

# Hospitals caring for rural Aboriginal patients: holding response and denial

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## Abstract

**Objective.** To investigate how policy requiring cultural respect and attention to health equity is implemented in the care of rural and remote Aboriginal people in city hospitals.

**Methods.** Interviews with 26 staff in public hospitals in Adelaide, South Australia, were analysed (using a framework based on cultural competence) to identify their perceptions of the enabling strategies and systemic barriers against the implementation of official policy in the care of rural Aboriginal patients.

**Results.** The major underlying barriers were lack of knowledge and skills among staff generally, and the persistent use of ‘business as usual’ approaches in their hospitals, despite the clear need for proactive responses to the complex care journeys these patients undertake. Staff reported a sense that while they are required to provide responsive care, care systems often fail to authorise or guide necessary action to enable equitable care.

**Conclusions.** Staff caring for rural Aboriginal patients are required to respond to complex particular needs in the absence of effective authorisation. We suggest that systemic misinterpretation of the principle of equal treatment is an important barrier against the development of culturally competent organisations.

**What is known about this topic?** The care received by Aboriginal patients is less effective than it is for the population generally, and access to care is poorer. Those in rural and remote settings experience both severe access barriers and predictable complexity in their patient care journeys. This situation persists despite high-level policies that require tailored responses to the particular needs of Aboriginal people.

**What does this paper add?** Staff who care for these patients develop skills and modify care delivery to respond to their particular needs, but they do so in the absence of systematic policies, procedures and programs that would ‘build in’ or authorise the required responsiveness.

**What are the implications for practitioners?** Systematic attention, at hospital and clinical unit level, to operationalising high policy goals is needed. The framework of cultural competence offers relevant guidance for efforts (at system, organisation and care delivery levels) to improve care, but requires organisations to address misinterpretation of the principle of equal treatment.

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## Introduction

The poor health status of Aboriginal and Torres Strait Islander Australians is well documented, and has been the subject of official policy and program attention for many years, most recently under the rubric of ‘Closing the Gap’.<sup>1</sup> The mainstream health system has responded to increased funding and clear portfolio responsibility,<sup>2</sup> with increasing attention to the burden of illness that Aboriginal people experience<sup>3</sup> and the need for effective health care.<sup>4</sup>

However, change is patchy. There is evidence that access and quality of care for Aboriginal people is compromised in relation to screening, prevention of complications and potentially preventable hospitalisations.<sup>5</sup> Although emergency department visits and hospitalisation rates for Aboriginal people are relatively higher than for the general population, procedure rates are lower and waiting times longer, and nearly double for some surgeries.<sup>6</sup> There is less access to supportive and rehabilitation services, such as cardiac rehabilitation,<sup>7</sup> and lower access to

kidney transplantation,<sup>8</sup> and continuity of care across different health and support services is compromised.<sup>9</sup>

Engagement with the health system is made more difficult for Aboriginal people by their past and present experiences of exclusion, shaming and stereotyping.<sup>10–14</sup> Language and interpersonal communication breakdowns across the cultural divide lead to difficulty in assessing symptoms, reaching an accurate diagnosis and providing effective care.<sup>11,15,16</sup>

Aboriginal and Torres Strait Islander people living in rural and remote areas of South Australia often have English as a second (or subsequent) language, have little or no experience of the city and have limited financial resources. They are admitted to public hospitals in Adelaide, the capital city, more often (1.6-fold) than their non-Aboriginal counterparts and often need to stay longer.<sup>17</sup>

This situation persists, despite legislation and policy that authorises or requires tailored responses to the needs of Aboriginal patients.<sup>18</sup> The Department of Health has endorsed the Cultural Respect Framework,<sup>19</sup> which acknowledges that the health system ‘does not provide the same level and quality of care to treat illness’ for Aboriginal people, and the need to improve both performance and accountability.<sup>19</sup>

The South Australian Health Care Act 2008 (Part 1:5(b), p. 7) places an obligation on the State’s public health services to recognise and respect Aboriginal people and cultures, and provides a legislative basis for tailoring health care to meet the needs of Aboriginal patients.

The aim of the present study was to investigate barriers against the implementation of these requirements, as reported by staff in city hospitals who provide care for rural Aboriginal patients in South Australia.

### *Institutional racism and cultural competency*

Some authors have concluded that the reasons for the observed disparities in care for Aboriginal patients are not clearly understood,<sup>20</sup> whereas others highlight the importance of recognising and addressing institutional racism.<sup>21–23</sup> Racism is generally understood to mean individual beliefs and actions that are unfair and oppressive to ‘other’ racial groups. Institutional racism refers

to the overt and subtle ways in which the operation of institutions and organisations has the effect of discriminating against minority populations.<sup>24</sup> This is ‘built-in’ racial discrimination, occurring with or without direct intention by individuals. Given the evidence summarised above, it must be accepted that institutional racism exists in the Australian healthcare system, despite both good intentions and significant effort to improve care.

The framework of cultural competence supports systematic efforts to improve the effectiveness of care, and remove or reduce the impact of discrimination against minority groups, in health care.<sup>25</sup> The framework is multilayered, calling for attention at system, organisation, profession and individual levels.<sup>26</sup> Cultural competence is a characteristic of the healthcare system, rendering it more capable of delivering culturally safe care to patients.<sup>27</sup>

### **Methods**

The present study, part of a larger action research project, received ethical approval from six institutional ethics committees, including the Aboriginal Health Council of South Australia. The partnership and project management arrangements are described elsewhere.<sup>28</sup>

Six clinical units (in all five major public hospitals in Adelaide) that admit significant numbers of country Aboriginal patients were approached to participate. In consultation with unit leaders, individuals with experience in providing care to rural Aboriginal patients and from a range of disciplines were identified and approached. All 26 agreed to participate, and interviews were conducted individually ( $n=22$ ) or in pairs ( $n=2$  pairs). One participant was Aboriginal, and eight were male. This purposive sample is not designed to be statistically representative.

Interviews (conducted in 2009–10) elicited staff views about the experience of providing city hospital care to country Aboriginal patients. Questions were open ended and asked participants about barriers and their underlying causes, as well as strategies for improving care, as shown in Fig. 1.

Interviews were audiorecorded, transcribed and coded using NVivo8 software (QSR International; [http://www.qsrinternational.com/products\\_previous-products\\_nvivo8.aspx](http://www.qsrinternational.com/products_previous-products_nvivo8.aspx), accessed

<p><b>Role:</b> Please explain what you do in your job.</p> <p><b>Barriers:</b> Can you talk about your experiences of providing care for Aboriginal people from remote regions and what gets in your way in your efforts to provide effective care?</p> <p><b>Causes and underlying issues:</b> Why do you think this happens? When you identify an issue, do you have any way of raising it for resolution?</p> <p><b>Enablers:</b> Thinking about your experience of these problems or barriers, what are the factors in your working environment that have helped to make things better?</p> <p><b>Strategies:</b> Thinking back on your experiences, if you had the power, what are the important changes that would improve the care for Aboriginal people from remote areas?</p>
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**Fig. 1.** Interview and focus group outline.

17 July 2014). Text addressing systemic barriers and enablers and/or strategies was analysed using the framework of cultural competence. Cultural competence is usually defined as 'a set of congruent behaviours, attitudes, and policies in a system, agency or among professionals' that enable effective cross-cultural work.<sup>25</sup> Analysis focused on the ways participants conceptualised the underlying causes of difficulties. The practical challenges they discussed are presented elsewhere.<sup>17,28-31</sup>

## Results

Participants discussed two major themes: (1) individual cultural (in)competence; and (2) the impact of 'business as usual' requirements. They offered strategies to address many of the barriers. The results are presented below, with representative quotes (a unique number and the profession of the participant are shown in parentheses after each).

### *Cultural (in)competence*

The difficulties of establishing trust and good communication across cultures and among people with very different life experiences and worldviews, and the importance of making it work if clinical care is to be safe and effective, were discussed by most participants. They used several terms, such as 'cultural awareness', and focused on personal knowledge gained from experience and training.

[I have had to ask] is my colleague suggesting the person's being aggressive because they're being aggressive or are they just a person in distress who doesn't understand and who is frustrated and it is being perceived as aggression because of my colleague's own personal views and values about that person's race or ethnicity and I've seen situations where that's occurred. . . and no-one really stopped to take the time to sort of think 'is this an issue actually with the patient or is this actually an issue with my colleague?' 'Who owns this issue here?' (4, receptionist)

Cultural sensitivity isn't sort of being mamby pamby about it, it's understanding how to approach things. . . I just don't know what to say to make the interaction whereas some of the Registrars who have been up north have worked out what to do. (8, senior doctor)

When we first wanted to get Ngangkaries [traditional healers] down, going through admin was a nightmare because they basically wanted ABN numbers and all that sort of stuff and then 'what are the qualifications of these people?' and it was an absolute nightmare. (3, psychologist)

The administrative staff referred to above were seen to change their own practice and interactions as a result of direct experience in an Aboriginal community:

. . . and so admin staff going up [to the Lands] then recognise the importance of a Ngangkari and can see that it's the community that determines if a person is a good Ngangkari or not and that you don't need the ABN. (3, psychologist)

More confident staff emphasised the importance of respect, engagement and knowledge of their patients' home environments and country, and their use of language and health concepts. Although some participants criticised the quality of cultural awareness training, there was broad support for its use:

. . . people that have had cultural training are usually quite aware and 'okay this reaction might be because of A, B and C' so they tend to work quite well with it but you do notice sometimes, I think, a difference between people that haven't had that sort of training. (13, social worker)

### *Managing two worlds together: business as usual often doesn't work*

The second major theme, raised by almost all participants, was the requirement to apply 'business as usual' approaches even though they differentially restrict patients' access to care, undermine quality or simply don't work. Many of the problems are predictable; for example, discharge arrangements (including medications) and the inflexibility of appointment systems.

I think because it's all too hard quite often a discharge plan doesn't get made as it would for anyone else. (7, senior nurse)

They're now being asked to pay for that medication to go home with and that brings up all sorts of issues in terms of 'can I afford it?', 'I didn't sort of prepare ahead of time for this' . . . for people who are struggling, that means a large amount of money and for people who are remote, I guess in particular the Aboriginal patients that we see, it's very foreign to them. (13, social worker)

People say they are non-compliant, but do they really understand in the first place, these tablets you have to keep taking forever. You have to go and get more tablets, do they actually understand that? I don't know. (16, doctor)

She'd got herself organised, she'd got the bus organised and she'd got two little kids. She got there twenty minutes late, to the hospital, and they refused to see her and this woman had escaped violence, she was fleeing in a shelter, she was working really hard at maintaining her independence under huge, huge amounts of stress and a variety of things going on and then she got refused care. (23, midwife)

When staff spoke of the reasons for failure to adapt and accommodate the predictable challenges arising in complex care journeys for these patients, the problem of lip service and fine words not being backed by action was prominent.

Unless you're going to mean something rather than look good because, you know, 'I'm the senior administrator who wrote this lovely document'. It's actually supposed to mean something and those sorts of ideas should be all flourishing around the hospital. But they don't and then you have to ask and so why don't they? Well talking the talk is – makes them feel fantastic, good Christians or whatever we're supposed to be feeling about ourselves, but actually

doing that sort of thing is quite a different matter and that's where the barrier is. (24, doctor)

Others referred directly to the lack of a systematic approach, and the resulting loss of momentum for change.

Probably the biggest barrier at the moment, is that there is no system in place really (14, coordinator)

Yes I have been thinking about it and it is so big, there are so many issues, I don't even know where you begin. (16, doctor)

It completely crashed out through lack of support. Absolute lack of management support and isolation and not having things sent up through the echelons. (23, midwife)

Although many of the participants expressed empathy with their patients, recognising the complexities of their health care journeys,<sup>29</sup> others articulated the principle of equal treatment as a barrier.

...it was like you treated them like any other Tom, Dick or Harry that came through the ward. We did our normal treatment, did what we had to do and when it came to discharge, yeah...you just did the normal protocol for everybody and that's been my experience for 20 years. (9, nurse)

I treat – all patients are the same so there wouldn't be any other treatments for Aboriginals or Muslims or – you know, there's difficulties with the language barrier but I've never come across that with the Aboriginal ladies, they've always spoken English to me or if we haven't the Aboriginal liaison is with them...I can't see there's any things that are being missed because the service we're giving is the same as anybody else. (22, ward clerk)

The adaptation of the system of care most often mentioned involved the roles of Aboriginal Liaison Officers (ALOs) and project staff.

Having the Aboriginal Project Officer...is great in the way that he can actually communicate with all the different areas. He's familiar with all of the remote areas and he has the contacts so he'll often direct us to particular people. (20, allied health)

Participants also lamented the low numbers of ALOs employed, and the resultant difficulty for them to specialise in particular clinical areas, or to be involved pro-actively.

They can only look after the disasters, and they don't have time to prevent the disasters from happening because they are too busy working on the disasters. (16, doctor)

Other adaptations included clinical coordinator roles. These were staff with time allocated for liaison and coordination with referring agencies and primary care providers. Participants also cited support services (accommodation and transport), and the use of outreach services and telemedicine, extra time for explanation and staff personally filling gaps.

I think it's just taking that time, taking that time to go a bit further and find out. I suppose that's where my role comes into place and I guess I have that time to do that and I suppose I carry that responsibility as well, do that bit more. (14, care coordinator)

...but we have [specialist] link nurses throughout the state as well. So yeah we have these nurses out there that come down, have done a small amount of training here, have regular meetings so they get updated. (12, care coordinator)

[Pilot study of] teleconferencing to substitute for appointments for rural and remote families and it was really positively received by parents, saying that they'd love that service to be set up. (20, allied health)

Having a longer amount of time to sit down and spend with someone, develop some kind of rapport and see what they understand about their health condition would be helpful. (5, doctor)

Often if they're travelling back on the bus – I mean I probably shouldn't be saying this but we've all done it – we've all just taken out \$20 and often we'll go and buy chicken and some bottles of water and some fruit and give it to them to take back with them on the bus. We've all done that out of our own pocket because, you know, you just think that's how you'd want one of your family members to be treated. (3, doctor)

## Discussion

Staff interviews indicated widespread attention to the challenges of caring for country Aboriginal patients, as well as some lack of empathy. Cultural competence was generally understood only as a characteristic of individuals, to be developed through both training and direct experience, particularly exposure to the life circumstances of Aboriginal people in rural and remote regions.

This focus on the individual level is consistent with experience in the US, where cultural competence is a mandated requirement in healthcare. In a systematic review of instruments that seek to measure cultural competence, Kumaş-Tan *et al.*<sup>32</sup> found problematic assumptions about what it is, and a tendency to reduce it to the level of individual knowledge and skills. This focus on the individual, leading to an overemphasis on training, has been noted by others in this field<sup>33</sup> and in international development programs.<sup>34</sup>

Participants also discussed several strategies at the level of the hospital and/or the clinical unit that support a culturally competent care system. The roles of ALOs and clinical coordinators were most prominent, along with the availability of support services, like accommodation and transport assistance.

However, there was also a sense that the adaptations in use were largely those that could be constructed as 'bolt-ons' to normal systems of care. Problems that required flexibility in existing systems (e.g. appointment scheduling or the use of outreach modes of care) were less likely to be adopted.

The views and experiences of staff depict a system that functions at the edge of its capacity in seeking to meet the needs of country Aboriginal patients, so that relatively small problems (e.g. late planes) have consequences that reverberate in poorer health and additional costs. Although some clinical units have developed practical responses to patient needs, at the organisational level (and in the thinking of some staff) there seems to be a failure to acknowledge that such responses need to be reliably available. This situation persists despite policy that is intended to authorise the tailoring of care to the needs of Aboriginal patients.

It is always easier to write high policy goals than it is to implement effective action to achieve them; and the challenges of reliably providing good care and good access for rural and remote Aboriginal people are complex and serious. The patients (and their families and carers) undergo complex geographical and care journeys, and this complexity is predictable due to the interaction of rigidities and gaps in the system of care (e.g. communication gaps between acute and primary care) with underlying social factors (e.g. lack of financial resources and relatively poor health literacy).<sup>17</sup>

We note that non-Aboriginal people living in rural areas also experience complex care journeys, and both their access to care and its quality are affected by some similar barriers.<sup>35</sup> As Aboriginal observers often say, 'If we could fix care for Aboriginal people, we could fix it for everyone'.

But these considerations merely reinforce the reality that effective care for Aboriginal people (particularly those from rural and remote areas) requires both policy attention and modifications to the way care is provided. The policy is in place, but implementation is patchy at best. We suggest two explanations.

First, it is notable that high policy has not been systematically translated to the operational level. Staff expressed not only the usual need to find solutions to patient care problems, but also the lack of processes to embed those solutions or the ability to rely on operational protocols for positive authorisation and guidance. We contrast this situation with that confronting staff caring for people with blood-borne infections, another marginalised group. In that case, the principle of universal precautions (i.e. caring for all patients in a way that would prevent transmission) was quickly operationalised into protocols, suitable equipment, guidelines, training and resources for every predictable problem.

Second, we suggest that implementation is neglected because of misinterpretation of the principle of equal treatment. This principle (that all people should be treated equally in access to healthcare) has always included the clarification 'according to need'. The concept of equitable (rather than equal) care is used to emphasise this requirement.<sup>36</sup> The problem for (rural) Aboriginal patients seems to lie in denial that their particular needs are legitimate. We suggest that this difficulty has deep origins in a broader political problem; that is, the unresolved question of recognition of the place and role of Aboriginal and Torres Strait Islander people in Australian society and in law.<sup>37</sup> The framework and tools of cultural competency, with their emphasis on organisational as well as individual capacities,<sup>38,39</sup> offer a practical way to address this problem.

## Competing Interests

The authors affirm that they have no competing interests and that the funder of this study had no influence on the writing or publication of this paper.

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