

## Hospital care for Aboriginals and Torres Strait Islanders: appropriateness and decision making

*Why is our most needy population receiving a different type of inpatient care?*

WE ARE WELL AWARE of the excess mortality of Australian Aboriginals and Torres Strait Islanders, their higher hospital admission rates and their longer duration of hospital stay.<sup>1,2</sup> However, despite this, relative to their need, Aboriginals and Torres Strait Islanders underutilise specialist healthcare, both as inpatients<sup>3</sup> and outside hospitals.<sup>4</sup> This situation is exacerbated by demonstrable underfunding of primary care services for Indigenous Australians.<sup>4</sup>

In this issue of the Journal, Cunningham (*page 58*)<sup>5</sup> reports an analysis of Australian hospital separation data which documents significantly fewer diagnostic and therapeutic procedures performed on patients identified as Indigenous. Cunningham took into account variables possibly affecting use of procedures, including diagnosis, age, sex and place of residence, and acknowledged the problem of incomplete identification of hospital patients as Indigenous. The adjusted data still show fewer recorded procedures in Indigenous compared with non-Indigenous inpatients. These differences are significant within certain disease and diagnostic groups, and of a magnitude which cannot be ignored. Cunningham's study is also consistent with a large body of research from other countries showing disparities according to ethnic group and gender in the use of procedures.<sup>6,7</sup>

Are the reasons for these disparities in use of procedures related to disease characteristics (including severity), the patient (including preferences and comorbidities), the clinician or the institutional setting? Are they appropriate? And what exactly do these findings indicate?

Ideally, decisions regarding medical care are based on evidence, or at least consensus opinion as reflected in a range of standard practices or options. Patient goals and values are then factored in, together with provider and institutional preferences and consideration of available resources. The end-result should be an individualised decision for each patient. Cunningham's findings suggest that, somewhere along this chain within hospitals, different decisions about use of procedures are being made that correlate with, but may not be caused by, ethnic origin.

It seems implausible that such significant and Australia-wide differences could implicate large numbers of individual clinicians and result from purely personal biases based on race. The disparities are more likely a result of subtler systemic practices, not ill-intentioned but still discriminatory, and almost invisible within an individual patient-provider encounter. The challenge for clinicians is to further dissect the available information and identify the true cause from the many possible contributory factors. For

example, it is likely that in some disease conditions where aetiology is well identified in a population and where the disease is endemic that fewer investigations (and therefore procedures) are needed. Renal biopsy may be performed less frequently to investigate renal disease in Indigenous patients, in whom identified antecedent chronic diseases are endemic. Iron-deficiency anaemia may be treated with anthelmintic drugs rather than first confirming the cause. Alternatively, there may be situations in which a population is genuinely underserved relative to need (eg, some forms of elective or semi-elective surgery).

Possible patient factors should also be identified and dealt with. These include stage of presentation, comorbidities, consent and anticipated postprocedural compliance. All may be reasons why a procedure is not performed, but all these factors can be ultimately overcome, in particular with greater recognition of the importance of primary care. The Royal Australasian College of Physicians has emphasised that adequate primary care is a prerequisite for effective specialist care.<sup>8</sup>

The uptake of services is more than "patient related" and cannot be separated from the provision of services; societal and institutional factors also structure the doctor-patient encounter within which decisions are made.<sup>9</sup> Compliance is likely to improve when a patient's understanding and ownership of his or her disease is matched by a commitment (in the broadest sense) to providing high quality communication and a range of treatment options. The national underdevelopment of key services — Aboriginal Health Workers, Liaison Officers, and particularly interpreter services — shows a lack of appreciation by health institutions of the importance of involvement of Indigenous patients in decision making.

Finally, could clinician factors be a major issue in this disparity in the use of procedures? Do we try hard enough and devote sufficient resources to the early diagnosis of serious conditions, to ensuring stabilisation of comorbidities, to obtaining meaningful consent, and to ensuring good postprocedural care and compliance? Do we have preconceived and incorrect perceptions of cultural appropriateness? Are the expectations we factor into our decision making, often derived from our knowledge of group outcomes, appropriate for this individual patient? It is certainly interesting that for trauma and infectious diseases, in which the decision-making process may be less subjective, Cunningham found no difference overall in the likelihood of having a procedure. However, even within these groups, large differences could be seen at an individual "principal diagnosis" level.

To improve and structure our medical decision making, we need to continue to develop standardised protocols based on best evidence. Subsequent careful recording of consent processes, together with documentation of the decisions reached and the reasons behind them, will shed further light on the issues raised by Cunningham's data. Cunningham's article shows why clinicians need to contribute to the interpretation of population health information. As presented, these data do not identify the specific clinical procedures possibly denied to Aboriginal and Torres Strait Islander inpatients, and, although the findings have flagged the disparity in procedures, more information is needed for clinicians to take these concerns to the next level of analysis.

Specifically, these findings should prompt us to review the decision-making processes determining use of diagnostic and therapeutic procedures in Aboriginal and Torres Strait Islander inpatients. Specialist colleges, societies, hospital units and individual clinicians now have a responsibility to review their own data and establish whether the trend in differential use of procedures applies to their area and, if so, what is driving this difference. The next chapter in this story needs to tease out the connections between healthcare need, use of procedures and health outcomes. If healthcare services are to foster equity rather than further institutionalise inequity, inappropriate reasons

for different use of procedures need to be identified and the problems rectified.

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## Measles transmission in healthcare settings in Australia

*Healthcare settings should not be the place to get measles*

IN A RECENT ISSUE OF THE JOURNAL, Blake and colleagues described a cluster of three cases of measles from western Sydney.<sup>1</sup> The index patient acquired measles overseas, while the other two patients acquired the infection during a hospital visit and probably in the waiting room of a general practice, respectively. Measles is highly contagious and can spread with relative ease in healthcare settings, especially if there is a failure to diagnose the infection, to isolate the infectious patient or to notify the case so that other infection control measures can be implemented.

Other recent Australian outbreaks of measles have also been associated with virus importation from overseas and subsequent nosocomial transmission.<sup>2-4</sup> Measles was imported in nine separate incidents investigated in Western Australia between March 1999 and October 2000, and subsequently transmitted among hospital patients, visitors and healthcare workers on two separate occasions.<sup>2</sup> Victoria has experienced two outbreaks in the past three years,<sup>3,4</sup> and a third is evolving (Dr Sean Tobin, Medical Officer, Communicable Diseases Section, Department of Human Services, Victoria, personal communication). In two of the three outbreaks, the index patient had returned from overseas during the incubation period, and genotyping

provided strong evidence that the viruses were imported. All three outbreaks involved predominantly young adults.

Healthcare staff aged in their 20s or early 30s accounted for six of the 75 cases in the 1999 Victorian outbreak (a doctor, three nurses, a social worker and a medical student<sup>3</sup>), and for two of the 51 cases in the first of the 2001 Victorian outbreaks (a medical student [the index case] and a nurse who remained unvaccinated despite being identified as susceptible in the previous outbreak<sup>5</sup>). In the latter outbreak, an unvaccinated 11-year-old child also became infected after attending an emergency department at the same time as an infectious patient. In the current outbreak, one case was in a 36-year-old hospital orderly, and another in a 30-year-old pharmacy assistant, both almost certainly infected while at work (Dr Sean Tobin, personal communication).

The hospital orderly, born in 1965, might have been expected to be immune to measles, having grown up when measles virus was circulating in the community and measles epidemics occurred every two years.<sup>6</sup> However, people born between about 1968 (when measles vaccine was first licensed in Australia) and 1981 (when a measles-mumps combination vaccine was introduced to the Australian