Racial and ethnic identification and quality of care: an Australian perspective

Knowing if a patient is Indigenous can be key to improving their care

An article published in 2010 in the *New England Journal of Medicine* advocated the collection of data on the race and ethnic groups of patients by medical practices in the United States. This was part of an initiative to computerise medical records and broaden the collection of demographic data. The authors suggested that such data could be used to detect health disparities, optimise the effectiveness of quality improvement interventions, and generate more reliable data on quality of care and outreach to patients. According to the authors, the "most common and strongest objection" was that doctors (and other practice staff) believed that "knowing a patient's race and ethnic group is, or should be, clinically irrelevant".[1]

Doctors are motivated by quality of care,[1] but in this US initiative, there is an incentive for the data collection in the form of additional reimbursement. In Australia, incentives have been introduced for doctors to improve the management of infectious and chronic disease among Indigenous Australians (eg, payment for additional immunisations for children, access to health assessments at an earlier age and programs to improve access to medicines).[2,3] However, these incentives have generally had limited uptake.[2,3] This has been attributed to a failure to collect information on whether or not patients are Indigenous. In 2009, using a combination of an analysis of the available literature and *de-novo* qualitative research, we examined strategies for improving the identification of Indigenous people in general practice in order to facilitate the uptake of new measures associated with the Closing the Gap objective.[4]

Three issues emerged from discussions with general practitioners that have important implications for improving the identification of Indigenous patients in general practice. First, there was a clear consensus that the poorer health status of Indigenous patients indicated a need to improve their medical care. Second, in order to convince clinicians and overcome resistance to identifying Indigenous patients, the relevance of identification to quality of care needs to be demonstrated. Third, the experienced clinicians interviewed for our report could not provide any examples demonstrating how identifying Indigenous patients had improved medical care. In part, this last issue seemed to arise from the way clinicians conceptualise quality of care.

Campbell and colleagues proposed a model of quality of care with two dimensions — access and effectiveness.[5] Access means availability, accessibility, affordability and acceptability while effectiveness is operationalised as the processes of interpersonal and clinical care. Interpersonal care relates to the interaction between health care providers and their patients. Clinical care relates to the technical aspects of care.[5] This distinction is also reflected in guidelines developed in the US to address disparities in health.[6]

Our research indicated that one of the barriers preventing clinicians from making the link between identifying their Indigenous patients and and quality of care is that they tend to focus on *effectiveness* of care rather than *access* to care. For example, in focus groups, none of the clinicians talked about access to additional or modified health services as a reason for identifying Indigenous patients, even though this is a cornerstone in reducing health disparities.[4] However, at case study sites, we found that clinicians who did associate identification with accessing specific services or applying different sets of clinical guidelines were more confident and willing to ask patients about their ethnicity. Focusing on awareness of health services specifically available to Indigenous people, the rationale underlying these services and the associated incentives resulted in significant increases in completed health assessment for Indigenous people.[4]

Making the link between the collection of identifying data with quality of care is also important from the perspective of the community. Consultation with the community has revealed that, while many community members were prepared to identify as Indigenous, they did not see this information as relevant to the quality of care they received.[7] Understanding that they might directly benefit from information provision was seen as further incentive for patients to identify as Indigenous. Not surprisingly, displaying promotional material in practices (including Indigenous flags etc.) significantly improved Indigenous identification.

Knowing a patient's ethnicity can help orientate clinicians to a range of issues and health service options that they might not otherwise have considered. Ensuring that identification results in improved care requires that this information (like any other aspect of a patient's social history) is considered a starting point for enquiry that reflects the clinical and interpersonal imperatives of any interaction. Increasing the willingness of doctors to enquire about ethnicity will require a doctor more easily making the link between knowing a patient's ethnicity and his or her quality of care. While this will involve improving doctor and patient awareness, it will also require having systems in place that enable information about ethnicity to contribute explicitly to improved quality of care.

"Knowing a patient's ethnicity can help orientate clinicians to a range of issues and health service options…"

Margaret Kelaher
BScPsych, PhD,
Deputy Director,
Centre for Health Policy,
Programs and Economics

Amy Parry
BA, DipPH, Research Fellow,
Centre for Health Policy,
Programs and Economics

Susan Day
BA, PhD, Senior Research
Fellow, Centre for Health
Policy, Programs and
Economics

Yin Paradies
MMedStats, MPH, PhD,
Senior Research Fellow,
McCaughey Centre

Ian Anderson
MBBS, PhD,
Director, Murrup Barak,
Melbourne Institute for
Indigenous Development

University of Melbourne,
Melbourne, VIC.

kelaher@unimelb.edu.au

doi: 10.5694/mja11.10844

Acknowledgements: The research on which this perspective was based was conducted for the Lowitja Institute and funded by the Australian Primary Health Care Research Institute. Margaret Kelaher is funded by an Australian Research Council Futures Fellowship.

Competing interests: No relevant disclosures.

Provenance: Not commissioned; externally peer reviewed

1 Wynia MK, Ivey SL, Hasnain-Wynia R. Collection of data on patients' race and ethnic group by physician practices. *N Engl J Med* 2010; 362: 846-850.
2 Kehoe H, Lovett RW. Aboriginal and Torres Strait Islander health assessments — barriers to improving uptake. *Aust Fam Physician* 2008; 37: 1033-1038.
3 Kelaher M, Dunt D, Thomas D, Anderson I. Comparison of the uptake of health assessment items for Aboriginal and Torres Strait Islander people and other Australians: implications for policy. *Aust New Zealand Health Policy* 2005; 2: 21.
4 Kelaher MA, Parry A, Day SE, et al. Improving the identification of Indigenous people in mainstream general practice. Melbourne: Cooperative Research Centre for Indigenous Health, 2010. www.lowitja.org.au/files/docs/Identification_report_Kelaher2010.pdf (accessed Mar 2012).
5 Campbell SM, Roland MO, Buetow SA. Defining quality of care. *Soc Sci Med* 2000; 51: 1611-1625.
6 Washington DL, Bowles J, Saha S, et al; Society of General Internal Medicine, Disparities in Health Task Force. Transforming clinical practice to eliminate racial–ethnic disparities in healthcare. *J Gen Intern Med* 2008; 23: 685-691.
7 Scotney A, Guthrie JA, Lokuge K, Kelly PM. "Just ask!" Identifying as Indigenous in mainstream general practice settings: a consumer perspective [letter]. *Med J Aust* 2010; 192: 609. ❑