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Aboriginal and Torres Strait Islander health assessments

Barriers to improving uptake

Background

This study investigated the reasons for low uptake of Medicare Benefits Schedule rebated health assessments for Aboriginal people and Torres Strait Islanders in mainstream general practice in the Australian Capital Territory region.

Methods

Surveys gauging attitudes to Aboriginal and Torres Strait Islander health issues were completed by 145 general practitioners, practice and division staff, and semistructured interviews were conducted with 16 staff members from nine general practices.

Results

Survey responses indicated concerns about introducing routine identification processes for all patients. Interviews showed low levels of identification and significant barriers to change.

Discussion

Barriers to the uptake of health assessments include low levels of routine identification of Aboriginal and Torres Strait Islander patients, little awareness of Aboriginal and Torres Strait Islander specific GP mediated health interventions, and lack of support for preventive health interventions targeted on the basis of Aboriginal and or Torres Strait Islander status. Poor uptake is likely to persist without a more strategic approach to overcoming these barriers.

■ **Aboriginal and Torres Strait Islander health assessments (HAs) have been progressively introduced into the Medicare Benefits Schedule (MBS) since 1999¹ (Table 1) and were designed to address the higher morbidity and mortality rates in Aboriginal people and Torres Strait Islanders (Figure 1).**

The implementation of HAs reflects the gravity of Aboriginal and Torres Strait Islander health disadvantage. It is sometimes suggested that Aboriginal and Torres Strait Islander people are simply one of a range of high needs groups and therefore do not require a unique primary health care response. However, justification for Aboriginal and Torres Strait Islander specific measures is provided by:

- Aboriginal people and Torres Strait Islanders have a life expectancy at birth 17 years lower than the Australian average, a much greater gap than other disadvantaged groups (Table 2), and
- Aboriginal and Torres Strait Islander death rates are substantially higher than those in the nonindigenous population across all socioeconomic disadvantage quintiles (Figure 2).

The 17 year life expectancy gap for Aboriginal people and Torres Strait Islanders is at least partly explained by poorer primary health care access, as indicated by MBS expenditure data. In non-Indigenous Australians, health service usage rises with illness level: people with one significant medical condition have an MBS usage about four times the national average, and expenditure rises to 12 times the average for people with five conditions.² This pattern is not reflected in Aboriginal and Torres Strait Islander expenditure. Despite morbidity rates 2.5 times higher than nonindigenous people, MBS expenditure is estimated to be 45% of the nonindigenous average.³

The health impact of reduced primary health care access is demonstrated by:

- hospitalisation rates eight times the national average for chronic ambulatory care sensitive conditions, ie. chronic condition

Table 1. MBS rebated health assessments for Aboriginal people and Torres Strait Islanders

	Child health assessment	Adult health assessment	Older persons health assessment
MBS item	708	710	704
Age range (years)	0 to under 15	15–54	55 and over
Medicare rebate (as at May 2008)	\$171.15	\$204.00	\$171.15
Date of effect	1 May 2006	1 May 2004	November 1999

admissions which could be reduced by effective, timely and appropriate nonhospital care,⁴ and

- late presentation and diagnosis of chronic disease. For example, approximately 40% of Aboriginal patients in end stage renal failure programs were not known to have had renal disease before presenting with renal failure.⁵

Study of the health impact of HAs as a tool for managing the health of indigenous people is in its early stages.⁶ However, indications are that systematic approaches, including HAs, have the potential to achieve earlier diagnosis and treatment for undetected disease and better treatment of existing disease, thereby reducing morbidity and health care costs.^{7,8}

Despite their potential positive impact, HA uptake remains low. Nationally, less than 10% of eligible adults have participated in a HA.⁹ In the Australian Capital Territory (ACT), 156 adult HAs have been conducted during 2004–2008, covering up to 7% of the eligible population (note: some may have had more than one HA).¹⁰

While Aboriginal community controlled health services (ACCHSs) play a vital role in Aboriginal health, it is estimated that 60% of Aboriginal people and Torres Strait Islanders access health care elsewhere.¹¹ Mainstream general practice therefore has an important role in ensuring better service provision, including improved HA uptake.

The three GP mediated Aboriginal and Torres Strait Islander specific health interventions (HAs, child and adult immunisations, access to Aboriginal and Torres Strait Islander specific PBS listing),

all depend on identification of the target population at the point of service delivery. Two studies indicate that a maximum of 28% of mainstream general practices have routine identification processes for all patients.^{12,13} The same studies indicate improving general practice identification is critical in improving coverage of Aboriginal and Torres Strait Islander specific immunisation programs. Better identification has also been recognised as crucial to improving existing communicable disease reporting systems as they relate to indigenous status information.¹⁴

Methods

Research was conducted between May 2006 and June 2007 and was based in the ACT Division of General Practice (ACTDGP). The research comprised two aspects: a cross sectional study of general practitioners, practice nurses and other practice and divisional staff in the ACTDGP's catchment area (this comprised a survey about attitudes likely to influence identification uptake); and qualitative data collected via semistructured interviews (alignment between survey reported attitudes and processes at the practice level was assessed).

Ethics approval

All survey and interview participants were given an information sheet and consented to participate. Winnunga Nimmityjah Aboriginal health service (WNAHS), the Canberra based ACCHS, was closely involved in the project and approved the research design. Additional institutional ethics committee approval was not sought as the elected WNAHS board members provide this role.

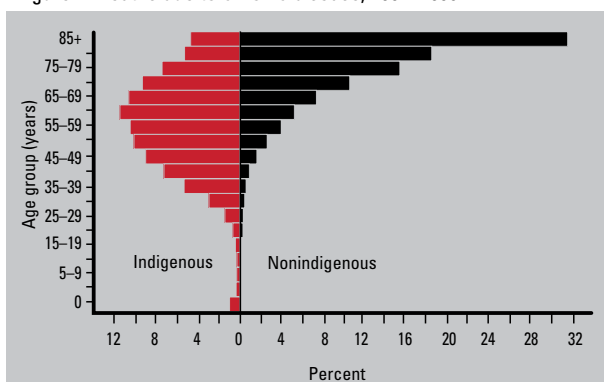
Surveys

A questionnaire used in a separate study was adapted for use in this research.¹⁵ The final version comprised 18 statements about Aboriginal and Torres Strait Islander health issues. Respondents rated their level of agreement against a five point scale. The survey addressed:

- perceived barriers to routine identification
- the concept of specialised services for Aboriginal people and Torres Strait Islanders, and
- commonly held views about Aboriginal and Torres Strait Islander health.

The survey was mailed to all general practices on the ACTDGP database, and all practice staff (n=>552) and division staff (n=22)

Figure 1. Deaths due to chronic disease, 2002–2006



Source: AIHW National Mortality Database

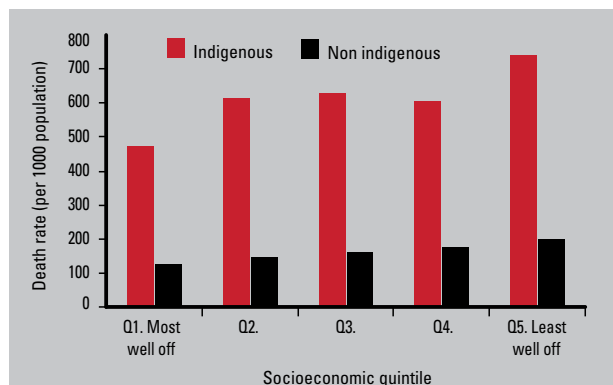
were invited to participate. Surveys were also distributed at ACTDGP educational events. A total of 145 survey responses were received (Table 3). The exact response rate cannot be calculated, but was 25.3% at best and possibly lower.

Data were analysed using simple descriptive statistics with Microsoft Excel. Comparisons were made by proportional distribution for the entire sample. Differences in responses were explored according to self reported occupational type.

Interviews

Twenty-four of 25 practices in two regions in the ACTDGP's catchment area were invited to participate (total number of practices in catchment 94; total GPs, 330). Clinicians were offered the opportunity to be interviewed, resulting in completed interviews from nine general practices (response rate 9/24; 37.5%). Semistructured interviews were conducted with 10 GPs, two practice nurses and four practice managers or equivalent. The interviewer transcribed key information and thematic analysis was used to study the responses.

Figure 2. Death rates (0–64 years) by socioeconomic quintile, 1997–1998



Source: Glover J, Tennant S, Page A. The impact of socioeconomic status and geographic location on indigenous mortality in Australia, 1997–99. Occasional Paper Series No.1, Public Health Information Development Unit, Adelaide, 2004

Results

Surveys

Between 30–37% of responses indicated a range of concerns about routine identification. Breakdown by occupational category showed practice staff were more likely than others to have concerns about routine identification.

Responses indicated majority support for specialised health treatment for Aboriginal and Torres Strait Islander patients (61%) and the view that a person's indigenous status was relevant to GP provided health care (69%).

Several statements, such as: 'Aboriginal people and Torres Strait Islanders get too much money spent on them' were supported by 8–15% of respondents. Larger proportions supported perceptions that Aboriginal and Torres Strait Islander health issues were mainly in nonurban areas (22%) and that mainstream services were accessible to all (30%).

Semistructured interviews

Routine identification processes were found in only one practice, where the practice had a waiting room poster to encourage identification. Despite this, all participants felt confident they would know if patients were Aboriginal or Torres Strait Islander, and at interview, six of the nine participating practices reported having no such patients. Some expressed fear of causing offence if they were to ask patients to identify, however one participant felt this fear was unjustified. A few thought if routine identification was required, the process would not be difficult. One participant believed identification breached privacy legislation, and could potentially be used against the Aboriginal and Torres Strait Islander population. Two participants thought identification might help target recall services and one said it would help Aboriginal and Torres Strait Islander patients access extra, appropriate services. However, the majority felt identification would benefit neither the practice nor the patient.

Uptake of health assessments

None of the participants had conducted a HA and few knew they existed. There was some awareness about HAs for nonindigenous

Table 2. Life expectancy at birth in Australia (years)

Population category	Male	Female
All Australians (1999–2001) ²⁰	77.0	82.4
Aboriginal people and Torres Strait Islanders (1996–2001) ²¹	59.4	64.8
All Australians (1920–1922) ²²	59.0	65.0
Most disadvantaged (2000–2001) ²³	76.2	82.1
Least disadvantaged (2000–2001) ²²	79.8	84.5
Living in remote area ²⁴	73.1	79.7
Living in highly accessible area (1998–2000) ²⁴	77.3	82.7

Source: AMA report card series 2007, Aboriginal and Torres Strait Islander health: institutionalised inequity, not just a matter of money

people (75+ years, introduced 1999; and 45–49 years, introduced 2006), and when prompted, some people thought these were the HAs being referred to. Barriers to uptake included lack of time and too few Aboriginal people or Torres Strait Islanders in the practice; while others had little confidence HAs would deliver clinical benefits. Barriers to all ‘complex’ MBS items (such as care planning) were commonly mentioned; some emphasised that all such items, not just HAs, were impractical.

No different treatment?

In contrast to survey findings, most participants did not agree that patient treatment should differ because of Aboriginal and/or Torres

Strait Islander status. Differential treatment was seen as problematic, with several participants emphasising ‘we treat everyone the same here’. Although one participant felt the gravity of Aboriginal and Torres Strait Islander health issues justified indigenous specific measures, this was not supported by most participants.

Almost all participants knew of higher morbidity and mortality rates in Aboriginal and Torres Strait Islander populations. However, this was generally seen as insufficient justification for unique treatment. A commonly stated view was many cultural or ethnic groups also had higher risks of particular conditions and no special treatment for Aboriginal or Torres Strait Islander patients was needed.

Table 3. Survey results (grouped in theme clusters)

Survey statement	Strongly agree/ agree	Neutral	Strongly disagree/ disagree
Perceived barriers to the introduction of routine patient identification			
Asking all patients whether they are Aboriginal or Torres Strait Islander would offend our nonindigenous patients (n=141)	30%	28%	41%
I’m apprehensive about what reaction I might get if I ask patients whether they are Aboriginal or Torres Strait Islander origin (n=144)	33%	25%	41%
There may be a few Aboriginal people or Torres Strait Islanders in our practice, but it’s such a small percentage, it’s not feasible to ask everyone if they are of Aboriginal or Torres Strait Islander origin (n=137)	37%	15%	47%
Specialised treatment on the basis of Aboriginal and Torres Strait Islander status			
Aboriginal people and Torres Strait Islanders should be entitled to specialised health treatment (n=144)	61%	15%	24%
Knowing whether a patient is of Aboriginal or Torres Strait Islander origin is relevant to the health care GPs provide (n=144)	69%	13%	17%
We treat all patients as individuals here so there’s no need to identify subgroups such as Aboriginal people or Torres Strait Islanders (n=141)	26%	20%	54%
When it comes to health services, Aboriginal people and Torres Strait Islanders should be treated no differently from other people, otherwise it’s discriminatory (n=144)	26%	15%	58%
Asking people to identify as Aboriginal or Torres Strait Islander is racist (n=143)	10%	14%	74%
Our practice treats everyone equally so it doesn’t make sense to record Aboriginal or Torres Strait Islander status (n=140)	19%	16%	64%
Collecting data on Aboriginal or Torres Strait Islander status is meaningless – it’s just political correctness (n=145)	12%	13%	74%
Views on relevant issues			
If people don’t look Aboriginal or Torres Strait Islander I don’t think they should be able to say they are (n=145)	8%	12%	79%
Aboriginal people and Torres Strait Islanders get too much money spent on them (n=143)	15%	19%	66%
Aboriginal people and Torres Strait Islanders do have poorer health but it’s largely a problem of their own making (n=143)	13%	20%	67%
Aboriginal and Torres Strait Islander health problems occur mainly in rural and remote areas (n=144)	22%	15%	63%
I don’t see why Aboriginal people or Torres Strait Islanders should have problems using the same medical services as everyone else (n=142)	30%	17%	52%
Aboriginal people and Torres Strait Islanders in Canberra are generally as healthy as nonindigenous people (n=143)	11%	28%	60%
You can usually tell who might be Aboriginal or Torres Strait Islander by appearance (n=145)	12%	16%	72%
People who obviously look Aboriginal or Torres Strait Islander may have health issues, but for many of the others who look much the same as everyone else, I can’t see they have specific health issues different from other patients (n=144)	8%	23%	68%

Response to ideas for improvement

Participants were asked about improving HA uptake and identification and most responded constructively after prompting. However, there was little consensus and some areas, such as administrative staff training, were rarely mentioned. Suggestions included:

- workshops supporting HA implementation
- more divisional support, including one-to-one practice visits
- increasing number of doctors
- awareness raising for Aboriginal and Torres Strait Islander people
- reducing required paperwork
- kits, posters or brochures
- a 'one-stop-shop' (eg. website) summarising GP relevant Aboriginal and Torres Strait Islander health interventions
- improvements in software functionality, including HA templates.

Discussion

The research showed low awareness of HAs and significant barriers to increased uptake. Provision of HAs depends on identifying the target population at the point of service delivery, but understanding of why and how Aboriginal and Torres Strait Islander patients should be identified, and the ramifications identification has for provision of appropriate health care was limited. The Commonwealth Government definition of Aboriginal and or Torres Strait Islander status¹⁶ was often unfamiliar to interview participants and other practice and division staff.

Survey results indicated significant levels of apprehension, fear of offending and feasibility concerns about introducing standardised identification processes. Attitudes that Aboriginal and Torres Strait Islander status was relevant to the health care provided by GPs were not reflected in practice.

This inconsistency may be partly explained by the difference in specificity of survey questions compared to interview questions. For example, survey respondents generally supported the statement that indigenous status was relevant to GP care, whereas in interviews, participants struggled to give examples of how treatment would differ for such patients. In fact, the contrary view ('everyone should be treated the same') was commonly expressed, and this is more difficult to reconcile with survey findings. A process to translate generalised attitudinal support into processes at practice levels is needed.

The inconsistency of suggested improvements may reflect the lack of consensus about 'the problem' being addressed. For example, some participants felt HAs were driven by a bureaucratic desire for quantifiable MBS items, and queried their clinical benefit to patients. This is problematic for improved uptake, as adoption of population health interventions is improved where their evidence base is widely accepted.¹⁷

This study identified a number of barriers to greater uptake of HAs including:

- lack of identification processes and little support for change
- knowledge barriers (eg. lack of awareness about the HAs)
- lack of support for general practices about identification and use of Aboriginal and Torres Strait Islander specific health interventions

- attitudinal barriers (eg. views that Aboriginal and Torres Strait Islander patients are one of many high needs subgroups, and therefore special treatment is unjustified)
- perceived lack of resources (time and workforce) to undertake HAs
- process barriers (eg. general practice software does not facilitate identification)
- lack of coordinated divisional engagement with Aboriginal and Torres Strait Islander health issues generally and mainstream identification specifically, and
- lack of support for Aboriginal and Torres Strait Islander specific health interventions.

Most fundamentally, attitudes that Aboriginal and Torres Strait Islander health is not sufficiently different to warrant a unique response, and that general practice should 'treat everyone the same' will need to shift if identification and uptake of HAs is to improve.

Limitations of this study

Survey response rates were not high and may be unrepresentative of the population. However, concerns about identification were echoed in interviews. Interview participants may also be unrepresentative, as they volunteered to participate, were clustered by practice, and may be dissimilar from practices who declined. The findings may also be confined to urban areas with relatively low proportions of Aboriginal people and Torres Strait Islanders. However the main findings, such as low levels of identification, accord with those of previous studies^{12,13} and it seems likely the problem is generalised throughout Australia.

The survey gauged the views of non-GP practice staff and divisional staff, as well as GPs. This is significant as division staff are important sources of information for general practice. Likewise non-GP practice staff can help create an environment conducive to effective identification and may administer the identification question. The attitudes of the person collecting indigenous origin data influences the quality of data collected.¹⁸ Issues of Aboriginal and Torres Strait Islander identity and related government interventions have been identified as particularly emotive for nonindigenous people in the health sector, with such topics frequently raising feelings of guilt, anger and anxiety.¹⁹

Implications for general practice

- Medicare Benefits Schedule rebated health assessments for Aboriginal people and Torres Strait Islanders are an important aspect of quality primary health care, but are underutilised.
- To the extent current practice departs from HA guidelines, Aboriginal and Torres Strait Islander patients are not receiving best practice care, and GPs are not fully using the potential of HAs to address the life expectancy gap between indigenous and nonindigenous people. In addition, GPs are missing out on the revenue and health information, which such health assessments generate.
- Only a minority of mainstream general practices have routine identification processes in place for all patients – GPs need to

know which patients are Aboriginal and or Torres Strait Islander as a first step.

- Aboriginal and Torres Strait Islander patients cannot be identified by appearance. The only accurate way to check is to ask all patients the national standard identification question: ‘Are you of Aboriginal and/or Torres Strait Islander origin?’ This needs to be done in a culturally appropriate manner.

Conflict of interest: at the time of writing this article Helen Kehoe was employed by the Commonwealth Department of Health and Ageing.

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Disclaimer

The views expressed in this article are solely those of the authors and should not be attributed to the Department of Health and Ageing or the Minister for Health and Ageing.

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