provided data that could be analysed for comparison of changes between groups. Given the small patient population, it may have been possible to review the records of patients at the beginning of the project, and/or review a sample of patients at some point in the intervention, to obtain better quality data and a wider range of data. Examples are information about health-check administration, data systems and the different inputs of staff. Limited information was provided about immunisation, and the accuracy of that information relied on the judgement of a single immunisation support officer. Given the small number of children in the target age group of two to five years, a better way to gather data, within the constraints of personnel and time, may have been simply to gather a copy of the target children's immunisation records for later review. No information was gathered about immunisation of other age groups of Indigenous people. Given that delay in vaccination is an issue in infants, and that additional vaccination is recommended for young people and adults, this study could have provided an opportunity to review performance of the study group in these areas.

Interviews provided valuable information; however, limitations of the data need to be acknowledged. Those recruited represented a range of views and reached saturation in the data but some views may not be represented, such as those of older male Indigenous patients. Intercalating interviews of staff and of Indigenous community members might have allowed for the development of a wider range of lines of questioning of staff suggested by patients. It would have been interesting and productive to bring together the multidisciplinary development team to discuss the findings of the study; however, this

group of people no longer work in the same area. Discussion of results with my Primary Care Network colleagues will, however, be a useful exercise and is planned as part of the next steps, along with discussions with my other colleagues in IUIH. Triangulation of interview findings was undertaken for staff with DGP officers, and for patients with the Indigenous chronic disease team, and with DGP officers. Discussion of patient results with staff and of staff results with patients could have been an additional form of triangulation within the study rather than being used as a follow-on activity. Interviews were confined to patients and health care providers. An understanding of views of higher-level managers and of policy officers may have suggested more strongly the opportunities available to undertake next steps to act on the needs of practices to undertake change.

8.5 Links with other research

Greenhalgh led and authored a systematic review on 'Diffusion of Innovations in Service Organisations' (2004) which emphasised the complexity of these processes and drew together separately –developed concepts from different fields. In her words, the review affirmed

...the useful list of innovation attributes that predict (but do not guarantee) successful adoption; the importance of social influence and the network through which it operates; the complex and contingent nature of the adoption process; the characteristics (both "hard" and "soft") of organisations that encourage and inhibit innovation; and the messy, stop-start, and difficult-to-research process of assimilation and routinization.³⁰⁷

This review has been highly influential, and married well with concepts of RE in emphasising context, social forces and levels of influence. Greenhalgh and Pawson were later co-investigators in the RAMSES II project to develop standards for Realist Evaluation.³⁰⁸

Much of the work we undertook in PIPCGP was compatible with Greenhalgh's framing of the literature from sociology, psychology and evidence-based medicine research, and her contention that an evidence-based innovation undergoes a lengthy period of negotiation amongst potential adopters in which the meaning is discussed, contested and reformed. Perceived complexity of an innovation can be reduced by demonstration or practical experience. Intervention to reduce response barriers improves the chances of adoption. Social discourse can increase or decrease perceived advantage. Where the decision to adopt is collective, sustained success is more likely. We consulted adopters and potential

adopters to develop our support strategy which included codifying the required knowledge, providing feedback on adoption and providing access to ongoing support. We created an interest group of practices with members across the clinical and administrative team who were willing to innovate.

Greenhalgh's review asserted that establishing a practice ('routinization') is promoted by an organisation's capacity to support through a learning culture and resource availability, particularly where there is devolved decision making; by feedback about consequences of adoption and opportunities to modify and improve the innovation. New adopters will be particularly influenced by adopters of similar professional, socioeconomic and cultural background. Opinion leaders can be identified amongst peer groups, and Champions identified amongst organisational managers. Further, active networking between organisations of similar type allows shared meanings may be developed, and the innovation becomes "the norm". A policy 'push' can promote an innovation mainly by providing funding, however where there is not organisational readiness, the effect may be negative, resulting in disengagement from the innovation.³⁰⁷

In the PIPCGP study, both practice managers and doctors were identifiable as Champions. These were very committed to Indigenous health because of identity or experience, and were able to more effectively lead practice staff to change. One doctor was identifiable as an opinion leader by virtue of specific expertise in Indigenous health, and a practice manager who also worked as a general practice accreditor was an opinion leader because of more general expertise. Practice structure and culture were not specifically investigated in the study. Interview material did highlight frustrations within some corporate practices, where, for example, the information system could not be updated, or the duration of appointments could not be varied to better meet the needs of patients.

In Greenhalgh's recent book, the implementation of evidence with patients in the clinical encounter was examined. She maintained that use of evidence depends equally on 'hard' elements of research evidence, guidelines and patient decision tools, and on 'soft' elements of the clinician-patient relationship, active listening and other human qualities.³⁰⁹ In relation to Indigenous patients, cultural safety of the encounter, the relationship and the clinic as an organisation, it seems from the PIPCGP findings, form an additional "soft" element.

Greenhalgh has been critical of evidence-based medicine methods such as the Cochrane EPOC group, as their work examines those who are willing to participate in a trial of an innovation, therefore are aligned with adopters but not non-adopters.³⁰⁹ Further, she described six biases of evidence-based medicine against patients, including a narrow view of patient-centred care as within but not outside the medical consultation, insufficient attention to power imbalances that suppress the patient voice, and exclusion of those who do not access care.³¹⁰ A shortcoming of evidence-based medicine that I have found also is the lack of consideration of history and cultural issues, which I hoped to address in studying this particular local context, where these factors clearly influence each and every clinical encounter.

Having understood that patients view having a health check as the start of a health journey with a primary care provider, the literature of more sustained engagement of patients with the health care system applies. One study that stands out is that of Davy et al. regarding primary health care engagement by Indigenous patients for care of chronic disease, in Indigenous-specific services¹⁷⁰. Davy reviewed the literature, as discussed in section 3.6 and also explored Indigenous people's sustained engagement with Indigenous-specific health services through a large qualitative research project. Ninety seven primary health care staff and 136 Indigenous patients with chronic disease and carers were interviewed across four sites, two of which were urban Indigenous health services. The researchers concluded that enhancing and maintaining strong relationships between patients and providers, and the service being part of the community were major factors that sustained engagement.³¹¹ My research provides additional evidence that the requirement of mainstream health services is in some ways the same. The research leads me to suggest that general practices should see themselves increasingly not as 'mainstream' which defines their exclusionary nature, but as community linked and locally accountable entities, working in collaboration with ACCHOs.

Having realised the strong need for Indigenous social connections in a health care context, urban Indigenous studies that examine both are of interest. A notable study is the Adelaide Aboriginal and Torres Strait Islander health study which explored social links and health in detail. Gallaher et al. (2009) through the use of survey / interviews with Indigenous people found that most experienced racism, predominantly in formal settings such as justice and education, and thought that racism affected their health. Those who experienced more racism were less trusting of institutions. Indigenous people's social connections were described. Group participation was equal with that of other community members, and

groups were mainly sporting groups, Aboriginal community organisations, local council initiatives and volunteer groups. More than half said all or most of their social network were of the same ethnic or cultural group. Most people reported that they attended a GP within their neighbourhood, and many also attended other health services outside the neighbourhood, including an ACCHO, which provided an opportunity to socialise.³¹² The threads suggested in PIPCGP patient interviews have been explained more fully in the Adelaide study. The connection between history of adversity, current racism, and poor access to care is thus illustrated.

The way of using both types of primary care service discussed by Indigenous people in Adelaide is consistent with that described by some PIPCGP participants. Emch, Root and Carrel, regarding health geography, described 'distance decay' patterns of locational analysis of different types of health services by function, reproduced in many countries. Routine care such as immunisation is accessed close to home, with few people travelling far to receive it. Higher level care for major problems is often accessed at greater distances (for example emergency department use), and there is an in-between pattern of initial and then later access to more distant services for acute problems of longer duration.²⁸⁵ Routine healthcare must be convenient and able to fit in with a person's daily life, a neighbourhood engagement that may cause an Indigenous patient to gravitate towards their local general practice. Utilising both mainstream and Indigenous-specific services may be a smart option for some patients, who are able to maintain social ties in this way and also access additional allied health or support services. Those with multi-morbidities, however, may do less well where there is a lack of care coordination.

Looking closely at the levers for change in mainstream services that seem necessary, Gardner (2013) pointed out that the change in health policy emphasis is being enacted through better resourcing of middle management systems.¹⁴¹ Sibthorpe (2016) explained that this has been enacted in Indigenous-specific services through three channels, all driven by data: performance indicators; accreditation standard compliance and CQI.

Performance indicators are adopted for priority conditions over short cycles and should be locally relevant, targeting change in focused activities. Accreditation and standards provides a longer term influence on organisational structure and processes including practice environment, staffing, information systems and community networking. CQI is internally managed, more directly affecting patient activities and outcomes⁴⁶

8.6 Contribution of the PIPCGP study

This study has confirmed barriers in mainstream general practice described in Schutze's study⁴², and highlighted an important additional barrier relating to the quality of the staff patient relationship. I have shown that the relationship focus that is important to Aboriginal and Torres Strait Islander people for chronic disease care in Indigenous specific services evident from Davy's work³¹¹ is just as important for mainstream general practice care. My larger study stands alongside Liaw's work¹⁷⁴ to show that Indigenous status identification in mainstream practices can be quickly improved with specific intervention, but that adding preventive care is more difficult. My study provides evidence that the main barrier is likely to be lack of staff patient relationship building, and has indicated an improved model for relationship building for mainstream practitioners to consider. The further contribution of my study is to put the spotlight on Indigenous immunisation in mainstream general practice. Supporting high rates of immunisation is highly information dependent, and high-activity groups of general practices may be the nexus for change. A specific action resulting from the study was a national level agreement applying to Queensland on National Immunisation Register Indigenous status information- sharing with an Indigenous child's immuniser, to enable catch up of Indigenous schedule vaccines.

8.6.1 Improving community engagement of mainstream practice

The examples provided in section 5.2.2 illustrate some of the Indigenous history and Indigenous community landmarks that abound in Northern Brisbane. Indigenous connections are all around us, but still many general practice staff were unaware of these places and institutions. This speaks to the lack of acknowledgement of Indigenous people in the education system and in daily local life as well as in mainstream health care settings.

Community engagement by the PIPCGP study practices was desired but hard to achieve. The general practices of the study were themselves diverse in that they ranged widely in the number of doctors employed, and Indigenous patient groups concentrated in some of the larger and some of the smaller practices. Some had recognisable Indigenous community groups in proximity to their neighbourhood while others did not. Some practices liaised with a health organisation or an elders group either formally or informally, and a few practices relied on individual interactions with a local Elder to inform the practice. The high community expectations and resultant stress on Elders over time was discussed by them at interview. ACCHOs are recognised as representing the interests of urban Indigenous communities in relation to health matters. ACCHOs are directed by a board of local

community members, spreading the responsibility in a sustainable way, taking some of the pressure off local individuals.

The Indigenous Health Practice incentive and chronic care planning items under Medicare do tie patients to practices for allocating service benefits. In consideration of the need for Indigenous patients to engage with their own community, it is important that the yearly sign-up of patients associated with Medicare requirements be not seen as a call for exclusive allegiance, and does not create discomfort for the patient. Social needs may not be met by their practice. Accountability for preventive care rests either with the Primary Health Network or the local Health Authority. Performance reporting regarding Indigenous preventive care could be made available to local Indigenous communities and their representatives, ACCHOs, as suggested by Couzos.¹⁵¹ ACCHOs can provide leadership, another necessary component of change.

8.6.2 Inclusivity

Mainstream general practice has largely excluded the specific concerns of Indigenous people. Transforming Eurocentric practice to become multi-inclusive is essential for improving health equity in Australia, and including Aboriginal and Torres Strait Islander people is the most critical part of that agenda in Australia. The current major shift in the main treatment model of Australian general practice to patient centred, long-term multidisciplinary practitioner-patient partnerships aims to better address chronic disease.¹⁵³ It is timely to ensure that practice guidelines and accreditation guidelines include mandatory Indigenous status recording and Indigenous-specific protocols, rather than persisting with optional inclusion of these elements. This would increase the visibility to health staff of Indigenous patients who choose to identify, given the opportunity. The RACGP's new 'Standards for Patient Centred Medical Homes' document is framed as applicable to both general practices and ACCHSs, however currently none of the Indigenous protocols are mandatory, all optional.³¹³ Routines of Indigenous identification, Indigenous health checks, and Indigenous immunisation should be built into the fabric of the Medical Home.

8.6.3 Better data availability for practices

National Health Performance Authority Reports have been publicly available at the PHN level, for example in MyHealthyCommunities regional reporting of immunisation¹⁴³ (see section 3.8.4). Health check delivery data is now publicly available for smaller areas via the Indigenous Health Check Tool.¹⁹⁰ Given the general practice interest in audit data, my work suggests that better data availability to practices, for example through Medicare and

through the Australian Immunisation Register, may be an effective influencing strategy, particularly for those practices who see a relatively large number of Indigenous patients.

8.6.4 Aiming for better immunisation coverage

In 2016, the Australian childhood register was expanded to become the Australian Immunisation Register, and vaccine provider payment for information on children under age seven years was re-instituted. The register aims to capture immunisation records linked to Medicare identification of all persons at all ages. This is likely to improve the quality of immunisation history information available to general practices. Much data is captured electronically, and individual encounters can be manually submitted. Patient consent is advised to be sought for recording Indigenous status. Doctors, nurses, pharmacists, and other immunisers can be linked with the register, and can now easily obtain due and overdue reports for the children aged under 7 years that they have vaccinated, based on the national schedule but not the state-based Indigenous schedules³¹⁴.

In the past two years, most states have authorised pharmacists to provide a range of adult vaccines. While this may go some way to improving access to influenza vaccine, the PIPCGP study suggests that the main advice Indigenous people rely upon about both child and adult immunisation is advice from their GP. Public Health Units in this period of change should actively support immunisation data management, practice and networking. They could also have a role in advocating to software producers for better adapted patient records systems, inclusive of preventive care protocols for Indigenous people and utilising visibility of this status at the point of care.

8.6.5 Aiming for more health checks

The national uptake rate of health checks continues to be lowest in metropolitan areas. The PIPCGP study shows that some Aboriginal and Torres Strait Islander people will take up that offer in their preferred general practice, given the right conditions. PHNs continue to commission from ACCHOs or directly provide support to general practices for this service development, in liaison with ACCHOs. Their complementary roles in assisting with accreditation could extend to supporting development of quality improvement activities in the area of Indigenous preventive care, and the organisation of GP peer groups for Indigenous primary care.

8.6.6 Accreditation promotion and appropriate accreditation standards

While accreditation works well for general standards, additional standards that might apply to subgroups in the community need careful consideration. The story I captured in Northern Brisbane practices about accreditation has been that practices in the outer suburbs are more likely to be newly established, to open and close quickly, and to remain unaccredited for longer, cost and time being the barriers to achieving accreditation. These outer suburbs, where housing costs are lower than more central suburbs, have higher concentrations of Indigenous people. Several outer-suburb practices indicated interest in participating in the PIPCGP study but did not persist because of lack of accreditation, which meant they were unable to access the additional financial incentives for Indigenous-patient care. There may be some sense in additional measures to foster accreditation in these areas, for the benefit of all the local inhabitants, perhaps even a targeted approach for practices with higher numbers of Indigenous patients. The elimination of deficiencies within information systems can be driven by the setting of standards and the monitoring of adherence to standards.

8.6.7 Extending the practice of CQI

The reach of CQI seemed to be limited in the PIPCGP study practices. Knight's large collaboratives study, reported in 2012, showed improvement in most process indicators, with the exception of Indigenous access²⁴⁹ While standards already dictate that there is CQI, practices should be well versed in how best to use it for the benefit of a range of patient types. Indigenous-specific projects such as the ABCDE have shown ways to improve CQI and specific targets and strategies appropriate to Indigenous people. Influences identified in research by Schierhout et al. included the team valuing of clinical data for improvement purposes, collective efficacy, and organisational change towards a population health orientation—driven either by strong management or by strong community influence³⁰²

8.6.8 Support of high-activity mainstream practices

Special support of Indigenous high-activity mainstream services might be considered. Targeted upgrading of the internal information system and formal reporting of the activity and outcomes in those practices that, for example, have more than 100 registered Indigenous patients might be considered by health policy makers. This may enable better engagement of all practice staff including practice managers in Indigenous preventive care. The practice reported on by Johanson,²³³ that best exemplified the expanded

Indigenous care role, discontinued the offering of a weekly Indigenous clinic and Aboriginal Health Worker visits once the single organising doctor left the practice.

8.7 Conclusion

The PIPCGP study confirms that barriers in mainstream general practice exist but can be addressed. Indigenous status identification can be improved quickly and with relative ease using existing guidelines, information and resources. Instituting other preventive measures is more challenging and involves relationship building at multiple levels to promote inclusivity.

The findings of the study point to a number of recommendations for practice, policy and future research.

- . 1. Mainstream practice efforts to strengthen patient-centred care of chronic disease should include Indigenous cultural and relationship-focused training for staff, Indigenous patient service planning, and quality improvement.
2. A continued dialogue and partnership between Community Controlled Health Services and Primary Health Networks, with the assistance of Public Health Services, is essential to support practices with concentrations of Indigenous patients.
3. Supply of general practice information systems in Australia which support tailored care for Indigenous people could be another lever for change, as could more detailed activity monitoring linked to financial incentives to provide high quality preventive care.
4. More Indigenous-directed or collaborative research is needed to explore effective provider / Indigenous patient relationships for primary health care in the general community setting. Given the common history of Indigenous groups around the world, it is likely that there are issues in common in this setting, and that we could learn from diverse approaches.

Epilogue

While finalising my thesis I visited my supervisor in Townsville and was able to attend the annual Eddie Koiki Mabo Lecture at James Cook University, 2017. Having lived in Far North Queensland, Mabo has been one of my heroes. This event honours him, a Torres Strait Islander man who worked for Indigenous people throughout his life. The Australian Institute of Aboriginal and Torres Strait Islander Studies has provided a brief history of his life. Mabo was active in the 1967 Referendum campaign, helped found the Townsville ACCHO, was a co-founder and director of the Townsville 'black community school', served on the National Aboriginal Education Committee for three years from 1975, and worked as a groundsman at JCU. In 1982 Koiki, as first plaintiff with four fellow Mer Islanders, made claim for ownership of land on the island of Mer, to the High Court of Australia. He and his solicitor won research grants from the Australian Institute of Aboriginal and Torres Strait Islander Studies to conduct research for the case. After ten years, the High Court decided in favour of the plaintiffs. This decision changed land law in Australia, and the Native Title Act 1993 was passed by the Australian Parliament in the following year. The way was cleared for further traditional land claims. Unfortunately, Mabo had died from cancer, aged fifty-six, four months before the decision.³¹⁵

The talk was convened by Professor Martin Nakata, whose paper on the interface between Torres Strait Islander and Western culture had helped me understand that there were multiple, fluid layers of difference between cultures. He was pleased that an undergraduate student he had mentored would be standing up on the podium.

Professor Megan Davis, an Aboriginal woman, academic, constitutional lawyer, United Nations Human Rights Council expert, member of the Referendum Council and worker for Indigenous people, delivered the talk. She presented the background to the Social Justice Package that, along with constitutional change, was recommended to the Australian Government as part of the response to the Mabo case. There was no discernible response from the government on the package, according to Professor Davis. Two decades later, she said, these issues have been taken up again by the First Nations National Constitution Convention, which issued the Uluru Statement from the Heart on May 26, 2017. This followed six months of discussion around the country with Indigenous people, about options for constitutional recognition. Ten guiding principles were set down, and three actions were supported: truth telling, treaty, and a voice in parliament.³¹⁶

We should learn from this. Modern general practice organisations are partners in care with their activated patients, recognising and assisting patients to build on their strengths and assets along the life course. These organisations are motivated by a desire to help bring about health equity in their local community. It follows naturally, then, that general practices should partner with Aboriginal and Torres Strait Islander people. Individually, many Indigenous people work tirelessly for their community. Collectively, when faced with dispossession, oppression, and continuing discrimination over the last nine generations, Aboriginal and Torres Strait Islander people have taken a long-term approach, based on positivity, sharing, hope and collective action.

The Uluru statement finishes in this way:

*In 1967 we were counted, in 2017 we seek to be heard. We leave base camp and start our trek across this vast country. We invite you to walk with us in a movement of the Australian people for a better future.*³¹⁷ (Referendum Council, 2017)

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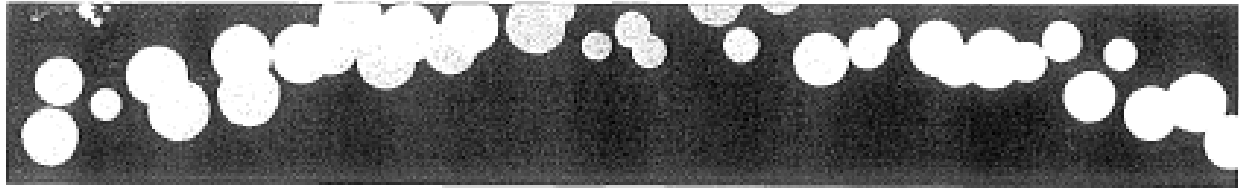
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Appendices

1. Ethical Clearance statements and associated documents
2. PIPCGP Study Tools
3. PIPCGP Workshop Programme and Toolkit contents

8.7 Appendix 1. Ethical Clearance statements and associated documents

Document	Date	Page
Letter of support for the project from the Director, Institute for Urban Indigenous Health	18.05.2010	246
Notification of approval from the Chair, Human Research Ethics Committee, Centre for Healthcare Improvement, Queensland Health	23.06.2010	248
Notification of acceptance of Site Specific Assessment for Moreton Bay Public Health Unit from the Coordinator, Human Research Ethics Committee, Centre for Healthcare Improvement, Queensland Health	08.02.2011	251
Notification of approval from the Chair, Behavioural and Social Sciences Ethical Review Committee, The University of Queensland	06.12.2011	252
Letter of support for modification and extension of the project from the Chief Executive Officer, Institute for Urban Indigenous Health	02.04.2012	254
Notification of approval of amendment to the project from the Coordinator, Queensland Health Central Health Ethics Review Committee	19.04.2012	255
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IUIH
CA- QAIHC
21 Buchanan Street
WEST END QLD 4101

18 May 2010

Dr Sue Vlack
Public Health Physician
Brisbane North
Public Health Unit
Bryden Street, Windsor

Dear Dr Vlack,

**RE: Promoting identification, immunisation and screening of Aboriginal
and Torres Strait Islander people in urban General Practice**

As discussed, I am writing to confirm support of the Institute for Urban Indigenous Health (IUIH) for the above project. As you are aware, the Institute has as one of its key objectives to increase access to service delivery, both mainstream and Indigenous specific for all Aboriginal and Torres Strait Islander peoples in south east Queensland. This project will provide valuable information to assist in planning and service development in this regard.

The IUIH was established in July 2009 as a strategic response to the significant growth and geographic dispersion of the Aboriginal and Torres Strait Islander populations within the south east Queensland region. It has the support of four partnering local Aboriginal Community Controlled Health Services operating in south east Queensland. These organisations support the IUIH to facilitate an integrated approach to urban Indigenous health.

The IUIH has also identified several other external stakeholders, such as Queensland Health, the Divisions of General Practice and the University of Queensland, to engage with as collaborating partners to help identify gaps in service delivery, priority needs for the region and potential avenues for future improvement.

I look forward to working with you and supporting the implementation of the research processes in relation to this important project.

If you require any further information, please contact me on 0408 771 438 or email me at shannoncoughlin@bigpond.com.

Yours faithfully,

A handwritten signature in cursive script, appearing to read 'C. Shannon'.

Prof Cindy Shannon
IUIH Director



Queensland
Government

Office of the Human Research Ethics Committee

23 June 2010

Enquiries to:

Phone: 07 323 59452

Fax: 07 3405 6131

Our Ref: HREC/10/QHC/8

E-mail: martin_paterson@health.qld.gov.au

Dr Susan Vlack
Locked Bag 2
Stafford DC 4053

Dear Dr Vlack

HREC Reference number: HREC/10/QHC/8

Project title: Promoting identification, immunisation and screening of Aboriginal and Torres Strait Islander people in urban General Practice

Thank you for submitting the above project for ethical and scientific review. This project was considered by the QldHealth - Central Office Committee Human Research Ethics Committee (HREC) held on 23 June 2010.

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007)*, *NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007)* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Attached is the HREC Composition with specialty and affiliation with the Hospital (Attachment I).

I am pleased to advise that the Human Research Ethics Committee has granted approval of this research project. The documents reviewed and approved include:

Document	Version	Date
GP/Consultant Information Sheets: Information and consent forms for participants: the practice, practice observation, staff interview, patient interview		01 April 2010
Interview Schedules / Topic Guides: research tools: practice audit, observation guidelines, interview guides.		01 April 2010
Covering Letter		01 April 2010
Summary/Synopsis		01 April 2010
Application		
Response to Request for Further Information		21 May 2010
Response to Request for Further Information: Response letter		21 May 2010
Response to Request for Further Information: Urban Indigenous Health letter		22 June 2010

Please note the following conditions of approval:

1. The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
 - a. Unforeseen events that might affect continued ethical acceptability of the project.

Serious Adverse Events must be notified to the Committee as soon as possible. In addition the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form. In the case of Serious Adverse Events occurring at the local site, a full report is required from the Principal Investigator, including duration of treatment and outcome of event.

2. Amendments to the research project which may affect the ongoing ethical acceptability of a project must be submitted to the HREC for review. Major amendments should be reflected in a revised online NEAF (accompanied by all relevant updated documentation and a cover letter from the principal investigator, providing a brief description of the changes, the rationale for the changes, and their implications for the ongoing conduct of the study). Hard copies of the revised NEAF, the cover letter and all relevant updated documents with tracked changes must also be submitted to the HREC coordinator as per standard HREC SOP. Further advice on submitting amendments is available from http://www.health.qld.gov.au/ohmr/html/regu/regu_home.asp
3. Amendments to the research project which only affect the ongoing site acceptability of the project are not required to be submitted to the HREC for review. These amendment requests should be submitted directly to the Research Governance Office/r (by-passing the HREC).
4. Proposed amendments to the research project which may affect both the ethical acceptability and site suitability of the project must be submitted firstly to the HREC for review and, once HREC approval has been granted, then submitted to the RGO.
5. Amendments which do not affect either the ethical acceptability or site acceptability of the project (e.g. typographical errors) should be submitted in hard copy to the HREC coordinator. These should include a cover letter from the principal investigator providing a brief description of the changes and the rationale for the changes, and accompanied by all relevant updated documents with tracked changes.
6. The HREC will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.
7. The Principal Investigator will provide an annual report to the HREC and at completion of the study in the specified format.
8. The District administration and the Human Research Ethics Committee may inquire into the conduct of any research or purported research, whether approved or not and regardless of the source of funding, being conducted on hospital premises or claiming any association with the Hospital; or which the Committee has approved if conducted outside [name] Hospital Health Service District.

HREC approval is valid to 31 May 2013.

Should you have any queries about the Herd's consideration of your project please contact the Research Ethics and Governance Unit. The HREC terms of Reference, Standard Operating Procedures, membership and standard forms are available from http://www.health.qld.gov.au/ohmr/html/regu/regu_home.asp

Please complete a Site Specific Assessment (SSA) Form for this study and send it to regu@health.qld.gov.au. This is required to complete the final authorisation.

Once authorisation to conduct the research has been granted, please complete the Commencement Form (Attachment II) and return to the office of the Human Research Ethics Committee.

The HREC wishes you every success in your research.

Yours faithfully



for
Professor Mervyn Eadie
CHAIR
HUMAN RESEARCH ETHICS COMMITTEE
CENTRES FOR HEALTHCARE IMPROVEMENT

Office of the Human Research Ethics Committee

8 February 2011

Dr Susan Vlack
Locked Bag 2
Stafford DC 4053



Enquiries to:
Phone: 07 323 59452
Fax: 07 3405 6131
Our Ref: HREC/10/QHC/8
E-mail: martin_paterson@health.qld.gov.au

Dear Dr Vlack

HREC Reference number: HREC/10/QHC/8

Project title: Promoting identification, immunisation and screening of Aboriginal and Torres Strait Islander people in urban General Practice

Thank you for your letter of 2 February providing a Site Specific Assessment (SSA) form for the project as requested in our letter of 23 June 2010 advising that the project had received approval from the Human Research Ethics committee. The SSA form is used in this office to provide agreement for the project to be recorded on the Database of Research Activity.

Please complete the attached Commencement Form and return to the office of the Human Research Ethics Committee.

The HREC wishes you every success in your research.

Yours faithfully

A handwritten signature in black ink, appearing to read "Martin Paterson".

Martin Paterson
Coordinator, Human Research Ethics Committee
Centres for Healthcare Improvement

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THE UNIVERSITY OF QUEENSLAND
Institutional Approval Form For Experiments On Humans
Including Behavioural Research

Chief Investigator: Dr Susan Vlack

Project Title: Promoting Indigenous Preventive Care In General Practice

Supervisor: Dr Andrew Page, Prof Maxine Whittaker, Prof Cindy Shannon

Co-Investigator(s): Dr Christine Selvey, Dr Hai Phung

Department(s): School of Population Health

Project Number: 2011001330

Granting Agency/Degree: PhD

Duration: 30th June 2014

Comments:

Expedited review on the basis of approval from the Queensland Health Central Office Committee HREC dated 23.06.2011.

Name of responsible Committee:-

Behavioural & Social Sciences Ethical Review Committee

This project complies with the provisions contained in the *National Statement on Ethical Conduct in Human Research* and complies with the regulations governing experimentation on humans.

Name of Ethics Committee representative:-

Associate Professor John McLean

Chairperson

Behavioural & Social Sciences Ethical Review Committee

Date

6/12/2011

Signature

Research & Innovation Division

DIRECTOR
Ian G Harris

The University of Queensland
Cunliffe-Stewart Building
Research Road
Brisbane Qld 4072 Australia
Telephone 07 3365 3888
International +61 7 3365 3889
Facsimile 07 3365 4455

Additional Notes to Ethics Approval

1. The clearance number should be quoted on the protocol coversheet when applying to a granting agency and in any correspondence relating to ethical clearance.
2. Clearance will normally be for the duration of the project unless otherwise stated in the institutional clearance form.
3. Adverse reaction to treatment by subjects, injury, or any other incidents affecting the welfare and/or health of subjects attributable to the research should be promptly reported to the Head of School, the Occupational Health & Safety Unit, and the Ethics Committee.
4. Amendments to any part of the approved protocol (including change of Investigator/s), documents, or questionnaires attached to the clearance must be submitted to the Ethics Committee for approval.
5. Unforeseen events that might affect continued ethical acceptability of the project must be immediately reported to the Ethics Committee.
6. Discontinuation of the project before the expected date of completion must be reported to the Ethics Committee, giving reasons.
7. The Chief/Principal Investigator/s are responsible and accountable for full compliance of the protocol by all investigators.
8. The Committee reserves the right to visit the research site and view materials at any time, and to conduct a full audit of the project.
9. It is the Committee's expectation, whenever possible, that work should result in publication. The Committee would require details to be submitted for our records.
10. Staff and students are encouraged to contact either the Ethics Officer (3365 3924), or Chairperson on other issues concerning the conduct of experimentation/research (e.g., involvement of children, informed consent) prior to commencement of the project and throughout the course of the study.

2 April 2012

Dr Susan Vlack
Public Health Physician
Moreton Bay Public Health Unit
PO Box 1025
Redcliffe Q 4020

Dear Dr Vlack

**RE: Promoting Indigenous Preventive Care in General Practice
Extension Project**

I am writing to confirm support of the Institute for Urban Indigenous Health (IUIH) for the proposed modification and extension of this project as documented in your research application and discussed on March 12.

The project is in keeping with aims and activities of the IUIH, in particular with "Close the Gap" activities in support of General Practices planned for the northern Brisbane area.

I look forward to continuing the work with you and supporting implementation and completion of the research processes associated with this project.

If you require any further information, please contact me on ph. 3648 9500.

Yours sincerely,



for

Mr Adrian Carson
Chief Executive Officer

Office of the Human Research Ethics Committee



Queensland Health

19 April 2012

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Our Ref: HREC/10/QHC/8
E-mail: REGU@health.qld.gov.au

Dr Susan A. Vlack
Moreton Bay Public Health Unit
PO Box 1025
Redcliffe, QLD 4020

Dear Dr Vlack

HREC Reference number: HREC/10/QHC/8: Promoting identification, immunisation and screening of Aboriginal and Torres Strait Islander people in urban General Practice
Amendment number: HREC/10/QHC/8/AM01

The above amendment was reviewed at the meeting of the QH Central HREC held on 16 April 2012. I am pleased to advise that the amended documents reviewed and approved at the meeting were:

Document	Version	Date
Summary of Revision & Extension		
Application: NEAF Application Code AU1/D85C016		
Site Specific Participant Information Sheet: Practise Immunisation Data Request	4	13 April 2012
Protocol	2	02 April 2012
Approval from UQ Ethics		

The Qld Health - Central Office Committee HREC is constituted and operates in accordance with the National Health and Medical Research Council's *"National Statement on Ethical Conduct in Human Research (2007)"*, *NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007)* and the *"CPMP/ICH Note for Guidance on Good Clinical Practice"*.

Copies of this letter and supporting documents have been forwarded to the Research Governance Officer at OHMR, on your behalf. The Acknowledgement Letter from the OHMR RGO is enclosed with this letter. You are not required to undertake any further research governance procedures.

It should be noted that all requirements of the original approval still apply.

Yours faithfully


Katrina Brosnan
A/HREC Co-ordinator
QH Central Human Research Ethics Committee



THE UNIVERSITY OF QUEENSLAND
Institutional Approval Form For Experiments On Humans
Including Behavioural Research

Chief Investigator: Dr Susan Vlack

Project Title: Promoting Indigenous Preventive Care in General Practice - 21/01/2016 - AMENDMENT

Supervisor: Dr Andrew Page, Prof Maxine Whittaker, Prof Cindy Shannon

Co-Investigator(s): Dr Christine Selvey, Dr Hai Phung

Department(s): School of Population Health

Project Number: 2011001330

Granting Agency/Degree: PhD

Duration: 30th June 2017

Comments:

Name of responsible Committee:-

Behavioural & Social Sciences Ethical Review Committee

This project complies with the provisions contained in the *National Statement on Ethical Conduct in Human Research* and complies with the regulations governing experimentation on humans.

Name of Ethics Committee representative:-

Associate Professor John McLean

Chairperson

Behavioural & Social Sciences Ethical Review Committee

Date

JPME

Signature

25/1/2016

Additional Notes to Ethics Approval

1. The clearance number should be quoted on the protocol coversheet when applying to a granting agency and in any correspondence relating to ethical clearance.
2. Clearance will normally be for the duration of the project unless otherwise stated in the institutional clearance form.
3. Adverse reaction to treatment by subjects, injury, or any other incidents affecting the welfare and/or health of subjects attributable to the research should be promptly reported to the Head of School, the Occupational Health & Safety Unit, and the Ethics Committee.
4. Amendments to any part of the approved protocol (including change of Investigator/s), documents, or questionnaires attached to the clearance must be submitted to the Ethics Committee for approval.
5. Unforeseen events that might affect continued ethical acceptability of the project must be immediately reported to the Ethics Committee.
6. Discontinuation of the project before the expected date of completion must be reported to the Ethics Committee, giving reasons.
7. The Chief/Principal Investigator/s are responsible and accountable for full compliance of the protocol by all investigators.
8. The Committee reserves the right to visit the research site and view materials at any time, and to conduct a full audit of the project.
9. It is the Committee's expectation, whenever possible, that work should result in publication. The Committee would require details to be submitted for our records.
10. Staff and students are encouraged to contact either the Ethics Officer (3365 3924), or Chairperson on other issues concerning the conduct of experimentation/research (e.g., involvement of children, informed consent) prior to commencement of the project and throughout the course of the study.

8.8 Appendix 2. PIPCGP Study Tools

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Promoting Indigenous Preventive Care

PRACTICE ENROLMENT INFORMATION SHEET

Your general Practice is invited to become one of a group of practices in Northern Brisbane who aim to promote the preventive healthcare of the Aboriginal and Torres Strait Islander people within their practice over the coming 12 months. The purpose of this project is to find out more about the processes of identification, immunisation and health screening of Indigenous people in General Practice, and to evaluate an intervention to assist General Practices to carry out this activity.

This information will be used to assist in improving the provision of services to practices by Divisions of General Practice and by Public Health Services. All the information collected about the practice in this study will be treated in the strictest confidence, and will NOT be available to anyone outside of the research team. Reports published will not identify individuals or specific General Practices. There are no foreseeable risks involved in participating in this study.

This study is being conducted by Dr Susan Vlack as student research in collaboration with academic colleagues, to provide experience and learning under supervision, with the intention of gaining a PhD qualification. The researchers include: Drs Susan Vlack, Christine Selvey and Hai Phung from Queensland Health, Dr Andrew Page and Professors Cindy Shannon and Maxine Whittaker from the University of Queensland. Professor Shannon also represents the Institute for Urban Indigenous Health.

What Participation Involves

Participating practices will be expected to

- conduct a Cultural Identification, Immunisation and Screening Audit on entry to the program, at four months, eight months and at 12 months, to be conducted in cooperation with the Division of General Practice (see audit form)
- enable staff to participate in a pre and post intervention written survey
- ensure in the first three months that at least 2/3 of staff, administrative and clinical, attend a 2 hour workshop for cultural orientation, and
- ensure that at least one clinical staff member of the practice attends a two hour education session about best practice in identification of Indigenous patients, appropriate immunisation and health screening for all age groups of Indigenous people
- give permission for the research team to access the following:
 - de-identified audit results, provided by the Division of General Practice,

Participating practices will be provided with

- a "how to" manual for better utilizing practice software for identification and recall of patients, at the beginning of the intervention period,

- advice and support from the Division of General Practice officer to optimise practice software for Indigenous patient identification and recall
- written materials from the workshop and the education sessions detailed above

Participating practices are encouraged to use the following provided materials within the practice, available throughout the intervention period:

- a patient "update your details" form which features Indigenous Identification, appropriate use of which will be discussed in the workshop
- promotional posters, pamphlets and postcards for patients to be used in the waiting room (identification to Medicare, immunisation)
- an Indigenous adult patient held health card for immunisation and screening

Some practice staff may be invited during the twelve month study period to

- participate in an interview, where individual informed consent is obtained
- participate in an observational study of behaviour in the waiting room, where there is consent of the practice representative
- facilitate interview or survey of Indigenous patients of the practice, where individual informed consent of patients is obtained

The practice might also be contacted by the research team at a later date, on one or more occasions over the next three (3) years, and invited to participate in further research. Practice staff will be under *no obligation* to participate in any further research, if we do contact you.

Information Collected

From all participating practices:

- practice audit at 0, 4, 8, and 12 months (see audit form)
- staff survey pre and post intervention

From some individual participants, where individual informed consent has been obtained

- in-depth interviews with approximately 8 General Practitioners, 4 Receptionists and 10 Indigenous patients in northern Brisbane
- observation in the waiting rooms of 4 practices in northern Brisbane

Participation is Voluntary

Participation in this study is entirely voluntary. Practice participation consent should be signed by the Practice Manager or the Principal Doctor, as the appropriate representative of the practice, and it is expected that the staff groups is aware and consents to participation. It is completely up to the practice representative to decide whether or not the practice should participate in this project. The decision to participate or not will not affect support available to your practice from Division of General Practice staff.

Freedom to Withdraw

Although we ask for a 12 month commitment, your practice is free to withdraw from this study at any time, and for any reason. Staff are also free to not answer any specific questions, should they choose not to. A decision to withdraw from the study or skip particular questions will NOT affect how staff are treated by practice support staff in the community.

Confidentiality

All information collected during this study will be treated in confidence. Individual staff, patient or Practice names will NOT be recorded on interview or survey responses, but kept separately. Only members of the research team will have access to the collected information, and any reports will be written in a way that the practice and individual identities are protected.

Benefits

Preventive care can assist in closing the gap in health and life expectancy for the Indigenous people who attend the practice. Participating practices will be supported to implement best practice guidelines in preventive health care for Indigenous people. Knowledge gained from the study will inform improvements to support services for General Practice. Indigenous health screening is well remunerated by Medicare, and high immunisation coverage within the practice is rewarded by provider incentive.

Enquiries

If you have any questions about this study please contact Dr Susan Vlack at the Brisbane North Public Health Unit on (07) 3624 1100.

This study adheres to the Guidelines of the ethical review process of Queensland Health and of The University of Queensland. Whilst you are free to discuss your participation in this study with project staff (contactable on 07 3624 1100), if you would like to speak to an officer of Queensland Health or of the University not involved in the study, you may contact the Ethics Officer on (Queensland Health) or 07 3365 3924 (The University of Queensland).

Attachment: Audit form (13pages)

Promoting Indigenous Preventive Care

CONSENT FORM FOR THE PRACTICE

I (print name), _____ as
representative of _____ (General Practice) in
my role as _____ (position at practice) agree to the
practice being part of this study. I have read the Information Sheet and I fully understand the nature and
purpose of this study and what is required of me and of other practice staff.

I have read the project information sheet. I understand that the practice is **free to withdraw** from this
study at any time, and for any reason. I understand that even if I do consent to participation of the
practice, I and other individual practice staff have the right not to answer any particular question or
participate in any particular activity, should I/they choose not to. I also understand that any direct
involvement of patients will be on the basis of their individual informed consent.

I understand that all information collected during this study will be treated in **total confidence**, and that
my responses and those of other staff and patients will be stored securely. Names will NOT be recorded
with responses but kept separately. Only members of the research team will have access to the
information that is gathered, except in relation to the practice audit which is primarily a tool to be used
by the practice in cooperation with the Division of General Practice. Audit forms completed by
intervention practices will be passed on to the research team by the Division of General Practice in de-
identified form.

I understand that the research team may contact me on one or more occasions during the next three
years, and invite individual staff or the practice to participate in further research. I understand that staff
members and the practice will be under no obligation to participate in any further research, should I be
invited to do so.

The study has been fully explained to me by _____.

I understand that I can contact Dr Susan Vlack from Queensland Health Central Regional Public Health
Services on 3142 1812, if I have any questions.

Signed: _____ Witness _____

Full name: _____ Full name: _____

Date: _____ Date: _____

Promoting Indigenous Preventive Care

INFORMATION SHEET

Your general Practice has agreed to become one of a group of practices in Northern Brisbane who aim to promote the preventive healthcare of the Aboriginal and Torres Strait Islander people within their practice over the coming 12 months. The purpose of this project is to find out more about the processes of identification, immunisation and health screening of Indigenous people in General Practice, and to evaluate an intervention to assist General Practices to carry out this activity.

This information will be used to assist in the provision of services to practices by Divisions of General Practice and by Public Health Services. All the information collected about the practice in this study will be treated in the strictest confidence, and will NOT be available to anyone outside of the research team. Reports published will not identify individuals or specific General Practices. There are no foreseeable risks involved in participating in this study.

A key element of preventive health care for Indigenous people is identification for care, and research suggests there are social barriers for both staff and patients that affect the process of Indigenous identification.

What is an observational study?

Direct observation is one way of gathering information about behavioural interactions, particularly where there are sensitive issues involved. The observer sits unobtrusively within the setting and records what happens, focusing on behaviours and interactions of interest.

What Participation Involves

The participants are the staff of the practice, and the patients attending the practice, in the reception area / waiting room. The staff and patients go about their usual activities.

An interviewer will be present in the waiting room. One task will be to observe activities in the waiting room. Another task, usually undertaken after the patient has registered, will be to invite Indigenous patients to be interviewed. This would be a process of explaining the study, asking about Indigenous status, obtaining informed consent for interview, and arranging an appointment for or conducting interviews with Indigenous people.

Information Collected

The observer will write "field notes" about the general environment and activity, and about receptionists and others conducting processes in the waiting room such as registering a new patient, updating patient details, making an appointment for another time, and managing the waiting patients.

Participation is Voluntary

Participation in this study is entirely voluntary. It is completely up to you to decide whether or not the practice should participate in this project.

Freedom to Withdraw

You are free to withdraw from this study at any time, and for any reason. You are also free to not answer any specific questions, should you choose not to. A decision to withdraw from the study or skip particular questions will NOT affect how you are treated by practice support staff in the community.

Confidentiality

All information collected during this study will be treated in confidence. Individual staff, patient or Practice names will NOT be recorded the final record of observation. Only members of the research team will have access to the collected information, and any reports will be written in a way that the practice and individual identities are protected.

Benefits

Understanding how best to interact with Indigenous patients can assist in those patients accepting the care that is offered and becoming a regular patient of the practice, enabling opportunities for continuity of care and preventive care. Preventive care and care planning for chronic conditions can assist in closing the gap in health and life expectancy for the Indigenous people who attend the practice. Knowledge gained from the study will inform improvements to support services for General Practice.

Enquiries

If you have any questions about this study please contact Dr Susan Vleck at the Brisbane North Public Health Unit on (07) 3624 1100.

This study adheres to the Guidelines of the ethical review process of Queensland Health and of The University of Queensland. Whilst you are free to discuss your participation in this study with project staff (contactable on 07 3624 1100), if you would like to speak to an officer of Queensland Health not involved in the study, you may contact the Ethics Officer on 3234 0034.

Attachment: objectives of observational study

Promoting Indigenous Preventive Care

CONSENT FORM FOR WAITING ROOM OBSERVATION

I (print name), _____ as practice manager or principal doctor of

_____ (General Practice name)

_____ (General Practice address)

agree to the observation of waiting room conditions and behaviour being recorded as part of this study. I have read the Information Sheet and I fully understand the nature and purpose of this study, and what is required of me and of other practice staff.

I understand that the practice is **free to withdraw** from this study at any time, and for any reason. I understand that even if I do consent to participation of the practice, I and other individual practice staff have the right not to answer any particular question or participate in any particular activity, should I/they choose not to.

I understand that all information collected during this study will be treated in **total confidence**, and that recordings about staff and patients will be stored securely, and that individual's names will not be recorded. Only members of the research team will have access to the information that is gathered.

The study has been fully explained to me by _____.

I understand that I can contact Dr Susan Vlack from Queensland Health Public Health Services on 36241100, if I have any questions.

Signed: _____

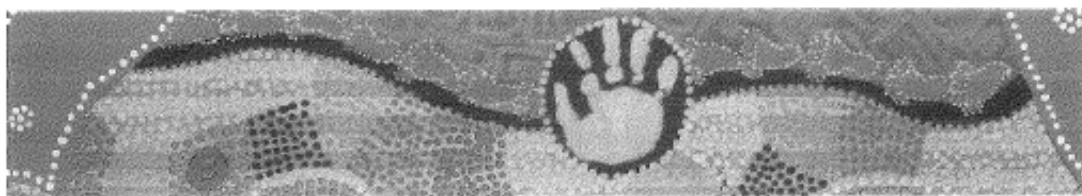
Witness _____

Full name: _____

Full name: _____

Date: _____

Date: _____



Promoting Indigenous Preventive Care

STAFF INTERVIEW **INFORMATION SHEET**

The General Practice you work in is one of a group of practices in Northern Brisbane who aim to focus on promoting the preventive healthcare of the Aboriginal and Torres Strait Islander people over the coming 12 months. The immunisation and health screening the practice will be promoting is recommended for all Aboriginal and Torres Strait Islander people in Australia.

The purpose of this project is to find out more about the processes of identification, immunisation and health screening of Indigenous people in General Practice, and to assess the support that is provided to assist General Practices to carry out this activity.

This information will be used to improve support for General Practices, so that they may provide immunisation and health screening for Aboriginal and Torres Strait Islander people and their families in a culturally secure and acceptable way.

This study is being conducted by Dr Susan Vlack as student research in collaboration with academic colleagues, to provide experience and learning under supervision, with the intention of gaining a PhD qualification. The researchers include: Drs Susan Vlack, Christine Selvey and Hai Phung from Queensland Health, Dr Andrew Page and Professors Cindy Shannon and Maxine Whittaker from the University of Queensland. Professor Shannon also represents the Institute for Urban Indigenous Health.

All the information you give for this study will be treated in the strictest confidence, and will NOT be available to anyone outside of the project team. Reports published will not identify individuals or specific General Practices. There are no foreseeable risks involved in participating in this study.

What Participation Involves

It is asked that you spend about 30 minutes giving your views and answering questions about Indigenous identification, immunisation and health screening within your current practice and in general. This could be done today or at another time more suitable to you.

The interview will be conducted by a project worker who is independent of the practice. The interview will be recorded on tape, and the interviewer may take notes. The interviewer may recontact you by phone at a later date to clarify points discussed in the interview.

Participation is Voluntary

Participation in this study is entirely voluntary. It is completely up to you to decide whether or not you participate in this project.

Promoting Indigenous Preventive Care

CONSENT FORM FOR STAFF INTERVIEW

(full name)

Date of Birth ____/____/____

Male ☐

Female ☐

of _____ (____)
(address) (phone)

Are you of Aboriginal or Torres Strait Islander origin?

Yes, ☐ Aboriginal

Yes, ☐ Aboriginal and Torres Strait Islander

Yes, ☐ Torres Strait Islander

No ☐

Please specify your ethnicity: _____

I consent to interview regarding preventive health care for Aboriginal and Torres Strait Islander people in General Practice.

The project has been explained to me. I understand that the information given is **confidential** and will be available only to the project team, and not to practice staff. I understand that my responses will be stored securely. I understand that I will not be identifiable in any reports of the project.

I understand that I am **free to withdraw** from the interview at any time, and for any reason.

I understand that even if I do consent to participation in the interview, I have the right not to answer any particular question should I choose not to.

The study has been fully explained to me by _____.

I understand that I can contact Dr Susan Vlack from Queensland Health Public Health Services on 3142 1812, if I have any questions.

Signed: _____

Witness _____

Full name: _____

Full name: _____

Date: _____

Date: _____

Promoting Indigenous Preventive Care

PATIENT INTERVIEW INFORMATION SHEET

The purpose of this project is to find out more about the processes of identification, immunisation and health screening of Indigenous people in General Practice, and to assess the support that is provided to assist General Practices to carry out this activity.

This information will be used to improve support for General Practices, so that they may provide immunisation and health screening for Aboriginal and Torres Strait Islander people and their families in a culturally secure and acceptable way.

All the information you give for this study will be treated in the strictest confidence, and will NOT be available to anyone outside of the project team. Reports published will not identify individuals or specific General Practices. There are no foreseeable risks involved in participating in this study.

What Participation Involves

It is asked that you spend about 20 minutes giving your views and answering questions about Indigenous identification, immunisation and health screening for you and your family in General Practices you have attended. This could be done today or at another time more suitable to you.

The interview will be recorded on tape, and the interviewer may take notes. The interviewer may recontact you by phone at a later date to clarify points discussed in the interview.

Participation is Voluntary

Participation in this study is entirely voluntary. It is completely up to you to decide whether or not you participate in this project.

Freedom to Withdraw

You are free to withdraw from this study at any time, and for any reason. You are also free to not answer any specific questions, should you choose not to. A decision to withdraw from the study or skip particular questions WILL NOT affect your healthcare in any way.

Confidentiality

All information collected during this study will be treated in confidence. Individual patient or Practice names will NOT be recorded on final records of interview. Only members of the project team will have access to the collected information, and any reports will be written in a way that practices and individual identities are protected.

Benefits

Preventive care can assist in closing the gap in health and life expectancy for Aboriginal and Torres Strait Islander people. This study will help General Practices to provide recommended immunisation and health screening for Indigenous people in a culturally secure and acceptable way. Knowledge gained from the study will inform improvements to support services for General Practice. The practice receives Medicare funding to provide Indigenous health screening and immunisation.

Enquiries

If you have any questions about this study please contact Dr Susan Vlack at the Moreton Bay Public Health Unit on (07) 3142 1800.

This study adheres to the Guidelines of the ethical review process of Queensland Health and of The University of Queensland. If you would like to speak to an officer of Queensland Health or of the University not involved in the study, you may contact the Ethics Officer on 07 3405 6121 (Queensland Health) or 07 3365 3924 (The University of Queensland).

Promoting Indigenous Preventive Care

CONSENT FORM FOR PATIENT INTERVIEW

I, _____
(full name)

of _____
(address) (phone)

consent to interview regarding preventive health care for Aboriginal and Torres Strait Islander people in General Practice.

The project has been explained to me. I understand that the information given is confidential and will be available only to the project team, and not to practice staff. I understand that my responses will be stored securely. I understand that I will not be identifiable in any reports of the project.

I understand that I am free to withdraw from the interview at any time, and for any reason.

I understand that even if I do consent to participation in the interview, I have the right not to answer any particular question should I choose not to. I understand that my participation or refusal to participate will not affect my healthcare within the practice in any way.

The study has been fully explained to me by _____.

I understand that I can contact Dr Susan Vlack from Queensland Health Public Health Services on 3142 1800, if I have any questions.

Signed: _____

Witness _____

Full name: _____

Full name: _____

Date: _____

Date: _____

Date of Audit: _____

Practice postcode: _____ Practice Suburb: _____

Background Information for the practice, during the past four months

No. attended relevant educational session

Number of receptionists: _____

Number of male doctors: _____

Number of female doctors: _____

Number of practice nurses: _____

Number of trained nurse immunisers: _____

Number of Indigenous staff: _____

Number of staff who have left: _____

At present:

Number of patients registered _____

Number of Indigenous patients registered _____

AGPAL Accreditation status: _____

☐

currently accredited

	☐ Accreditation scheduled or in progress ☐ No accreditation	
Bulk billing policy includes	☐ all patients ☐ Immunisation	☐ concession card holders ☐ Indigenous health check ☐ none of these

Practice opening hours: _____

Distance to nearest public transport link: _____

Indigenous community transport to the practice available ☐ Yes ☐ No

Promotion of cultural identification

Does the practice have a primary person responsible for recording Indigenous Identification? ☐ Yes ☐ No

Is cultural awareness and Indigenous Identification included in orientation for new staff members? ☐ Yes ☐ No

Does your practice promote Indigenous Identification Via?

☐ On hold message system

☐ Television monitor

Do you have any of the following on display

☐ Aboriginal or Torres Strait Islander Art

☐ Posters and pamphlets on why Indigenous identification is necessary

☐ Indigenous health promotion posters and pamphlets

☐ Indigenous magazines

☐ Aboriginal or Torres Strait Islander flag

Waiting room

☐
☐
☐
☐
☐

Treatment room

☐
☐
☐
☐
☐

Consult rooms

☐
☐
☐
☐
☐

Does the practices new patient information form include the nationally agreed standard Indigenous status question for health and community service?) ☐ Yes ☐ No

Are you of Aboriginal or Torres Strait Islander origin?	
Yes, ☐ > Aboriginal	Yes, ☐ > Aboriginal and Torres Strait Islander
Yes, ☐ > Torres Strait Islander	No ☐

Any further comments?

Follow-up/action discussed with clinical team	Undertaken by:	Division assistance required E.g.: resources, education, practice visit
	☐ Practice manager ☐ Nurse ☐ GP ☐ Other	

Recording cultural identification

Is your practice:

- ☐ Computerized
☐ Paper-based
☐ Both

What software does your practice use?

- ☐ Medical Director/Pracsoft®
☐ Practix®
☐ Best Practice®
☐ Zedmed®
☐ Other

How does your practice record a patient's cultural background?

- ☐ It is recorded in the patient details tab in Medical Software
☐ It is recorded in clinical notes
☐ It is recorded in billing program
☐ A note is made on summary sheet of paper based record
☐ Other

Does the practice reception area have a private area available for patients wishing to disclose information verbally?

- ☐ Yes ☐ No

Any further comments?

Follow-up/action discussed with clinical team	Undertaken by:	Division assistance required E.g.: resources, education, practice visit
	☐ Practice manager ☐ Nurse ☐ GP ☐ Other	

Immunisation and Health checks

Do you have pamphlets/posters on Indigenous Immunisation in your waiting room

☐ Yes ☐ No

Are all staff aware of additional vaccines funded for Indigenous people

☐ Yes ☐ No

How does your practice report additional Indigenous childhood Immunisations?

☐ Electronically /Medicare online

☐ Manually via computer printout or VIVAS paper record

How does your practice report additional Indigenous young people and adult Immunisations?

☐ Manually via computer printout or VIVAS paper record

☐ Do not report

Do you have pamphlets/posters on Indigenous health checks in your waiting room?

☐ Yes ☐ No

Are your staff aware of Indigenous Health checks

☐ Yes ☐ No

Does your practice have a system for generating recall/reminders for additional Indigenous Immunisations and health checks?

☐ Computer generated letter

☐ Manually generated letter

☐ Telephone

☐ SMS

Any further comments?

Follow-up/action discussed with clinical team	Undertaken by:	Division assistance required E.g.: resources, education, practice visit
	☐ Practice manager ☐ Nurse ☐ GP ☐ Other	

Clinical data base search

Baseline.../.../... 6 months.../.../... 12 months.../.../...

Number of Indigenous patients aged 0-14 (print list)			
Number of Indigenous patients aged 15-54			
Number of Indigenous patients aged 55+			
Number of Indigenous people who have received Influenza vaccine in last 12 months			
Number of Indigenous people over the age of 15 who have received Pneumovax 23 in last 5 years			

Billing data base search

Baseline .../.../... 6 months.../.../... 12 months.../.../...

Number of child health checks (item 708)			
Number of Adult health checks (item 710)			
Number of Older person health checks (item 704)			
Number of older person health checks (item 706)			
Number of Health assessments (item 715) from 1st May 2010			
Number of follow up visits with practice nurse/AHW (item 10987)			

ACIR search

Number of Indigenous children who are fully immunised according to ACIR (including Hep A & Pneumovax 23®)	
---	--

Any further comment?

Activity Sheet

Name:

Date:

Description	
What do you want to achieve?	
Plan	
What exactly will you do?	
Who will carry out the plan?	
When will it take place?	
Where?	
Practice? Other?	(please specify):
What do you predict will happen	
What data/information will you collect to know whether there is an improvement?	

Sample Activity Sheet

Name: Top Practice

Date: 01/04/2010

Description
What do you want to achieve?
Ensure all Indigenous children's Immunisation records are up to date in clinical program and on ACIR.
Plan
What exactly will you do?
• Print list of children identified as indigenous on our database • Print up history from ACIR secure site for each child • Check history against clinical notes and child health record book • Update clinical notes as required • Notify ACIR of vaccines given but not recorded on secure site. • Set recall for due/overdue vaccinations ensuring additional vaccines required at 18 and 24 months are set.
Who will carry out the plan?
Practice nurse
When will it take place?
The week commencing 5 th April 2009.
Where?
Practice – spare consult room with internet access
What do you predict will happen
There will be discrepancies between what is recorded in clinical program, health record book and on ACIR.
What data/information will you collect to know whether there is an improvement?
Number of clinical records updated Number of encounters notified to ACIR Number of child health books updated

Staff Interview Guide

The interviewer will aim to interview GPs and other Clinical Staff, Practice Managers and Receptionists. Both genders should be included and the questions should be similar for each category.

It is a pre-requisite that there is a private space for interviews, i.e. a separate room out of sight and hearing of practice staff and patients. The interviewer will aim to interview staff at the practice, but also offer the alternative of an interview at another location (particularly where the practice is small), or a phone interview at a more convenient time, or a future day at the practice as a fourth option.

Question Guide:

1. What has been your experience of dealing with Aboriginal and Torres Strait Islander patients?
2. Do you think Indigenous patients are comfortable in the practice? (Expand)
3. Why/ why not?
4. Which records system does your practice use?
5. How can the practice work better or smarter to:
 - identify Indigenous patients?
 - deliver all immunisations recommended for all Indigenous age groups?
6. Is the practice geared up to offer Indigenous health checks for children and adults?
7. What barriers have you experienced to the change?
8. How could Health checks activities be better supported? (Expand)
9. Invite feedback about the intervention.

Patient Interview Guide

All interviewees should be selected as identifying as Aboriginal and/or Torres Strait Islander and be over 18 years of age. Both genders and a range of ages should be included.

It is a pre-requisite that there is a private space for interviews, i.e. a separate room out of sight and hearing of practice staff and patients. The interviewer will aim to interview Indigenous patients at the practice, but also offer the alternative of an interview at another location (particularly where the practice is small), or a phone interview at a more convenient time, or a future day at the practice as a fourth option.

The interviewer should also offer the patient the opportunity to have another Indigenous person of their choice accompany them at interview.

Question Guide:

1. What has been your experience of being a patient at mainstream General Practices?
2. Do you think Indigenous patients are comfortable in the practice? (*Expand*)
3. Why/ why not?
4. Did you identify as an Indigenous person at your first visit?
5. Please tell me about your experience identifying
6. How can the practice work better or smarter to:
 - be a comfortable place for Indigenous patients?
 - identify Indigenous patients for their records?
 - deliver all immunisations recommended for all Indigenous age groups?
7. Have you or a family member (child or adult) ever come in when not sick , and had a health check at this practice or another mainstream General Practice.
8. What do you think about these health checks? (*Expand*)

Waiting Room Observation Guide

Objectives:

1. To describe the interaction between the patients and the staff, including Indigenous patients and staff
2. To note positive or negative features on the part of staff and of patient.
3. To note any effect the presence of the observer seems to have on the situation.

Activities to document:

1. Observe the patients as they come in and are greeted – who they talk to, where they sit, the visual and reading material or other they have to use, the setup with regard to children waiting
2. Observe a patient registering to see a doctor:
booked appointment - on time / late
drop in
3. Observe the process of waiting and any continuing interaction between the staff and patient
4. Observe a new patient registering : the process of recording the required information, the positive and negative aspects from the point of view of the patient
5. Observe the ascertainment of Indigenous status
6. Observe a patient being bulk billed and/or paying for a consultation
7. Observe a patient making a new appointment or asking for another service
8. Observe unusual activity or interactions

8.9 Appendix 3. PIPCGP Workshop Programme and Toolkit contents

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TOOLKIT	289
PART ONE: Information on Indigenous health and preventive care	
PART TWO: Resources for use in the practice	
PART THREE: Local resources developed or adopted for workshop	
PART FOUR: Promoting Indigenous preventive care study tools	

Program

Event	Don't Meet Difference with Indifference – Indigenous Cultural Awareness
Date	Tuesday 17 th November, 2009
Activity #	746751 – 4 x Category 2 QA&CPD RACGP Points
Venue	GPpartners Training Room, Centro Lutwyche 543 Lutwyche Road, Lutwyche Qld 4030
Speakers	Tammy Pope, Indigenous Management and Professional Services Dr. Sue Vlack, Public Health Physician, Brisbane Northside PHU Bronwen Cox, GPpartners

Course Coordinator Bronwen Cox

Time	Program
6:30 – 6.45pm	Registration & dinner
6.45 – 7.45pm	Tammy Pope, Indigenous Management Professional Services
7.45 - 8.00pm	Break
8.00 – 8:30 pm	Dr. Sue Vlack, Public Health Physician, Brisbane Northside PHU Identification, Immunisation and Screening Project.
8:30 – 9.00 pm	Bronwen Cox Indigenous Health Checks
9 – 9.15pm	Evaluation and Close

GPpartners is an accredited Royal Australian College of General Practitioners provider of CPD activities for general practitioners. This activity has been awarded QA&CPD points.

This activity has been endorsed by APEC number 000901330 on behalf of Royal College of Nursing, Australia according to approved criteria. Attendance at this seminar earns you 2 Continuing Nursing Education (CNE) points as part of the Royal College of Nursing, Australia Life Long learning Program.



PIPC PRACTICE TOOLKIT

PART ONE: Information on Indigenous health and preventive care

Introduction to the Study and Clinical Aspects Power Point presentations, October 2010. Dr Susan Vlack, Moreton Bay PHU, Queensland Health.

RACGP on line cultural awareness training for General Practice Staff: availability, description, requirements for Indigenous Practice Incentive Payment

The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples 2003, policy brief from The University of Queensland Centre for Burden of Disease and Cost Effectiveness.

Australian Bureau of Statistics Factsheets

Diabetes in the Aboriginal and Torres Strait Islander population

Tobacco smoking in the Aboriginal and Torres Strait Islander population

Health of Aboriginal and Torres Strait Islander Males

Health of Aboriginal and Torres Strait Islander Females

Eckermann AK, Dowd T, Chong E, Nixon L, Gray R, Johnson S *BINAN GOONJ: Bridging Cultures in Aboriginal Health 2nd Edition* Churchill Livingstone Elsevier Australia, Sydney, 2006

Chapter 5: Cross-cultural communication and culture shock, pp 103-146

Couzos S and Murray R. *Aboriginal Primary Health Care: An Evidence-based Approach 3rd Edition*. Oxford University Press, 2008

Chapter 4: Organising Prevention, pp 114-130

Chapter 5: The Well Person's Health Check, pp 131-194

PART TWO: Resources for use in the Practice

Closing the Gap Frequently Asked Questions for health professionals (Medicare brochure)

PATIENT INDIGENOUS IDENTIFICATION:

New Patient Information form (Australian General Practice Accreditation Ltd)

"Ask the Question" brochure (Australian Institute of Health and Welfare)

"Your Cultural Background" CALD/ Indigenous patient details update form

"Recording Indigenous Status" on practice software: Best Practice; Genie; Medical Director; Practix (GP Partners DGP article)

Instructions for best utilizing practice software for Indigenous identification, alert and recall (GP Partners DGP article)

National best practice guidelines for collecting Indigenous status in health data sets (Booklet, AIHW, 2010)

PATIENT HEALTHCHECK GUIDELINES (NACCHO / RACGP):

Indigenous Child Preventive Health Life Cycle Summary

Summary of Child Health Recommendations

Indigenous Adult Preventive Health Life Cycle Summary

Summary of Adult Health Recommendations

Fagerstrom Test of nicotine dependence

PATIENT HEALTH CHECK ADMINISTRATION (Medicare):

Aboriginal and Torres Strait Islander Health in General Practice – a summary of MBS, PIP, PBS and specific health services (GP Partners DGP)

Medicare Benefits Schedule (item 715) Health Check Fact Sheet

Medicare Child Health Assessment (0-14) Fact Sheet

Medicare Adult Health Assessment (15-54) Fact Sheet

Medicare Older Person (55+) Health Assessment Fact Sheet

Medicare Benefits Schedule (item 10987) Practice Nurse/ Indigenous Health Worker Follow up Fact Sheet

Medicare Benefits Schedule (items 81300-81360) Allied Health Service Fact Sheet and Referral form

GP Referral for Dental Service under Medicare for people with chronic and complex conditions Fact Sheet and Referral Form

PRACTICE INCENTIVE PROGRAM, INDIGENOUS HEALTH (Medicare)

Medicare guidelines

PIP IHI Application for the Practice

Patient Registration for PIP IHI and PBS co-payment

Patient Consent for PIP IHI and PBS co-payment

Patient Withdrawal of Consent for PIP IHI and PBS co-payment

PIP IHI and PBS Co-payment measure Fact Sheet for patients

Indigenous PIP IHI Calculator, (Moreton Bay DGP) for second study group.

IMMUNISATION SCHEDULE (Queensland Health)

Wallchart: All ages, general, medical risk and Indigenous specific, featuring pictures of vaccine boxes and listing of patient eligibility for funded vaccines.

PART THREE: Local resources developed or adopted for workshop

"UPDATE YOUR DETAILS" A5 tear off pad: single page form for patients recording Indigenous status; address; telephone numbers (GP Partners DGP)

INDIGENOUS ADULT-HELD RECORD CARD: immunisation schedule and screening service dates (Moreton Bay PHU)

INDIGENOUS IMMUNISATION POSTCARDS AND POSTER SETS for practices (Moreton Bay PHU):

“Prickle on Time” Indigenous schedule featuring 4 age groups:

infant; young child; young people; elders

LAPEL PIN: Workshop participants were provided with a lapel pin depicting three Australian flags: The national flag, the Aboriginal flag and the Torres Strait Islander flag.

PART FOUR: Promoting Indigenous Preventive Care Study Tools

Study summary

Practice Audit form

Staff Interview guide

Patient interview guide

Waiting Room observation guide