

# Disparities in experiences and outcomes of hospital care between Aboriginal and non-Aboriginal patients in New South Wales

Differences exist between Aboriginal and non-Aboriginal patient experiences, but are not universal

A recently published study across 23 countries and 28 populations highlighted the pervasiveness of poor health outcomes among Indigenous people.<sup>1</sup> In Australia, while gaps in health status between Aboriginal and non-Aboriginal people are well documented,<sup>2,3</sup> until now little was known about the extent of differences in Aboriginal patients' experiences of care and self-reported outcomes following hospitalisation. In New South Wales, the Bureau of Health Information (BHI) has recently released a report based on survey responses from 2682 Aboriginal and 22 997 non-Aboriginal patients.<sup>4</sup> The report highlights differences between Aboriginal and non-Aboriginal patients' experiences, particularly in terms of interpersonal aspects of care, coordination and integration, and patient-reported outcomes. Many of the findings have implications for hospital doctors.

Most aspects of care were rated highly by the majority of Aboriginal adults admitted to hospital in NSW. However, for many questions of clinical relevance, there were significant gaps between Aboriginal and non-Aboriginal patients' responses. The proportion of patients who responded that they were completely involved in decisions about their care and treatment was similar across the two groups (Aboriginal patients, 58%; non-Aboriginal patients, 60%). However, there were statistically significant differences (based on non-overlapping 95% confidence intervals) in the proportions who responded that doctors always answered questions in an understandable way (Aboriginal patients, 66%; non-Aboriginal patients, 74%); they were given enough information about how to manage their care at home (68% *v* 73%); completely adequate arrangements were made for care following their discharge (64% *v* 70%); doctors always knew enough about their medical history (65% *v* 71%); and staff completely considered patients' family and home situation in planning their discharge (68% *v* 72%). Compared with non-Aboriginal patients, fewer Aboriginal patients believed that care and treatment definitely helped them (70% *v* 77%) and more responded that they experienced a complication related to their hospital care (22% *v* 16%).

Questions about respectfulness and courtesy were answered differently by the two groups: 86% of Aboriginal patients felt that their cultural or religious beliefs were always respected, compared with 91% of non-Aboriginal patients.

These findings are important for clinicians to consider because experiences of care matter. They matter not only because health care providers should aim to meet patients' expectations about how they want to be treated but also because, to a great extent, health care experiences shape outcomes of care. Through clear communication and respectful interactions, clinicians promote and support patient adherence to treatment, inform patients about their key symptoms, involve patients in making decisions about their care, and ultimately contribute to better clinical outcomes.<sup>5,6</sup>

Policy emphasises the importance of respect;<sup>7</sup> however, respect is not a well delineated concept and varies across cultures and between individuals. It is mostly enacted in clinical interactions, according to people's expectations and cultural norms, and is consistent, and diligent effort on the part of doctors is required. While clinicians strive to provide the same level of care to all their patients — giving equal treatment for equal need — when it comes to respect and other interactions, equal care may not be enough.

The delivery of respectful care also requires purposeful team effort. Teams articulate, socialise, emphasise and reinforce the need to be alert and responsive to different patient expectations. Discussing expectations in routine, team-based care helps doctors to tailor their interactions with Aboriginal patients to ensure an appropriate and caring response.

Importantly, the BHI survey found that differences in experiences of care between Aboriginal and non-Aboriginal patients were not apparent across all local health districts. At a district level, Aboriginal patient responses were less positive for a range of none to 20 of the 55 questions in the survey. While other NSW patient surveys have shown that patients treated in rural hospitals reflect more positively on their experiences than those treated in urban hospitals,<sup>8</sup> this pattern was not generally apparent for Aboriginal patients. However, in one rural district, Aboriginal patients' experiences were similar to those reported by non-Aboriginal patients and, in one urban district, Aboriginal patients responded more positively to three questions. When asked to reflect broadly on their experiences of hospital care, 78% of Aboriginal patients in this district reported that it was "very good", compared with 64% of non-Aboriginal patients.

Improving Aboriginal health is a national imperative. The BHI report shows that gaps in experiences and

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outcomes of care are not universal, and identifies areas where doctors can play a role individually and together with other staff to minimise disparities. As this is the first time that data on Aboriginal experiences have been provided to frontline clinicians and local managers, our capacity to assess whether such variation is the result of specific efforts to bridge gaps in experiences of care was limited. However, the

fact that they are not present everywhere suggests that they are not inevitable.

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