Closing the gap — better health intelligence is required

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To the Editor: National best practice guidelines recognise that accurate data on the health of Indigenous Australians are crucial to improving health service delivery.[1]

The draft revision of the RACGP *Standards for general practices* acknowledges the need for improvement and requires that a practice demonstrates how it routinely records, in active patient health records, self-identified Aboriginal and Torres Strait Islander status.[2] This is a commendable improvement but should be further strengthened, requiring that Indigenous status be recorded for at least 90% of active patients, the level required for a history of allergies.

Improved record keeping in general practice has resulted in the potential to improve Indigenous identification among patients notified with a communicable disease. This enables the documentation of health disadvantage, and allows evaluation of measures aimed at closing the gap in health outcomes between Indigenous and non-Indigenous people.

Demographic data in the NSW notifiable diseases database (NDD) were audited for all 258 Hunter New England (HNE) *Salmonella* infection notifications in 2007 by interviewing patients and their referring general practitioners. Interviews were completed for 83% of patients.

Indigenous status was poorly recorded. The NDD listed three patients with salmonellosis as Aboriginal, but showed an unknown status for 87%. Among patients who had attended a GP during their illness (66%), practice records listed two as Aboriginal, but Indigenous status was unknown for 70%. Most GPs (95%) reported using electronic medical records, and 89% completed pathology requests with practice software. Many GPs (60%) requested information on how to appropriately ask about a patient's Indigenous status.

Interviews with patients who had been notified as having had salmonellosis identified 13 as Aboriginal, and no resistance to identification was encountered. The crude salmonellosis notification rates per 100 000 population were 42.2 (95% CI, 19.3–65.1) for Aboriginal HNE residents and 25.5 (95% CI, 21.7–28.6) for non-Aboriginal HNE residents which, while not statistically significant for this small sample, suggests a differential salmonellosis burden, consistent with studies elsewhere.[3] The true burden of disease was likely to have been substantially higher, as many infections are not notified.[4] The differential burden may also be an underestimate if Aboriginal HNE residents were less likely to be notified than non-Aboriginal residents due to, for example, reduced access to health services.

The widespread availability of electronic practice software for generating pathology requests provides a new opportunity to substantially improve Indigenous identification in communicable disease notifications.[3] Indigenous status should be routinely recorded by GPs and automatically included on their pathology request forms and subsequent laboratory notifications. There is now a need for a coordinated national approach to ensure consistent inclusion of Indigenous status on all laboratory notification data.

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1 Australian Institute of Health and Welfare. National best practice guidelines for collecting Indigenous status in health data sets. Canberra: AIHW, 2010. (AIHW Cat. No. IHW 29.) http://www.aihw.gov.au/publications/ihw/29/11052.pdf (accessed Jul 2010).

2 The Royal Australian College of General Practitioners National Expert Committee on Standards for General Practices. RACGP Standards for general practices — draft 4th edition for consultation. Melbourne: RACGP, 2010. http://www.racgp.org.au/Content/NavigationMenu/PracticeSupport/StandardsforGeneralPractices/4th_edition_RACGP_draft_standards.pdf (accessed Jul 2010).

3 Improving Indigenous Identification in Communicable Disease Reporting Project Steering Committee. Improving Indigenous identification in communicable disease reporting systems [discussion paper]. Canberra: Department of Health and Ageing, 2004. http://www.publichealth.gov.au/pdf/reports_papers/technical%20papers/IIICDRS_indigenous_reporting.pdf (accessed Jul 2010).

4 Hall G, Yohannes K, Raupach J, et al. Estimating community incidence of *Salmonella*, *Campylobacter*, and Shiga toxin-producing *Escherichia coli* infections, Australia. *Emerg Infect Dis* 2008; 14: 1601-1609. ❏