

Facilitating engagement through strong relationships between primary healthcare and Aboriginal and Torres Strait Islander peoples

Carol Davy,¹ Alan Cass,² John Brady,³ Joanne DeVries,⁴ Barry Fewquandie,⁴ Suzzane Ingram,⁵ Ricky Mentha,⁶ Pamela Simon,⁷ Bernadette Rickards,⁶ Samantha Togni,^{6,2} Hueming Liu,⁵ David Peiris,⁵ Deborah Askew,³ Elaine Kite,¹ Leda Sivak,¹ Maree Hackett,⁵ Josée Lavoie,⁸ Alex Brown¹

There are significant disparities in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians. Chronic conditions account for the bulk of these disparities.¹ Cardiovascular disease is the single leading cause of death,² diabetes is at epidemic levels,³ and rates of chronic kidney disease are also disproportionately high compared to other Australians.⁴ Given the high prevalence of chronic disease, it is of concern that access to and use of primary healthcare services by Aboriginal and Torres Strait Islander Australians is often far lower than would be expected.⁵⁻⁷ Furthermore, as chronic disease is, by definition, often a permanent condition in a person's life,⁸ sustained engagement with primary healthcare is important for long term management and wellbeing in the face of illness. Rates of sustained engagement with healthcare services over time are, however, also far lower than would be expected given the high burden of chronic disease experienced by Aboriginal and Torres Strait Islander peoples.⁵

A number of researchers have investigated the reasons why engagement rates are suboptimal. Some of the broad reasons Aboriginal and Torres Strait Islander peoples are dissuaded from engaging with care

Abstract

Objective: Given the high prevalence of chronic disease, it is of concern that access to and sustained engagement with primary healthcare services by Aboriginal and Torres Strait Islander Australians is often far lower than would be expected. This study sought to explore ways in which relationships can support sustained engagement with healthcare services.

Methods: Semi-structured interviews were conducted with 126 Aboriginal and Torres Strait Islander participants with and without chronic disease and 97 Aboriginal and Torres Strait Islander and non-Indigenous healthcare providers, healthcare service managers or administrative staff.

Results: Our findings indicate that when faced with acute health issues, Aboriginal and Torres Strait Islander participants did prioritise care, provided that the service was both physically and emotionally welcoming. Trustworthiness of healthcare providers and strong relationships with patients were the most important factors for encouraging sustained engagement overtime.

Conclusions: Responsibility for sustaining relationships does not rest solely with Aboriginal and Torres Strait Islander patients. Rather, healthcare providers need to commit to the process of building and maintaining relationships.

Implications: First and foremost healthcare providers should take time to establish and then maintain relationships. Healthcare services can also contribute by ensuring facilities are welcoming for Aboriginal and Torres Strait Islander peoples.

Key words: primary health care, Indigenous health, chronic disease, service delivery

include the lack of culturally appropriate healthcare services, racist or discriminative behaviour by healthcare staff, the cost of seeking healthcare and a lack of time or ability to attend appointments.^{9,10} Aboriginal and Torres Strait Islander peoples in remote communities may be particularly disadvantaged due to the lack of availability

of a broad range of healthcare services.^{11,12} Where services do exist, it is often difficult to build lasting relationships with healthcare providers due to the high turnover of staff.¹³ According to the 2008 National Aboriginal and Torres Strait Islander Social Survey, almost 30% of Aboriginal and Torres Strait Islander peoples over the age of 15 living in

1. *Wardliparingga Aboriginal Research Unit, South Australian Health and Medical Research Institute*

2. *Menzies School of Health Research, Northern Territory*

3. *Inala Indigenous Health Service, Queensland*

4. *Wuchopperen Health Service, Queensland*

5. *The George Institute for Global Health, New South Wales*

6. *Baker IDI Heart & Diabetes Institute, Northern Territory*

7. *Tharawal Aboriginal Medical Service, New South Wales*

8. *Centre for Aboriginal Health Research, University of Manitoba, Canada*

Correspondence to: Dr Carol Davy, South Australian Health & Medical Research Institute, PO Box 11060, Adelaide, SA 5001; e-mail: carol.davy@sahmri.com

Submitted: November 2015; Revision requested: December 2015; Accepted: March 2016

The authors have stated they have no conflict of interest.

urban environments have also experienced problems accessing healthcare services.¹⁴ Some researchers have suggested various ways in which access could be better facilitated. For example, ensuring that Aboriginal and Torres Strait Islander peoples are employed within healthcare services can enhance relationships with patients and promote access.¹⁵ Creating a healthcare service that belongs to and is part of the community also improves access to healthcare services for Aboriginal and Torres Strait Islander peoples.¹⁶ For remote communities in particular, outreach services through which care is provided within the community setting have also been shown to improve rates of engagement with patients.¹⁷ Few researchers, however, have specifically considered the question of how to support sustained engagement within this context. This paper draws on findings from the Kanyini Qualitative Study (KQS) to identify how sustained engagement between Aboriginal and Torres Strait Islander peoples and their healthcare services can be better supported. The KQS is one of a series of discrete yet inter-related studies conducted by the Kanyini Vascular Collaboration (KVC) team (<http://www.kvc.org.au/>) with Aboriginal and Torres Strait Islander communities and

primary healthcare partners in New South Wales, Western Australia, South Australia, Queensland, the Northern Territory and Australian Capital Territory.

Methods

Four ethics committees approved the KQS, one in Central Australia, one in New South Wales and two in Queensland. Five healthcare service sites agreed to participate in the study. According to the Australian Standard Geographical Classification System,¹⁸ two services were in capital cities (RA1), two were in major regional centres (RA2-3), and one was in a remote area (RA4). Three of the participating healthcare services were Aboriginal Community Controlled Health Organisations (ACCHOs), and one was a government-administered Aboriginal healthcare service. The final site had services provided by a number of government healthcare services as well as four ACCHOs.

Our research team comprised a group of geographically dispersed Aboriginal and Torres Strait Islander and non-Indigenous researchers, many of whom were also clinicians. The team also included five Aboriginal and Torres Strait Islander Research Fellows (ARFs), four of whom were embedded

within KVC partner healthcare services as half-time Aboriginal Health Workers whilst also working half-time on this study. The fifth ARF was employed within a collaborating research organisation but had been an Aboriginal Health Worker prior to participating in the research. Our team also included a further five research staff who had experience in undertaking qualitative research. One researcher identified as an Aboriginal Australian while the remaining four were from a variety of cultural backgrounds.

From July 2008 to February 2010, the ARFs and the qualitative researchers within our research team conducted semi-structured interviews with 223 participants (Table 1). Of the 126 Aboriginal and Torres Strait Islander community participants, 111 identified as Aboriginal, 10 as Torres Strait Islander and five as both Aboriginal and Torres Strait Islander. A further 97 participants who were Aboriginal and Torres Strait Islander or non-Indigenous healthcare providers, healthcare service managers or administrative staff also participated in the study (Table 2). A purposive sampling technique¹⁹ was utilised in order to gain perspectives from a range of both community members living with chronic disease and their carers, as well as a variety of clinical, administrative and management staff working in the services that provided care. Community participants were invited to participate in the study by the ARF in their area, while healthcare providers were invited to participate at opportune moments including during staff meetings. While written informed consent was obtained from all participants, records were not kept in relation to the number of community members or staff who chose not to participate. Interview guides were developed and piloted prior to the first interview. Separate guides – one for community members and one for healthcare professionals – contained on an average of 13 questions incorporating suggested 'prompts'.

Our entire research team was involved in data analysis which began soon after the initial interviews were completed. Although the qualitative analysis computer software program NVivo 8 was used to assist with organisation of data in subsequent stages of our analytic process, initially a 'manual' approach was used to inductively code interview data to emergent themes, in order to establish the underlying principles of qualitative data analysis for team members not familiar with this research method. After reading and re-reading the interview transcripts, themes were

Table 1: Summary characteristics of all study participants.

	Aboriginal and Torres Strait Islander participants (n=126)	Healthcare providers (n=97)	Total participants (n=223)
Female	71 (56%)	62 (64%)	133 (60%)
Male	55 (44%)	35 (36%)	90 (40%)
Urban	43 (34%)	30 (31%)	73 (33%)
Regional	27 (21%)	38 (39%)	65 (29%)
Remote/Very Remote	56 (45%)	29 (30%)	85 (38%)

Table 2: Summary of healthcare provider participant characteristics.

Healthcare Provider Participants	No.	Aboriginal Identity		Type of Healthcare Service		
		Aboriginal and Torres Strait Islander	Non-Indigenous	ACCHO ^a	Gov ^b	NGO ^c Private Sector
Aboriginal Health Worker	17	17	-	16	1	-
Nurse	29	4	25	13	14	2
Doctor	10	-	10	8	1	1
Allied Health	6	1	5	5	1	-
Registered Nurse manager	4	1	3	2	2	-
General Practitioner manager	6	2	4	4	2	-
Aboriginal Healthcare Worker manager	3	3	-	1	2	-
Non-clinical manager	5	3	2	3	2	-
Board member	2	2	-	2	-	-
Chief Executive Officer	4	3	1	4	-	-
Administrative staff (receptionist, driver, etc.)	9	7	2	6	3	-
Healthcare adviser	2	-	2	-	-	2
TOTAL	97	43	54	64	28	5

a: Aboriginal Community Controlled Health Organisation

b: Government-run Service

c: Non-Government Organisation

identified which then became the subject of multiple and enthusiastic team discussions. These discussions were integral to our iterative analytic approach and, critically given the nature of this research, allowed team members to compare perspectives, interpretations and understandings. Commensurate with interviewers' skills and experience, themes highlighted during these discussions were explored during subsequent interviews across the sites. Although at the outset informed by grounded theory techniques,²⁰ our analytic process became subject to real-world challenges, in particular resourcing and time constraints, which arose from conducting a large, complex, multi-site study with a geographically-dispersed research team. Analysis and interpretation of data at the between-sites level was undertaken from May 2012 to July 2013. Findings from this between-site analysis are presented and discussed below.

Results

Our findings indicate that a number of factors sustained engagement between Aboriginal and Torres Strait Islander peoples and their healthcare services. We also found that competing demands and the stress associated with being diagnosed with chronic disease meant that care was not always a priority. However, when faced with acute health issues, Aboriginal and Torres Strait Islander peoples did prioritise care if the healthcare service was physically, relationally and emotionally welcoming. In particular, healthcare providers who were able to build strong and trusting relationships and who cared for more than just the physical needs of their patients encouraged care seeking. While strong relationships were also one of the keys to sustaining engagement, when relationships broke down as a result of discrimination or distrust, Aboriginal and Torres Strait Islander peoples were likely to disengage from healthcare services. This in turn impacted on future engagement.

Healthcare – 'Health' was not always a priority

Our study identified a number of reasons why Aboriginal and Torres Strait Islander community members did not always engage with primary healthcare services. In many cases these were related to the number of competing demands that Aboriginal and Torres Strait Islander peoples negotiate on a

daily basis. It appeared that there was rarely just one problem, but a whole range of needs that required attention before people could think about seeking care for themselves.

Because sometimes people miss out on their appointments because they don't have cars, they don't have money because they're all on welfare. And then there's a lot of children in the house, you've got to find a babysitter, you've got to take some kids with you, and there's a problem, and a lot of our people miss out on appointments that are very, very vital to their health issues, and they've got to go...we definitely need transport for our customers. (Aboriginal, Community participant, Female, Urban)

For those living in remote areas, maintaining engagement with required treatments often involved an inability to participate in cultural activities, moving away from family and community and dislocation from their Country. The term Country is used in relation to the spiritual connections that Aboriginal and Torres Strait Islander feel with the land. Many community participants found this separation unsustainable, to the extent that some prioritised their connections with family and community over opportunities to prolong their life.

People get homesick when they go into town to stay on the [dialysis] machines. They miss their bush food, they miss everything. Even their family members, they've got to like be split apart... Some people I know from [community names withheld] they just gave up hope and just came back to the communities and just long stay with the families, they just passed away...They miss out on a lot. (Aboriginal, Community participant, Male, Very Remote)

As perceived by a healthcare provider participant, even when treatment was available closer to home, it did not necessarily mean that healthcare providers understood either the client or the social and kinship contexts in which they lived.

It's also just the momentum of the system to get the most overwhelmed person and put them in the most overwhelming situation by virtue of the fact that none of the Australian graduates want to work in this little Aboriginal community "Well we'll just get someone from Nigeria and just plonk them there without any understanding of Medicare, Australian medications, the prescribing system, the health care system, with minimum orientation and no cultural orientation". (Non-Indigenous, Practitioner, Female, Remote)

The possibility of being diagnosed with chronic disease was so stressful for some that

they chose not to engage with services.

I don't know, I don't want to know what's wrong with me half the time, I'm getting around fine and that, you know... you kind of get around fine and then go to the doctors and get a test done... they find what's wrong with you... and then you start stressing out about it... that's the way I am, I think what you don't know, you know, whereas [my husband] he's different... he's got to go and... I even said to him if I get taken to hospital and they tell me I haven't got long to live... don't tell me... I don't want to know... I just really stress out... (Aboriginal, Community participant, Female, Urban)

Reprioritising – Opportunities to engage

Until the seriousness of their condition became undeniable, for many community participants leading busy lives, healthcare had not been a major focus.

Yeah, that was me exactly before, I was exactly like that [finding it hard to maintain motivation to stay healthy]. I'd walk every now and again, but it's not until something drastic or dramatic happens to you and then it makes you reassess your life and then you can see the path you were going down. Like when you are sitting in a bed and you have got three or four doctors doing different things... that's an eye opener, you know. I thought, "Oh, shit I was doing something wrong". (Aboriginal, Community participant, Male, Regional)

In many cases, community participants described engaging with healthcare services only after acute events such as a heart attack. Some were also motivated to engage after others in their family or community experienced a life-threatening episode.

[When a bloke I played touch football with] had the heart attack it really made me sit up and think... we took it for granted, our health. We thought we were immortal. We could just live forever. But when he had the heart attack... I went and got checked up... But you know, that was one story where what happened to them changed a lot of the way people thought... Now men are starting to see well, you know, you need to look after it [your health]... (Aboriginal, Community participant, Male, Urban)

These types of traumatic events often proved to be turning points in peoples' lives. One community participant spoke of reassessing his life after a sudden heart attack and described engaging more regularly with healthcare providers, which in turn helped him manage his health.

No I didn't [have a regular doctor]. You know what black guys are like, they don't like seeing doctors ... Yeah [since my heart attack] I see the doctor quite regularly ... it makes me feel good every time I go around and see the doctor, and [he] checks all my weight and everything and my size around the waist and it's all coming down, so that's good ... so I was sort of getting in tune with my body. (Aboriginal, Community participant, Male, Regional)

Some healthcare provider participants attributed the increasing awareness of the impact of chronic disease to direct experiences within the patient's family and community, especially when "[t]hey can see there're a lot of people that are dying young around them." (Aboriginal, Practitioner, Female, Regional). These providers reaffirmed the community perspective that life-threatening events frequently proved the catalyst to long-term engagement.

One of those guys...he's just such a great success story in that...I mean it's terrible he had his big scare and went into hospital and nearly died, but he's quit smoking and he's just taken his life into his hands as a result, and he's so happy ... And it's really lovely to see him thriving. (Non-Indigenous, Practitioner, Female, Regional)

Welcoming spaces – Continued engagement

While acute events may motivate people to engage with care, both community and provider participants believed that having the right type of healthcare service in place was crucial to supporting continued engagement. Welcoming spaces where community members felt comfortable, accepted, and able to build strong and trusting relationships with healthcare providers encouraged people to remain engaged with care. This 'welcoming space' did not just represent the physical place but also encompassed emotional (feeling supported and cared for), and relational (the quality of relationships between patients and providers) elements. One of the most important aspects of a welcoming space was the presence of Aboriginal and Torres Strait Islander staff. Community members needed to feel the healthcare service was "their place" (Non-Indigenous, Manager, Female, Regional) and noted the importance of feeling well treated.

I can only answer you for myself, but you could ask any other Aboriginal person that wants to be cared for and improve their health and to stay healthy, they'll tell you that the

Doctors that work for the Aboriginal Medical Service, to my way of thinking and talking is they're good people. They really care for the Aboriginal people. And [name withheld] I'm not only saying that because I'm a regular and we know one another, I'm saying this from my heart and I know the people who attend this place and come here for their check-ups. They're very pleased with how they're treated. (Aboriginal, Community participant, Male, Urban)

The use of health posters depicting Aboriginal and Torres Strait Islander people, as well as paintings and other artefacts that demonstrate the commitment of staff to providing culturally appropriate healthcare, were also considered to be important.

... It's right from when you walk through the door, brother. It's when you walk in, you see the paintings up there, you see the artefacts, you know. All that sort of stuff makes you feel welcome and makes you want to sit in the waiting room for an hour to wait ... half an hour, five minutes, whatever. Because you feel that, you know, you're okay there. Yeah. And the ladies in the front, they're lovely. They're all good. Really good crew. I don't think I've had a bad experience over there ... (Aboriginal, Community participant, Female, Urban)

Aboriginal and Torres Strait Islander staff – whether doctors, nurses, healthcare workers or administration officers – were key to creating the much needed feelings of belonging and acceptance.

So, it's very important to have your own people and you feel open to talk to, that sort of stuff. You go to a non-Indigenous doctor and they look at you sometimes indifferent, and you can't be sort of more open to them, sort of thing. (Aboriginal, Community participant, Male, Urban)

Sustained engagement wasn't just about Aboriginal and Torres Strait Islander staff however. Strong relationships with all healthcare staff were fundamental to community members' long-term engagement with a healthcare service.

You fellas in there [staff in the health centre] give us, the community members, a reason to come in. I don't know whether youse even know that. But because of the way you fellas handle all your responsibilities, you make us want to come there. There are lots of places in our state, in our nation, where it's because of the people within the organisation that people don't attend ... You look at those organisations where people aren't going, why is that? (Aboriginal, Community participant, Female, Urban)

Relationships with healthcare staff were considered by many participants to be just as - if not more - important than the type of building or the quality of medical care on offer. When healthcare providers understood patients' care needs and demonstrated genuine interest in the peoples' lives, community participants reported feeling welcomed, respected and accepted.

They're [medical staff] caring, first of all. They care what's going on. Like everything. Like they'll ask, first of all health and they ask about home. And then with me, like I said, like time is the biggest thing that I don't have and they just take the time out just to say, something nice, like you know, like I'm anaemic so my doctor will look up [my blood results] and say, "Oh you're getting it up there, yeah very good woo hoo!" And I'll feel better just walking in, I didn't come in to see you about that, but that's good, like a help for me. (Aboriginal, Community participant, Female, Urban)

Closely aligned with building relationships were the provider's ability to be flexible and their commitment to maintaining a connection with patients. Providers who focused on taking "a motivational interviewing approach" (Non-Indigenous, Manager, Male, Urban), treating each encounter as an opportunity to help support behavior change, if not on that day, then at another time in the future, believed that this was particularly successful in supporting sustained engagement. Community participants also emphasised the need to achieve understanding within care encounters.

I think a good doctor and a good nurse is someone that actually talks to you and not talk at you ... not just babble on and keep talking and you don't have a clue and they're not going to stop and help you understand. (Aboriginal, Community participant, Female, Remote)

Services that were able to provide this more holistic approach to care were highly valued.

Yeah. It's the holistic approach over here. It's the whole bundle. You know, it's the environment, it's the people, it's the care, you know, the service, right through to, the whole lot. From admin right through to your doctors and where you're sitting. It's really good. (Aboriginal, Community participant, Female, Urban)

Healthcare services that went beyond merely providing medical treatment to become part of the community were held in particularly high regard. This, in turn, encouraged sustained engagement.

They've got a high-quality preschool next door. They charge us bugger all compared to the rest of them. They pick them up and drop them off. They'll pick me up. They'll look after me. They look after my teeth. They look after me. If I need a lift, no worries. They'll come and pick me up. They'll actually be concerned. Like, I've got more people caring about me here than I've had in my own neighbourhood in the last five years, you know... And this year, I have been using them. And I've been a lot better off. (Aboriginal, Community participant, Male, Urban)

Hindering engagement – Distrust and discrimination

Often trust between Aboriginal and Torres Strait Islander communities and their healthcare services did not come easily, with both clients and providers having to “work hard for it” (Aboriginal, Practitioner, Female, Regional). Interruptions to patient-provider relationships occurred as a result of a breach of this trust, which then needed to be regained over time in order to re-establish the same level of engagement.

As workers, if we break our connection with people, we can go back to 'delicate' [engagement] from 'robust' very easily. That just because we think we've achieved a robust relationship, if we then disengage for any reason ... then we actually go back to at least 'delicate'. We don't remain in the 'robust'. We've got to re-earn our 'robust' credentials ... And I think that does show how profoundly underlying is the basic distrust, however much people may know that they have to rely on outside service providers. (Non-Indigenous, Practitioner, Female, Remote)

While some people were deterred by the stories they heard from others, distrust also resulted from firsthand encounters of racism or inferior treatment.

... a lot of people didn't want to go there [the local mainstream health service] because they felt the place was unfriendly, the staff were not friendly towards them and there was a lot of attitudes happening, people felt they were discriminated against, and the place was very sterile ... it wasn't like a, it wasn't a comfortable environment ... and people spoke ... didn't speak in the way we speak ... like very abrupt, loud and abrupt, communication wasn't there too, you know? Just that lack of understanding in how you talk, the tone you use for Indigenous people ... so there was that, where there was no probably no cultural knowledge with the staff ... Yeah, like discrimination, racism, or you know, just ignorance and no sensitivity and no understanding of

Indigenous health issues ... (Aboriginal, Community participant, Female, Urban)

Community members as well as healthcare staff participating in this study dwelt on the emotional impact of these situations. Some described ‘losing faith’ in healthcare services and people walking away from necessary care as a result.

I don't think the community have a lot of faith in mainstream, and I have to admit I've seen it where I've taken a client, or a couple of clients, to the hospital, and they're just treated atrociously. And I don't think it was because of their condition ... It was because they identified as being Aboriginal ... one of our clients was admitted because he had a heart attack, and she [one of our nurses] went in to visit him, and she could actually hear the nurses in the hallway speaking about him. And she walked out and she tore strips off them, because they were just so derogatory to him. And he ended up getting up and walking out. (Aboriginal, Manager, Female, Urban)

Yet, healthcare providers were often perplexed and frustrated when patients disengaged from care. Some were concerned with people’s apparent resistance to engaging with care, believing that it was about not “being dominated by white people” (Non-Indigenous Practitioner, Male, Remote). Other providers realised that there may be many reasons why people choose to disengage and importantly, recognised that healthcare services may need to apply multiple strategies to support patients to remain engaged.

But when you've got people who are clearly already disempowered, and disadvantaged, to say that they should be taking responsibility ... "It's up to them to come into the clinic, and if they don't present, well then that's their own decision". How can we say that they've made an informed decision? That's, you know, another ethical question. ... And there's absolutely no one strategy ... one doesn't fit all sort of sizes. So you've got to have a range of strategies. (Non-Indigenous, Manager, Female, Remote)

Discussion

Our study found that a number of factors supported sustained engagement between Aboriginal and Torres Strait Islander peoples and their healthcare services. These included opportunities that arose after life-threatening events. Nevertheless, accessing healthcare services and remaining engaged in care is likely to require more than simply the availability of medical facilities in times of

need. Sustained engagement was most likely when community members felt that the healthcare service was part of their community and where patients could have faith in and develop strong relationships with healthcare providers. These relationships needed time to develop and were built on the foundation of trust and respect. Importantly, sustaining these relationships required flexible approaches to care which acknowledged and accounted for competing interests, accepting that people may not always prioritise their own healthcare needs.

While Aboriginal and Torres Strait Islander staff were more likely to form a strong connection with patients,²¹ participants in this study also acknowledged the importance of developing relationships with non-Indigenous healthcare providers.²² Patients often found relationships more difficult to form with non-Indigenous healthcare providers, needing a willingness on the part of these providers to understand healthcare from the perspective of Aboriginal and Torres Strait Islander patients and their broader community and kinship contexts.²³

Developing these types of relationships went well beyond the use of a patient-centred care approach. Defined as care that is “respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions”,^{24,p6} patient-centred care does little to acknowledge the importance of building relationships with the community in order to better understand the social and cultural context in which the patient lives. Examples of tailored services include the use of local language wherever possible when communicating with patients or providing appropriate healthcare facilities and services that accommodate cultural sensitivities and expectations. The notion of tailored care also assists with prospectively planning to meet the particular needs of the local population rather simply responding to the patients that walk through their door.²⁵

Developing and sustaining these types of relationships will take time.²⁶ In the context of colonial history and perpetual racial discrimination experienced by Aboriginal and Torres Strait Islander peoples,^{27,28} healthcare providers will need to demonstrate respect for their patients, their patients’ family and the communities they serve. Community members will also need to make time to develop trust and faith in their healthcare services. Time is also needed to establish

effective communication strategies, ensuring that healthcare providers understand their patients and that patients understand their healthcare providers.^{29,30} Finally, time is necessary for healthcare providers to engage with and understand the social and cultural aspects of the local community in order to better understand the needs of their patients.³¹ All are especially important for non-Indigenous healthcare providers who have little previous knowledge of the social or cultural contexts in which they practice.

Health systems can support or inhibit this type of engagement. The strategies that systems could employ to support healthcare providers include ensuring that providers have the time to connect with patients, their families and the community;²⁶ providing cultural safety training and ongoing professional development to ensure that providers not only understand but take responsibility for their own cultural impositions to ensure they can provide culturally appropriate care to the community they serve;³⁰ and designing employment contracts that facilitate the flexibility necessary for providers to deliver the type of care that communities need.³² Healthcare services could be better supported with the required resources to engage appropriately with communities. Employing and providing educational and career opportunities Aboriginal and Torres Strait Islander staff would assist with ensuring that patients feel welcomed and comfortable in engaging with services.³³

Strengths and limitations

A large number of Aboriginal and Torres Strait Islander community members and healthcare providers participated in this study. Participants came from a mix of remote, regional and urban contexts. Healthcare providers were drawn from the same healthcare centres that provided services to the Aboriginal and Torres Strait Islander community members who were involved in this study. Despite the large number of participants and the variety of contexts in which the study was conducted, it should not be assumed that the findings are necessarily transferrable to all primary healthcare services. The wide diversity of Aboriginal and Torres Strait Islander communities in Australia, each with locally specific healthcare and community needs, requires a contextualised approach to improving healthcare services.

The research team that undertook this study comprised a group of geographically dispersed Aboriginal and Torres Strait Islander and non-Indigenous researchers, many of whom were clinicians with medical, nursing or health worker qualifications. All of the team members brought a wide variety of perspectives and understandings to the research which further enriched the analysis and interpretation of the data collected. One of the most important strengths of our multicultural, multi-disciplinary research team was the ability to listen to and respect each other's point of view and then discuss potential solutions until members were in agreement with the outcome. In particular, this provided an opportunity to discuss what was clear (explicit), and also what was not (tacit), in the stories being told by both community and healthcare provider participants.³⁴ We also acknowledge that working within this research space was not without some costs. The process of negotiating the research space³⁵ continued throughout analysis and interpretation. Considerable effort was therefore made, particularly in the early stages of data analysis, to create a safe space to jointly exchange, consider, discuss and debate perspectives.

Conclusions

The challenge for healthcare providers is clear. Improvements in Aboriginal and Torres Strait Islander health will not be achieved by simply providing 'more' services. Instead, enhancing and maintaining relationships between patients and providers appears to be at the heart of the potential for sustained engagement. Relationships in turn depend on a number of factors associated with both the provider and the service. Time to build trust and faith in the healthcare provider is essential. So too is the need for healthcare providers to demonstrate respect for and engage with not just patients but also the wider community. For healthcare services, ensuring that Aboriginal and Torres Strait Islander peoples feel welcomed and accepted and employing Aboriginal and Torres Strait Islander staff will support the development of these important relationships. Given that chronic disease is a long lasting condition that can be managed but rarely cured, sustained engagement with appropriate primary healthcare services will result in better health outcomes for Aboriginal and Torres Strait Islander peoples.

Acknowledgements

We acknowledge the contribution that Jeannie Devitt and Michael Howard made to the KQS. This research is a project of the Australian Primary Health Care Research Institute, which is supported by a grant from the Commonwealth of Australia as represented by the Department of Health. The information and opinions contained in it do not necessarily reflect the views of the Australian Primary Health Care Research Institute or the Department of Health. This research was also supported by a health services research program grant from the National Health and Medical Research Council (Grant ID # 402797). Maree L Hackett is a recipient of a National Heart Foundation Future Leader Fellowship, Level 2 (100034, 2014-2017).

References

1. Zhao Y, Dempsey K. Causes of inequality in the life expectancy between Indigenous and non Indigenous people in the Northern Territory, 1981-2000: A decomposition analysis. *Med J Aust.* 2006;184:490-4.
2. Brown A, Walsh W, Lea T, Tonkin A. What becomes of the broken hearted? Coronary heart disease as a paradigm of cardiovascular disease and poor health among Indigenous Australians. *Heart Lung Circ.* 2005;14(3):158-62.
3. O'Dea K, Rowley KG, Brown A. Diabetes in Indigenous Australians: Possible ways forward. *Med J Aust.* 2007;186(10):494-5.
4. Cass A, Cunningham J, Wang Z, Hoy W. Regional variation in the incidence of end-stage renal disease in Indigenous Australians. *Med J Aust.* 2001;175(1):24-7.
5. Australian Institute of Health and Welfare. *Australia's Health 2012. The Thirteenth Biennial Health Report of the Australian Institute of Health and Welfare.* Canberra (AUST): AIHW; 2012.
6. Johanson RP, Hill P. Indigenous health: A role for private general practice. *Aust Fam Physician.* 2011;40(1-2):16-9.
7. Britt H, Miller GC, Henderson J, Charles J, Valenti L, Harrison C, et al. *General Practice Activity in Australia 2011-12.* Sydney (AUST): University of Sydney; 2012.
8. Weeramanthi T, Henty S, Connors C, Ashbridge D, Rae C, Dunn M, et al. The Northern Territory Preventable Chronic Disease Strategy - promoting an integrated and life course approach to chronic disease in Australia. *Aust Health Rev.* 2003;26(3):31-42.
9. Johnstone M, Kanitsaki O. The spectrum of 'new racism' and discrimination in hospital contexts: A reappraisal. *Collegian.* 2009;16(2):63-9.
10. Anikeeva O, Katteri R, Bywood P. Closing the Gap initiative - successes and ongoing challenges for divisions of general practice. *Aust Fam Physician.* 2012;41(7):523-7.
11. Department of Health and Ageing. Report on the Audit of the Health Workforce in Rural and Regional Australia. Canberra (AUST): Government of Australia; 2008.
12. Productivity Commission. *Australia's Health Workforce, Research Report.* Canberra (AUST): Government of Australia; 2005.
13. Alford K. *Comparing Australian with Canadian and New Zealand primary care health systems in relation to Indigenous populations: Literature review and analysis.* Melbourne (AUST): University of Melbourne; 2005.
14. Australian Institute of Health and Welfare. *Measuring the Social and Emotional Wellbeing of Aboriginal and Torres Strait Islander Peoples.* Canberra (AUST): AIHW; 2009.

15. Aspin C, Brown N, Jowsey T, Yen L, Leeder S. Strategic approaches to enhanced health service delivery for Aboriginal and Torres Strait Islander people with chronic illness: A qualitative study. *BMC Health Serv Res.* 2012;12:143.
16. National Aboriginal Community Controlled Health Organisation. *Constitution for the National Aboriginal Community Controlled Health Organisation.* Canberra (AUST): NACCHO; 2011.
17. Gruen R, Weeramanthri T. Outreach and improved access to specialist service for Indigenous people in remote Australia: The requirements for sustainability. *J Epidemiol Community Health.* 2002;56:517-21.
18. Department of Health. *Australian Standard Geographical Classification - Remote Area (ASGC-RA)* [Internet]. Canberra (AUST): Government of Australia; 2015 [cited 2015 Aug 17]. Available from: <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/content/ra-intro>
19. Morse JM. Sampling in grounded theory. In: Bryant A, Charmaz K, editors. *SAGE Handbook of Grounded Theory.* London (UK): SAGE; 2007.
20. Grbich C. *Qualitative Data Analysis. An Introduction.* London (UK): Sage Publications; 2013.
21. Harrington Z, Thomas DP, Currie BJ, Bulkanhawuy J. Challenging perceptions of non-compliance with rheumatic fever prophylaxis in a remote Aboriginal community. *Med J Aust.* 2006;184(10):514-7.
22. Andersen SM, Chen S, Carter C. Fundamental human needs: Making social cognition relevant. *Psychol Inq.* 2000;11(4):269-318.
23. Lowe J. Balance and harmony through connectedness: The intentionality of Native American Nurses. *Holist Nurs Pract.* 2002;16(4):4-11.
24. Institute of Medicine (US) Committee on Quality of Health Care in America. *Crossing the Quality Chasm. A New Health System for the 21st Century.* Washington (DC): National Academy Press; 2001.
25. Browne AJ, Varcoe CM, Wong ST, Smye VL, Lavoie JG, Littlejohn D, et al. Closing the health equity gap: Evidence-based strategies for primary health care organizations. *Int J Equity Health.* 2012;11:59.
26. Lavoie JG, Wong ST, Chongo M, Browne AJ, MacLeod ML, Ulrich C. Group medical visits can deliver on patient-centred care objectives: Results from a qualitative study. *BMC Health Serv Res.* 2013;13:155.
27. Cunningham J, Paradies YC. Patterns and correlates of self-reported racial discrimination among Australian Aboriginal and Torres Strait Islander adults, 2009-09: Analysis of national survey data. *Int J Equity Health.* 2013;12:47.
28. Ziersch AM, Gallaher G, Baum F, Bentley M. Responding to racism: Insights on how racism can damage health from an urban study of Australian Aboriginal people. *Soc Sci Med.* 2013;73(7):1045-53.
29. Strong J, Nielsen M, Williams M, Huggins J, Sussex R. Quiet about pain: Experiences of Aboriginal people in two rural communities. *Aust J Rural Health.* 2015;23:181-4.
30. Durey A, Thompson SC, Wood M. Time to bring down the twin towers in poor Aboriginal hospital care: Addressing institutional racism and misunderstandings in communication. *Intern Med J.* 2012;42(1):17-22.
31. World Health Organization. *Closing the Gap in a Generation.* Geneva (CHE): Commission on Social Determinants of Health; 2010.
32. Taft SH, Nanna PD. What are the sources of health policy that influence nursing practice? *Policy Polit Nurs Pract.* 2008;9:274-87.
33. Gibson O, Lisy K, Davy C, Aromataris E, Kite E, Lockwood C, et al. Enablers and barriers to the implementation of primary health care interventions for Indigenous people with chronic diseases: A systematic review. *Implement Sci.* 2015;10:71.
34. Fine M. Working the hypens: Reinventing self and other in qualitative research. In: Denzin NK, Lincoln YS, editors. *Handbook of Qualitative Research.* Thousand Oaks (CA): Sage; 1994. p. 70-82.
35. Cui K, editor. *Substantiate the Reflexivity: The Insider-outsider Role of an Ethnographic Researcher. Proceedings of the 11th European Conference on Research Methods;* 2012 June 28-29; University of Bolton; Bolton, UK. Reading: Academic Publishing International; 2012.