



## Literature review

### **Barriers and challenges mainstream practices face in delivering culturally targeted and responsive healthcare for Aboriginal and Torres Strait Islander people.**

#### ***Purpose***

For the information of the Project Reference Group and to inform project activities, this paper provides findings from a literature review conducted by Dr Tim Senior exploring barriers and challenges mainstream practices face in delivering culturally targeted and responsive healthcare for Aboriginal and Torres Strait Islander people.

#### **Background**

As part of the project to implement the third edition of the NACCHO/RACGP National Guide to a Preventive Health Assessment in Aboriginal and Torres Strait Islander people, we performed a two-part review of the literature to inform our approaches to ensure that the best available evidence was being used to implement changes across the system.

The first part of the review looked at best practice approaches for implementing clinical guidelines, both in the ACCHO sector and in the mainstream general practice sector.

The second part of the literature review identifies challenges and barriers face by mainstream general practices in providing care for Aboriginal and Torres Strait Islander patients.

It should be noted that these literature reviews are an environmental scan of the literature, and not a systematic review. Many of the publications are reports (classified as grey literature) rather than published in peer-reviewed journals. The overall project is one of practical implementation, with the goal of widespread use of a guideline, rather than an overview of the academic literature regarding implementation science, and limits of time and capacity have made this a pragmatic literature review, as is appropriate for a project of this sort.

#### **Lessons for the National Guide Project**

The findings of this literature review are applicable to the mainstream services in the project. It will be important for the governance and running of the project to involve Aboriginal and Torres Strait Islander leadership at all stages, and for this to be visible to practices.

Practices will need to acknowledge that it is likely that their Aboriginal and Torres Strait Islander patients will have had adverse experiences in the health system, possible even in their practices, and to be guided in taking steps to remedy this. It is highly unlikely that training or education of practice staff on its own will achieve this, and practices will need support and guidance in achieving this from Aboriginal and Torres Strait Islander people and organisations involved in the project.

The nature of the collaboratives methodology means practices are able to develop and trial their own methods in practice, and share these. It would be helpful for the RACGP to be able to capture these and

report on them, as measures that enhance the quality of care for Aboriginal and Torres Strait Islander patients that can be shared with other practices more widely may have a more broad impact.

### **Findings of the literature review**

Part two of the literature review had more complex findings than part one, due to the range of settings, methodologies and perspectives. Much of the research was based on surveys or focus groups of health professionals, and these were often non-Indigenous professionals. However, the perspectives of Indigenous and non-Indigenous people were often different, as highlighted by McBain-Rigg and Veitch (1). Therefore, evidence formed by the opinions of Aboriginal and Torres Strait Islander people will be privileged in this review, as this is more likely to reflect the actual barriers as experienced by those using the service, rather than perceived barriers by those not experiencing them.

Some of the evidence comes from systematic reviews, and these provide a consolidation of evidence from a range of areas, frequently with thematic analysis, and commentary on the quality of the evidence and strength of the findings. Systematic reviews, therefore, are more likely to provide evidence of challenges and barriers, as well as ways of overcoming them, that will be applicable across the country in a range of settings.

While this literature review looks at the barriers and challenges faced by practices, most of the research also looks at potential solutions, and these will also be described, especially where there are congruent solutions identified across the literature.

### **Findings from general Systematic Reviews**

One of the main findings in the systematic review by Gwynne, Jeffries and Lincoln confirms the underlying need for research such as that described here, and projects such as the implementation of the National Guide. It is that Aboriginal people fare worse than non-Aboriginal people when accessing usual healthcare services (2). The papers they include demonstrate that usual mainstream care doesn't take account of specific needs of Aboriginal and Torres Strait Islander people. They also show, however, that tailored services that do take account of these needs get better outcomes.

They go on to describe the enablers that allow services to provide this tailored care. These are:

Cultural competence – this includes Aboriginal co-design of services, and incorporating local Indigenous customs and beliefs into healthcare services. There is training for staff and zero-tolerance for racism.

Participation rates – these are indicative of health service effectiveness, and services can be more effective where they monitor attendance rates, and work with their patients to promote and facilitate attendance.

Organisational – this goes to organisational effectiveness, including leadership, management and governance.

Clinical governance and compliance – this ensures that clinical assessment, treatment and follow-up processes facilitate good clinical outcomes, including the use of clinical audit.

Availability of services – this goes to the importance of health literacy, in people understanding when they need a service, and that they can access that service in a way that suits them.

Given the finding that Aboriginal people fare worse in mainstream services, it is worth looking at what Indigenous Australians value about primary healthcare, and this is the focus of another systematic review

by Streak Gomersall et al (3). They compared perspectives of ACCHOs and mainstream services, finding consistent themes across the literature.

1. ACCHOs accessibility was highly valued. This was seen in terms of practical measures, such as providing transport, outreach services and a welcoming physical environment, but also in emotional and relational terms, that staff understood them, were proactive and ACCHOs were social meeting places.
2. The way ACCHOs delivered care was highly valued, in the time taken to get to know patients, and was responsive and tailored to their needs over time.
3. The behaviour of individual staff at ACCHOs was valued towards patients, in the way they were respectful and non-judgemental. It also included the Aboriginal and Torres Strait Islander identity of some staff.
4. A comprehensive, holistic approach to care was highly valued, in that care was not only clinical, but included community events, group activities and enhanced support for patients.
5. Aspects of mainstream care that were mentioned included a lack of shared understanding, and a lack of respect, including times where patients have felt patronised or even threatened.

Another systematic review looked at the enablers and barriers for providing chronic disease care to Indigenous people from Australia, New Zealand, Canada and the US(4). They were able to synthesis five findings from their literature.

Their first finding was about the design of programs. They needed to be designed in partnership with the local community, and take account of the local context, including political will and the policy environment, and the local service capacity. While adequate funding was necessary, often including multiple funding streams, this impact this had on reporting requirements was also important. There needed to be adequate workforce, and employment of local Indigenous staff enabled community engagement.

The second finding explored the workforce requirements in more detail. Indigenous workers needed to be included in decision making, and attention needed to be paid to ensuring the retention of staff, their cultural education and wellbeing.

The third finding related to clear referral pathways and care co-ordination, supported by IT systems.

The fourth finding was to ensure partnerships between patients and providers that allowed patients to make decisions about themselves, taking into account the competing demands on them. There also needed to be clear, culturally safe communication.

The fifth finding related to access, and ensuring that services were culturally safe and welcoming places for patients and their families.

The systematic review by Harfield et al looked at the characteristics of Indigenous primary care services that allowed them to be effective (5). They describe 7 characteristics, and all of these are underpinned by culture, in that local culture was embedded in the way the services worked, and the culture of the community was highly respected. They draw the contrast with other models of chronic care that don't mention culture, such as the Wagner Chronic care model or the Southgate Model (see paper for references).

The first three characteristics they describe contribute directly to this inclusion of culture. There were a culturally appropriate and skilled workforce (especially Indigenous staff), community participation, especially community control, or the Alaskan concept of "customer-owners," and self-determination and empowerment. The other characteristics were that services were accessible – meaning affordable,

available, acceptable, and people were aware of them; commitment to continuous quality improvement; flexible approaches to care; and comprehensive, holistic care including prevention and traditional healing.

### **Findings from more specific systematic reviews**

Other systematic reviews looked specifically at aspects found in the systematic reviews already mentioned.

There were two systematic reviews looking at improving the cultural competency of the health workforce. The review by Clifford and colleagues found studies from the US and Australia. Interventions were based around education and training of health professionals, employment of a health worker or culturally-specific health programs (6). Unfortunately, the lack of evaluations and poor methodological quality didn't allow any conclusions to be made about the effectiveness of these interventions. They were able to say "Although education and/or training of health professionals is an important component of an overall framework for cultural competence, it is generally insufficient to change health professionals' behaviour, and in turn, patient-related outcomes.... Improving these types of outcomes is likely to require structural changes at the level of the organization, to reinforce and sustain behaviour change in health professionals."

The systematic review by Jongen, McCalman and Bainbridge noted that educational interventions showed some improvements in self-reported knowledge, skills and attitudes of health professionals, but there was no evidence of improved patient outcomes (7). They suggested that "cultural competence training approaches should prioritise the teaching of practical skills and the application of these skills in practice, as well as their assessment through demonstrable practitioner behaviour."

A third systematic review looked at access to primary care services. Davy and colleagues described patient factors and service factors that contribute to access for Aboriginal and Torres Strait Islander people (8). Of note was their finding that social and cultural determinants of health influenced the accessibility of health services, and that accessibility was enhanced by services that found ways to address these locally.

Factors influencing accessibility were that people had to perceive the need to access healthcare, and then be able to seek healthcare, and able to reach it – for example through (affordable) transport. They need to be able to afford to use the service. Services influenced these through their engagement at a community and an individual level.

### **Barriers and challenges as seen by Aboriginal and Torres Strait Islander people**

The systematic reviews described above provide an overview of the themes in the literature. These can usefully be supplemented by research which asks Aboriginal and Torres Strait Islander people themselves what these barriers are. There is also research asking (predominantly non-Indigenous) health professionals what their views of the barriers are, but acting on these views runs the risk of not responding to the actual needs of Indigenous people themselves.

This is shown by McBain-Rigg, who asked both Indigenous and non-Indigenous people about the cultural barriers to healthcare in Mount Isa (1). Non-indigenous people tended to talk about barriers in terms of policies and procedures, posters on the wall and culturally appropriate information leaflets. Aboriginal and Torres Strait Islander people mentioned these, but they wouldn't be effective without a relationship with a healthcare provider in the service.

A number of studies asking Aboriginal and Torres Strait Islander people about their interactions with health services were consistent in their findings. These included interviews with people with diabetes (9).

People on multiple medication (10), men with reproductive health problems (11), people with chronic illnesses (12), and Aboriginal cultural mentors working in medical education (13).

All of these interviewees highlight that Aboriginal and Torres Strait Islander people are very keen for information, education and support from their health professionals, but that their experiences of their interactions with health professionals were often unsatisfactory. Discriminatory behaviour, judgemental attitudes and feeling patronised were frequent descriptions. The complexity of the health system also acted as a barrier to effective care. The importance of developing a long-term trusting relationship with health professionals was commonly highlighted in all these studies. The importance of culturally appropriate services was also important, with the presence of Aboriginal and Torres Strait Islander staff and the involvement of family, peers and social networks in management of chronic disease highlighted as part of this.

The experience described at Inala, a mainstream state-run health service in Queensland, shows that these perspectives can be used to create a culturally safe health service, in the physical environment and in the training of staff (14).

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