So close, yet so far: how a lack of accountability undermined COAG’s Aboriginal and Torres Strait Islander health goals

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So close, yet so far: how a lack of accountability undermined COAG’s Aboriginal and Torres Strait Islander health goals

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Disclaimer

The views and opinions expressed in this report are those of the author and do not necessarily reflect the official policy or position of the AIHW.

Style

This thesis is presented in the form of a report written for the AIHW with additional appendices. It conforms with the AIHW style guide (see http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442468412). The AIHW’s referencing system is based on the Vancouver system, but uses author-date citations in the text instead of superscript numbers. It also uses a modified Vancouver style for the reference list.

Dedication

To the memory and ongoing influence of Dr Puggy Hunter.
Executive summary

Background

The health disparity between Aboriginal and Torres Strait Islander people and other Australians remains one of the nation’s foremost public health challenges. The multi-pronged Indigenous reform agenda sponsored by the Council of Australian Governments (COAG), designed to redress this failure, has been in place for several years. However change is slower than hoped and uptake of the health measures it introduced is generally low. Primary health care provided by the general practice sector was a central focus of COAG’s health agenda. New, targeted, evidence-based health interventions specifically for Indigenous people and mediated by general practitioners (GPs) were added to similar existing interventions. On paper, these interventions held the promise of considerable health gains. However little attention was paid to the historically low uptake of such interventions or the sector through which they were to be delivered. The consequence has been generally poor coverage of the Aboriginal and Torres Strait Islander population and unrealised potential for improved health outcomes.

Overall assessment

GPs are the lynchpin of the Australian primary health care system and are critical to improving Aboriginal and Torres Strait Islander health outcomes. However GPs are fully occupied with front-line patient care: it is unreasonable to expect them to be aware of every new government policy and have the capacity to spontaneously implement them. Evidence on effective change management in the general practice sector shows that coordinated, multi-layered support strategies can enlist GP participation, support changes in behaviour and deliver targeted public health benefits. Research focussed on the barriers to and enablers of GP-mediated health interventions specifically for Indigenous people dovetails with these generic findings. One of the main issues is deceptively simple: GPs cannot offer services specifically for Aboriginal and Torres Strait Islander people if they do not know which patients are Indigenous. Lack of functionality in clinical information systems to require and use Indigenous status, low awareness of interventions specifically for Aboriginal and Torres Strait Islander people, concerns about providing different treatment to patients on the basis of Indigeneity and contested understandings of ‘who is Indigenous’ feed into this problem. The lack of effective Indigenous identification also affects all data collection processes to which GPs contribute. Studies of these issues reached substantial consensus on the impediments to better identification and how best they should be addressed.

This information was available at the time the COAG measures were designed and introduced. However it was not applied strategically and only some barriers were addressed in isolation. Insufficient attention was paid to coordination and implementation: the lack of follow through and an atomised allocation of responsibilities exacerbated this piecemeal approach.

Despite the considerable potential contribution of these GP-directed initiatives to the Closing the Gap health targets, no single agency or dedicated task force was assigned carriage of this responsibility. This lack of coordination and accountability is a major contributor to the persistence of low Indigenous identification. These defects limited the uptake of GP-mediated health interventions specifically for Indigenous people, and continue to undermine the effectiveness of the COAG health agenda.
While missed opportunities over the past four years cannot be regained, many previously recommended strategies remain valid and have been recently re-endorsed by stakeholders. There are also new opportunities presented by the national health reform agenda to integrate factors for change in the general practice sector.

**Project findings and key recommendations**

**National accountability and strategic approach**

There is no point of central control, responsibility or accountability for improving the uptake of interventions mediated by GPs specifically for Aboriginal and Torres Strait Islander people. Implementation of GP-mediated health interventions specifically for Indigenous people is uncoordinated and uptake remains low relative to need. Mechanisms likely to improve Indigenous identification in the sector are known and available, but have not been implemented. Improved data collection and service delivery stemming from the identification of Aboriginal and Torres Strait Islander people in the general practice sector are integrally linked, but are not coordinated with this joint aim in mind.

**Recommendation #1: national accountability**

Establish a point of national accountability for improving Indigenous identification in the general practice sector to take a strategic approach to improving contingent service delivery and data collection.

This point of accountability should involve relevant stakeholders such as representative and professional bodies for general practice, Aboriginal and Torres Strait Islander peak health bodies, Medicare Locals, data agencies, software providers, health policy makers and administrators in making needed changes.

**Clinical information systems**

Clinical information systems used in the general practice sector are the most important mechanism to improve the identification of Aboriginal and Torres Strait Islander patients, but have not been enlisted by government to do so.

**Recommendation #2: information systems and software**

Establish a process to ensure general practice clinical information systems:

- support Indigenous identification in line with existing nationally agreed processes
- optimise uptake of health interventions specifically for Aboriginal and Torres Strait Islander people
- maximise the quality of Indigenous status information in data generated by general practice.

The first step in implementing this recommendation is to convene a meeting of stakeholders. The Australian Institute of Health and Welfare (AIHW) could host such a meeting, which should be used for multi-lateral information exchange. The government should explain the rationale for change and outline needed modifications, software vendors could communicate their own parameters and what might assist them in making such changes, while GPs and
other users of the systems can advise on how changes can practically support best clinical practice.

**Information provision**

There is no comprehensive information source about GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people. GPs, Medicare Locals, Aboriginal Community Controlled Health Services (ACCHSs), Aboriginal and Torres Strait Islander people and other stakeholders should have access to this information in ways that are useful to them.

**Recommendation #3: information reporting and feedback**

- Establish a one stop shop website on all GP-mediated Aboriginal and Torres Strait Islander specific health interventions targeting both providers and consumers.
- Expand publicly available statistics to include all GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people to enable monitoring of uptake.
- Provide meaningful feedback to Medicare Locals, general practices and Aboriginal and Torres Strait Islander communities and organisations on uptake of such interventions as they relate to local and regional needs.

This recommendation mainly involves bringing existing information together in more user-friendly ways. For example, information about GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people is available in various places, but has not been integrated or presented in ways GPs and Aboriginal and Torres Strait Islander people find easy to use. In the same way, information about uptake and indicators of need does exist, but has not been integrated and tailored to the needs of stakeholders. These processes should be based on consultation with GPs, Aboriginal and Torres Strait Islander people and Medicare Locals as the main target audiences for these products.

**Pathology processes**

Where data generated by GPs contributes to data collections, it is mainly transmitted via pathology processes. These processes do not at present require the inclusion of Indigenous status. Despite several investigations of this long-standing policy goal, national change has not been achieved. Until this is addressed, improvements in Indigenous identification processes in general practice cannot be translated into data quality improvements.

**Recommendation #4: pathology processes**

Include Indigenous status as a required element in both paper and electronic pathology processes.

The government has the capacity to set requirements for pathology forms and has undertaken extensive analysis of issues related to this goal. This should now be translated into addressing any remaining barriers and moving to implement this recommendation.
1 Approach

This section provides information on how the research was undertaken.

Perspectives of the author

My interest in Indigenous status identification in the general practice sector has developed over the last decade and a half. This interest has been fuelled by my deepening awareness of the impact this identification has on service delivery for, and data collection about, Aboriginal and Torres Strait Islander people.

I worked at the National Aboriginal Community Controlled Health Organisation (NACCHO) from 1998 to 2005. During this time, NACCHO, under the inspirational leadership of the late Dr Puggy Hunter, was successful in achieving a long-standing goal of having preventive health checks specifically for Aboriginal and Torres Strait Islander people added to the Medicare Benefits Schedule (MBS). I remember the excitement we all felt, believing an important step had been made with great potential benefits for Aboriginal and Torres Strait Islander people.

Later, during my role at the Australian Capital Territory Division of General Practice between 2006 and 2007 I was disheartened to find awareness and uptake of the health checks was almost non-existent among mainstream GPs. This role allowed me to investigate the barriers to uptake; barriers which I found echoed in other research (IIICDRPSC 2004; NCIRS 2003; Riley et al. 2004). I realised the problems were systemic, not local.

My work during 2007–2010 at the Department of Health and Ageing (DoHA) coincided with a change of Australian Government and the transformation of the Indigenous-led Close the Gap campaign from a risk to be managed to the incoming government’s policy: Closing the Gap. In this role, I was supported to publish my earlier research in the Australian Capital Territory Division of General Practice, and had the opportunity to work on policy development for the Indigenous Chronic Disease Package. I was also involved in implementing the Pharmaceutical Benefits Scheme (PBS) copayment measure. Despite the satisfaction of helping achieve better access to medicines for Aboriginal and Torres Strait Islander people, I found the siloed approach to package implementation across DoHA disappointing, and saw many missed opportunities for cross-measure integration.

In moving to the AIHW in 2011, I was again fortunate to be involved in a project which drew upon my expertise in the general practice sector, but from a new, data-focussed, perspective. I was to manage a project funded by COAG to evaluate implementation of the National best practice guidelines for collecting Indigenous status in health data sets. I successfully advocated for a focus on the general practice sector in this project on the basis of the service delivery, as well as data collection, benefits improved identification would bring. I was lead author of the overall project report as well as the specific report on the general practice sector. With the support of the AIHW, I was able to build on my work to complete this research report to satisfy the remaining requirements of my Master of Public Health.

Data sources and intellectual approach

I undertook this research through a process of situational analysis of secondary data. This process was best suited to the research questions I sought to investigate, as it enables the
relevant elements of complex situations to be drawn together, compared and considered (Clarke 2005).

My main data sources were: literature about problem identification; information about the general practice sector and Indigenous identification issues; policy and program documents about changes implemented; and impact data (Table 1.1).

My analytical approach was first to understand the problem—why GPs did not ask all patients about their Indigenous status, and why this behaviour was complex and persistent. These investigations led me to a better understanding of the general practice sector and why making any changes initiated by government in this context is difficult.

I then turned my attention to key recommendations from the few available studies specifically investigating the impact of low Indigenous identification in general practice on service delivery and data collection (IIICDRPSC 2004; Kehoe & Lovett 2008; NCIRS 2003; Riley et al. 2004). I compared these recommendations with findings on success factors in making change in the general practice sector in other subject areas (De Domenico et al. 2005; KPMG Consulting 2000). By integrating the two, I developed an evidenced-based plan for how change should have been made.

I investigated the changes introduced by the Indigenous Chronic Disease Package under the COAG Closing the Gap reforms from this perspective: especially the extent to which the Australian Government’s hoped-for health gains rested upon the general practice sector.

Having developed an ideal plan of action and checked what had actually occurred, I undertook a content analysis to compare the two, and highlighted where known barriers had been ignored, where the full potential of reforms had not been fulfilled, and where emerging opportunities to advance Indigenous identification had been missed.

I also checked available evidence to look for changes over time. While information on how changing identification might be impacting on data collections is not available, ongoing general practice surveys give some indication of whether processes are changing. I investigated MBS and PBS data which show uptake of some GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people to see if uptake had increased over time. I also looked at the analysis of the early phase of Indigenous Chronic Disease Package implementation (MSHR 2013).

**Ethics considerations**

My research was based upon publicly available material and did not involve collection of data from human participants; therefore it did not require ethics approval.

**Literature review**

Rather than being confined to a specific section, relevant literature is reviewed and integrated throughout this report. Pertinent material was sourced organically over the past six years, using a snowball approach to trace leads and potential sources. This approach also allowed unpublished work to be identified. In addition, a literature search using online health databases such as PubMed was conducted in the second half of 2012 to cross-check available literature and to locate any recently published materials.
### Table 1.1: Main data sources

<table>
<thead>
<tr>
<th>Data category</th>
<th>Research questions</th>
<th>Data elements</th>
</tr>
</thead>
</table>
| Literature on problem identification and solution generation | The problem of low identification:  
- How do we know it exists?  
- What do we know about it?  
- Why does it matter?  
- How should we fix it? | Incomplete Indigenous identification in health data collections (various, including: MacRae et al. 2012; Vos et al. 2007)  
Low uptake of GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people (for example health checks and immunisations) (AHMAC 2011; Kelaher et al. 2005)  
Studies of Indigenous-specific immunisation showing low Indigenous status identification in general practice is a barrier to improved immunisation coverage and recommending solutions (NCIRS 2003; Riley et al. 2004)  
Study of communicable disease reporting showing low Indigenous status identification in general practice is a barrier to improvements and recommending solutions (IIICDRPSC 2004)  
Study of Aboriginal and Torres Strait Islander health check uptake showing low Indigenous status identification in general practice and associated issues are barriers to improved uptake and recommending solutions (Kehoe 2007a; Kehoe 2007b; Kehoe & Lovett 2008)  
Overall study of Indigenous identification in general practice and strategic recommendations (Kelaher et al. 2010)  
BEACH data indicating low Indigenous status identification in general practice (Britt et al. 2012a; Britt et al. 2012b) | |
| Information about the general practice sector and Indigenous identification issues | What are the general practice sector attributes which affect how changes can be made?  
What is the evidence for how change can be made in the general practice sector?  
Why is identification of Indigenous status complicated?  
What is the current situation? | Information about the general practice sector: (various, including: AIHW 2008; Britt et al. 2012a; Britt et al. 2012b; Duckett & Willcox 2011; PHCRIS 2010; Scott & Coote 2007)  
What works in making general practice sector changes (De Domenico et al. 2005; KPMG Consulting 2000)  
Historical/current issues: links between state-imposed identification and discrimination; the shift to self-identification; the contested issue of ‘special treatment’ (various, including: ALRC 2003; Gardiner-Garden 2003; Gorringe et al. 2011; Gray 2011; HREOC 1997; McDermott 2006; Paradies 2006; Toombs 2011)  
Aboriginal and Torres Strait Islander people’s views on identification (ABS 2011; ABS 2012b; Kelaher et al. 2010; Scollney et al. 2010)  
Stakeholders’ views on current identification issues (AIHW forthcoming b) | |
| Policy and program documents about changes implemented | What changes did the COAG Indigenous Chronic Disease Package introduce? | COAG Closing the Gap commitments (COAG 2007)  
The Indigenous Chronic Disease Package (various DoHA publications) and other measures (for example various RACGP publications) | |
| Impact data | Have the changes improved:  
- identification rates?  
- service delivery?  
- data collection? | Medicare statistics (publicly available online) which show usage of MBS and PBS items  
Indigenous Chronic Disease Package Evaluation (MSHR 2013) |
2 The problem: low Indigenous identification in general practice

This section describes the landscape of low rates of Indigenous identification in the general practice sector. It sets out the scope of this report and the terminology used, the problem of low Indigenous identification and the relevant COAG context. It explains the impact of Indigenous identification in the general practice sector, first by demonstrating its necessity for the delivery of targeted health interventions for Aboriginal and Torres Strait Islander people, and second by showing its importance in improving Indigenous status elements in data generated by the sector. The section also provides available evidence indicating that rates of identification are low.

2.1 Scope and terminology

To acknowledge the separate Indigenous peoples of Australia, the term ‘Aboriginal and Torres Strait Islander people’ is preferred in this report. However ‘Indigenous’ is also used, especially in the context of ‘Indigenous status’ or where it assists readability. It is acknowledged that Indigenous people may be of either Aboriginal or Torres Strait Islander origin or both.

In this report, identification of Indigenous status means asking the national standard Indigenous status question and recording responses in line with the National best practice guidelines for collecting Indigenous status in health data sets (AIHW 2010a).

This report focuses on the general practice sector. Other primary health care providers, such as physiotherapists, are excluded as they do not control access to health interventions specifically for Aboriginal and Torres Strait Islander people in the way GPs do.

Aboriginal Community Controlled Health Services (ACCHS) are also excluded: mainstream (that is non-Indigenous-specific) general practices are the sole providers in scope. While ACCHS are central to improving Indigenous health, it is estimated that between 50–60% of Aboriginal and Torres Strait Islander people access health care elsewhere (AHMAC 2011; Couzos & Thiele 2009). Mainstream GPs, as well as ACCHSs, therefore play an important role in Indigenous health. Data also indicate Indigenous identification is not problematic in the ACCHS sector, where about 95% of clients have their Indigenous status recorded (AIHW 2011).

2.2 The problem in detail

There is unrealised potential for primary health care to better address ill health in the Aboriginal and Torres Strait Islander population. Health promotion, prevention and early intervention in particular could all be improved as demonstrated by the following examples:

• Considerable opportunistic vaccination is missed; nearly one third (around 30%) of all Aboriginal and Torres Strait Islander people never vaccinated against influenza or invasive pneumococcal disease had visited a GP in the previous two weeks (AHMAC 2011).
• Between July 2008 and June 2010, rates for potentially preventable hospital admissions, including those that could have been avoided through effective preventive measures or
early diagnosis and treatment, were five times as high for Aboriginal and Torres Strait Islander people compared with non-Indigenous Australians (AHMAC 2012).

- About 40% of Aboriginal and Torres Strait Islander patients in end stage renal failure programs were not known to have had renal disease before presenting with renal failure (Van Buynder et al. 1993), highlighting issues with late presentation and diagnosis of chronic disease.

Paradoxically, although mainstream general practice plays a vital role in improving Aboriginal and Torres Strait Islander people’s health, Indigenous health is a marginal issue for most mainstream GPs. It has been estimated that more than 70% of GPs may never treat an Indigenous patient (Couzos & Thiele 2009). Given the Aboriginal and Torres Strait Islander population is about 3% of the total Australian population, changes which prioritise Aboriginal and Torres Strait Islander health care are unlikely to occur spontaneously. Instead they require strategic and on-going support.

One way in which general practice could improve the care provided to Aboriginal and Torres Strait Islander people is by boosting access to targeted programs designed to overcome health disparities between Indigenous and non-Indigenous Australians (Couzos & Thiele 2010; Reath 2005).

As outlined in Section 7, most of these programs are mediated via GPs but have not reached their potential. Indications are that only a minority of mainstream general practices ask all patients for their Indigenous status, and this reduces GPs’ ability to provide primary health care appropriate to need (AMA 2012a). This is because without knowing which patients are Indigenous, general practices are unable to offer the health interventions targeted to their particular needs.

As well as limiting service delivery, poor identification processes undermine the completeness of Indigenous status information generated by the general practice sector. These inaccuracies flow into a number of national data collections and reduce the policy relevance of these collections for Indigenous health. Asking the Indigenous status question therefore contributes to health outcomes by facilitating both improved data collection and service delivery (Figure 2.1).
It should be emphasised that despite this conceptual simplification, identification alone guarantees neither better service delivery nor data collection. It is a necessary but not sufficient requirement for such improvements to occur (Kelaher et al. 2010). For example, the ACCHS sector, where identification is high, has health check rates not dissimilar to the low coverage evident nationally (AIHW 2013b). Likewise, until data transfer mechanisms between the two are improved, better practice-level identification is largely irrelevant to national data collections. Identification must be improved not as an end in itself, but in lock step with the ends it seeks to achieve. In the general practice sector, service delivery impact far outweighs data collection impact, and so it is service delivery which should be the prime motivator and rationale for change.

**COAG commitments**

In December 2007, COAG endorsed a range of commitments regarding Indigenous wellbeing. The health specific targets were to close the life expectancy gap between Indigenous and non-Indigenous Australians within a generation and to halve the gap in mortality rates for Indigenous Australian children under five within a decade (COAG 2007) (Box 2.1).
Box 2.1: The COAG Closing the Gap commitments

The COAG commitments were:

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

COAG efforts directed to overcoming Indigenous disadvantage were implemented through a range of intergovernmental agreements and funding allocations (Close the Gap Steering Committee for Indigenous Health Equality 2010). Key elements in this structure relevant to the health sector were the:

- National Indigenous Reform Agreement (NIRA): a head agreement under which National Partnership Agreements were made, allocating $5.0 billion across Australian and state and territory governments
- National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: the specific agreement relevant to health, with funding of $1.6 billion
- Indigenous Chronic Disease Package (ICDP): the Australian Government’s contribution to the National Partnership Agreement (DoHA 2010b). The ICDP comprised 14 separate measures (Table 2.1) and was allocated funding of $805.5 million.

This COAG architecture included three main elements relevant to this report:

- **Targeted, not population-wide, approach**: the aim was to uplift one subgroup to ‘catch up’ with the general population. It established measures solely for the Aboriginal and Torres Strait Islander population, which required identifying this group separate from the non-Indigenous population and providing them with these programs. If the target population was not identified, the measures – no matter how soundly based – could not be delivered.
- **Data quality improvements**: it recognised that the ability to measure health gaps between Indigenous and non-Indigenous people, and to monitor progress in closing those gaps, was essential to both delivering and demonstrating Closing the Gap commitments. Specific data quality improvement projects are discussed in Section 5.
- **GP focussed**: the ICDP was largely focussed on the general practice sector. Apart from a self-evaluation measure, it comprised 13 measures, 7 of which targeted or were accessed via GPs (Figure 2.2). These included supports for GPs to engage with Aboriginal and Torres Strait Islander health, new interventions specifically for Aboriginal and Torres Strait Islander people to be directly provided by GPs, and support services to which GPs could refer their Aboriginal and Torres Strait Islander patients. The programs were available equally to GPs in mainstream practices and in the ACCHS sector.
<table>
<thead>
<tr>
<th>Main elements</th>
<th>Aims</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tackle chronic disease risk factors</td>
<td>To reduce modifiable risk factors (smoking, poor nutrition, lack of exercise) by tobacco control interventions and health promotion activities</td>
<td>National action to reduce Indigenous smoking rate (A1) Helping Indigenous Australians to reduce the risk of chronic disease (A2) Local Indigenous community campaigns to promote better health (A3)</td>
</tr>
<tr>
<td>2. Primary health care services that can deliver: improving chronic disease management and follow-up care</td>
<td>To improve the limited uptake of health checks and follow-up care by providing incentives for general practices, supporting Aboriginal and Torres Strait Islander people to participate in their health care and providing affordable medicines</td>
<td>Subsidising PBS medicine co-payments (B1) Higher utilisation costs for MBS and PBS (B2) Supporting primary care providers to coordinate chronic disease management (B3) Improving Indigenous participation in health care through chronic disease self-management (B4) Increasing specialist and allied health follow-up care (B5) Monitoring and evaluation (B6)</td>
</tr>
<tr>
<td>3. Fixing the gaps and improving the patient journey: workforce expansion and support</td>
<td>To improve the capacity of the primary care workforce by communication and marketing; additional scholarships and training positions and Indigenous-specific clinical practice and decision support guidelines</td>
<td>Workforce education and training (C1) Expanding the outreach and service capacity of Indigenous health services (C2) Engaging Medicare Locals to improve Indigenous access to mainstream primary care (C3) Attracting more people to work in Indigenous health (C4) Clinical practice and decision support (C5)</td>
</tr>
</tbody>
</table>

Source: Urbis 2010a.
Figure 2.2: Elements of the ICDP

Note: CD = chronic disease.
2.3 GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people

The range of GP-mediated health interventions available specifically for Aboriginal and Torres Strait Islander people is designed to address the higher morbidity and mortality levels in this population. For the purposes of this report;

- GP-mediated interventions mean those directly delivered by GPs or contingent upon action by GPs to be accessed, for example, referral by a GP to another service provider
- health interventions mean those directly benefiting individual Aboriginal and Torres Strait Islander patients in a way distinct from services provided to non-Indigenous patients.

By these definitions, services via community-based Aboriginal and Torres Strait Islander-specific workers such as tobacco control workers and Indigenous health outreach workers are not included, as these workforces support Aboriginal and Torres Strait Islander communities without GPs’ involvement. Similarly, the Practice Incentive Program Indigenous Health Incentive (PIP IHI) and support positions based in Medicare Locals are not included, as they provide support to general practices, but do not directly result in specialised services to Aboriginal and Torres Strait Islander patients. These initiatives are discussed in Section 5.

GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people are outlined below in two categories: those introduced before COAG Closing the Gap commitments, and those introduced as part of those commitments. This distinction is made because of the time difference—earlier interventions were introduced up to 10 years before COAG measures. This time lag should have allowed for refinements to implementation of such measures.

Pre ICDP measures

**Medicare Benefits Schedule-rebated health checks**

Health checks tailored for the specific needs of Aboriginal and Torres Strait Islander people were added to the Medicare Benefits Schedule (MBS) progressively. Annual checks specific to people 55 and over were introduced in 1999, 2-yearly checks for people aged 15–54 in 2004, and annual checks for children aged 0–14 in 2006. In 2010, the three separate checks were amalgamated to a single MBS item number (715), and time intervals at which they could be undertaken were standardised to once every nine months (DoHA 2012f).

These early detection and treatment interventions are especially important for the Aboriginal and Torres Strait Islander population, which has a greater burden of undiagnosed and untreated illnesses, an earlier onset of chronic disease and higher rates of infectious diseases compared to non-Indigenous Australians (Kelaher et al. 2005). Potential health benefits of the health checks were considerable: in Queensland, health check trials reduced rates of sexually transmissible infections by 50% in a two-year period (Kelaher et al. 2005).

**Health check follow-up services**

Despite their importance, health checks alone are unlikely to lead to health benefits: follow-up services are also required (Spurling et al. 2009). In fact, if follow-up treatment cannot be provided, some authors consider the provision of screening may not be justified (Bookallil & Thomas 2006; Burgess 2007). The need for follow-up services to address health issues
identified by health checks is likely to be high. One study showed over 60% of Aboriginal and Torres Strait Islander people having a health check required referrals to either specialists or allied health professionals (Spurling et al. 2009).

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

- practice nurses or registered Aboriginal Health Workers (MBS item 10987). The number of follow-up services was increased under the ICDP from 5 to a maximum of 10 services per patient in a calendar year (DoHA 2010d)
- allied health professionals (MBS items 81300–81360) across a range of specialisations (Table 2.2) up to a maximum of 5 services in a calendar year (DoHA 2011a).

Table 2.2: MBS item numbers and allied health providers

<table>
<thead>
<tr>
<th>MBS item number</th>
<th>Allied health provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>81300</td>
<td>Aboriginal or Torres Strait Islander health service provided by an eligible Aboriginal Health Worker†</td>
</tr>
<tr>
<td>81305</td>
<td>Diabetes education</td>
</tr>
<tr>
<td>81310</td>
<td>Audiology health service</td>
</tr>
<tr>
<td>81315</td>
<td>Exercise physiology</td>
</tr>
<tr>
<td>81320</td>
<td>Dietetics</td>
</tr>
<tr>
<td>81325</td>
<td>Mental health services</td>
</tr>
<tr>
<td>81330</td>
<td>Occupational therapy</td>
</tr>
<tr>
<td>81335</td>
<td>Physiotherapy</td>
</tr>
<tr>
<td>81340</td>
<td>Podiatry</td>
</tr>
<tr>
<td>81345</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>81350</td>
<td>Osteopathy</td>
</tr>
<tr>
<td>81355</td>
<td>Psychology</td>
</tr>
<tr>
<td>81360</td>
<td>Speech pathology</td>
</tr>
</tbody>
</table>

Notes: † Aboriginal Health Workers who have been awarded a Certificate Level III in Aboriginal and Torres Strait Islander Health (or an equivalent or higher qualification) from a Registered Training Organisation that meets training standards set by the Australian National Training Authority’s Australian Quality Training Framework can register with Medicare Australia to provide this item.

Source: DoHA 2011a.

Immunisation

Aboriginal and Torres Strait Islander children in some locations and adults throughout Australia have different recommended immunisation programs from non-Indigenous people (Table 2.3) (DoHA 2013a). These are designed to address the much higher burden of vaccine-preventable diseases in the Aboriginal and Torres Strait Islander population. For example, hospital separations for influenza and pneumonia in 2010–11 were more than five times higher for Aboriginal and Torres Strait Islander people, compared with non-Indigenous Australians, based on data from the six jurisdictions where Indigenous data was considered of sufficient quality for statistical reporting purposes (SCRGSP 2013).

Some recommended immunisations for Aboriginal and Torres Strait Islander people are supported by additional government funding through the National Indigenous Pneumococcal and Influenza Immunisation (NIPII) program (DoHA 2013f). This program provides free pneumococcal vaccination to Aboriginal and Torres Strait Islander people from 50 years and those aged 15 to 49 who are at high risk of invasive pneumococcal disease, and
free influenza vaccination for all Aboriginal and Torres Strait Islander people 15 years and over.

Table 2.3: Additional* vaccines recommended for Aboriginal and Torres Strait Islander people

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacille Calmette-Guérin (BCG) vaccine</td>
<td>Neonates living in areas of high tuberculosis incidence (Northern Territory, Queensland, northern South Australia) 1 dose</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Children resident in the Northern Territory, Queensland, South Australia and Western Australia 2 doses in the 2nd year of life (exact ages may differ between jurisdictions)</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Adults who have not previously been vaccinated against hepatitis B and are non-immune</td>
</tr>
<tr>
<td>Influenza</td>
<td>All persons aged 15 and over Consider in all children aged 6 months and older, especially those aged less than 5 years Annual vaccination</td>
</tr>
<tr>
<td>Pneumococcal conjugate (13vPCV)</td>
<td>Children resident in the Northern Territory, Queensland, South Australia and Western Australia Booster dose in 2nd year of life in addition to primary course</td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (23vPPV)</td>
<td>Persons aged 15–49 with underlying conditions increasing the risk of invasive pneumococcal disease including: people who smoke, have heart disease, kidney disease, lung disease, severe asthma or diabetes; or have an immune-compromising condition such as HIV infection or cancer; or are heavy drinkers All persons 50 and over</td>
</tr>
</tbody>
</table>

Notes: * In addition to those vaccines recommended for all Australians or those in particular medical, occupational, behavioural or other risk groups.


Coverage for adult vaccination for influenza and invasive pneumococcal disease has increased, but falls well short of original program targets (Table 2.4). Unlike childhood immunisations which are recorded in the Australian Childhood Immunisation Register, national adult immunisation data is available only via responses to national surveys, with the latest information relating to 2004-05.

The 2004–05 National Aboriginal and Torres Strait Islander Health Survey found that around 30% of all Indigenous Australians who had never been vaccinated against influenza or invasive pneumococcal disease had visited a doctor in the previous two weeks, reflecting missed opportunities for vaccinations initiated by GPs for these patients (AHMAC 2012).

Table 2.4: Comparison of reported immunisation coverage with program targets

<table>
<thead>
<tr>
<th></th>
<th>Aboriginal and Torres Strait Islander people aged 50 and over</th>
<th>Aboriginal and Torres Strait Islander people aged 15-49 with risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza vaccination</td>
<td>Coverage 60% Target 80%</td>
<td>Coverage 29% Target 60%*</td>
</tr>
<tr>
<td>Pneumococcal vaccination</td>
<td>Coverage 34% Target 80%</td>
<td>Coverage 13% Target 60%*</td>
</tr>
</tbody>
</table>

Note: * An overall target of 80% of those with risk factors was set. As the proportion of those aged 15–49 years who had risk factors was not known, a target of 50% of the total population in that age group was set in 2004, and was to be increased to 60% in 2006 (NCIRS 2003).


Additional vaccinations are also recommended for Aboriginal and Torres Strait Islander children in some areas. Immunisation coverage of Aboriginal and Torres Strait Islander children differs from other Australian children, with some age groups showing lower immunisation (AHMAC 2012). In 2011, the gap in immunisation coverage for Indigenous
children at 12 months was 7 percentage points less than non-Indigenous children, at 2 years the gap was less than 1 percentage point and by 5 years the gap was about 3 percentage points.

**Improving access to medicines listed on the PBS**

Despite higher burdens of morbidity and mortality, Aboriginal and Torres Strait Islander people have less access to medicines listed on the PBS than non-Indigenous people (Couzos et al. 2011; Keys Young 1997; Urbis Keys Young 2006; Urbis 2011). Three government initiatives to address the lack of access to PBS medicines for Aboriginal and Torres Strait Islander people were initiated before the ICDP.

Two of these initiatives, special supply arrangements in remote areas and the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples Program, are delivered via ACCHSs or other Indigenous-specific health services. Therefore they are not affected by the extent of Indigenous identification in mainstream general practice and are not discussed in this report.

Under the third initiative, a number of medicines were included in the PBS for limited, but in some cases not exclusive, prescription to Aboriginal and Torres Strait Islander people (DoHA 2012e). These medicines target conditions which have a high prevalence or impact in the Indigenous population and include anti-fungals and antibiotics to treat chronic middle ear infections (Appendix A). This enables Aboriginal and Torres Strait Islander people to access the medicines at subsidised rates, and therefore reduces the financial barriers to improved access to necessary medications. PBS listings specifically for Aboriginal and Torres Strait Islander people are available to all prescribers, and hence in the mainstream general practice sector are affected by the extent of identification processes.

**ICDP measures**

The ICDP expanded the range of earlier health interventions specifically for Aboriginal and Torres Strait Islander people where individual access is mediated by GPs (DoHA 2011b). Major interventions introduced by the ICDP, including the PBS copayment measure, an increased number of MBS-rebated follow-up services after a health check, and access to care coordination services, are outlined below. Other measures established or strengthened by the ICDP, such as improved access to specialist services, are not discussed here as they have been introduced in selected areas and are not available to all GPs.

**Pharmaceutical Benefits Scheme copayment measure**

One of the most important elements of the ICDP was the PBS copayment measure. This measure, introduced in July 2010, reduces the cost of PBS medicines for eligible Aboriginal and Torres Strait Islander people with, or at risk of, chronic disease (DoHA 2010c). For eligible patients, the copayment is reduced to the concessional rate, while for concessional patients the copayment is reduced to zero.

This measure significantly extended earlier medicines access programs and exceeded long-standing proposals for better medicines access (Couzos 2005; NACCHO et al. 2004). The Section 100 arrangements were confined to ACCHSs and other Indigenous specific services in remote areas and the QUMAX program was restricted to ACCHSs in non-remote areas. By contrast, the PBS copayment measure could be provided by mainstream general practices regardless of their location. Properly implemented, this measure had the capacity to replicate the increased access to PBS medicines achieved by Section 100 arrangements throughout Australia, and held the potential to deliver substantial health improvements.
Higher MBS and PBS costs
This ICDP measure had two parts. First it acknowledged the funding implications the ICDP would have on the MBS, the PBS and the Practice Incentive Program; if the ICDP was effective, expenditure for Aboriginal and Torres Strait Islander people would increase (DoHA 2010d). Second it increased the number of follow-up services after a health check provided by a practice nurse or Aboriginal Health Worker from 5 to 10 per patient per calendar year.

Access to care coordination
General practices engaged in the PIP IHI\(^1\) can refer Aboriginal and Torres Strait Islander patients to care coordinators for assistance if they have prepared a care plan and the patient meets eligibility requirements (DOHA 2012b). Care coordinators help patients access services required by their care plan, including by arranging appointments and ensuring regular reviews by the GP. As at December 2012, about 100 full-time equivalent care coordinators were employed: over 60 in Medicare Locals and the remainder in the ACCHS sector (DoHA 2013c).

Summary of GP-mediated health interventions specific for Aboriginal and Torres Strait Islander people
The initiatives established either before or through the ICDP resulted in a substantial package of GP-mediated health measures specifically for Aboriginal and Torres Strait Islander people (Box 2.2). As a result, current clinical and financial implications of effective Indigenous identification have never been greater.

<table>
<thead>
<tr>
<th>Box 2.2: Main GP-mediated Indigenous-specific health interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-Indigenous Chronic Disease Package</strong></td>
</tr>
<tr>
<td>• MBS-rebated health checks specifically for Aboriginal and Torres Strait Islander people (MBS item 715)</td>
</tr>
<tr>
<td>• 5 MBS-rebated follow-up services (MBS item 10987) provided by a practice nurse or registered Aboriginal Health Worker after a health check</td>
</tr>
<tr>
<td>• 5 allied health follow-up services (MBS items 81300–81360) after a health check</td>
</tr>
<tr>
<td>• Pneumococcal and influenza immunisations for Aboriginal and Torres Strait Islander adults</td>
</tr>
<tr>
<td>• Different Aboriginal and Torres Strait Islander children’s immunisation in some states and areas</td>
</tr>
<tr>
<td>• PBS listings specifically for Aboriginal and Torres Strait Islander people</td>
</tr>
<tr>
<td><strong>Introduced via Indigenous Chronic Disease Package</strong></td>
</tr>
<tr>
<td>• Cheaper medicines through the PBS copayment measure</td>
</tr>
<tr>
<td>• Care coordination</td>
</tr>
<tr>
<td>• Access to 10 MBS-rebated follow-up services (MBS item 10987) provided by a Practice Nurse or registered Aboriginal Health Worker after a health check (increased from 5 pre-ICDP)</td>
</tr>
</tbody>
</table>

\(^1\) The PIP IHI is discussed at Sections 5 and 6.
While these interventions are of considerable importance, they entailed separate consideration of eligibility, as each has different criteria for access (Appendix B). While some criteria are straightforward, others are not. For example, in determining eligibility for access to the PBS copayment measure, GPs must assess whether the patient is unlikely to adhere to their medicines regimen without this assistance. This requires judgements about financial and other considerations which mainstream GPs may or may not be well-placed to make.

2.4 General practice sector’s contribution to data collections

Under-identification of Aboriginal and Torres Strait Islander people undermines data collections across the health sector (MacRae et al. 2012). The scale of the Indigenous burden of disease, and the impact of existing interventions, cannot be measured accurately when Indigenous status data is inaccurate. Several unsuccessful efforts have been made over recent decades to establish a framework for comprehensive data collection from the general practice sector (Britt et al. 2012b). Despite these failures and the continued absence of a specific data collection for the general practice sector, general practice contributes to national data collections through pathology requests and death certificates.

Data generated by pathology processes

General practice contributes to data collections mainly via pathology processes. These data collections include those relating to cancer, Pap tests and notifiable communicable diseases. Pathology providers generally send information to data collections, but the content they transfer is dependent on information they receive on pathology request forms. Transmitting Indigenous status from general practices to national data collections via pathology processes is a multi-step exercise: any break in the process means the data is lost (Figure 2.3). There are currently problems in every step of the process: general practices generally do not ask or record Indigenous status, pathology forms do not include space to record this, and pathology providers neither record nor pass it on to data collection points.

Cancer

Cancer causes considerable levels of disease and death within Aboriginal and Torres Strait Islander communities (Vos et al. 2007). However national collections for cancer data are not adequately provided with Indigenous status of patients, as pathology request forms are the main source of cancer data. Reporting deficiencies from the pathology process are carried into the Australian Cancer Database, the national repository of cancer incidence. Consequently the database does not provide reliable national data on the incidence of cancer among Indigenous Australians. One analysis concluded that reported Indigenous cancer incidence rates probably underestimate actual cancer incidence by 15–25% (Zhang et al. 2011).

Pap smear registers

The incidence of cervical cancer in Aboriginal and Torres Strait Islander women is more than twice that among non-Indigenous women, and mortality due to cervical cancer in Indigenous women is more than 5 times that of non-Indigenous women. Up to 90% of the most common type of cervical cancer could be prevented through regular screening (AHMAC 2011). Pap smear registers, which rely entirely on pathology request forms as their data source, can only show Indigenous status for incidence of, and mortality from, cervical cancer. This means that
participation, rescreening, cytology and histology trends cannot be determined for Aboriginal and Torres Strait Islander women (AIHW 2012b).

**Notifiable communicable diseases**

A range of communicable diseases are required to be notified to the National Notifiable Diseases Surveillance System. These notifications are primarily sourced from pathology laboratories in most jurisdictions, with information provided directly from general practices a less important data source (AIHW forthcoming a). As for other data sets generated through pathology processes, Indigenous status is not completed for all records in notifiable communicable disease registers, and this impedes policy responses. For example, in 2011, Indigenous status was not reported for over 30% of gonorrhoea notifications, nearly 50% of chlamydia notifications and 60% of hepatitis C notifications (The Kirby Institute 2012).

**Source:** AIHW forthcoming a.

**Figure 2.3: Information transfer via pathology processes**

**Other data generated by general practice**

Apart from pathology processes, death certificates are the other mechanism via which GPs contribute to national data collections. Medical practitioners, including GPs, complete Medical Certificates of Cause of Death and these are a major contributor to national deaths.
data (ABS 2011). These certificates should include information about the Indigenous status of the deceased person but are not always complete. In 2009, just over 1% of deaths registered did not state whether the person was Aboriginal, Torres Strait Islander, or neither. In some states and territories the number of death certificates without Indigenous status recorded was greater than the number of deaths registered for Aboriginal and Torres Strait Islander people. Improvements in Indigenous identification in the general practice sector are needed in order to increase the quality and completeness of deaths data.

2.5 Evidence of the problem

Available data sources about Indigenous identification processes in the general practice sector indicate rates of routine identification are low.

Over the 10 financial years from 2002–03 to 2011–12, GPs reported an average of about 1.6% of patient encounters were with Aboriginal and Torres Strait Islander people (Britt et al. 2012a). However in 2004, when GPs were requested to ask the standard identification question as part of other cultural background questions, the proportion of patients identified as Aboriginal or Torres Strait Islander increased (Britt et al. 2007). The study estimated the under-identification of encounters with Aboriginal and Torres Strait Islander patients was over 36% (Britt et al. 2007). This indicates Aboriginal and Torres Strait Islander people attend mainstream general practice, but often do not have their Indigenous status recognised or recorded.

The only national survey of identification practices in the general practice sector, carried out in 2003, investigated the reasons for under-identification (NCIRS 2003). Responses indicated only 7% of practices asked all patients for their Indigenous status. Practices instead tended to ask if they thought a patient may be Indigenous, relied on patients to self-identify or only asked new patients (Figure 2.4). The last process — of asking only new patients — is likely to have minimal impact on establishing Indigenous status for the overall practice population, as this tends to remain stable over time. The proportion of GP encounters with new patients is less than 8% and has decreased significantly since 2002–03 (Britt et al. 2012b).
Smaller studies of identification processes in general practice support these national data. A Queensland study found 7 out of 21 practices surveyed asked all patients for their Indigenous status (Riley et al. 2004). Although largely concerned with qualitative investigations, an Australian Capital Territory study found none of the 9 practices that participated asked patients (Kehoe & Lovett 2008). Another Australian Capital Territory study which interviewed Aboriginal and Torres Strait Islander people found only 1 of the 28 participants (all of whom had attended mainstream general practice) had been asked for their Indigenous status (Scotney et al. 2010).

These studies largely preceded the changes implemented by COAG from 2010 (see Section 6). However, available data suggest that identification of Indigenous status in general practice continues to be low.

Feedback from Divisions of General Practice in 2009–10 indicated the identification of Aboriginal and Torres Strait Islander patients was a challenge to Closing the Gap implementation (APCC 2012). Issues of practice staff feeling uncomfortable in asking about Indigenous status and beliefs there were no Aboriginal and Torres Strait Islander people in the practice were noted, echoing findings of earlier studies discussed in Section 4. Although this data related to early phases of implementation, ongoing cross-sectional surveys of GPs also show there is no evidence of COAG reforms increasing the proportion of patient encounters recorded as Aboriginal or Torres Strait Islander. This proportion was 1.2% in 2002–03 and 1.6% in 2011–12 but the variation between the beginning and end of this period was not statistically significant (Britt et al. 2012a). Lack of awareness of Indigenous status of patients has been recognised as an on-going impediment to realising the benefits of the ICDP (MSHR 2013; Russell 2013).

2.6 Summary

This section discussed the problem of low rates of Indigenous identification in the general practice sector. Improved identification is a necessary first step to increase uptake of targeted health interventions for Aboriginal and Torres Strait Islander people. It is also needed to improve the completeness of information general practice provides to data collections. Both of these requirements gained priority in the COAG Closing the Gap processes. The number of health interventions specifically for Aboriginal and Torres Strait Islander people increased, and the clinical and financial implications of Indigenous identification in the general practice sector became greater than ever before. Long-standing deficiencies in Indigenous status data affecting almost all health data collections were recognised as an impediment to the government’s ability to measure the gap over time. Data quality improvement projects, discussed in Section 5, were funded to address these deficiencies.

The Australian Government’s contribution to achieving the commitments to health equity was focussed on the general practice sector, and mainstream GPs were included on an equal footing to the ACCHS sector. National health gains were expected to be delivered through the general practice sector, and were therefore dependent on the sector’s identification processes. All indications suggest these processes miss a considerable proportion Aboriginal and Torres Strait Islander people. Poor identification processes constituted a roadblock to program implementation. The failure to recognise the extent of this challenge laid the groundwork for poor uptake of health interventions specifically for Aboriginal and Torres Strait Islander people in the years to come.

The next section examines the causes of low Indigenous identification in the general practice sector.
3 Why is Indigenous identification low?

This section builds on the discussion of the overall problem contained in the previous section by examining the factors contributing to the low rate of identification in the general practice sector. First, it describes sector attributes relevant to making any change in the general practice sector. Second, it considers issues related to Indigeneity and third, it discusses contextual factors relevant to the sector.

3.1 Sector attributes

Overview

The general practice sector primarily comprises private practices under corporate or individual ownership. In 2011, about 24,700 GPs were estimated to be working in about 7,000 practices across Australia (PHCRIS 2013a; PHCRIS 2013b), with most GPs working in private rooms under corporate or individual ownership. As of 2011–12, about 10% of GPs worked in solo practices, 40% worked in practices of between 5–9 GPs, and more than 20% worked in practices of 10 or more GPs (Britt et al. 2012a). Smaller numbers of GPs work in acute care hospitals, 24 hour clinics and other settings.

GPs are for many Australians the ‘face’ of the health care system as a whole. About 80% of people visit a GP at least annually (Duckett & Willcox 2011). GPs are the access point not only to the primary health care they provide, but to other forms of health care including referrals to specialists and access to secondary and tertiary hospital-based care.

GPs in private practice enjoy a high degree of autonomy. According to one report, they are ‘strongly independent and zealously guard that independence’ (KPMG Consulting 2000). Australian GPs have greater levels of autonomy than in many other countries. They can establish their business, charge fees and provide a wide scope of services with few restrictions imposed by government (Scott & Coote 2007). Economic autonomy, gained through their ability to set their own fees, is matched by high levels of clinical autonomy. In contrast to health settings such as hospitals, primary health care like that provided by GPs is disaggregated, with few systems of oversight incorporated at the point of care (ACSQHC 2011).

GPs benefit from the overall dominance enjoyed by the medical profession, which has high status and influence in the health system (Belcher 2009). Through professional representative bodies, such as the Australian Medical Association, GPs are able to lobby effectively for their interests (AMA 2012b). GPs and these representative bodies have at times had an adversarial relationship with the Australian Government, particularly in relation to fee structures.

GPs are trained to, and are generally rewarded for, providing atomised care: dealing with presenting issues on an individual patient basis. As the morbidity of the population has shifted from acute to chronic conditions, this approach has become less relevant. However the needed shift away from a focus on the individual to population-based care will not happen of its own accord: it involves cultural change and systematised support (APCC 2012).

Achieving the Australian Government goals of ensuring effective identification processes and implementing health interventions specifically for Aboriginal and Torres Strait Islander people is problematic in this environment. What government control exists resides at the
national, rather than the state or territory level. Attempts by the Australian Government to influence the sector have a mixed track record.

Potential avenues to support changes in the general practice sector include: funding models; clinical information systems; professional and training support bodies; and accreditation processes. The Australian Government has varying levels of influence in each of these areas.

**Funding structure**

As well as payments directly from patients, general practice is funded by two types of payments from the Australian Government.

The government pays standard rebates set by the MBS for medical consultations; known as the ‘fee for service’ component. GPs can accept the Medicare fee as payment in full for services rendered (‘bulk bill’ patients), or charge an additional fee to patients to ‘top up’ this amount (Duckett & Willcox 2011). An example of government-led change made through MBS rebates was the addition of health checks for Aboriginal and Torres Strait Islander people. Adding these items to the MBS and attaching a higher rebate to them gave a financial incentive for GPs to undertake the checks.

‘Fee for service’ approaches reward high-throughput services that militate against quality of care for the increasing proportion of chronic, rather than acute, illnesses (Duckett & Willcox 2011). To balance this, the Australian Government has established a ‘blended payments’ approach to provide incentives for quality of care improvements (DHS 2012; Duckett & Willcox 2011). Despite scant evidence of their ability to deliver health outcomes (Wright 2012), blended payments have become a feature of the general practice funding environment through the Practice Incentives Program. An example of government-led policy change through this Program is payments to GPs for achieving childhood immunisation targets. As discussed in Section 6, new incentive payments are being used to encourage a greater focus on Aboriginal and Torres Strait Islander health.

**Clinical information systems**

The private ownership of general practices contributes to the diversity of practice software in use. As at 2008, about 35 different providers supplied general practice sector software (AIHW 2008). There is little standardisation across these software products (Jolly 2011) and features and functionality are largely dictated by market pressure. Initial work to develop standards for electronic health records was undertaken in several projects during the 1990s, and standards were recommended, but not mandated, in 2003 (Britt et al. 2012b). Despite these efforts, the lack of standardisation has persisted, resulting in:

> a negative effect on interoperability…ensur(ing) that national data collection programs cannot rely on passive data collection from GP desktops to provide a reliable picture of the care provided to the population (Britt et al. 2012b:iv).

Given the small proportion of Aboriginal and Torres Strait Islander people in most practice populations, it is not surprising that demand for features which support Indigenous identification and access to health interventions specifically for Aboriginal and Torres Strait Islander people has been negligible.

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2 The Practice Incentives Program includes Service Incentive Payments.
Clinical information systems are an important element in making change in the general practice sector. However, processes through which government can influence software functionality are not straightforward.

One option is the use of incentives to encourage change. Under the Practice Incentive Program, GPs were rewarded for installing computers and using prescribing software, and computerisation increased from 15% of GPs in 1997 to 70% in 2000 (McInnes et al. 2006).

The government also sometimes mandates changes in software to meet requirements of new policies and in such cases funding to support the changes is generally supplied. For example, changes to dispensing software used by pharmacists was needed in order to deliver the PBS copayment measure, and funding to purchase these changes from software suppliers was allocated by government to do so.

Another option to achieve government-led policy change in clinical information systems is to mandate requirements in processes with which the general practice sector seeks to be compatible. For example, the Australian Government (via the National E-health Transition Authority) is currently setting communication, privacy and other requirements for the Personally Controlled Electronic Health Record (PCEHR). Software providers will work to ensure their products achieve compliance with these requirements.

To date, none of these options have been applied to the goal of improving Indigenous identification within general practice.

**Training and support**

Training spans the entire professional career of a GP: undergraduate medical training, GP registrar training and on-going professional education. Training provides opportunities to influence the skills, knowledge and attitudes of GPs. An example of Government-sponsored changes made through training was the development and endorsement of the *Indigenous health curriculum framework* to embed Aboriginal and Torres Strait Islander health in the undergraduate core curriculum (Mackean et al. 2007).

Professional colleges, the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM), play an important role in training and support. As they are controlled by the profession, the Australian Government has relatively little influence over their work. However the government can contract them to undertake specific projects. For example as discussed at Section 6, the RACGP was funded by government to develop a cultural awareness training program.

In contrast to the professional colleges, Divisions of General Practice were initiated and funded by the Australian Government. Divisions were gradually established from 1992 to provide support to the general practice sector (Baum 2008). Examples of government-led changes which were funded and delivered via Divisions include practice accreditation, childhood immunisation and uptake of information technology (Nicholson et al. 2012). Divisions have recently been transitioned to Medicare Locals as part of national health reforms (Australian Government 2011). Although the scope and role of Medicare Locals is broader than that of Divisions, they will retain a central role in supporting change in the general practice sector. As discussed in Section 6, Medicare Locals are being funded by government to support improvements in Indigenous identification in the general practice sector.
Accreditation

Accreditation mechanisms, an important way to influence the general practice sector, are controlled by the profession. For practices choosing to participate, accreditation standards for general practices are set by the RACGP (RACGP 2010), with assessment against those standards carried out by independent assessment agencies. Although the Australian Government does not control accreditation, it can seek to influence its impact. The Government has made accreditation a requirement for participation in the Practice Incentive Program. In 2011, about 4,800 general practices, representing about 68% of all practices, were accredited (SCRGSP 2013).

Accreditation changes were recommended to improve Indigenous identification (Kelaher et al. 2010; NCIRS 2003). As discussed in Section 6, these reforms are in train.

Summary

The general practice sector is a strong and central element of the Australian health care system, mainly comprising private businesses with high levels of financial and clinical autonomy. The Australian Government does not exercise ‘command and control’ over the sector, but does have opportunities to support the achievement of desired policy goals. The government has initiated some changes via funding models and support processes through Medicare Locals, and the RACGP has also revised accreditation requirements. However the potential to support change through modifying clinical information systems has not been addressed.

3.2 Issues related to Indigeneity

Seeking Indigenous status is commonplace: it is included in the Census and in many service delivery areas as well as health. The process is presented as non-controversial: a simple administrative exercise similar to obtaining other basic personal information such as name and address (AIHW 2010a). However, asking for Indigenous status and responding to the question is not straightforward.

Indigenous identity may have more in common with gender identity than with information such as date of birth. While often presented as binary and fixed, both gender and Indigenous identification may be more accurately understood at least in part as ‘fluid, multiple, differing in degrees, and [socially] constructed’ (Gardiner-Garden 2003:16). Rather than immutable attributes, these and other forms of self-identity are ‘complex, multi-faceted socio-historical constructs’ (Paradies 2006:356).

The identification of Indigenous status has historically been intrinsically linked with prevailing discriminatory practices: it was used to ‘surveil and control’ Indigenous people (Paradies 2006:355). Even today, Aboriginal and Torres Strait Islander people often opine while they are the most researched people in the world, they have benefited little from this process (Yu 2012). Data collection has been described as analogous to overall race relations in this country: ‘a history of denial and subjugation’ (Yu 2012:4). Determining who was or was not Indigenous has been the basis of discrimination throughout much of Australian history.

Categorisations of degrees of Indigeneity generated by government, coupled with pervasive beliefs in the inferiority of Aboriginal people, were the basis of forced separations of children from their families (HREOC 1997). Despite present day legal equality, prejudice and discrimination continue.
Without an understanding of the history and status of race relations in Australia and ‘the push of the past into the present’ (McDermott 2006:465), it is impossible to grasp the complexities raised by the question of Indigenous status. This section investigates the ways in which Indigenous status is and has been defined and how such definitions have impacted upon Aboriginal and Torres Strait Islander people.

**Definitions of Indigeneity**

Definitions of Indigeneity in Australia have changed over time (Gardiner-Garden 2003). Over 60 classifications and categorisations have been used since European arrival (ALRC 2003).

Until recent times, Indigenous status was determined by the state (Toombs 2011) and imposed upon an individual regardless of their self-perceptions. The categorisation applied determined the person’s status in law. Being labelled as an Aboriginal person meant the denial of rights accorded to other Australians.

From the mid-1800s to the mid-1900s Indigeneity was determined by ‘blood-quotum’ (ALRC 2003; Gardiner-Garden 2003). People were classified by the state to be of ‘full blood’ (no non-Indigenous descent), ‘half-caste’ (one Aboriginal and one non-Indigenous parent), ‘quadroon’ or ‘quarter-caste’ (non-Indigenous parentage other than one Aboriginal grandfather or grandmother) or ‘octoroon’ (non-Indigenous parentage other than one Aboriginal great-grandfather or great-grandmother) (Toombs 2011). In practice, skin colour was the primary marker of ‘quantum of Aboriginality’ (Toombs 2011).

By the late 1960s ‘blood-quantum’ definitions were generally replaced by the definition of an Aboriginal person as ‘a person who is a member of the Aboriginal race of Australia’ (Gardiner-Garden 2003:4). Only relatively recently has the process of assessment of Indigenous status shifted from state-determined to self-identification. A three-part definition of Indigeneity was proposed in the 1980s (ALRC 2003):

> An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he (she) lives. (Department of Aboriginal Affairs, Report on a Review of the Administration of the Working Definition of Aboriginal and Torres Strait Islanders (1981), Commonwealth of Australia, Canberra, cited in Gardiner-Garden 2003).

For reasons of practicality, the national standard Indigenous question (Box 3.1) asks for self-recognised descent (or origin). This question conflates two of the criteria (descent and self-identification) and does not address the third (community acceptance). Requirements to ‘prove’ Indigeneity vary in different circumstances.

Some government programs involving benefits of monetary value require certification or evidence of Indigeneity. For example access to loans or other financial assistance via Indigenous Business Australia requires such proof (IBA 2013).

In other circumstances, such as the health system, a person’s response to the question is the sole criterion for establishing Indigenous status. However, not all stakeholders agree with this approach. The National Aboriginal Community Controlled Health Organisation, peak

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3 Although included in the Commonwealth working definition from 1972, issues of Torres Strait Islander status definitions are distinct from Aboriginal people (e.g. Torres Strait Islanders were not mentioned in the Australian Constitution and have been dealt with in Censuses differently from Aboriginal people) (Ross 1996).
body for the ACCHS sector, for instance, has expressed concerns about self-declaration as the basis for access to Aboriginal and Torres Strait Islander specific health interventions (Couzos and Thiele 2010).

**Box 3.1: The national standard Indigenous identification question**

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

Responses:
- No
- Yes, Aboriginal
- Yes, Torres Strait Islander

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

**Discrimination**

Historically, Indigenous status has provided the basis for discrimination and racism, and disadvantage and prejudice persist to the present day.

Aboriginal people were legally prevented from voting in most states until 1949, with forms of voting discrimination persisting until 1983 (AEC 2011; Attwood 2003). Racism was entrenched in the Australian legal system, and Aboriginal people faced discrimination in every facet of life: sport, the military, housing and employment (Awofeso 2011). The state exercised almost complete control over Aboriginal people: where they could live, if and when they could travel or marry (de Plevitz & Croft 2003). Aboriginal children were excluded from mainstream education and Aboriginal status was the basis for separate and discriminatory treatment in health care (Grant et al. 2008). The Aboriginal population was seen as a reservoir of infection and a potential threat to the health of non-Indigenous people, with Aboriginal people suffering communicable diseases transported by force to ‘lock hospitals’ (Grant et al. 2008).

By the early 1900s all mainland Australian states and the Northern Territory had established Chief Protectors or Protection Boards with legal authority over the lives of Aboriginal and Torres Strait Islander people, including the power to remove children from families (HREOC 1997). In Queensland, regardless of whether their parents were alive, the Director of Native Welfare was the legal guardian of all Aboriginal children until 1965 (HREOC n.d.). On this legislative basis, between 10–33% of Indigenous children were forcibly separated from their families between about 1910 to 1970 (HREOC 1997:37), and later became known as the ‘Stolen Generations’.

Forced separations were based on different treatment of people of different quantums of Indigeneity. Those of ‘full blood’ were considered ‘primitives’ doomed to extinction as a result of the arrival of more evolved Europeans (Attwood 2003; Grant et al. 2008; Smith 2003). Those of ‘mixed blood’ were seen as having the potential to ‘merge’ with the white population and eventually become productive, though lesser, citizens (HREOC 1997:29). The goal was to ‘check in every possible way the breeding of half-castes…and separate the quadroon and octoroon types, at an early age, from the aboriginal, [sic]’ (Bleakley, quoted in Gray 2011:69). If those of ‘mixed blood’ could be removed from the influence of ‘full bloods’ at a sufficiently early age, it was considered possible over time to ‘breed out the colour’, or, as it was more colloquially expressed ‘pug im up white’ or simply ‘fuck ‘em white’ (Gray 2011).
Forced separations did not have an impact only on those removed, but caused repercussions across Aboriginal communities. Those left behind, those who lived in fear of separations, and those who cut off ties from their Aboriginal communities in order to avoid forced separations were all affected (HREOC 1997). As described by McDermott, in this context of repression, the denial of Aboriginal heritage was commonplace:

My mother dealt with our Aboriginality like her mother before her, by simply denying it…the family fiction bequeathed to her was that her father came off a boat from Trinidad. This country is awash with dubious ‘ancestors’, such as Javanese royalty and surprisingly skinny-legged Maori…when you’re unaware how far-reaching was the control of Aboriginal lives by mission managers, ‘The Welfare’ or police, it’s hard to comprehend the lengths to which Aboriginal Australians went to escape that control. Many simply identified as Indian, Fijian, Italian…whatever would get the authorities off your back and keep your children by your side (McDermott 2006:464).

Removal of children sanctioned by government continues to resonate in contemporary identification issues at a number of levels. First, concealed or denied Indigenous status, which may preclude self- or community-identification as Indigenous, is estimated to affect 100,000 Australians (McDermott 2006). Oral traditions among families may in some instances be the only basis for determining Aboriginal descent (ALRC 2003). Second, even where Indigenous descent is known to the person removed, the efforts of the state to sever links with their Aboriginal family and land can prevent community acceptance or identification. Third, the legacy of historical repression is continued by contemporary experiences of discrimination, reflected in distrust of the health system and fear that being identified as Indigenous will result in negative treatment (Awofeso 2011; McDermott 2006).

Although discriminatory legislation has been repealed, racism continues to exist in Australia, with negative attitudes towards Aboriginal and Torres Strait Islander people commonly reported (Pedersen et al. 2004). About 28% of non-Indigenous Australians would be concerned if a relative were to marry an Indigenous person; and about the same proportion of Aboriginal and Torres Strait Islander people report experiences of discrimination within the past 12 months (Awofeso 2011). ‘New’ or ‘institutional’ racism can be discerned in areas such as public housing, welfare and criminal justice systems, which can fail to meet the needs of, or disproportionately impact on, Aboriginal and Torres Strait Islander people. Health systems themselves have been described as part of this ‘institutionalised inequity’ (AMA 2007). These new forms of racism continue to have negative health consequences for Aboriginal and Torres Strait Islander people.

**Contemporary issues**

Contemporary issues relating to Indigenous status play out both against this backdrop of historical discrimination and present-day prejudice.

The number of people identifying as Indigenous in Australian censuses has increased at rates in excess of that attributable to natural increase (Ross 1996). This has been ascribed to both a general increased willingness to identify, and durability of the ‘transmission’ of Indigenous status despite increases in intermarriage between Indigenous and non-Indigenous people (Gardiner-Garden 2003; Paradies 2006; Ross 1996). Differences over time in how people choose to identify are to be expected when Indigeneity is understood as a social construct that can change over the life course and in different situations, rather than as an immutable attribute determined by genetics. However, changing boundaries of Indigenous status complicate health data. The health status of Indigenous people can appear to improve if people newly identifying as Indigenous share health characteristics closer to the non-
Indigenous population than to people previously identified as Aboriginal or Torres Strait Islander (Altman et al. 2008; McDonald & Russ 2003).

Pervasive media and government stereotypes signal that ‘real’ Aboriginal and Torres Strait Islander people are dark skinned disadvantaged people living in remote areas. Beliefs about who can or should identify as Indigenous are typically linked with these stereotypes, and these can affect both Indigenous and non-Indigenous people (Awofeso 2011; Paradies 2006). Aboriginal study participants saw strong links between physical appearance, especially skin colour, and Indigenous identity (Kickett-Tucker 2009; Toombs 2011).

Stereotypes dependent on deprivation, appearance and cultural ‘otherness’ deny universal human attributes of diversity, individuality and change to Aboriginal and Torres Strait Islander people (Paradies 2006). They also fuel lateral violence, where attacks are turned inwards within an oppressed group rather than directed to the system of oppression (Gorringe et al. 2011). As noted by Gorringe and others:

> Words which undermine Aboriginal identity are commonly used as insults and tools of social exclusion (such as ‘coconut’, ‘text book black’ or ‘air-conditioned black’), as are accusations of supposed privilege and favouritism applied to those perceived as (or even accused of being) ‘real blackfellas’ (Gorringe et al. 2011).

For some Indigenous and non-Indigenous people a hierarchy of ‘authenticity’ applies. The closer the conformity with cultural ‘otherness’, the more authentically Indigenous the person is seen to be (Insight 2012). On the other hand, many Aboriginal and Torres Strait Islander people reject such hierarchies; believing instead Indigeneity is not dependent on criteria such as visual appearance. From this viewpoint, Indigenous heritage is considered to take precedence over non-Indigenous heritage, as reflected in the adage ‘Aboriginality is like a cup of coffee—it doesn’t matter how much milk you put in, it’s still coffee!’ (Queensland Government Queensland Health 2011).

The boundaries of Indigeneity are most contested where perceived or actual benefits or privileges arise from such identification (Gorringe et al. 2011). Contemporary prejudices against Aboriginal and Torres Strait Islander people have been traced to a basis of ‘racial resentment’; where they are perceived as receiving unwarranted benefits (Pedersen et al. 2006). In this study non-Indigenous participants interpreted measures specifically for Aboriginal and Torres Strait Islander people as evidence that Indigenous people wanted not equality, but rights additional to those available to others. This was viewed as inimical to the strongly held position that all Australians should be ‘treated the same’ (Pedersen et al. 2006).

This view may be best encapsulated by a high-profile critic of the use of Indigeneity as the basis for special treatment, who argued that:

> Present governments are encouraging separatism in Australia by providing opportunities, land, moneys and facilities available only to Aboriginals. Along with millions of Australians, I am fed up to the back teeth with the inequalities that are being promoted by the government and paid for by the taxpayer under the assumption that Aboriginals are the most disadvantaged people in Australia. I do not believe that the colour of one’s skin determines whether you are disadvantaged (Hanson 1996).

The health sector is not immune from these views. Issues of Aboriginal and Torres Strait Islander identity and related government interventions have been identified as particularly emotive for non-Indigenous people in the health sector, with such topics frequently raising feelings of guilt, anger and anxiety (Rasmussen 2001). Johns has suggested that opposition to government programs targeting health and other improvements for Aboriginal and Torres Strait Islander people is increasing (cited in Awofeso 2011).
The concept of interventions targeted on the basis of Indigeneity is the foundation of the entire national COAG Closing the Gap commitments. These programs are not whole-of-population based, but are designed to lift one disadvantaged group to the level of the majority. They build upon a history of programs specifically for Aboriginal and Torres Strait Islander people (Gardiner-Garden 2003), which, although often misguided, were based on the notion that the different situation of Aboriginal and Torres Strait Islander people required targeted responses. Differential treatment on the basis of race is allowed under the Racial Discrimination Act 1975 (Cth). Programs defined as ‘special measures’ are not considered discrimination where these are designed solely to advance disadvantaged groups, and are not continued after their objectives are met.

Arguments against programs specifically for Aboriginal and Torres Strait Islander people deny past injustices and their ongoing impacts. They ‘continue an inexplicable blindness to the contemporary consequences of past policies’ (McDermott 2006). A system that conflates equality with equal treatment is flawed. Instead, it is equality of outcomes that systems should aim to foster. In the health system, this means everyone should be equally able to maintain their optimum level of health. However this requires different, rather than identical, responses to the needs of different groups. As noted by Dr Michael Wooldridge, then Commonwealth Minister for Health and Family Services;

Justice does not mean treating everyone the same….justice means giving people their due. Aboriginal people are justly entitled to health care that addresses their needs (Wooldridge 1998).

Summary
The history of defining Indigenous status in Australia is intrinsically linked with discrimination. Despite legislative equality, racism and prejudice continue to the present day. Relations between Indigenous and non-Indigenous Australians are not fully resolved and provision of special treatment on the basis of Indigeneity is contested. In this environment, identifying Aboriginal and Torres Strait Islander people and providing them with health services for which other Australians are excluded was a policy goal fraught with complexity requiring careful strategic management.

3.3 Contextual factors
The service delivery and data collection policy goals that depend upon, or have influence over, improved Aboriginal and Torres Strait Islander identification each involve different stakeholders (Figure 3.1). The large number of stakeholders and the interconnectedness of their aims highlight the need for integrated and systematic approaches. However this environment is characterised by a lack of coordination.

One important point of disaggregation is between service delivery and data collection. Stakeholders have emphasised that members of the general practice team do not identify themselves as ‘data collectors’. Therefore, data generation must be embedded in the clinical or financial core business of practice management and patient care. Data quality improvements should be presented not as a stand-alone goal, but as a by-product of improved service delivery to Aboriginal and Torres Strait Islander people. Yet service delivery programs are largely the responsibility of DoHA (responsible for policy processes) and Medicare, within the Department of Human Services (responsible for administration and payment processes), while the Australian Bureau of Statistics (ABS) and the AIHW manage data collection and analysis. Collaborative effort across these organisations to improve Indigenous identification has been minimal.
Service delivery initiatives are also disaggregated. Different health interventions specifically for Aboriginal and Torres Strait Islander people are administered by different parts of government agencies. In the past, key Aboriginal and Torres Strait Islander health initiatives, such as the Primary Health Care Access Program and Healthy for Life have been administered by the area of DoHA with specific responsibility for Indigenous health: the Office for Aboriginal and Torres Strait Islander Health (OATSIH). Such programs have mainly been implemented through Indigenous specific health services; primarily the ACCHS sector. In contrast, the 14 ICDP measures are generally available to both ACCHS and mainstream general practices, and are administered by 7 different Divisions in DoHA (Appendix C).

OATSIH manages three measures and was apparently also intended to be responsible for overall governance of the ICDP (Urbis 2010a). However in practice these responsibilities are very limited, consisting of ‘post box’ coordination functions. OATSIH has not been tasked to direct effort across the department. As a consequence, collaboration across the areas implementing the measures has not been ideal. For example, implementation of the PBS copayment measure required changes to pharmacy-based software and funding was allocated for this purpose. It also provided a logical opportunity to support changes to the general practice sector which would not only help GPs use the measure, but facilitate the collection and use of Indigenous status data overall. As the improvements to general practice software cut across several measures and were not confined to the PBS copayment measure, they were not progressed.

These discontinuities are reflected in communication to the public. Health interventions for Aboriginal and Torres Strait Islander people have not been presented as a consolidated whole to general practices or Indigenous consumers. This is demonstrated by the ICDP information for GPs (DoHA 2010a). Instead of providing a comprehensive guide to all GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people, it did not include immunisation or specific PBS listings.

Perhaps more fundamentally, the focus of work at the Australian Government level is often on initiation, rather than implementation. As demonstrated by problems besetting recent Government initiatives such as the installation of pink batts and national broadband cabling, potential pitfalls between sound policy and good implementation are considerable. In health policy, implementation has been identified as possibly the most difficult part of achieving change, with resources required and barriers to change frequently underestimated (Palmer & Short 2000).

Lack of attention to implementation is most clearly illustrated by the case of MBS-rebated health checks for Aboriginal and Torres Strait Islander people. The health check was introduced before the ICDP so it was not allocated a place in ICDP implementation. This was in spite of the fact that low health check uptake was well-known, and that health checks were integrally important to achieving ICDP outcomes.

The absence of ‘follow through’ is not confined to health checks. Optimising the application of a program is not generally considered ‘part of the job’. Adding a new item to the MBS or PBS is instead seen as a self-limited task. Ensuring the new item reaches everyone who might benefit is not usually funded or recognised as a government responsibility. As noted by one observer, ‘the Department of Health and Ageing exhibits no interest in regularly assessing the effectiveness of its own programs’ (Russell 2010). The centrality of improved identification to realising the benefits of new Indigenous-specific measures was highlighted to government at early stages of ICDP implementation (Kelaher et al. 2010). However no area of government was allocated responsibility for doing so.
Instead, as illustrated by the stakeholder map, implementation was characterised by the fragmentation of work into sub-elements and the lack of an overarching point of accountability and oversight. The sheer number of disparate elements supports a situation of the ‘tragedy of the commons’. In this situation all would benefit from improved identification but no individual stakeholder wishes to incur disproportionate costs from doing so. It means that improving identification benefits all but is core business to none.

3.4 Summary

This section explained that delivery of the COAG Closing the Gap health agenda faced considerable difficulties.

First, the general practice sector is not controlled by government and there are only a few mechanisms to promote change. Second, Indigenous identification is complex and provision of special services on the basis of Indigeneity is contested. Third, the government agencies through with the reforms were to be delivered were disaggregated and uncoordinated. Effort was directed to initiation, rather than to implementation, of new policies. Taken together, these factors present considerable barriers to the implementation of any reforms in the general practice sector, and raise particular challenges to the introduction of Indigenous-specific health measures.

The next section examines how identification could be improved: first by looking at generic options for government-led changes and the lessons from successful examples of this, and second by investigating findings and recommendations specific to the area of Indigenous identification.
Figure 3.1: Stakeholders in the identification of Aboriginal and Torres Strait Islander patients in the general practice sector.
4 How can we solve the problem?

The previous section discussed the range of factors that result in low levels of routine identification of Indigenous status in the general practice sector.

This section considers how this problem could be addressed from two perspectives. The first part of the section investigates how any kind of change in the general practice sector needs to be managed. It outlines the options open to the Australian Government for encouraging change and describes lessons learnt from previous government-sponsored efforts to direct change in the sector. The second part of the section looks specifically at the field of Aboriginal and Torres Strait Islander identification in the general practice sector. It outlines the barriers identified and recommendations made by previous studies. Finally, lessons from both generic and specific sources are synthesised into a plan for action.

4.1 How can changes be made in the general practice sector?

Making changes in the health system is difficult: it is characterised by ‘system inertia’ which makes it highly resistant to change (Coiera 2011). Generic health system barriers to change are in this case overlaid first with the specific attributes of the general practice sector and second with Indigenous-specific issues described in Section 3.

The values of the (largely non-Indigenous) medical profession have been identified as a major influence on how new health policies are implemented (Lloyd et al. 2009). Implementation is undermined where elements of the new policy are inconsistent with these values. Taken together, these factors ensure that changing the low rate of Indigenous identification in general practice is a significant policy challenge.

Key principles for changing behaviour in the general practice sector have been explored using Rogers’ diffusion of innovation model (Kelaher et al. 2010). This model suggests changes are implemented gradually: first by early adopters (about 13% of practitioners), then by the early majority and the late majority (about 35% each) and finally by the laggards (about 15% of practitioners). The aim of change instigators should be to prioritise uptake among early adopters and so achieve critical mass where change uptake is self-sustaining. Kelaher and others also drew upon the work of Greenhalgh, and noted factors likely to increase adoption of change among early adopters were: clear benefits to users; compatibility with users’ existing values and needs; ease of uptake; ability to adapt the change to local needs; and support for uptake (Kelaher et al. 2010).

Culture change in the health system needed to facilitate the implementation of effective Aboriginal and Torres Strait Islander health policy is best supported by multiple strategies (Lloyd et al. 2009). These include providing evidence of the problem to be addressed in ways meaningful to providers, such as: clinical audits, system-wide changes like structured quality improvement and patient recall processes, and leadership in the creation and promulgation of new beliefs and values.

As described in Section 3, government options to initiate change in the general practice sector are limited. Control mechanisms which may be used in other areas of government (such as legislation, regulation and penalties) are not appropriate.

There is some potential to influence behaviour through financial incentives: the number or rebate attached to MBS items can be increased, and blended payments can be initiated.
Likewise there is scope to support behaviour change through modifications to clinical information systems and training programs. Such programs should include the whole practice team, not just GPs, as administrative and nursing staff are critical to the process.

**Track record**

The challenges of change management initiated by government in the general practice sector are not new. While each reform has its own specific issues, some common lessons relevant to improving Indigenous identification in the sector can be drawn from previous experience. Two examples are reported here: first, the General Practice Immunisation Incentives (GPII) Scheme, and second the National Integrated Diabetes Program Diabetes Service Incentive Payments.

The GPII Scheme, part of a national strategy to increase childhood immunisation coverage, aimed to achieve 90% of practices having 90% of children aged under 7 in their practice population fully immunised. The program evaluation investigated how it could provide a model for other population health initiatives in the general practice sector. The report found the success of the GPII Scheme demonstrated that general practice behaviour could be directly influenced and that the same approach could be applied to other population health initiatives (KPMG Consulting 2000). Key lessons identified included:

- The introduction of the change should be undertaken via an integrated national strategy: components such as financial incentives were important but must be sited within that strategy.
- The population health intervention should aim to address a nationally recognised health priority, with this recognition shared widely by GPs and the general community.
- The clearer the health benefit of the intervention is to GPs and consumers, the greater the chance for GP change adoption.
- The intervention should be supported with meaningful engagement with jurisdiction health authorities and consumers. For example, providers and consumers must be aware of the intervention, believe in its safety and efficacy, and likewise grasp the negative consequences of not accessing the intervention.
- The intervention should be embedded through GP education based on best practice evidence and the development of clinical guidelines, especially where knowledge in the area is in development. Training was needed before and during implementation, and on an on-going basis.
- The intervention needs to be endorsed by all general practice support, professional and representative groups. The structured support provided via Divisions of General Practice at local, jurisdiction and national levels was identified as a critical element of the GPII’s effectiveness.
- Any administration, reporting and double handling required by the intervention should be minimised.

In addition, the GPII depended upon known, measureable targets and regular feedback on performance against those targets. Childhood immunisation coverage was calculated and quarterly statements produced showing the immunisation history for each child at all participating practices (DHS 2010). Practices and Divisions regularly used this information to ensure their records were up to date and to complete any missing or overdue immunisations (General Practice Queensland 2009:8).
A review of the National Integrated Diabetes Program Diabetes Service Incentive Payments found that factors which contributed to uptake of the incentive among GPs included streamlined administrative processes, systematic business planning at the practice level, information technology systems which facilitated uptake and assistance from Divisions (De Domenico et al. 2005).

As demonstrated by these case studies, successful change strategies are characterised by multi-channel strategies implemented within an overall plan. An effective plan to support changes to general practice behaviour to improve identification and uptake of health interventions specifically for Aboriginal and Torres Strait Islander people would ideally address each of these attributes.

4.2 Barriers and recommendations

Previous studies

Several studies relevant to the identification of Indigenous status in the general practice sector have been conducted. Some have considered this from the perspective of delivery of health interventions specifically for Aboriginal and Torres Strait Islander people, while others have focussed on data collections to which general practices contribute. Other investigations have considered the views of Aboriginal and Torres Strait Islander people in this process. All studies have highlighted barriers to improved identification and developed strategies to address them. Similarities in these findings and levels of agreement across recommendations are striking. While no single study is comprehensive, when taken together, they provide a solid basis for how the problem should be addressed.

An evaluation of the National Indigenous Pneumococcal and Influenza Immunisation (NIPII) program identified attitudinal issues as major barriers to improved identification of Aboriginal and Torres Strait Islander patients. Such attitudes included the view that ascertaining Indigenous status was discriminatory, that patients should be treated as individuals and that Indigenous status was irrelevant to patient care. It noted that:

> there appears to be some lack of appreciation of population issues and equity issues involving Indigenous health by GPs, due to the strong individual patient focus in general practice (NCIRS 2003:29).

There was also a ‘cost/benefit’ view: GPs felt it was unlikely they would see Aboriginal or Torres Strait Islander patients, and therefore asking patients for their Indigenous status was unnecessary.

The NIPII evaluation recognised improved identification as critical to the success of the adult immunisation program, and that this was best achieved through national level holistic training and accreditation rather than vaccination-specific efforts. However it noted that vaccination provided a good example of the health benefits of identification (NCIRS 2003).

A Queensland immunisation study found similar barriers to improved identification (Riley et al. 2004). The barriers included:

- lack of awareness among GPs
- the view Aboriginal and Torres Strait Islander people were reluctant to acknowledge their Indigenous status
beliefs that Aboriginal and Torres Strait Islander people represented a minimal proportion of their practice population and therefore did not require special consideration

- the expectation that people should self-identify without prompting
- a belief that questioning both Indigenous and non-Indigenous people may cause offence.

In addition, while generally aware of recommended Indigenous-specific immunisations, ‘few GPs identified a duty of care in regard to actively identifying and advising clients who might benefit’ (Riley et al. 2004:10). The Queensland study also noted that consumers feared substandard service and racist attitudes and this was a disincentive to identify. It recommended that asking for Indigenous status be mandatory, and that patients should be informed about the implications of identifying as Indigenous. It suggested the process should be supported by policy and protocols, training from Divisions of General Practice and data reporting requirements.

A study of the low uptake of health checks specifically for Aboriginal and Torres Strait Islander people in the Australian Capital Territory found comparable challenges (Kehoe 2007a; Kehoe 2007b; Kehoe & Lovett 2008). These included:

- Knowledge barriers: for example, ignorance of the definition of Indigenous status (there was confusion whether ‘part-Aborigines’ and ‘half and quarter-caste Aborigines’ could be considered as Aboriginal) and ignorance of health checks and other Aboriginal and Torres Strait Islander specific interventions.
- Support barriers: for example, general practice software did not facilitate identification or use of interventions specifically for Aboriginal and Torres Strait Islander people (Box 4.1) and there was little targeted support from Divisions.
- Attitudinal barriers: for example, the provision of specialised care to Aboriginal and Torres Strait Islander people was seen as inconsistent with commitments to ‘treating everyone the same’, and higher morbidity and mortality rates in the Indigenous population were not considered an adequate rationale for special treatment.

**Box 4.1: Software barriers**

Barriers found in general practice software included:

- Indigenous status not prominently displayed on screens used by the GP
- instances where Indigenous status entered by the receptionist was not visible in the screens used by the GP
- standard Indigenous question and responses not used
- Indigenous status not required to be completed: users not prompted to complete
- Indigenous status not linked to clinical decision support (for example, GPs not prompted to use health checks and other interventions specifically for Aboriginal and Torres Strait Islander people, age-relevant templates for health checks not in use, ‘wizards’ to assist with templates which automatically fill required fields from existing data drawn from elsewhere in the patient record not available).

Source: Kehoe 2007a.

Attitudes about the importance of ‘treating everyone equally’ were particularly interesting. Treatment of patients is necessarily different: only men have prostate checks, only people with diabetes need diabetic foot checks. Further questioning of participants often showed
that it was not different treatment as such that was seen as problematic, but different
treatment on the basis of race, or Indigeneity.

The key recommendation from this study was that a national strategy be developed to
improve identification in general practice and the uptake of health initiatives specifically for
Aboriginal and Torres Strait Islander people. In addition, improvements to practice software,
capturing the clinical impact of health checks and training specifically targeted to counter
common misconceptions were recommended.

Another study, which approached Indigenous identification from a data collection rather
than a service delivery perspective, reached similar conclusions and produced extensive and
strategic recommendations (IIIICDRPSC 2004). Major areas where recommendations were
made included:

- reforms of health service software
- provision of training materials, programs and community campaigns
- achieving ‘once only’ collection but multiple use of data on Indigenous status.

The study also called for resourcing to ensure strategic approaches to improving
identification, including the establishment of ‘field officers’ to support primary data
collectors such as general practices, and a national body to oversee the implementation of the
recommendations.

A national study which provided a comprehensive assessment of identification in general
practice found barriers included the assumption that if people did not ‘look’ Indigenous they
were unlikely to have the social or health problems of those who did (Kelaher et al. 2010).
Fear of offending people or prompting negative reactions led to reluctance to ask the
standard identification question. Other barriers to asking Indigenous status were:

- lack of awareness of why the information would be clinically relevant
- the assumption there were no Indigenous patients in the practice
- a belief that patients should be treated equally and failing to do so would be racist
- that it was up to patients to self-identify if they wished.

Recommendations from this study included integrating identification processes into practice
management, promoting a general practice environment conducive to identification, raising
Aboriginal and Torres Strait Islander people’s awareness of the benefits of identifying,
improving practice software systems and tightening general practice accreditation standards.

Although not focussed on the general practice sector, a further study about Indigenous
identification in other health settings found similar issues should be addressed in staff
training: with a focus on asking all clients regardless of appearance, ensuring staff
understood the purpose of seeking Indigenous status information and why some Indigenous
people maybe apprehensive about identifying (Heffernan et al. 2009). Similar attitudinal and
process barriers were found in hospital settings (Queensland Government Queensland
Health 2011).

Aboriginal and Torres Strait Islander people’s views on identifying their Indigenous status
have been specifically investigated in a number of studies. A qualitative study of a group of
Aboriginal and Torres Strait Islander people in the Australian Capital Territory investigated
views about identification (Scotney et al. 2010). Participants reported they would be prepared
to identify as Indigenous if asked, as long as they were informed about the rationale for the
question and the benefits of identifying as Indigenous.
Other studies investigating Aboriginal and Torres Strait Islander participants’ views (ABS 2011; ABS 2012b) found that identification would be encouraged by:

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

Effective identification requires GPs to ask and patients to respond: some have suggested that patient reluctance to disclose Indigenous status is likely to play an important role in low identification rates. However evidence suggests this is not the case, as rates of Indigenous identification are high in other settings. In the ACCHS sector, 95% of clients have Indigenous status recorded (AIHW 2011); over 60% of the total Aboriginal and Torres Strait Islander population have identified via the Voluntary Indigenous Identifier (VII) program (AHMAC 2012); and nationally, about 88% of Aboriginal and Torres Strait Islander people were identified correctly in public hospital admissions data (AIHW 2013c).

Although differing in scope and perspective, all available studies point to similar barriers to improving Indigenous identification in the general practice sector and reach consensus on a range of recommendations and strategies for addressing these.

**AIHW general practice workshops**

As part of data quality improvement work allocated through the National Indigenous Reform Agreement, the AIHW convened national workshops for stakeholders in improving the identification of Aboriginal and Torres Strait Islander people in the general practice sector in 2011 and 2012 (AIHW forthcoming b). Based on the breadth of stakeholders identified (Figure 3.1), a wide range of organisations was invited to participate.

Some of the studies discussed above were conducted nearly 10 years ago. However the barriers discussed by workshop participants were largely the same as those identified in those studies. Input from both workshops likewise supported recommendations from previous studies. Recommendations focussed on the lack of national integration; the need for change to be supported by e-health and software; the need for tailored support and communication to members of the general practice team, Aboriginal and Torres Strait Islander consumers and the general (non-Indigenous) public; and support for those working in the field through creation of a community of practice. Input from stakeholders at the workshops is outlined below.

**National integration**

Participants identified the lack of national integration as a fundamental problem which undermined all facets of improving Indigenous identification in the general practice sector, especially given the range of disparate stakeholders and programs involved. The priority attached to identification, collaboration and coordination, and clarity of goals and strategies were all impeded by the lack of a single coordinating agency to drive change. For example, participants thought one important symptom of the absence of national coordination was the lack of a single comprehensive web resource for GPs, Aboriginal and Torres Strait Islander people and the general public. Achieving such a resource was strongly recommended.

**E-health and practice software**

Software requirements and functionality to record Indigenous status data were identified as being of paramount importance to improving identification, and this was seen as closely
linked to e-health initiatives. The advent of e-health provided opportunities to drive consistency and mandate compliance with nationally-agreed Indigenous identification processes across all general practice software.

**Change in the general practice team**

Comprehensive, whole-of-practice team training was identified as an important way to support change in the general practice sector. However it was noted that if recommendations relating to standardisation of software were implemented, the need for specific training would be considerably lessened.

**Empowering Aboriginal and Torres Strait Islander people**

Aboriginal and Torres Strait Islander people needed information to empower and encourage them to identify as Indigenous in the general practice setting. People needed to know that disclosing their Indigenous status would not be used to their disadvantage; rather, this information was needed to provide better healthcare support and generate accurate data on which to base policy and funding decisions.

**Awareness raising for non-Indigenous people**

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

**Build a community of practice**

Another expression of the lack of national coordination was the lack of a forum for the range of stakeholders needed to improve Indigenous identification in this sector. Many participants had not previously had communication with others working in this space. Others had not seen their work as linked to the bigger picture of improving the accuracy and completeness of Indigenous status data in general practice. Participants supported the creation and maintenance of a community of practice for organisations and individuals involved in the work of improving Indigenous identification.

4.3 **Synthesis of key information**

Key information about barriers and recommended solutions is notably similar across lessons learnt from effective change processes, change promotion theory, available studies and recent stakeholder workshops (Table 4.1).
Table 4.1: Synthesis of key information

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Recommended solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of national integration/strategic approach</td>
<td>Integrated national strategy implemented by resourced point of leadership and accountability</td>
</tr>
<tr>
<td>Lack of conviction of need and impact of intervention</td>
<td>Capture and demonstrate clinical impact of interventions</td>
</tr>
<tr>
<td></td>
<td>Engage with early adopters</td>
</tr>
<tr>
<td></td>
<td>Gain engagement of general practice support, professional training and representative groups</td>
</tr>
<tr>
<td>Practice software does not support collection and use of Indigenous status</td>
<td>Improve and standardise practice software</td>
</tr>
<tr>
<td></td>
<td>Use e-health initiatives to drive change</td>
</tr>
<tr>
<td>General public unaware/unsupportive</td>
<td>Awareness campaign to address prejudices, provide health rationale and raise awareness</td>
</tr>
<tr>
<td>Providers unaware/unsupportive</td>
<td>Initial and ongoing training and support to providers targeted to knowledge and attitudinal barriers to:</td>
</tr>
<tr>
<td></td>
<td>• educate about available interventions and their health benefits</td>
</tr>
<tr>
<td></td>
<td>• disseminate the relevance of Indigeneity to clinical care</td>
</tr>
<tr>
<td></td>
<td>• address fears of racism, unequal treatment</td>
</tr>
<tr>
<td></td>
<td>• reconcile with commitments to equality and fairness</td>
</tr>
<tr>
<td></td>
<td>• refute misconceptions of Indigenous status and appearance</td>
</tr>
<tr>
<td></td>
<td>• create a one stop shop for information</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander consumers unaware</td>
<td>Empowerment and awareness raising for Aboriginal and Torres Strait Islander people</td>
</tr>
<tr>
<td></td>
<td>Implications for Aboriginal and Torres Strait Islander clients of identifying to be explained when asking</td>
</tr>
<tr>
<td></td>
<td>One stop shop for information</td>
</tr>
<tr>
<td>Lack of support for general practice team*</td>
<td>Systematic structured support for general practice team via Divisions</td>
</tr>
<tr>
<td>Identification not required by general practice accreditation standards*</td>
<td>Tighten accreditation standards</td>
</tr>
<tr>
<td>Isolation and disaggregation across programs and services depending on improved identification</td>
<td>Build community of practice</td>
</tr>
<tr>
<td></td>
<td>Link with national strategy and implementation</td>
</tr>
<tr>
<td></td>
<td>Clear understanding of roles, responsibilities and accountabilities</td>
</tr>
<tr>
<td>Change is too difficult</td>
<td>Ensure streamlined administrative processes</td>
</tr>
<tr>
<td></td>
<td>Provide feedback on known measurable targets and uptake data</td>
</tr>
<tr>
<td>No financial incentive to change*</td>
<td>Provide financial incentive</td>
</tr>
</tbody>
</table>

Note: * areas in which progress has since been made.

4.4 Summary

This section investigated two approaches to determining how the collection of Indigenous status information in the general practice sector should be improved. The first approach was generic. It examined general practice sector characteristics relevant to change management and options for government in seeking to make changes in that environment. It also looked at findings from previous reforms. The second approach was topic-specific. It investigated work to date on improving identification in the general practice sector, including earlier qualitative and quantitative studies as well as the most recent stakeholder consultation processes. The lessons from both these approaches were synthesised to develop an evidence-based check list for reform most likely to support optimum levels of identification (Table 4.1).

The next section examines efforts undertaken to date which have relevance to Indigenous identification. These are grouped into those activities undertaken by government and those undertaken by non-government organisations.
5 Efforts to date

The previous section analysed change management options and outlined a template for their application to the implementation of Indigenous-specific measures provided by general practice. With this template in mind, this section examines initiatives implemented by both government and non-government agencies which are, or should have been, related to improving Aboriginal and Torres Strait Islander status identification in the general practice sector.

It should be noted some initiatives are not solely directed to the general practice sector, and the rationale for initiatives may or may not have been linked to previous recommendations.

5.1 Government

Although the Australian Government has not tackled low Indigenous identification in the general practice sector in a planned way, it has initiated a number of programs which are relevant to this goal. These are discussed in the categories of activities separate from Closing the Gap commitments and those which are related to these commitments.

Activities separate from Closing the Gap commitments

Voluntary Indigenous Identifier

The Voluntary Indigenous Identifier (VII) program was established in 2002 in response to recommendations to improve Indigenous access to the MBS and PBS (DHS 2013b; Keys Young 1997). The VII enables Aboriginal and Torres Strait Islander people to record their Indigenous status with Medicare (AIHW 2010b). As at May 2012, nearly 340,000 people had done so, representing about 60% of the total estimated Aboriginal and Torres Strait Islander population (AHMAC 2012). Participation continues to increase by about 3,000 people per month. Indigenous status data in the VII is held within government agencies and is not visible at the point of care, either to consumers or health providers.

Audits of Indigenous status under-identification seek to establish the most accurate information on Indigenous status through face to face interviews conducted by staff independent of service providers (AIHW 2013c). The VII allows Aboriginal and Torres Strait Islander people to record their Indigenous status directly, without the involvement of health service providers or other third parties to mediate this process. Data held in the VII database may therefore constitute ‘gold standard’ information on Indigenous status, and provide a superior data source to that derived from audit methods currently considered to be best practice.

Despite the high quality and coverage of VII data, it has only been used for national statistical estimates (AIHW 2013a). VII data are generally not used to improve Indigenous status data in health data collections, or to improve service delivery at the point of care. Apparently broader use is prevented by privacy concerns, but it is not known if this position is based on formal legal or privacy expert analysis. There are precedents for wider use of VII data. The Australian Childhood Immunisation Register used it to double the rates of Indigenous

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4 There are several versions of the VII form: some allow non-Indigenous people to record their non-Indigenous status but others do not (see VII forms at DHS n.d. and Medicare Australia n.d.).

The currently circumscribed role allowed for VII data usage contravenes the data collection principle of ‘collect once: use many times’ (AIHW 2008). Given the potential benefits to Aboriginal and Torres Strait Islander people through greater use of VII data, a transparent investigation of its potential should be undertaken. Should existing wording of the VII registration preclude wider usage, Aboriginal and Torres Strait Islander people should be given the opportunity to opt in to a more useful version of this data collection.

**Best practice guidelines**

The National best practice guidelines for collecting Indigenous status in health data sets (the Guidelines) were developed to support a systematic approach for collecting and recording the Indigenous status of clients (AIHW 2010a). The Guidelines represented an important step in building consistency but are unlikely to improve identification processes in the general practice sector for three reasons.

First, guidelines targeting health professionals generally do not achieve desired outcomes, and the gap between recommended and actual practice can be considerable (Turner et al. 2008).

Second, the Guidelines are general to all health settings and do not support the unique needs of the general practice sector. They privilege data collection aspects of recording Indigenous status as opposed to service delivery implications—the opposite of the needs of the general practice sector. In some areas the Guidelines are incorrect for general practices. They state disclosing Indigenous status will not affect service delivery, whereas in the general practice sector this is exactly the policy goal (AIHW 2010a:14).

Third, there is no agency responsible for Guidelines implementation in the general practice sector. State and territory governments have agreed to implement them throughout the health sector, but do not have authority in this context.

Despite these issues, guidelines relevant to general practice on the collection and use of Indigenous status would provide a useful reference tool. This could be achieved by amending the current Guidelines or developing a separate document specific to general practice.

**E-health initiatives**

The Australian Government approved the development of the Personally Controlled Electronic Health Record (PCEHR) system in 2010, and allocated funding to build key national components of this system by July 2012. The 2012–13 Budget announced further funding over two years to operate the PCEHR system national infrastructure. Since July 2012, consumers have been able to register for an e-health record (DoHA 2013g).

Aboriginal and Torres Strait Islander people were identified as a key group to benefit from the PCEHR system (NEHTA 2012). However the system was not designed with the aim of improving the problems of Indigenous status data collection or service delivery. At the most basic level, Indigenous status has not been included in a standardised way in PCEHR clinical documents, and there was initially no scope for patients to record Indigenous status (AIHW 2012c). After advocacy from the AIHW, the second release of the system in November 2012 was amended to allow consumers to record their Indigenous status when they registered for a PCEHR. The extent to which this change will result in better data collection or service delivery is not yet clear. For example, it is not known if Indigenous status on the PCEHR will
be visible to general practices. More work will be needed to ensure that e-health changes contribute to improvements in Aboriginal and Torres Strait Islander health, through better access to Indigenous-specific health interventions and improved data collection.

In another e-health initiative, the government is working to transition pathology processes to electronic formats. However the area of DoHA responsible for this project was not aware of the long-standing goal of improving Indigenous data quality through including Indigenous status on pathology forms. Despite representations from the AIHW, Indigenous status has not been required on e-pathology processes.

Activities related to Closing the Gap commitments

In recognition of its importance, Schedule F of the NIRA included undertakings to improve Indigenous data quality at the state and territory, as well as national, levels (Appendix D). Jurisdiction level commitments relevant to improved identification in the general practice sector included:

• adopting the national standard Indigenous status question in the health sector through implementing the Guidelines by December 2012
• improving procedures for collecting Indigenous status information
• raising Aboriginal and Torres Strait Islander people’s awareness of the importance of identifying.

However these jurisdiction level commitments appear unlikely to impact on the general practice sector, as it is not within jurisdictional control. Guidelines implementation efforts reported by jurisdictions do not address this sector, and instead focus on the sectors of health within their control, primarily public hospitals (AIHW 2013c; Queensland Government Queensland Health 2011). Work to increase the Aboriginal and Torres Strait Islander population’s awareness of the importance of identifying should be relevant to all health sectors, including the general practice sector. However little information was provided on this area in recent national evaluation processes, with only New South Wales outlining such efforts (AIHW 2013c).

Australian Government commitments made under NIRA which are relevant to improved identification in the general practice sector comprised two AIHW projects:

• an evaluation of Guidelines implementation processes
• an investigation of the feasibility of including Indigenous status in pathology processes.

The evaluation of Guidelines implementation is underway (AIHW 2013c). Given the importance of identification in this sector to both service delivery and data collection, the general practice sector is included as a priority area. Work to date has described the challenges to implementation, most notably that there is no agency responsible for doing so (AIHW forthcoming b).

The second task, to investigate the inclusion of Indigenous status in pathology processes, has been completed (AIHW forthcoming a). The inclusion of Indigenous status on pathology forms to improve Indigenous status information was supported by state and territory communicable disease registers, cervical screening, and cancer registers, as well as by the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID). However the report did not recommend this (Appendix E). Instead, the longer term approach recommended at the national level depends largely on:
• development of a national primary health care data collection—a significant cross-jurisdictional and multi-stakeholder undertaking yet to begin
• e-health developments, which appear to have limited benefits for Aboriginal and Torres Strait Islander service delivery or data collection, and specifically do not include Indigenous status in e-pathology processes.

Short-term recommendations placed the onus on jurisdictions to progress disaggregated efforts, despite such an approach being dismissed by an earlier study in favour of coordinated national action (Acumen Alliance & ACT Health 2007). Although some progress has been made at a jurisdictional level, software barriers in general practice and pathology settings are best addressed nationally (Cousens & Perera 2012).

ICDP-generated commitments and status

Practice Incentive Program Indigenous Health Incentive

The Practice Incentive Program (PIP) Indigenous Health Incentive (IHI) was introduced in 2010 as part of the ICDP (DoHA 2012h). It aims to support general practices and Indigenous health services provide better health care for Aboriginal and Torres Strait Islander patients, including best practice management of chronic disease. The incentive comprises three levels of payments made to participating mainstream practices and Indigenous health services (Table 5.1).

As previously noted, incentives are one of the few mechanisms available to government in supporting change in the general practice sector, and when integrated into an overall plan, can be effective. However the design of incentive requirements is critical. While the PIP IHI is a welcome step to engage GPs, its requirements could do more to support identification improvements. For example, the PIP IHI does not require GPs to ask all patients for their Indigenous status.

Table 5.1: Components of PIP IHI

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

Source: DoHA 2012h

Support positions in Medicare Locals

Support via Divisions of General Practice (now Medicare Locals) has been identified as a critical element of effective government-initiated change in the general practice sector (KPMG Consulting 2000). The role of these bodies has been further strengthened under recent national health reform processes (DoHA 2011c). Instead of primarily focussing on GPs in private practice as Divisions often did, Medicare Locals are intended to support a range of
health professionals and build coordination across general practices, ACCHSs, aged care facilities and hospitals. The ICDP funded two new workforces within Medicare Locals (DoHA 2012d):

- 86 full-time equivalent Indigenous Outreach Workers, to support Aboriginal and Torres Strait Islander people to access primary healthcare services and follow-up treatment
- 86 full-time equivalent Indigenous Health Project Officers, to provide leadership in Aboriginal and Torres Strait Islander health issues within Medicare Locals, including increased awareness and understanding of the various Closing the Gap initiatives.

These positions represent a considerable step forward: this is the first time a national network of positions has been funded in Divisions or Medicare Locals to support general practices engage with Aboriginal and Torres Strait Islander health. However, improving identification is not given central importance in these roles (DoHA 2012g). As noted at early stages of implementation, central support for these positions was needed (Kelaher et al. 2010). It is not clear such support was provided, and changes have already been made since the positions were established. For example, the abolition of Divisions’ state based organisations brought about in the shift to Medicare Locals has the potential to weaken coordination across the network. Such changes should be monitored to ensure the positions stay on track.

5.2 Non-government

Royal Australian College of General Practitioners

The RACGP has implemented several changes relevant to improving Indigenous identification in the general practice sector, some funded by government and some undertaken of its own volition.

The most important of these reforms were changes made in 2010 to the RACGP accreditation standards for general practices. These strengthened the requirements regarding the recording of Indigenous status and now require practices seeking accreditation to demonstrate they routinely record Aboriginal and Torres Strait Islander status in their active patient records (RACGP 2010). A related position statement advises practices on meeting the new requirement; promotes use of the Guidelines; and explains the link between identification and improved service delivery and data collection (RACGP 2011b).

Under contract from DoHA, the RACGP also developed online cultural awareness training (RACGP 2011a). This aims to improve the primary health care services provided to Aboriginal and Torres Strait Islander people by increasing the cultural awareness of the practice team. Undertaking this training satisfies the requirement of the PIP IHI for cultural awareness training.

Both the accreditation changes and the cultural awareness training are welcome developments in improving Indigenous identification which have been recommended by previous studies. However accreditation changes will take time to have an impact. Practices gain accreditation for 3-year periods and a transition period is allowed for practices to move from earlier versions of the standards to current requirements. As a result new requirements may not affect accreditation for some practices until 2014. In addition, much will depend on how Indigenous identification requirements are implemented by accreditation assessors. Follow up is needed to check that implementation delivers the changes envisaged by the new standards.
In the same way, the effects of cultural awareness training should be monitored to ensure it is achieving positive impacts on Indigenous identification and service provision.

**Collaboratives**

The Australian Primary Care Collaboratives Program has shown it can effectively support change in the general practice sector in a number of areas (DoHA 2012a), and a pilot program directly focussed on improving Indigenous identification has been undertaken (Improvement Foundation 2011). Using quality improvement cycles common throughout the collaboratives, the project successfully increased identification and uptake of health checks specifically for Aboriginal and Torres Strait Islander people (Improvement Foundation 2011). In one mainstream clinic, for example, the baseline number of 34 identified Aboriginal and Torres Strait Islander patients increased to 179 at 6 months after project implementation and 396 at 12 months.

**5.3 Summary of activities to date**

Efforts undertaken by the Australian Government and non-government agencies to date have had mixed impact on Indigenous identification in the general practice sector.

As described above, the quality and coverage of VII data is considerable. However, its application has been restricted to the refinement of statistical estimates of MBS and PBS usage. As it is not made visible to service providers, it has no impact on improving access to Indigenous-specific health measures at the individual level. Neither is VII data made available to national health data collections: therefore it has not been used to improve the quality of Indigenous health data. Without a review of its function and parameters, it appears unlikely this situation will change in the foreseeable future.

Without an implementation strategy or responsible agency, the Guidelines appear unlikely to have a noticeable impact on identification processes in general practice. The AIHW’s Guidelines evaluation project may raise awareness of the problem of Indigenous identification in the general practice sector, but is not resourced to address this issue. Likewise the pathology business case project highlights an ongoing impasse on improving Indigenous identification in pathology processes.

Initiatives which hold promise but which will take time to have an impact are the PIP IHI and the RACGP accreditation standards. These should be monitored and refined as needed to ensure best outcomes.

The collaboratives’ approach has been proven to be effective. It showed that direct action at the practice level can effectively drive change: this option should be re-funded and extended.

The existing initiative likely to have the most immediate impact is support positions in Medicare Locals. Given the questionable impact of other activities, it is doubly important these positions are supported to meet their full potential to support change.

**5.4 Comparison of barriers, recommendations and recent developments**

Section 4 investigated available studies and recent stakeholder workshops to describe the barriers to improved Indigenous identification in the general practice sector and solutions recommended by these processes. This synthesis of key information provided a checklist of
features essential to achieving change (Table 4.1). Earlier parts of this section investigated relevant recent developments undertaken by the Australian Government and non-government agencies.

This section brings these two together, and compares the barriers and recommended actions drawn from previous studies with what has actually happened (Table 5.2). Using colour coding, this table highlights recommendations on which significant progress has been made (coded green), recommendations which have been partially addressed (coded amber) and recommendations which have not been recognised or addressed at all (coded red).

Government and non-government initiatives introduced since 2008 have begun to address long-standing barriers to improving the identification of Aboriginal and Torres Strait Islander status in the general practice sector. For the first time, Divisions of General Practice (now Medicare Locals) were nationally equipped with staffing specifically focussed on Aboriginal and Torres Strait Islander health, general practices were given financial incentives to systematically engage with Aboriginal and Torres Strait Islander health issues and accreditation standards for the general practice sector were strengthened to mandate the routine collection of Indigenous status from all patients.

These improvements should be nurtured to ensure they deliver maximum gains. Medicare Locals positions should be given adequate support and coordination; the initial interest demonstrated by practices accessing the one-off sign-on payment under the PIP IHI should be translated into improved care delivery to ensure momentum for change is captured. Feedback from patients and accrediting agencies should be monitored to ensure the mandatory accreditation requirement is being put into practice.

Although reforms addressed several major barriers, other constraints still exist.
<table>
<thead>
<tr>
<th>Barrier</th>
<th>Recommended solution</th>
<th>Post 2008 changes</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of national integration/strategic approach</td>
<td>Integrated national strategy implemented by resourced point of leadership and accountability</td>
<td>Nil</td>
<td>Yet to be recognised or addressed</td>
</tr>
<tr>
<td>Providers unaware/unsupportive</td>
<td>Gain engagement of general practice groups Capture and demonstrate clinical impact of interventions Training targeted to identified knowledge/attitude barriers Engage with early adopters</td>
<td>Cultural awareness training required by PIP IHI 2011 Collaboratives approach trialled in QLD</td>
<td>Introductory cultural awareness available Requires additional work and resourcing</td>
</tr>
<tr>
<td>General public unaware/unsupportive</td>
<td>Awareness campaign to address prejudices, provide health rationale raise awareness</td>
<td>Nil</td>
<td>Yet to be recognised or addressed</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander consumers unaware</td>
<td>Empowerment and awareness raising: informed of implications of identifying</td>
<td>One part of Indigenous Outreach Workers’ role</td>
<td>Requires additional work and resourcing</td>
</tr>
<tr>
<td>Lack of support for general practice team</td>
<td>Systematic support for general practice via MLs</td>
<td>MLs Outreach Workers &amp; Project Officers (2009–10)</td>
<td>Maximise potential of positions</td>
</tr>
<tr>
<td>No requirement for identification in general practice sector</td>
<td>Tighten accreditation standards</td>
<td>Standards changed 2011 National best practice guidelines for collecting Indigenous status in health data sets released Guidelines implementation agreed as NIRA Schedule F data quality improvement work</td>
<td>Uptake and impact to be monitored Guidelines inappropriate for GPs No explicit inclusion of general practice in NIRA; state &amp; territories do not control general practice sector</td>
</tr>
<tr>
<td>Stakeholder isolation and disaggregation</td>
<td>Networking: clarify roles and responsibilities Link with national strategy and implementation</td>
<td>AIHW workshops 2011 and 2012</td>
<td>No resources for ongoing networking No national strategy in place</td>
</tr>
<tr>
<td>Change is too difficult</td>
<td>Ensure streamlined administrative processes Provide feedback on targets and uptake data One stop Information shop</td>
<td>ICDP GP booklet</td>
<td>ICDP implementation fragmented ICDP GP booklet not comprehensive Uptake data not usable by MLs</td>
</tr>
<tr>
<td>No financial incentive to change</td>
<td>Provide financial incentive</td>
<td>PIP IHI 2010</td>
<td>Monitor impact: refine as needed</td>
</tr>
<tr>
<td>Practice software does not support collection/use of Indigenous status</td>
<td>Improve and standardise practice software Use e-health initiatives to drive change</td>
<td>Nil</td>
<td>Software changes to be addressed</td>
</tr>
</tbody>
</table>

Key: Not addressed Partially addressed Addressed
Major unaddressed barriers

National accountability
The most important unaddressed barrier is the lack of national leadership and accountability. There is no national strategy for improving Indigenous identification and programs are delivered in isolation. For example, data collection and service delivery aspects work separately, coordination across the seven DoHA Divisions that have carriage of the ICDP measures is lacking, and links between these measures and pre-ICDP health interventions are weak.

A prime example of this disjunction is the lack of attention paid to immunisation specific to Aboriginal and Torres Strait Islander people. Renewed commitments to achieving target levels of immunisation, especially in adults, would have reaped immediate and incontrovertible health benefits. It would also have provided an ideal springboard for the engagement of general practices with all specific measures. Instead, Indigenous-specific immunisation was not mentioned in ICDP information provided to GPs (DoHA 2010a) and recommendations to improve uptake, now 10 years old, remain largely unimplemented (NCIRS 2003).

The long-standing impasse on the inclusion of Indigenous status on pathology requests is further evidence of the absence of national commitment.

Once mechanisms for national leadership, coordination and planning have been established other unaddressed barriers can be progressed.

Clinical information systems and pathology processes
Clinical information systems have been recognised as central to change processes. Various improvements, such as ensuring the Indigenous status question is presented in line with nationally agreed processes, that systems do not default to non-Indigenous status, and that Indigenous status information is given prominence have long been recommended (IICDRPSC 2004; Kehoe 2007a; Kelaher et al. 2010). As noted in the recently released interim ICDP evaluation, weak clinical information systems and specifically their limitations in regard to measures that require effective identification of Aboriginal and Torres Strait Islander patients continue to undermine implementation (MSHR 2013).

Practice software offers the most potential to improve identification processes in general practice. The Australian Government has few grounds to interfere in the private market place of multiple software products, and there is no allocated funding to purchase the required changes. However there are two options available to ensure software providers make needed changes.

First, government could require Indigenous status in outputs to which general practice sector systems connect. Vendors are highly responsive to adapting software to make compliance with government requirements as easy as possible for GPs. Such outputs include pathology forms, the requirements of which are set by government. If Indigenous status was made a mandatory element of these forms in the same way Medicare numbers are, software systems would quickly adapt. GPs order about 47 pathology tests for every 100 patient encounters (Britt et al. 2012b). Given these high rates of pathology request generation, identification would dramatically increase if Indigenous status was required. Mandating Indigenous status on pathology requests, both electronic and paper-based, would therefore have a double benefit. Long-standing Indigenous data gaps in pathology generated information would be addressed, and identification at the practice level for all other purposes would be improved.
Another output controlled by government is the set of requirements for PCEHR compliance. These are supported both directly via NEHTA and indirectly via the new e-health incentive included in the Practice Incentive Program (DHS 2013a). Software compliance standards are currently being communicated to vendors and changes to general practice sector software are underway. Government could have chosen to include identification processes compliant with the Guidelines in these requirements and may still be able to do so.

Second, the Australian Government could convene and support user groups to call for needed changes in software. Vendors are keen to make changes in response to client demand. The small proportion of Aboriginal and Torres Strait Islander patients in most practices means their needs do not result in such client demand. In this area of market failure, making needed changes to software requires strategic government intervention. There are easily accessible groups of GPs with expertise in, and commitment to, improving Aboriginal and Torres Strait Islander health, including for example members of the RACGP’s Faculty of Aboriginal and Torres Strait Islander health and GPs working in the ACCHS sector. If convened and focussed on a consistent set of changes, their influence may well be sufficient to achieve desired outcomes. While there are several software products in use, the majority of practices use Medical Director. Efforts targeting this software package would give about 80% coverage of all mainstream GPs.

However achieved, Indigenous identification in the general practice sector should be integrally linked with promotion of best practice via use of the health interventions specifically for Aboriginal and Torres Strait Islander people. Prompts for appropriate measures should be built into these systems, in the same way that many mainstream interventions are. For example, once patients have been recorded as Aboriginal or Torres Strait Islander people in practice software, the GP should be prompted to offer a health check. The software should be loaded with the age-appropriate check lists required for this MBS item, and should provide ‘wizards’ or user prompts and templates to facilitate this process.

**Using information to improve identification and service delivery**

Recent feedback from stakeholders indicates that many GPs and Aboriginal and Torres Strait Islander people remain unaware of the specific health interventions available (AIHW forthcoming b). GPs have requested a simple and comprehensive website for all GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people since at least 2007 (Kehoe 2007a). However there is still no such resource available.

A booklet directed to GPs has been prepared (DoHA 2010a), but this is not comprehensive and is not in a format easy for GPs to use. Establishing a one-stop shop for this information is a common sense and basic step which is long overdue. GPs and Aboriginal and Torres Strait Islander people should be the main target audiences of the site. Presentation of the information should be appropriate to the users and not dictated by bureaucratic distinctions. For example, all measures should be included, not just those introduced by the ICDP.

While needed, such a website would be only a first step in improving communication. The measures should be marketed to both providers and Aboriginal and Torres Strait Islander people in ways appropriate for these distinct target audiences. Stakeholders have reaffirmed the findings of previous studies that Aboriginal and Torres Strait Islander people deserve to be informed of the implications of disclosing or not disclosing their Indigenous status in the general practice sector. Information about available health interventions will help empower Aboriginal and Torres Strait Islander people, enabling them to actively seek these services from their GPs. This patient-driven approach would help raise awareness of these services among general practices.
In the same way, general practices, Medicare Locals and Aboriginal and Torres Strait Islander people would all benefit from better data on uptake of specific health interventions. MBS and PBS statistics are available online, but are currently not easily searchable at a regional level, either by previous Division or current Medicare Local boundaries. State and territory level data is useful at a broad level, but does not inform Medicare Locals about the situation in their catchment area. Data should be provided to Medicare Locals and general practices in a way similar to data on childhood immunisation coverage rates (DHS 2010).

Quarterly reports should be provided on coverage of the target population at the individual practice level, and this should be benchmarked against other practices and national targets. Publicly available data should at least be readily accessible at the level of Medicare Local catchment areas. Existing information on individual MBS and PBS items should be extended to cover other relevant initiatives, such as numbers of prescriptions under the PBS copayment measure. Likewise, data on the PIP IHI should be kept up to date and presented in an easily understood format. As at June 2013, the most recent PIP IHI data available online relates to the May 2011 quarter, and its presentation is difficult to interpret.

Improving this data flow back to Medicare Locals and general practices is the first step to helping improve awareness and uptake of these measures. Ensuring this information is readily available to Aboriginal and Torres Strait Islander communities is, however, equally important. Doing so is in line with best practice in Aboriginal and Torres Strait Islander data management (ABS 2012a; NHMRC 2003; Yu 2012) and the National Aboriginal and Torres Strait Islander Health Data Principles (Appendix F).

**Other opportunities for change**

Some clinicians remain to be convinced of the health impact of interventions specifically for Aboriginal and Torres Strait Islander people. As highlighted by previous investigations (KPMG Consulting 2000) gaining such conviction is important to uptake of desired change. There is little available data on the health impact of specific interventions and further research is needed. Once available, this information should be used to refine the measures as needed and to provide information to providers about their efficacy. Findings of this research could help establish that measures specifically for Aboriginal and Torres Strait Islander people should be recognised as best practice to address the health disparities faced by this population. GPs’ duty of care to their patients could be reviewed in this light.

Currently, different eligibility requirements apply to many of the GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people (Appendix B). These varying requirements make it difficult for GPs and Aboriginal and Torres Strait Islander people to understand which interventions may be applicable to any particular person. Some, such as eligibility for the PBS copayment measure, require GPs to make non-clinical judgements. Eligibility requirements should be reviewed with the aim of making them as standard as possible. GPs are well-equipped to determine the approach needed for individual patients. The selection of appropriate measures is best situated at the clinician level, rather than by building in restrictions at the policy level.

At the same time, the design of GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people should be reviewed to ensure they are mutually supportive. For example, all Aboriginal and Torres Strait Islander people obtaining prescriptions under the PBS copayment measure have been determined by their GPs to either be at risk of, or currently suffering from, a chronic disease. It would therefore be reasonable to expect all such patients to have been offered a health check, but this is not a requirement of the PBS copayment measure.
Support measures for GPs should be strengthened. The collaboratives’ approach has demonstrated its effectiveness in achieving a number of clinical improvements and has also been shown to be useful in improving Indigenous identification and service delivery uptake. Funding should be directed to continue and extend work in this area.

Emerging opportunities should also be harnessed to improve identification. For example, the role of Medicare Locals provides scope to focus on the issue in new ways. Health needs analysis processes, where services are mapped to local needs, provides potential to prioritise the needs of Aboriginal and Torres Strait Islander people.

Population-wide approaches focussing on the non-Indigenous population should be considered. These should combat common misconceptions and refute the commonly held view of equality as equal treatment for all.

The VII should be investigated to consider its currently untapped potential to improve service delivery and data collection. If it is the case that existing consent processes prevent its use for these purposes on privacy grounds, it may be possible to ‘upgrade’ consent given by participants when they initially registered. For example, people currently registered on the VII could be contacted to ask if they wished to have their information used in these ways. If this is not feasible, an alternative national repository with capacity to improve service delivery and data collection should be established.

Although recently increasing, uptake of the PCEHR is lower than expected. About 174,000 people had registered as at May 2013 and uptake is likely to fall short of the initial goal of 500,000 registrations by July 2013 (Kaye 2013). More fundamentally, currently there appears no link between information collected at the practice level and existing data collections. It also seems unlikely that Indigenous status records on the PCEHR will affect individual service delivery. Therefore this area is not considered an immediately important priority. However it is likely that eventually some form of electronic health record will be in common use, and therefore the PCEHR should be reviewed to support improved data collection and service delivery for Aboriginal and Torres Strait Islander people.

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The National best practice guidelines for collecting Indigenous status in health data sets needs to more accurately reflect the needs of the general practice sector. This document should be reviewed to achieve this outcome.

The Evaluation of National Indigenous Pneumococcal and Influenza Immunisation Program 2003 was completed nearly 10 years ago, but has never been released by DoHA. Despite the passage of time, it contains important information on the only known national survey of identification processes in general practice and on improving the uptake of specific measures. Public release of this document is long overdue and would assist in raising awareness of and understandings of this issue.

5.5 Summary

This section examined initiatives implemented by both government and non-government agencies that have potential to improve Indigenous identification in the general practice sector.

These were integrated and compared with the key information about barriers and recommended solutions drawn from available studies and recent stakeholder workshops (Table 4.1). The outcome was an analysis which showed the status of each area of recommended action: recommendations on which significant progress had been made,
recommendations which had been only partially addressed and recommendations which to date have been largely ignored (Table 5.2).

Areas which are yet to be addressed and practical steps in order to progress them were discussed.

Based on this theoretical analysis, the next section gauges measurable signs of change in the sector. It describes indicators which signpost progress to date in improving both the identification of Indigenous status in general practice, and consequent Indigenous-specific service delivery.
6 Assessment of progress

The previous section investigated activities undertaken to date relevant to the implementation of GP-mediated Indigenous-specific health measures, and compared this to the template for change management developed in section 4.

In this section, a range of markers are identified and examined in order to determine the effect of these activities. These markers of change are considered in two categories. The first category assesses indicators which can show changes in identification rates and uptake of support measures. In this context, these are described as process indicators, as they show early changes in factors related to improving the delivery of Indigenous specific health measures. Information sources are the Bettering the Evaluation and Care of Health (BEACH) data indicating the proportion of patients identified as Aboriginal or Torres Strait Islander over time and available data on uptake of the PIP IHI. The second category assesses indicators which can show changes in service delivery uptake, which in this context are described as outcome indicators. Data sources are MBS and PBS statistics showing uptake rates of MBS and PBS items specifically for Aboriginal and Torres Strait Islander people and uptake of the PBS copayment measure.

6.1 Process indicators

**BEACH surveys**

BEACH surveys show no statistically significant change in the proportion of general practice encounters with Aboriginal and Torres Strait Islander people between 2002–03 and 2011–12. Rates of Aboriginal and Torres Strait Islander patients per 100 encounters varied between a minimum of 0.9 in 2008–09 and a maximum of 1.8 in 2003–04 (Table 6.1) (Britt et al. 2012a).

<table>
<thead>
<tr>
<th>Years</th>
<th>Total number of patients</th>
<th>Rate of Indigenous patients per 100 patient encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002–03</td>
<td>100,987</td>
<td>1.2</td>
</tr>
<tr>
<td>2003–04</td>
<td>98,877</td>
<td>1.8</td>
</tr>
<tr>
<td>2004–05</td>
<td>94,396</td>
<td>1.5</td>
</tr>
<tr>
<td>2005–06</td>
<td>101,993</td>
<td>1.0</td>
</tr>
<tr>
<td>2006–07</td>
<td>91,805</td>
<td>1.0</td>
</tr>
<tr>
<td>2007–08</td>
<td>95,898</td>
<td>1.0</td>
</tr>
<tr>
<td>2008–09</td>
<td>96,688</td>
<td>0.9</td>
</tr>
<tr>
<td>2009–10</td>
<td>101,349</td>
<td>1.3</td>
</tr>
<tr>
<td>2010–11</td>
<td>95,839</td>
<td>1.2</td>
</tr>
<tr>
<td>2011–12</td>
<td>99,030</td>
<td>1.6</td>
</tr>
</tbody>
</table>

*Source: Britt et al. 2012a.*

In 2011–12, about 10,700 of the 99,030 patient encounters (representing over 10% of encounters) were missing Indigenous status (Britt et al. 2012b). Measures which could be expected to improve identification rates, such as the PIP IHI introduced in 2010, do not yet appear to have done so.
Practice Incentive Program Indigenous Health Incentive

As the PIP IHI has a number of different elements, uptake data is complex to interpret. In addition, comprehensive data are not publicly available. Nevertheless, indications are that encouraging practice participation rates have not translated into effective levels of registration of the target population (Aboriginal and Torres Strait Islander people over 15 with chronic disease) and better chronic disease management. By April 2012, an estimated 2,900 practices and Indigenous health services had signed on for this incentive, representing 58% of the estimated 5,000 practices participating in the PIP overall (DoHA 2013b) (Table 6.2).

This encouraging level of practice participation has not resulted in optimum patient registration. These registrations, which must be renewed annually, totalled 40,000 in 2011 (the latest full year for which data are available), representing about 10.7% of the Aboriginal and Torres Strait Islander population over 15. The number of people in this age range with a chronic disease is not known as data on chronic disease are insufficient. However this coverage appears low relative to need, because chronic disease is estimated to be responsible for 70% of the health gap between Indigenous and non-Indigenous Australians (Vos et al. 2007).

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

Table 6.2: Uptake of PIP IHI 2010–2012 (approximate)

<table>
<thead>
<tr>
<th></th>
<th>Sign on payment</th>
<th>Patient registration</th>
<th>Outcomes payment Tier 1</th>
<th>Outcomes payment Tier 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>n.a.</td>
<td>31,000</td>
<td>4% of registered patients (1,240)</td>
<td>80% of registered patients (24,800)</td>
</tr>
<tr>
<td>2011</td>
<td>n.a.</td>
<td>40,000</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>April</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>2,900</td>
<td>29,000</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

Notes: Tier 1 outcomes payment = payment to practices/services for each registered patient for whom a target level of care is provided by the practice/service in a calendar year (development and review of a GP Management Plan or Team Care Arrangement).

Tier 2 outcomes payment = payment to practices for providing the majority of care for a registered patient in a calendar year with a minimum of 5 eligible MBS services.

n.a. – not available

Source: DoHA 2013b; MSHR 2013.

6.2 Outcome indicators

Medicare Benefits Schedule-rebated health checks

Coverage of Aboriginal and Torres Strait Islander MBS health checks should be high: eligibility is universal and known levels of need are considerable. Health checks are the gateway for other health interventions specifically for Aboriginal and Torres Strait Islander people, therefore low uptake impedes many other support measures. One-off health checks are unlikely to lead to health benefits (Calver 2005), instead regular checks are recommended (Spurling et al. 2009).

Health check uptake has risen gradually each year. Part of the increase is likely to be due to the change in 2010 from 2-yearly checks for people aged 15-54 to annual checks: this means
the same people may be having checks more frequently. However there are also indications of checks being done for those who have not previously received health checks (MSHR 2013). These increases coincide with, and may be linked to, the ICDP. However overall coverage of health checks remains low: during 2012, less than 20% of the population had access to a health check (Figure 6.1).

![Proportion of the Aboriginal and Torres Strait Islander population receiving health checks](image)

Notes: Population data used was the projected population, Aboriginal and Torres Strait Islander Australians, Australia and states/territories, 2006-2021, as the 2011 ERP is not due for publication until August 2013. Initial indications are that the number of people identifying as Aboriginal and/or Torres Strait Islander is much higher than projections. The proportions shown here will be lower when the new ERP is calculated.

Source: Medicare statistics.

Figure 6.1: Proportion of the Aboriginal and Torres Strait Islander population receiving health checks

Medicare Benefits Schedule-rebated follow-up services

MBS-rebated follow-up services are divided into two categories: item 10987 is for follow-ups provided by practice nurses or Aboriginal Health Workers and items 81300—81360 are for follow-ups provided by allied health professionals such as physiotherapists (Table 2.2). Both types of follow-ups are increasing, but the numbers are small (Table 6.3). The number of services provided by practice nurses and Aboriginal Health Workers is about three times higher than those provided by allied health professionals.

<table>
<thead>
<tr>
<th>Year</th>
<th>MBS item 10987 (follow-up by practice nurse or AHW)</th>
<th>MBS item 81300—81360 (follow-up by allied health professional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010–11</td>
<td>13,413</td>
<td>4,109</td>
</tr>
<tr>
<td>2011–12</td>
<td>27,604</td>
<td>8,021</td>
</tr>
<tr>
<td>2012–March 2013</td>
<td>38,465</td>
<td>10,817</td>
</tr>
</tbody>
</table>

Source: Medicare statistics.

Assessing coverage levels is not straightforward. The population in scope for these follow-up services is known: that is, people who have had health checks. However it is not known how many individuals accessed the services because only the overall number of follow-ups is available. People accessing follow-ups could have had between 1–5 allied health services

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(item numbers 81300–81360) and between 1–10 practice nurse or Aboriginal Health Worker services (item number 10987).

Despite these uncertainties, it is clear coverage continues to be low relative to population numbers and known levels of need (MSHR 2013). An illustrative example of the poor coverage of follow-ups by allied health professionals is provided by access to diabetes education (MBS item number 81305). The total number of MBS-rebated follow-ups provided by diabetes educators nationally was 260 in 2010–11 and 727 in 2011–12 (online Medicare statistics). Diabetes is estimated to cause about 12% of the health gap between Indigenous and non-Indigenous Australians (Vos et al. 2007). Indigenous death rates from diabetes during 2006–10 were reported to be seven times the non-Indigenous rate (AHMAC 2012). The prevalence of diabetes is unknown and there is a high rate of undiagnosed disease. However 6% of Aboriginal and Torres Strait Islander people overall and over 30% of Aboriginal and Torres Strait Islander people over 55 reported they had diabetes in 2004–05 (AHMAC 2012). The risk of developing diabetes has been recorded as high as 50% in men and 70% in women in some remote area studies. Over 4% of the overall Australian population has diabetes, and after accounting for age differences between the two populations, Aboriginal and Torres Strait Islander people are more than three times as likely to report having diabetes than other Australians (AIHW 2012a). On this basis, a conservative estimate of the proportion of the Aboriginal and Torres Strait Islander population with or at risk of diabetes could be 10%. Assuming then that 10% of Aboriginal and Torres Strait Islander who had a health check may have benefited from diabetes education, MBS-rebated follow-ups by diabetes educators reached about 3.6% of those who could benefit in 2010–11, and 7.5% in 2011–12.

**Specific medicines listed on the Pharmaceutical Benefits Scheme**

Uptake of PBS items listed specifically for Aboriginal and Torres Strait Islander people is increasing over time, but is low relative to need. Use of medicines listed exclusively for Aboriginal and Torres Strait Islander people during 2008-2012 (which were treatments for fungal infections and thiamine deficiencies) was analysed. The percentage of the Aboriginal and Torres Strait Islander population accessing these medicines was less than 2% in 2008 and rose to about 4% in 2012 (Figure 6.2). Further evidence of low coverage is provided by an analysis of nicotine replacement therapy between December 2008 and February 2011, when it was solely available on the PBS for Aboriginal and Torres Strait Islander people. This indicates between 1—3% of Aboriginal and Torres Strait Islander smokers gained access to this medication (AIHW forthcoming b).
Notes: 1. Estimates of the non-remote Indigenous population in scope were based on application of the proportion of remote and very remote population from the 30 June 2006 revised Indigenous ERP to population projections for relevant years.

2. Only the PBS items exclusive to Aboriginal and Torres Strait Islander people and listed throughout this period were included: i.e. items 1070H, 1574W, 1698J, 9024Y, 9025B, 9026C, 9027D, 9029F, 9030G and 9031H. Other items listed for Aboriginal and Torres Strait Islander people (i.e. items 9440W, 9160D, 2285G, 9198D, 5465P, 5571, 9047E and 2480M) were not included as they did not meet these criteria.

Source: ABS population data, Medicare statistics.

Figure 6.2: Proportion of the non-remote Aboriginal and Torres Strait Islander population receiving specific PBS-listed medicines (selected items)

Pharmaceutical Benefits Scheme copayment measure

In contrast to most other measures, the benefits of the PBS copayment measure are immediate and clear to both GPs and patients. Uptake reflects this: coverage for this measure is higher than for other GP-mediated health measures specifically for Aboriginal and Torres Strait Islander people.

As of June 2011, there were about 79,080 Aboriginal and Torres Strait Islander people receiving prescriptions under this measure (MSHR 2013) and by June 2012, this had increased to about 150,000 Aboriginal and Torres Strait Islander people. By June 2012, 5,127 (96%) pharmacies were participating in the program and 2.7 million prescriptions had been dispensed (DoHA 2012c).

The target population for this measure was mainly Aboriginal and Torres Strait Islander people in non-remote areas (as remote areas have improved access to PBS medicines under Section 100 arrangements). Eligibility restrictions apply and not all members of the non-remote population would be in scope. However using the whole non-remote Aboriginal and Torres Strait Islander population shows coverage of about 18% was achieved in 2011 and rose to about 34% in 2012. Estimates of the impact of other eligibility requirements were not feasible and so the actual percentage of those in scope may be higher than shown.
Notes: Estimates of the non-remote Indigenous population in scope were based on application of the proportion of remote and very remote population from the 30 June 2006 revised Indigenous ERP to population projections for relevant years.

Source: ABS population data, Medicare statistics.

Figure 6.3: Proportion of non-remote Aboriginal and Torres Strait Islander population accessing the PBS copayment measure

Care coordination

Access to care coordination support is increasing but coverage is low: as at June 2011, less than 160 Aboriginal and Torres Strait Islander patients had received such services nationally (MSHR 2013), while 3,220 Aboriginal and Torres Strait Islander patients received care coordination in the December 2012 quarter (DoHA 2013d). While levels of care coordination services are increasing, overall numbers are low relative to need and there is scope for further improvement.

6.3 Summary

This section assessed available data about improved identification and service uptake. Process indicators were equivocal: BEACH surveys show little change in the proportion of Aboriginal and Torres Strait Islander patients recorded in GP encounters over the past decade. While the proportion of practices engaged in initial sign on for the PIP IHI was encouraging, this has not translated to levels of patient registration or higher uptake of care plans. Service delivery uptake is a generally consistent picture of gradual increases from a low base. Even the PBS copayment measure, which has achieved the highest uptake of all GP-mediated interventions, is unlikely to be reaching the entire target population. Nonetheless, this measure is an ideal ‘market leader’. Its benefits are immediately obvious to both GPs and their patients, and access provides yet unrealised potential to ‘leverage’ access to other measures. Given that COAG measures were initially established for a 4-year period, achieving maximum uptake of targeted measures would have been the best way to ensure optimal health gains.

The following and concluding section draws together the evidence and arguments presented throughout this report. It also proposes recommendations for action.
Conclusion

This report investigated the low rates of identification of Aboriginal and Torres Strait Islander people in the general practice sector and the factors underlying this situation. It looked at the impact of low identification, primarily on service delivery but also on the linked issue of data collection.

Low rates of identification and correspondingly low uptake of measures specifically for Aboriginal and Torres Strait Islander people were first documented nearly 10 years ago. While always important, these problems became critical when the general practice sector was assigned a key role in achieving the COAG health commitments. National health gains became dependent in the first instance on this sector’s identification processes. The Australian Government’s failure to recognise the extent of this challenge to program implementation laid the groundwork for subsequent poor uptake and denied health benefits to many Aboriginal and Torres Strait Islander people.

Change initiated by government in the general practice sector is possible, but requires a strategic, coordinated approach. Instead, from the outset, implementation has been fragmented, measures to overcome barriers have been addressed randomly and accountability has been absent.

ICDP measures are largely progressed in isolation both from each other and from pre-ICDP initiatives. In the same way, service delivery efforts are disconnected from work to improve data collection, despite the integral links between identification for the purposes of data collection and service delivery. Most importantly, needed changes to clinical information systems have not been defined, recognised or supported by government.

New policies and programs have been developed without reference to the need for improved collection and use of Indigenous status data. Opportunities to drive change, such as the introduction of the Personally Controlled E-health Record, have been missed. The aim of overcoming data gaps by adding Indigenous status to pathology forms continues to elude government. Until this is addressed, improvements in Indigenous identification at the individual practice level are irrelevant to the majority of data streams generated by GPs. Not only did COAG processes fail to deliver a national approach to requiring Indigenous status in current paper-based forms, the development of electronic processes is duplicating the problem in new e-pathology processes.

At the most basic level, Aboriginal and Torres Strait Islander people and their GPs do not have easy access to comprehensive information about the targeted measures and their uptake relative to need. As illustrated by the effectiveness of childhood immunisation reporting processes, feedback loops can be critical to improving performance. However data on uptake of measures is patchy and is not designed to help Medicare Locals maximise their capacity to support general practices.

These failures are especially disappointing given that so much was achieved in policy terms. Changes which had been advocated for years were realised: identification processes were required in practice accreditation, Medicare Locals were provided with a national network of Indigenous health-focussed workers, medicines access was transformed. Together they presented a golden opportunity to revolutionise the care provided to Aboriginal and Torres Strait Islander people by mainstream general practice – an opportunity which to date remains unrealised.
Despite long-delayed, benefits accruing from strategic action remain available. Much of the
difficult work of developing policy and securing funding has been done. What is lacking is
the establishment of a central point of accountability and a planned approach to improving
Indigenous identification in the general practice sector.

Once a point of central responsibility is established (as set out in Recommendation 1), its first
priority should be to work with general practice software vendors to improve clinical
information systems. These systems need the functionality to prompt and support the
collection of Indigenous status in line with nationally-agreed processes, and to use this data
to improve the uptake of Aboriginal and Torres Strait Islander specific health interventions.

The inclusion of Indigenous status as a mandatory element in both paper and electronic
pathology processes is long overdue. Achieving this outcome will remove obstructions to the
transfer of Indigenous status data to national data collections and will also be an important
driver of clinical information system changes. When GPs need Indigenous status to finalise a
pathology request, the software will quickly adapt to make this task easy (as set out in
Recommendations 2 and 4).

The next important improvement is to set up a website to provide GPs and Aboriginal and
Torres Strait Islander people with comprehensive information about all GP-mediated health
interventions specifically for Aboriginal and Torres Strait Islander people. The website
should also facilitate access to uptake data on the interventions. Information on intervention
uptake should likewise be provided in a meaningful way to Medicare Locals, general
practices and Aboriginal and Torres Strait Islander communities. For example, health check
uptake could be shown as a percentage of the total Aboriginal and Torres Strait Islander
population at local and regional levels (as set out in Recommendation 3).

These four recommended actions would make a considerable and immediate impact on
current identification, service delivery and data collection processes. Together they would at
last help deliver the full potential of GP-mediated health interventions for Aboriginal and
Torres Strait Islander people.
Appendixes

Appendix A: Listings on the PBS for Aboriginal and Torres Strait Islander people

<table>
<thead>
<tr>
<th>Indication</th>
<th>PBS item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal colonisation with Staphylococcus aureus in an Aboriginal or a Torres Strait Islander person</td>
<td>9440W Mupirocin, Nasal ointment 20 mg (as calcium) per g (2%), 3 g (Bactroban)</td>
</tr>
<tr>
<td>Nicotine dependence in an Aboriginal or a Torres Strait Islander person as the sole PBS-subsidised therapy</td>
<td>9198D Nicotine, Transdermal patch releasing approximately 15 mg per 16 hours (Nicorette Patch)</td>
</tr>
<tr>
<td>Nicotine dependence in an Aboriginal or a Torres Strait Islander person as the sole PBS-subsidised therapy</td>
<td>5465P Nicotine, Transdermal patch releasing approximately 21 mg per 24 hours (Nicabate P)</td>
</tr>
<tr>
<td>Nicotine dependence in an Aboriginal or a Torres Strait Islander person as the sole PBS-subsidised therapy</td>
<td>5571F Nicotine, Transdermal patch releasing approximately 21 mg per 24 hours (Nicotinell Step 1)</td>
</tr>
<tr>
<td>Treatment of a dermatophyte infection in an Aboriginal or a Torres Strait Islander person where topical treatment has failed</td>
<td>2285G Terbinafine, Tablet 250 mg (as hydrochloride) (Lamisil, GenRx Terbinafine, Sebifin 250, Tamsil, Terbixel, Terbinafine-DRLA, Terbinafine-GA, Terbinafine 250, Terbix 250, Tinasil)</td>
</tr>
<tr>
<td>Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person</td>
<td>9024Y Ketoconazole, Cream 20 mg per g (2%), 30 g (Nizoral 2% Cream)</td>
</tr>
<tr>
<td>Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person</td>
<td>9025B Ketoconazole, Shampoo 10 mg per g (1%), 100 mL (Nizoral 1%)</td>
</tr>
<tr>
<td>Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person</td>
<td>1574W Ketoconazole, Shampoo 20 mg per g (2%), 60 mL (Nizoral 2%)</td>
</tr>
<tr>
<td>Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person</td>
<td>9026C Miconazole nitrate, Cream 20 mg per g (2%), 15 g (Daktarin)</td>
</tr>
<tr>
<td>Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person</td>
<td>9027D Miconazole nitrate, Cream 20 mg per g (2%), 30 g (Daktarin)</td>
</tr>
<tr>
<td>Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person</td>
<td>9028E Miconazole nitrate, Cream 20 mg per g (2%), 70 g (Daktarin)</td>
</tr>
<tr>
<td>Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person</td>
<td>9029F Miconazole nitrate, Powder 20 mg per g (2%), 30 g (Daktarin)</td>
</tr>
<tr>
<td>Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person</td>
<td>9030G Miconazole nitrate, Lotion 20 mg per mL (2%), 30 g (Daktarin)</td>
</tr>
<tr>
<td>Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person</td>
<td>9031H Miconazole, Tincture 20 mg per mL (2%), 30 mL (Daktarin)</td>
</tr>
<tr>
<td>Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person</td>
<td>1698J Nystatin, Cream 100,000 units per g, 15 g (Mycostatin)</td>
</tr>
<tr>
<td>Treatment of a fungal or a yeast infection in an Aboriginal or a Torres Strait Islander person</td>
<td>9160D Terbinafine, Cream containing terbinafine hydrochloride 10 mg per g (1%), 15 g (Lamisil)</td>
</tr>
<tr>
<td>Prophylaxis of thiamine deficiency in an Aboriginal or Torres Strait Islander person</td>
<td>1070H Thiamine hydrochloride, Tablet 100 mg (Betamin)</td>
</tr>
<tr>
<td>Treatment of whipworm infestation in an Aboriginal or Torres Strait Islander person; strongyloidiasis; treatment of hookworm infestation.</td>
<td>9047E Albendazole, Tablet 200 mg (Zentel)</td>
</tr>
<tr>
<td>Treatment of chronic suppurative otitis media in an Aboriginal or a Torres Strait Islander person aged 1 month and over</td>
<td>2480M Ciprofloxacin, Ear drops 3 mg per mL (0.3%), 5 mL (Ciloxan)</td>
</tr>
<tr>
<td>Hypomagnesaemia in an Aboriginal or a Torres Strait Islander person; Chronic renal disease in an Aboriginal or a Torres Strait Islander person.</td>
<td>5146W Magnesium, Tablet 37.4 mg (as aspartate dihydrate) (Mag-Sup)</td>
</tr>
</tbody>
</table>

Source: DoHA 2012e.
## Appendix B: Eligibility for GP-mediated health interventions specifically for Aboriginal and Torres Strait Islander people

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Patient eligibility</th>
<th>GP eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBS-rebated health checks specifically for Aboriginal and Torres Strait Islander people (MBS item 715)</td>
<td>All Aboriginal and Torres Strait Islander people</td>
<td>All GPs</td>
</tr>
<tr>
<td>Access to MBS-rebated follow-up services (MBS item 10987) provided by a practice nurse or registered Aboriginal Health Worker after a health check</td>
<td>Aboriginal and Torres Strait Islander people who have had a health check</td>
<td>All GPs can refer patients to health check follow-ups</td>
</tr>
<tr>
<td>Allied Health follow-up services (MBS items 81300–81360) after a health check</td>
<td>Aboriginal and Torres Strait Islander people who have had a health check</td>
<td>All GPs can refer patients to health check follow-ups</td>
</tr>
<tr>
<td>Different immunisations for Aboriginal and Torres Strait Islander adults</td>
<td>Hepatitis B: Adults who have not previously been vaccinated against hepatitis B and are non-immune Influenza: all Aboriginal and Torres Strait Islander people aged 15 and over Pneumococcal disease: Aboriginal and Torres Strait Islander people aged 15–49 with risk factors. All Aboriginal and Torres Strait Islander people over 50</td>
<td>All GPs</td>
</tr>
<tr>
<td>Different Aboriginal and Torres Strait Islander children’s immunisation in some states and areas</td>
<td>Aboriginal and Torres Strait Islander children under 7 in some locations</td>
<td>All GPs</td>
</tr>
<tr>
<td>PBS listings specifically for Aboriginal and Torres Strait Islander people</td>
<td>All Aboriginal and Torres Strait Islander people</td>
<td>All GPs</td>
</tr>
<tr>
<td>Registration in the PIP IHI</td>
<td>Aboriginal and Torres Strait Islander people 15 years or over with a chronic disease</td>
<td>Practices must be participating in the PIP IHI</td>
</tr>
<tr>
<td>Cheaper medicines through the PBS copayment measure</td>
<td>Aboriginal and Torres Strait Islander people of any age with or at risk of chronic disease who the GP considers would likely experience setbacks in the prevention or ongoing management of chronic disease if they did not take the prescribed medicine AND the GP thinks the patient is unlikely to adhere to their medicines regimen without the assistance of the PBS measure.</td>
<td>Mainstream practices must be participating in the PIP IHI; non-remote Indigenous Health Services are eligible to participate in the PBS copayment measure without being required to participate in the PIP IHI.</td>
</tr>
<tr>
<td>Care coordination</td>
<td>Aboriginal and Torres Strait Islander people with a care plan, enrolled for chronic disease management under the PIP IHI and referred by the GP.</td>
<td>Practices must be participating in the PIP IHI. In regions where the lack of availability of practices eligible for the PIP IHI limits referral to care coordination services, Medicare Locals can apply to DoHA for an exemption.</td>
</tr>
</tbody>
</table>
## Appendix C: ICDP measure management responsibility

<table>
<thead>
<tr>
<th>Measure</th>
<th>DoHA Division Management Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 National action to reduce Indigenous smoking rates</td>
<td>Business Group Division</td>
</tr>
<tr>
<td></td>
<td>Mental Health and Chronic Disease Division</td>
</tr>
<tr>
<td>A2 Helping Indigenous Australians reduce their risk of chronic disease</td>
<td>Mental Health and Chronic Disease Division</td>
</tr>
<tr>
<td>A3 Local Indigenous community campaigns to promote better health</td>
<td>Business Group Division</td>
</tr>
<tr>
<td>B1 Subsidising PBS medicine copayments</td>
<td>Pharmaceutical Benefits Division</td>
</tr>
<tr>
<td>B2 Higher utilisation costs for MBS and PBS</td>
<td>Medical Benefits Division</td>
</tr>
<tr>
<td>B3 Supporting primary care providers to coordinate chronic disease management</td>
<td>Primary and Ambulatory Care Division</td>
</tr>
<tr>
<td>B4 Improving Indigenous participation in health care through chronic disease self management</td>
<td>Mental Health and Chronic Disease Division</td>
</tr>
<tr>
<td>B5 Increasing access to specialist and multidisciplinary team care</td>
<td>Primary and Ambulatory Care Division</td>
</tr>
<tr>
<td>B6 Monitoring and evaluation</td>
<td>OATSIH</td>
</tr>
<tr>
<td>C1 Workforce support, education and training</td>
<td>Health Workforce Division</td>
</tr>
<tr>
<td>C2 Expanding the outreach and service capacity of Indigenous health organisations</td>
<td>OATSIH</td>
</tr>
<tr>
<td>C3 Engaging Divisions of General Practice to improve Indigenous access to mainstream primary care</td>
<td>Primary and Ambulatory Care Division</td>
</tr>
<tr>
<td>C4 Attracting more people to work in Indigenous health</td>
<td>Business Group Division</td>
</tr>
<tr>
<td>C5 Clinical practice and decision support guidelines</td>
<td>OATSIH</td>
</tr>
</tbody>
</table>

Source: Urbis 2010b
## Appendix D: National Indigenous Reform Agreement, Schedule F

**Agreed data quality improvements**

F1 In the period up to 30 June 2013, the Commonwealth and States and Territories will undertake the following actions to improve the performance indicator data required under this Agreement.

F2 A schedule to each jurisdiction’s Overarching Bilateral Indigenous Plan will clearly articulate the activities that jurisdiction will undertake, in the period up to 30 June 2013, against each action for which that jurisdiction is responsible. Plans will need to include concrete, objectively verifiable activities.

F3 Actions will be implemented consistent with the *Closing the Data Gaps* workplans.

<table>
<thead>
<tr>
<th>Agreed data quality improvements</th>
<th>Agreed action Responsible jurisdiction/agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ABS will implement improvements to Census Indigenous enumeration procedures to improve the quality of the Census count of Indigenous Australians.</td>
<td>Commonwealth Government/Australian Bureau of Statistics</td>
</tr>
<tr>
<td>The ABS will expand the scope of the Census Post Enumeration Survey to include very remote areas and discrete Indigenous communities.</td>
<td>Commonwealth Government/Australian Bureau of Statistics</td>
</tr>
<tr>
<td>The ABS and AIHW will lead analysis of the level of Indigenous identification in key data sets, including a baseline report and ongoing five-yearly studies to monitor identification levels over time.</td>
<td>The ABS and AIHW will work in partnership with all jurisdictions to assess the extent to which the Indigenous population is accurately identified in key data sets and to develop the evidence base on what strategies are likely to positively impact on the Indigenous population’s propensity to identify. The ABS and AIHW will establish governance arrangements to oversee the development of the data quality studies which will include members from appropriate data committees, (such as NAGATSIHID), the States and Territories, and other stakeholders. The ABS and AIHW will be responsible for the sampling strategies, methodology, and assessment of the level of under-identification in each data set. Timelines: A baseline report will be published in 2010 with recommendations on how to adjust each data set for more accurate data and on strategies to continue improving identification of Indigenous status through an ongoing program of work.</td>
</tr>
<tr>
<td>All jurisdictions will adopt the standard ABS Indigenous status question and recording categories on data collection forms and information systems for key data sets.</td>
<td>All jurisdictions.</td>
</tr>
<tr>
<td>Agreed data quality improvements</td>
<td>Agreed action Responsible jurisdiction/agency</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| All jurisdictions will improve procedures for collecting Indigenous status information in health and education data by training staff in key data collection positions about how and why to ask the Indigenous status question and to raise awareness about its importance. | All jurisdictions

There will likely be a need for staff in key data collection positions (such as hospital admissions staff and funeral directors) to undergo training which will need to be coordinated by the States and Territories.

The scale and form of such a program will be for each State and Territory to determine.

Information system changes may also be needed in some jurisdictions.

Timelines: Implementation by all jurisdictions of the AIHW’s Best Practice Guidelines in the health sector is to be completed by December 2012. After 12 months, it is proposed that the AIHW and ABS would undertake periodic evaluations of how the Guidelines have been implemented in the jurisdictions across the various health data collections. The AIHW and ABS would need to work closely with the states and territories to undertake these evaluations.

| All jurisdictions will develop and implement initiatives to raise the Indigenous community’s awareness about the importance of identifying as Indigenous when accessing services and to therefore raise the propensity for identification. | All jurisdictions.

All jurisdictions will develop and implement a program to raise the Indigenous community’s awareness about the importance of identifying as Indigenous when accessing services, with the aim of raising the Indigenous community’s propensity to identify. The program could include a variety of measures at the local, regional and/or state level and could build on existing engagement and consultation mechanisms. The scale and form of such a program will be for each State and Territory to determine.


The ABS will establish protocols with States and Territories for linking deaths data to Census records.

| The AIHW and ABS will lead, in partnership with the States and Territories, the development of national best practice guidelines for data linkage and an examination of current and planned data linkage work (Commonwealth and State and Territory) relevant to Indigenous identification. | The ABS and AIHW will work in partnership with all jurisdictions to develop and implement national best practice guidelines for linking data relating to Indigenous people. The guidelines for linking Indigenous data will cover linkage methods and protocols, privacy protocols, quality standards, and procedures.

Involvement of jurisdictions, and other stakeholders, in the governance arrangements for overseeing the work will help to ensure a consistent and informed program of data linkage work is carried out across Australia. Input from the Steering Committee will be sought in all phases of the proposed work including the development of agreed procedures, methods and protocols. This will help identify the need for any ongoing data linkage work.

This project will need to take into account existing and planned data linkage work across all jurisdictions (including the methods currently being used, and the results from any completed work). This will help inform the development of national guidelines.

In addition, the AIHW will build on its Indigenous Mortality Data Linkage Project. Currently, the project is a one-off data linkage process. This work will be continued with the aim of improving the estimates of Indigenous mortality and life expectancy on an ongoing basis. This would require jurisdictions to be prepared to supply relevant data, and to consider streamlining of data access protocols.

Timelines: It is estimated that best practice guidelines and a report on current and planned data linkage work relevant to Indigenous identification could be produced by December 2010. |
<table>
<thead>
<tr>
<th>Agreed data quality improvements</th>
<th>Agreed action Responsible jurisdiction/agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>The AIHW will lead the development of an enhanced Perinatal National Minimum Data Set collection to collect data in relation to smoking during pregnancy, child and maternal health and the Indigenous status of the baby.</td>
<td>The AIHW will work with all jurisdictions. Expanding the Perinatal National Minimum Data Set will involve assessing what is currently collected by States and Territories in regards to smoking during pregnancy, child and maternal health and the Indigenous status of the baby; and developing nationally consistent data elements. Once the data elements are included in the PNMDS their collection would be mandatory for all jurisdictions. This process would involve consultation with all jurisdictions, including a stakeholder workshop, drafting of data elements, and approval through the National Health Information Agreement governance process on the data elements. Once the proposed enhanced data elements have been drafted, jurisdictions will need to provide an assessment of the changes required to their processes and information systems. Changes for jurisdictions will be variable depending on what jurisdictions currently collect. Timelines: It is estimated that development of the indicators would take two years, with implementation for national collection in approximately three years. However this timeline will need to be flexible to address any jurisdiction-specific complexities.</td>
</tr>
<tr>
<td>The AIHW will, with stakeholders, review jurisdictional practices for collecting pathology information and develop a business case for the implementation of a nationally consistent pathology data collection, including Indigenous status.</td>
<td>The AIHW will work with all jurisdictions to develop a business case with options and costs for a national pathology data collection. The AIHW will undertake a review of the national data collections which largely rely on information recorded on pathology forms to obtain information on Indigenous status. To oversee the review, a steering committee needs to be established with key stakeholders and representatives from all jurisdictions. The review will involve investigating the pathology testing and notification processes in each State/Territory and the affected stakeholders (such as pathology labs, general practices/specialists, hospitals, software vendors/developers); with a view to understand potential implementation issues for consideration in the business case. Timelines: It is estimated that a Business Case which considers the costs and benefits of implementing a national pathology collection could be completed by June 2010, and would be considered by the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID and the National E-Health Information principle Committee.</td>
</tr>
<tr>
<td>The Commonwealth Department of Health and Ageing, in partnership with State and Territory health departments and in collaboration with AIHW, will develop national Key Performance Indicators for Indigenous-specific primary health care services: A coordinated data collection is also planned.</td>
<td>All jurisdictions, led by the Commonwealth Government. A national Key Performance Indicator framework will be developed through consultations with jurisdictions beginning July 2009. Approval of data elements will be sought through the National Health Information Agreement governance process. It is intended that a web based reporting system will be progressively developed and provided to Indigenous primary health care services to collect data associated with the national Key Performance Indicator framework. Financial support to facilitate the web based reporting system for OATSIH-funded Indigenous primary health care services will begin in 2009–10. While it is intended that all Indigenous-specific primary health care services could use the web based system for annual reporting from 2011–12, this is subject to agreement from States and Territories to meet an agreed share of the cost of implementing changes for State and Territory-funded services.</td>
</tr>
</tbody>
</table>
Appendix E: Recommendations regarding the inclusion of Indigenous status in pathology processes

(AIHW forthcoming a)

The Business Case makes two recommendations to improve Indigenous identification in the national disease registers. These recommendations have been supported in the majority of consultations undertaken for this project, including by the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID).

Recommendation 1: Long-term: National implementation to improve Indigenous identification in national health registers as part of broader work currently underway aimed at improving primary care data collection.

This involves a coordinated approach to national implementation in the context of development of a National Minimum Data Set on primary health care, and the announcement of the new E-Health record and reforms to the funding arrangements for primary care, which include the introduction of new reporting mechanisms.

This work will aim to standardise collection and recording of primary health care data across a number of sectors, including pathology.

Implementation of a primary health care NMDS will involve consultations with primary health care providers, pathology providers and software companies in regards to necessary changes required for the NMDS to be established and maintained. It would need to ensure that any necessary changes required to enable collection and recording of Indigenous status information be made through this broader work on improving primary health care data.

Recommendation 2: Short-term: Jurisdictions progress (or continue to progress), the inclusion of Indigenous status on pathology request forms through mechanisms identified below

The Business Case acknowledges that recommendation 1 will involve longer time frames than if Indigenous status was included on pathology forms as an isolated project. The Business Case therefore makes a second recommendation that in the short-term, jurisdictions should progress improvements in Indigenous identification in the national health registers, through the following mechanisms:

- Continuation of projects/pilot studies to include Indigenous status on pathology forms and consideration of their roll out state-wide
- Progressing required changes to state/territory public health legislation and regulations
- Progressing required changes for disease registers to adhere to the national standard format for Indigenous status
- Coordination between jurisdictions to achieve standardised requirements for pathology providers (and others affected by the proposed changes).
Appendix F: National Aboriginal and Torres Strait Islander Health Data Principles

All organisations with significant responsibilities in Aboriginal and Torres Strait Islander health data should encourage the application of these principles and establish meaningful partnerships with Aboriginal and Torres Strait Islander Australians.

Mindful of Aboriginal and Torres Strait Islander peoples’ understanding of ownership, including ownership of personal and community information, and any relevant agreements with various parties, including governments, these principles set out a culturally respectful foundation for the collection, storage and use of their health and health-related information.

Principle 1: The management of health-related information about Aboriginal and Torres Strait Islander persons must be ethical, meaningful, and support improved health and better planning and delivery of services.

Principle 2: The analysis, interpretation and reporting of Aboriginal and Torres Strait Islander health and health-related information should, where feasible, occur collaboratively with Aboriginal and Torres Strait Islander peoples.

Principle 3: The privacy and confidentiality of Aboriginal and Torres Strait Islander people will be protected in accordance with any relevant legislation and privacy codes.

Principle 4: Aboriginal and Torres Strait Islander peoples should be informed at the point of service that attendance/participation may contribute to administrative or mandatory data collections and that such data will be used to improve the quality, coverage and scope of health services and protect the public health. Data collection agencies and data custodians should have a policy that provides this information to people at the point of data collection and appropriate governance arrangements to review its implementation.

Principle 5: In general, free and informed consent should be obtained from Aboriginal and Torres Strait Islander peoples prior to any information management activities, except where mandatory reporting or legislative provisions apply. Otherwise, where there is a proposal to initiate an information management activity without the consent of Aboriginal and Torres Strait Islander peoples, it must be clearly demonstrated both that the activity will advance the interests of Aboriginal and Torres Strait Islander peoples and that it is impractical and infeasible to obtain further specific consent.

Principle 6: The value of the resources required to collect and use information should be assessed in the light of the potential benefit to Aboriginal and Torres Strait Islander peoples’ health.

Principle 7: The collection, collation and utilisation of information should be conducted in the most efficient and effective manner possible and minimise the burden on Aboriginal and Torres Strait Islander people.

Principle 8: Systematic and ethical processes for sharing information should be encouraged to assist in policy, planning, management and delivery of health services to Aboriginal and Torres Strait Islander people.

Principle 9: Aboriginal and Torres Strait Islander communities should be provided with feedback about the results and possible implications arising from data analysis.
Principle 10: Information collections require regular review and refinement in order to ensure ongoing relevance to service delivery and the potential for improved health outcomes.

Principle 11: Cultural respect and security of data practices must be promoted across all collections. Aboriginal and Torres Strait Islander individuals and communities should be afforded the same ethical and legal standards of protection as are enjoyed by other Australians. This may require the development and application of methods that are different to or in addition to those in mainstream data collections.

Endorsed by AHMAC October 2006
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### Abbreviations

<table>
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAPM</td>
<td>Australian Association of Practice Managers</td>
</tr>
<tr>
<td>AAPP</td>
<td>Australian Association of Pathology Practices</td>
</tr>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Services</td>
</tr>
<tr>
<td>ACIR</td>
<td>Australian Childhood Immunisation Register</td>
</tr>
<tr>
<td>ACRRM</td>
<td>Australian College of Rural and Remote Medicine</td>
</tr>
<tr>
<td>ADEA</td>
<td>Australian Diabetes Educators Association</td>
</tr>
<tr>
<td>AFDA</td>
<td>Australian Funeral Directors Association</td>
</tr>
<tr>
<td>AGPAL</td>
<td>Australian General Practice Accreditation Limited</td>
</tr>
<tr>
<td>AHMAC</td>
<td>Australian Health Ministers Advisory Council</td>
</tr>
<tr>
<td>AHPA</td>
<td>Allied Health Professionals Australia</td>
</tr>
<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
</tr>
<tr>
<td>AIATSIS</td>
<td>Australian Institute of Aboriginal and Torres Strait Islander Studies</td>
</tr>
<tr>
<td>AIDA</td>
<td>Australian Indigenous Doctors Association</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
</tr>
<tr>
<td>AMLA</td>
<td>Australian Medicare Locals Alliance</td>
</tr>
<tr>
<td>APEG</td>
<td>Australasian Paediatric Endocrine Group</td>
</tr>
<tr>
<td>APHCRI</td>
<td>Australian Primary Health Care Research Institute</td>
</tr>
<tr>
<td>APNA</td>
<td>Australian Practice Nurses Association</td>
</tr>
<tr>
<td>ATSIHWA</td>
<td>National Aboriginal and Torres Strait Islander Health Worker Association</td>
</tr>
<tr>
<td>CATSIN</td>
<td>Congress of Aboriginal and Torres Strait Islander Nurses</td>
</tr>
<tr>
<td>CDNA</td>
<td>Communicable Disease Network of Australia</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>DoHA</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>ERP</td>
<td>Estimated Resident Population</td>
</tr>
<tr>
<td>FaHCSIA</td>
<td>(Australian Government Department of) Families, Housing, Community Services and Indigenous Affairs</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
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</tbody>
</table>
GPA-plus  General Practice Australia-plus
GPET  General Practice Education and Training
GPII  General Practice Immunisation Incentive
HWD  Health Workforce Division (part of DoHA)
IAHA  Indigenous Allied Health Australia
ICDP  Indigenous Chronic Disease Package
LIME  Leaders in Indigenous Medical Education
MBD  Medicare Benefits Division (part of DoHA)
MBS  Medical Benefits Schedule
ML  Medicare Local
MSIA  Medical Software Industry Association
NACCHO  National Aboriginal Community Controlled Health Organisation
NAGATSIHID  National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data
NCAFP  National Congress of Australia’s First Peoples
NCIRS  National Centre for Immunisation Research and Surveillance
NCPP  National Coalition of Public Pathology
NDSS  National Diabetes Services Scheme
NEHTA  National E-health Transition Authority
NIPII  National Indigenous Pneumococcal and Influenza Immunisation
NIRA  National Indigenous Reform Agreement
NIRA PIMG  National Indigenous Reform Agreement Performance Information Management Group
NMDS  National Minimum Data Set
NPA  National Partnership Agreement
OATSIH  Office of Aboriginal and Torres Strait Islander Health (part of DoHA)
OHP  Office of Health Protection (part of DoHA)
PACD  Primary and Ambulatory Care Division (part of DoHA)
PBD  Pharmaceutical Benefits Division (part of DoHA)
PBS  Pharmaceutical Benefits Scheme
PCEHR  Personally Controlled Electronic Health Record
PGA  Pharmacy Guild of Australia
PHD  Population Health Division (part of DoHA)
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>PIP</td>
<td>Practice Incentives Program</td>
</tr>
<tr>
<td>PIP IHI</td>
<td>Practice Incentives Program Indigenous Health Incentive</td>
</tr>
<tr>
<td>PN</td>
<td>Practice Nurse</td>
</tr>
<tr>
<td>PSA</td>
<td>Pharmaceutical Society of Australia</td>
</tr>
<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>RCPA</td>
<td>Royal College of Pathologists of Australasia</td>
</tr>
<tr>
<td>SHFPA</td>
<td>Sexual Health and Family Planning Australia</td>
</tr>
<tr>
<td>VII</td>
<td>Voluntary Indigenous Identifier</td>
</tr>
<tr>
<td>WGIR</td>
<td>Working Group on Indigenous Reform</td>
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</tbody>
</table>
References

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