Author's response to reviews

Title: Reducing the health disparities of Indigenous Australians: Time to change focus

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Author's response to reviews: see over
Dear Dr Harris
Thank you for considering our manuscript and giving us the opportunity for revision and we sincerely appreciated the constructive and thoughtful comments of both reviewers in helping us to strengthen the paper. This has led to restructuring sections of the paper to provide a more logical flow. For example, we have separated the results and discussion section as suggested, moved some sections in the discussion to the introduction and edited others to increase the focus on the aim as suggested by Reviewer 2. We also reworked the discussion section to focus initially on problem areas which then led to possible solutions.
Thank you again and we look forward to hearing from you
Sincerely
Angela Durey and Sandra Thompson

Specific responses to reviewers’ comments.
Reviewer 1

1. Racism is defined, as is anti-racism, but the term race is not defined and similarly is not defined in relation to competing/complementary concepts such as ethnicity. The authors should define the concept of race.

Response: we expanded this section to address the suggestion - para beginning ‘We address the issue in a healthcare setting in Western Australia using race as a structuring or organising principle in social relations that is underpinned by relations of power (21). Singleton and Linton (22) suggest that race relates to physical characteristics including skin colour while ethnicity refers more to cultural factors such as language, beliefs and practices of a particular population group. They argue that meanings attributed to race are socially constructed often impacting on ethnicity where ethnic markers such as music and food become racialised in the dominant White culture. Reference is made in the US to ‘Black music’ or ‘Asian food’ with no reference made to ‘White music’ or ‘White food’, implying the normative invisibility of ‘Whiteness’.

2. The results and discussion are presented as one section. This structure makes it hard to distinguish data arising from the interviews and subsequent analysis from the authors’ own discussion of the literature. I infer that from the section ‘Models of care’ onwards, the content of the paper is largely discussion as none of this material is supported by quotes (I presume, for example, that the section on the effects of a market economy and neoliberalism reflect the views of the authors rather than the views of the interviewees?). I recommend that the results and discussion are clearly separated out into different sections so that the interviews and analyses are distinct from the discussion section.

Response: Separated ‘results and discussion section’ as suggested (also by Reviewer 2). Also moved sections ‘models of care’ and ‘Accountability for translating health care policies to practice’ to introduction to contextualise the project earlier in the paper. Incorporated in this section also are two separate references (Harris et al) suggested by Reviewer 1.

3. The limitations of the study should be discussed in the discussion section of the study. As it stands, limitations are not described other than the lack of input from doctors working in rural areas and from Indigenous doctors. Other limitations might include, for example, interviews being restricted to three doctors. Acknowledging that the study’s intention was to focus on high-quality, in-depth insights from experienced doctors rather than from any pre-specified larger number of participants, nevertheless, the study’s reliance on three interviewees should be commented on in the limitations section.Similarly, actual and theoretical limitations of the analytical methods should be commented on.

Response: Extended ‘limitations’ section which now follows a short summary of findings in the discussion section: ‘Potential limitations of this project included interviews being restricted to three non-Indigenous doctors. However, the study’s intention was to focus on the high-quality insights of doctors experienced working in this field rather than a pre-specified, greater number of participants. We were unable to recruit an Indigenous doctor to participate in formal data collection which would have added an important perspective to the paper. Other limitations included focusing on doctors
working in the metropolitan area rather than those practicing in rural and remote settings, although all had worked in different Indigenous and/or international settings’.

... actual and theoretical limitations of the analytical methods should be commented on

Response: this section was expanded to include literature that informed the qualitative process and with this in mind, the analysis section was expanded: ‘Our qualitative methods were informed by Wolcott who identified the importance of the researcher’s experience and understanding in interpreting the data (48). We also drew on the work of de Laine (49) to examine health care practice. Her critical approach to analysis identified power relations and how ‘patterns of domination of individuals and groups ... stem from fundamental structures and ideologies of social systems’ (De Laine, 1997: 125), that are often accepted as part of the ‘normal’ social order (De Laine, 1997: 127).’

Minor revisions:
In the abstract, in the last line of the results section, insert the words ‘their sense of’: ‘...lowering expectations and their sense of self-worth.’
Response: done – also in text on para beginning p7 ‘People often view racism …’

In the abstract, in the last line of the conclusions, and also in the final paragraph of the discussion section, I suggest deleting the word ‘historically’ as the authors are describing a contemporary phenomenon (as demonstrated in their results).
Response: done

Page 4 last line: delete the word ‘nations’ and replace with ‘people’.
Response: done

Can the authors please consider whether the statement on page 8 (‘many of those treated will form part of the elderly living with a poor quality of life, well illustrated by our burgeoning epidemic of dementia’) is a negative value judgement and, as such, is a distraction (after all, what is the alternative to providing care for old people with dementia?). The main part of the sentence makes a good point without needing this example.
Response: Example deleted and sentence changed to ‘This means there are a range of treatment choices for the well-to-do and considerable resources committed to the treatment and care of an increasing aged population (rarely Indigenous Australians), even though many of those treated will form part of the elderly population living with a poor quality of life’.

Page 15: the first sentence of the third paragraph (‘This scenario...’) doesn’t make complete sense to me and would benefit from some minor re-wording.
Response: changed sentence to ‘This scenario suggests a need for sensitivity to how internalised racism can manifest in seemingly innocuous health care interactions. Institutional and interpersonal commitment to respond respectfully in such situations is important to promote Indigenous health and wellbeing so patients feel ‘culturally safe’.

Page 17: I suggest insert the word ‘for’ in the heading: ‘Accountability for translating...’.
Response: done

Page 19: Maori words are not pluralised with an ‘s’, so the plural of Maori is Maori.
Response: done

Page 19, last line: a full stop is missing.
Response: done

Page 24, last two lines of the last sentence of the paper: the wording of this sentence can be improved maybe along the lines of: ‘...changing the discourse that places Indigenous people at the centre of the problem in Australia along with the failed service approaches that exist’.
Response: changed sentence to: ‘Encouraging health care providers to critically reflect on how normative, White privilege can reproduce inequities in Indigenous health care is an important step to
changing the discourse that places Indigenous people at the centre of the problem in Australia along with the failed service approaches that exist’.

Reviewer 2
1. The paper attempts to cover a lot of ground and would benefit from considerable editing down, and increased focus on the aim.
Response: In order to focus more on the aim, we have restructured the paper (see comments above) and to make it flow better and be more concise we have deleted the following sections
Deleted: para beginning ‘The Marmot Review ... reaping the rewards’
Deleted para beginning ‘Those who work within the mainstream health care system ... reproduces such practices’
Deleted para beginning ‘Psychiatric assessment, diagnosis, treatment ... in the next few years
Deleted sentence beginning ‘Hui and Trandis ... non-compliance with medication’

2. The language is rather dense and could be simplified.
Response: we have revised the paper to ensure sections are less dense, including in the abstract eg in results section: ‘While Whiteness can refer to skin colour, it also represents a racialized social structure where Indigenous knowledge, beliefs and values are subjugated to the dominant western biomedical model in policy and practice’.

3. There needs to be more discussion on how the ‘informal discussions with colleagues’ contributed to the study findings and interpretation. Although the researchers acknowledged that their experiences and knowledge assisted with the data interpretation, some discussion on how this affected the reported findings would add value to the article.
Response: To adequately address this comment, we have reworked the sections on methods, data collection and analysis:

Methods: The authors have worked for many years in a variety of health settings including education and research and have experience in domains such as medicine, public health, policy, nursing and anthropology. Our qualitative methods were informed by the analysis of Wolcott who identified the importance of the researcher’s experience and understanding in interpreting the data (50). We also drew on the work of de Laine (51) to examine health care practice. Her critical approach to analysis identified power relations and how ‘patterns of domination of individuals and groups ... stem from fundamental structures and ideologies of social systems’ (De Laine, 1997: 125), that are often accepted as part of the ‘normal’ social order (De Laine, 1997: 127). Our study aimed to supplement research examining barriers to Indigenous Australians’ access and uptake of health care (52, 53) and was approved by the Western Australian Aboriginal Health Information and Ethics Committee.

Data collection We were interested less in the number of participants recruited and more in achieving high quality insights of experienced doctors, committed to Indigenous health, who could deepen our understanding of the issue. Interviews were considered an appropriate method to gather data and encourage participants to reflect on factors promoting and impeding the delivery of quality health care to Indigenous Australians. Our participants were working in Perth, the state capital of Western Australia, and were selected based on their long experience in service delivery in the Indigenous health sector and because their insights and reflective thinking located the problems of medical care for Indigenous clients within a health system which failed to adequately acknowledge and respond to their patients’ needs. As Wolcott {Wolcott, 2001 #618} suggests, qualitative research combines the perspective of both the researcher and participants where researchers bring their own experience, cultural background, values and understandings to help inform the research experience. Recruitment and interviews were conducted by ST, a public health physician who had worked in
Indigenous health for many years. Her experience and observations in this field helped, not only to establish rapport with participants, but also to inform the interview questions and research process because of her familiarity with the context. Interviews conducted with Anglo-Australian medical doctors, two female and one male, were arranged at a time and place convenient to participants and interviewer and occurred over several months until there was repetition of themes. Voluntary consent was provided by participants. Interviews lasted from 40 to 120 minutes and occurred over many occasions with questions relating to the challenges participants experienced providing care for their Indigenous patients and the nature of the difficulties. Participants were encouraged to draw on their experiences and observations to reflect on whether mainstream health services undermine or promote quality care for Indigenous Australians. To add rigour to the research process and identify whether participants’ experiences and observations in interviews resonated with a wider group of practitioners experienced working in Indigenous settings, informal discussions were also held with other Indigenous and non-Indigenous medical colleagues working in Indigenous health research, education and practice on their observations while working professionally in policy, practice and community settings.

**Data analysis** Interviews were transcribed and imported into QSR NVIVO qualitative software package where an inductive, exploratory analysis was undertaken to identify and code key themes which were subsequently revised, modified, developed and refined (50). Both researchers analysed the interviews independently, discussed and corroborated their findings. Key themes from informal discussions with other Indigenous and non-Indigenous medical colleagues working in the Indigenous health area were identified independently by each researcher, discussed and reviewed to reach consensus. Member checking involved the researchers following up on interviews, and informal discussions offered a means to validate whether participants’ experiences and observations in interviews resonated with those of a wider group of practitioners experienced working in Indigenous health care.

Our observations were influenced not just by the recorded words, but by our own beliefs and values as White health professionals. While our past experience, knowledge and understanding of health care and Indigenous health assisted with interpreting the data, findings from interviews, informal discussions and observations also offered different perspectives so new meanings could emerge and lead to a deeper understanding of the issue. Quotes were selected to illustrate key themes identified in interviews. To ensure confidentiality, no information identifying participants is used in the paper.

Findings were reviewed, interrogated, refined and compared to existing literature on health care to Indigenous people including peer reviewed papers, government documents and grey literature such as unpublished reports. Literature was identified by systematic searching as well as citation snowballing and then examined for the role of broader structural issues such as institutional policies and practices on the health care of Indigenous patients. This approach gave us the opportunity to critically analyse power relations underpinning the systemic, institutional and interpersonal challenges health providers face when caring for Indigenous patients in mainstream settings.

4. The findings from the interviews need to be separated out from the discussion – it is sometimes difficult to tell what came from the interviews and what came from the authors’ reading of the literature. I would prefer the interview findings were left to speak for themselves.

Response: see comments to Rev 1
5. I wonder if the findings were forced into the headings of institutional, interpersonal and internalised racism, rather than arising out of an inductive approach? Some of the discussion under the subhead “Interpersonal racism” seems to better fit “institutional racism”.

Response: We have explained this more fully in the introduction to the findings: ‘Our findings deepened our thinking around racism which was a key theme identified by participants that stalled progress in improving Indigenous health. Racism manifested in hospital policies, practices and interactions between hospital staff and Indigenous patients which, over time, led to Indigenous patients perceiving racism in interactions even if it was absent. We have conceptualised racism respectively as institutionalised, interpersonal and internalised. However, we acknowledge these are not discrete categories as they interrelate closely in ways that maintain the status quo.’

6. The issues highlighted under the subheading internalised racism are important but I would argue against attributing them to internalised racism. My understanding of internalised racism aligns with the definition presented on page 32 of the manuscript - “Acceptance of attitudes, beliefs or ideologies among members of stigmatised ethnic/racial groups about the inferiority of one’s own ethnic/racial group.” (see Paradies, Harris, Anderson 2008, The Impact of Racism on Indigenous Health in Australia and Aotearoa: Towards a Research Agenda.” page.vi.).

Response: sentence changed to ‘Racism can also be internalised where members of a stigmatised racial group accept attitudes beliefs or ideologies about the inferiority of their own ethnic/racial group, (32), lowering their expectations, performance and sense of self-worth’. We also inserted the sentence ‘We argue that those who are White and privileged also internalise their racial positioning in the social order where they accept as the norm a sense of their own entitlement to goods and services, not easily accessed by those from other racial groups.’

I don’t think that “Indigenous patients perceptions that health care practices are racist even when not’ (p.15) is a manifestation of ‘internalised racism' but may be a reflection of collective and individual experiences. This is also a tricky area to explore from interviews with non-Indigenous health professionals. Perhaps a tighter focus on interrogating ‘whiteness’ would keep the authors on safer ground.

Response: We have changed this section to focus more on the learning opportunity for health care providers rather than the experience of the Indigenous patient. Under the heading ‘Internalised racism’ we have inserted ‘We acknowledge the challenges of White researchers exploring internalised racism in Indigenous Australians who have a long history, experience and collective memory of being on the receiving end of mainstream White policies and practices that are racist. The subtle but powerful damaging effects of racism are highlighted when, either individually or collectively, Indigenous Australians accept and internalise beliefs and attitudes about their inferiority and expect to be discriminated against in a range of social contexts including the health setting. However, such knowledge can provide an opportunity for learning and alert health care providers to be more vigilant about the consequences of their attitudes and practices, even where racism is not intended:’