Section 15
Indigenous Peoples

As at 30 June 2001, the Aboriginal and Torres Strait Islander population of Australia was estimated to be 458 520, or 2.4% of the total population. Persons identifying as being of ‘Aboriginal origin’ comprised about 90% of this estimated resident Indigenous population; persons of ‘Torres Strait Islander origin’ comprised 6%, and those with both Aboriginal and Torres Strait Islander origin comprised 4%. More than half of all Indigenous Australians lived in New South Wales and Queensland, with the majority residing in urban areas. New South Wales had the greatest number of Indigenous Australians (135 000) and the Northern Territory had the highest proportion, with around 29% of its population reporting as being Indigenous. Around 25% of the Indigenous Australian population lived in areas classified as ‘remote’ or ‘very remote’, compared with only 2% of the non-Indigenous population.

Indigenous peoples in remote areas were more likely to be admitted to hospital (21%) or to visit accident and emergency (A&E) or outpatient departments (9%) than Indigenous peoples in non-remote areas (19% and 5% respectively). For a variety of reasons, some people may use hospitals rather than general practitioners for their primary health care.

The provision of culturally appropriate health services, and the employment of Indigenous staff in health services, may also affect access. Both the *National Aboriginal Health Strategy* and the *Royal Commission into Aboriginal Deaths in Custody* have referred to the need for Aboriginal Hospital Liaison Officers to ensure that Aboriginal and Torres Strait Islander people have equitable access to mainstream health care services. They also recommend an increase in the cultural awareness and sensitivity of health care services to the distinct health needs of Aboriginal patients and their families (Austin 1996).

Indigenous persons are disadvantaged in a variety of ways that could affect access to and use of services, such as distance, availability of transport (particularly in remote areas), access to Medicare and the PBS, the proximity of culturally appropriate services, private health insurance cover, previous negative experiences of hospitals, and insensitive or inappropriate attitudes of health professionals (The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples, 2003; Austin 1996). Indigenous people also have a high burden of chronic illness that starts early in life and continues through to adulthood. Based on the best available evidence, the *NSW Aboriginal Chronic Conditions Area Health Service Standards* recommend self-management, community-oriented and individual-centred approaches, emphasising primary health care and the integration and coordination of care.

Inaccurate coding of Aboriginality on admission to hospital, and the problem of incomplete identification of hospital patients as Indigenous have also been reported (Fisher & Weeramanthri, 2002).

Survey results

Just over two-thirds (67%) of hospitals answered that they collect and use Aboriginal and Torres Strait Islander Origin Data. When developing policies, strategies and service delivery plans, 40.4% consult with the local Aboriginal community on the impact these may have on the community. Culturally sensitive brochures and information for Aboriginal and Torres Strait Islander people are provided by 51.6% of hospitals, and Aboriginal cultural awareness training is provided for staff by 59.2% of hospitals.

Aboriginal Hospital Liaison Officer

An Aboriginal Hospital Liaison Officer (AHLO) position exists in 53.9% of hospitals, although not necessarily in the paediatric unit. The AHLO’s primary role is one of support (73.8%), followed by advocacy (63.1%) and counselling (48.5%). Other services provided by the AHLO include welfare, social work, transportation and arranging accommodation for families, as well as being involved in the admission process (45.6%), the treatment process (54.4%) and discharge planning (83.5%).

Accommodation

Hospitals responded in many ways to the question concerning accommodation provided for extended Aboriginal and Torres Strait Islander families. Commonly, responses indicated that accommodation provisions were the same as for other families (28.7%). In 16.4% of responses, no special provision was made for extended Aboriginal and Torres Strait Islander families. However, in 12.3% of responses, extended hospital accommodation facilities were provided. A large proportion of those surveyed did not respond to this question (41.5%).

Preparation programs

A small number of hospitals provide some kind of hospital familiarisation program for Aboriginal and Torres Strait Islander children (8.1%).

CASE STUDY

A supporting parent with a child who has Down Syndrome lived 300 kilometres away from hospital. The child required extensive treatment, operations and check ups at a major paediatric hospital. The trips to the hospital put the family out of pocket so much, that they were forced into severe debt, facing court appearances to have those debts recovered. Instead of paying the rent, gas, phone and chemist bills, money was allocated for the parent and child to travel to the hospital. Often the family was at hospital three to five weeks apart, sometimes for two days, but mostly up to five days at a time. As well as travel costs, the family had to pay for accommodation, food and other essentials.

When the child had surgery the physical, emotional and financial strain on the family was enormous. Often, they would need to go to the hospital the night before surgery as the child was required in hospital at 7am. The train trip took four hours plus the tram trip to the hospital. As there were no trains early enough on the day, this made travelling on the day of surgery impossible. This meant having to pay for accommodation and meals and then travel to the hospital the next morning by taxi.

Normally, the child would be released from hospital two days later in the evening, usually very miserable and tired. The family were unable to travel back home immediately because the child would be unwell and the public transport system didn't cater for the time of release. This meant finding private accommodation and once again paying more money for meals and travel.

The Isolated Persons Travel and Accommodation Scheme was unreliable, as the family was only ever reimbursed for the return train trip costs. The accommodation units and other guest houses at the hospital were difficult to access because they were always full. Since the new Aboriginal Hospital Liaison Officer (AHLO) has been employed many of the financial, emotional and physical burdens have been lifted. The AHLO made sure that visits to the hospital were made less stressful by organising a place for the family to stay, meeting them off the train and driving them to hospital. This was of great assistance as the child had great difficulty getting on and off trams and trains, was scared of stairs, steps, escalators and heights, often freezing on the spot. The AHLO would also ensure a cup of coffee and a feed, support the family before, during and after the child's surgery, take them to meet the train and phone a couple of days later to see how the family was.

The personal care the AHLO delivered was wonderful and if there were more people employed to offer this kind of support, the quality of care for patients and parents could be extended to everyone.

Let's Meet Half Way
A Project Researching Aboriginal Families
Accessing the Royal Children's Hospital

Section 15 Recommendations

- All hospital staff should receive appropriate education and training to enhance their cultural sensitivities in dealing with Indigenous peoples
- Appropriate information and resources should be available in accessible locations for both consumers and staff
- Hospitals should develop specific strategies and policies to establish, strengthen and/or maintain partnerships with local area Aboriginal services.

CASE STUDY

My daughter and I recently attended the hospital for an outpatient appointment. Arriving at the hospital, I took a deep breath and walked towards the enquiry desk to ask for directions to the clinic we were going to. As I got to the clinic with my daughter I was so overcome by an overwhelming sense of fear and uneasiness so much so that I turned around and left the hospital and caught the first train home.

On the way home I felt shame and began to realise what I had done. My fears had denied my daughter her outpatient appointment and the care she needed. Later that day, I received a call from the Aboriginal Health Liaison Officer who had been expecting to see me earlier and I was able to confide in her about what had happened and how I felt. Through working together, I have been able to confront this fear and have been able to keep my daughter's past two outpatient appointments, which I feel really good about.

I guess there are a number of things that could contribute to how I felt about hospitals. I've always known that I was taken out of my mother's arms by welfare from hospital as a baby. Also in the last few years I have seen family members and friends go into hospital, and through death, knowing I would never see them come out again.

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