



# Evolving ANZCA's strategy towards Indigenous health: background paper

## 1 Purpose of paper

The purpose of this paper is to provide background information to inform the evolution of ANZCA's Indigenous health initiatives and is structured as follows:

- An introduction to the concept of health equity.
- Inequitable health outcomes and experiences of care for Indigenous populations in Australia and New Zealand.
- The broader policy context of key commitments to Indigenous health made by governments and NGOs in both countries (including requirements of the medical councils).
- Workforce challenges such as increasing the numbers of Indigenous practitioners, support for Indigenous practitioners and the unique challenges they face as well as the cultural competence of the non-Indigenous medical workforce.
- What other medical education organisations are doing to redress Indigenous health inequities.
- Options for ANZCA to evolve its approach to redressing health inequities for Aboriginal and Torres Strait Islander peoples in Australia, and Māori in New Zealand.

## 2 Methods

In developing this paper, ANZCA's Policy unit reviewed government strategies for Indigenous health in both Australia and New Zealand, as well as the strategies of other medical colleges, medical schools and health organisations in both countries. The unit also reviewed literature on health inequity, experiences of care for Indigenous patients, and experiences of training and working in the health sector for Indigenous doctors.

Policy unit staff also met with or talked to external groups to seek information about initiatives other organisations are undertaking and what may be useful for ANZCA to consider. In New Zealand, policy staff met with colleagues from other medical colleges, the Health Quality and Safety Commission, and Te Ohu Rata o Aotearoa (Te ORA). In Australia, policy staff talked to the Australian Indigenous Doctors' Association (AIDA), the National Aboriginal Community Controlled Health Organisation (NACCHO) and the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA). Feedback was also sought from individuals, including Aboriginal, Torres Strait Islander and Māori ANZCA trainees, interns and residents; members of ANZCA's Indigenous health committee; and Indigenous medical students attending the AIDA Conference.

## 3 The concept of health equity

The World Health Organization defines equity as "the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically." *Health inequities* therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms<sup>1</sup>.

The United Nations Declaration on the Rights of Indigenous People also addresses health equity. Article 23 states that Indigenous peoples “have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them...” and Article 24 (2) states “Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health<sup>2</sup>. Both the Australian and New Zealand governments have committed to this declaration.

A number of factors are necessary for achieving good health, including peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity<sup>3</sup>. Access to health services is also necessary. Access itself is a broad concept but can be considered as the “opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs<sup>4</sup>.

Inequitable health outcomes for Aboriginal and Torres Strait Islander people in Australia, and Māori in New Zealand, indicate that Indigenous populations in both countries are currently unable to access appropriate services in proportion to their needs. A US model of health equity emphasises that equity must be recognised as a quality issue, and the Institute of Medicine supports this, stating that equity is relevant to all quality improvement initiatives in health<sup>5</sup>. ANZCA’s mission is to serve the community by fostering safety and high quality patient care in anaesthesia, perioperative medicine and pain medicine. In line with its mission, there is significant opportunity for ANZCA to contribute to improved health outcomes and quality of care for Indigenous populations in Australia and New Zealand.

**Figure 1: Equality versus Equity**



Image from: The Annie E. Casey Foundation. Race Equity and Inclusion Action guide. Baltimore: The Annie E. Casey Foundation, 2014. From: <http://www.aecf.org/resources/race-equity-and-inclusion-action-guide/>

**3.1 Health outcomes for Indigenous populations in Australia and New Zealand**

The health and wellbeing of Indigenous people in Australia and New Zealand is an urgent health priority due to significant disparities between the health and wellbeing of Indigenous and non-Indigenous people in both countries across a wide range of measures<sup>6</sup>.

**3.1.1 Australia**

In Australia, Aboriginal and Torres Strait Islander people have a significantly shorter life-expectancy than non-Indigenous Australians, with 54.9 years the median age at death for an Aboriginal and Torres Strait Islander male compared with 78.6 years for a non-Indigenous male<sup>7</sup>. Statistics on surgery, hospitalisation and waiting times also suggests

differences in access to care for Aboriginal and Torres Strait Islander people. Compared to non-Indigenous Australians, Aboriginal and Torres Strait Islander people have an admission rate for emergency surgery almost twice as high; lower rates of elective admissions; experience longer median waiting times for elective surgery (37 days versus 43 days respectively); and are hospitalised at more than twice the rate<sup>8</sup>.

### 3.1.2 New Zealand

In New Zealand, Māori experience significant inequity in health outcomes compared to non-Māori. Māori have a shorter life-expectancy at birth than non-Māori (73 years for Māori males and 77.1 years for Māori females, compared to 80.3 years for non-Māori males, and 83.9 years for non-Māori females), and experience poorer outcomes across a broad range of health status indicators. Compared to non-Māori, Māori have a cardiovascular disease mortality rate over twice as high; a cancer mortality rate over 1.5 times as high; a higher prevalence of diabetes with significantly higher rates of complications including renal failure (five times as high) and lower limb amputation (three times as high); and a mortality rate for chronic obstructive pulmonary disease almost three times as high. Māori also have a suicide rate almost twice that of non-Māori; experience poorer oral health; higher probability of having an anxiety or depressive disorder; higher rates of interpersonal violence; and higher mortality rates from unintentional injury<sup>9</sup>. Directly relevant to anaesthesia, Māori also have significantly poorer outcomes following surgery. The Perioperative Mortality Review Committee found Māori have a 16 per cent greater risk of dying after surgery than New Zealand Europeans, and this difference remains after adjusting for socio-demographic and clinical factors<sup>10</sup>.

## 3.2 Experience of health care for Indigenous populations in Australia and New Zealand

Evidence suggests that Indigenous people in Australia and New Zealand receive poorer care in mainstream health services than non-Indigenous populations. Research into the experience of care is available in the New Zealand setting. In general, Māori experience higher rates of discrimination than non-Māori<sup>11</sup>, and this discrimination is also evident in the health care sector. The 2011/12 New Zealand Health Survey found 4.2 per cent of Māori adults self-reported experience of unfair treatment by a health professional on the basis of ethnicity, compared to 1.3 per cent of non-Māori<sup>11</sup>

Mauri ora Associates has reviewed Māori experiences of health services, and found Māori experience a number of barriers to healthcare. These are:

- **Organisational barriers** included location of services and the distance to travel; availability of appointments at suitable times (e.g. to fit around shift work), inflexible systems, lack of choice of provider, and having had previous negative experiences with health systems.
- **Cost barriers** included direct consultation and prescription costs, as well as indirect costs of lost wages, childcare and transport costs, and questioning whether a primary care visit would be “value-for money”.
- **Health provider barriers** included experiencing disrespectful or racist attitudes towards Māori. This included communication issues such as being talked down to or treated like a child, not having condition or treatment options explained, being treated roughly, and not being listened to. Lack of understanding of Māori culture and values was another health provider barrier.
- **Cultural fit barriers** involved not accessing services due to shyness or being uncomfortable discussing private matters; a preference to wait and see if issues would resolve themselves without treatment (often related to concerns over cost and prior bad experiences in health services); and a preference to be treated by Māori clinicians or providers, which was usually unfulfilled. Māori participants felt doctors from similar

cultural backgrounds would provide better care and would better understand how to meet the needs of Māori patients<sup>12</sup>. Research has also examined whether discrepancies in care between Māori and non-Māori may be contributing to poorer outcomes for Māori with cancer<sup>13</sup>. Discrepancies in care were evident throughout the care pathway. For example, cancer screening programmes have lower coverage for Māori; and Māori have more unmet need in primary care. Māori were likely to have shorter consultation times in primary care, and were less likely to be referred for specialist review than non-Māori. After a diagnosis of breast cancer, Māori women waited longer to receive treatment than non-Māori women, and Māori were less likely to receive curative treatment for lung or colon cancer than non-Māori. These differences in care were not accounted for by differences in disease-factors or comorbidity, and persisted after adjustment for age, sex, tumour type and stage, co-morbidity and small area deprivation. The researchers concluded that the health system as a whole (organisation, location, funding, staffing) is delivering lower quality cancer care to Māori, as a result of “subtle but accumulating disadvantage” throughout the course of care.

Disadvantage is evident elsewhere in the health sector, with the Accident Compensation Corporation finding Māori have lower claim rates than non-Māori despite higher injury rates; and Pharmac stating that Māori are under-represented in accessing key pharmaceuticals; despite higher need<sup>14,15</sup>.

In Australia, Aboriginal and Torres Strait Islander people face similar barriers to care. This is supported by evidence of higher rates of “did not wait” in the Aboriginal population versus the non-Aboriginal population and higher rates of “discharge against advice” in the Aboriginal population versus non-Aboriginal population<sup>16</sup>. There is also a known reluctance of Aboriginal staff and patients to self-identify and evidence of racism in services<sup>17</sup>.

**Patient perspectives: Quotes from Mauri ora Associates research on Māori experience of health services:**

“[There are] very few Māori doctors, so the majority of Māoris go to a Pākehā doctor. Whether [the Pākehā doctors] do it deliberately or not, they don’t encourage [patients] to take the services that are available to them.” (Waikato)

“Māori doctors... seem as though they care about you and they actually are interested in you and what is wrong with you.” (Auckland Rangatahi)

“I went through that hospital system just like I was a box, or a letter with a stamp on having to go through as a letter being posted, you know? People talked about me, not to me. These very bright, intelligent, and capable people talked about me.” (Hawkes Bay hauā)

“They talk to us like we’re simple minded. We’re very intelligent people.” (Hawkes Bay hauā)

“I’ve had doctors that have treated me like a little child because of my disability, and that’s not always easy [to endure]. Once I had a Pākehā doctor who gave me an injection. She said, ‘This will be stingy, stingy, hurty, hurty.’ She treated me like a little baby.” (Auckland)

“Some talk down to you, people do talk down to you because they don’t understand that you might know more than they think you know. You get treated like a child, rather than an adult. You might behave like a child for that reason. It’s just very hard some of the time.” (Auckland)

## 4 Broader policy context

### 4.1 Government commitments to Indigenous health in Australia and New Zealand

#### 4.1.1 Australia

Closing the Gap is a formal commitment made by all Australian governments to achieve Aboriginal and Torres Strait Islander health equality by 2030. It was developed in response to the Social justice report 2005, which called for the governments of Australia to commit to achieving equality for Aboriginal and Torres Strait Islander people in the areas of health and life expectancy within 25 years. The government strategy aims to reduce disadvantage among Aboriginal and Torres Strait Islander people with respect to life expectancy, child mortality, access to early childhood education, educational achievement, and employment outcomes. The Council of Australian Governments (COAG) has set measurable targets to monitor progress that are reported on to parliament annually, including closing the gap in life expectancy within a generation, and halving the gap in mortality rates for Indigenous children under five within a decade, as well as education targets<sup>18</sup>.

The Department of Health in Australia also has a National Aboriginal and Torres Strait Islander Health Plan 2013-2023. The plan is an evidence-based policy framework for developing policies and programmes that will improve Aboriginal and Torres Strait Islander health. The plan's vision is that "The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable."

The following principles inform the approach of the health plan:

**Health equality and a human rights approach:** This principle references human rights under the United Nations Declaration of the Rights of Indigenous People, and acknowledges the need for personal, environmental, and social conditions that foster good health. It also recognises that Aboriginal and Torres Strait Islander people must be able to participate in decision-making in all levels of healthcare.

**Aboriginal and Torres Strait Islander Community Control and Engagement:** This principle emphasises the need to enable full, ongoing participation of Aboriginal and Torres Strait Islander individuals and communities in decision making, service planning, and design and implementation of policies supporting their health and wellbeing.

**Partnership:** This principle encapsulates the Australian Government's intention to partner with state and territory governments, and with Aboriginal and Torres Strait Islander people, to implement the Health Plan and ensure it meets the diverse needs of Aboriginal and Torres Strait Islander people.

**Accountability:** This principle refers to the Government being publicly accountable for monitoring and reporting on implementation of the Health Plan. It also encourages non-government organisations to align their planning for Indigenous health, with the Health Plan<sup>19</sup>.

This Health Plan has direct relevance to ANZCA. In May 2017 the Council of Presidents of Medical Colleges (CPMC), signed a partnership agreement with the Australian Government to commit to working with Aboriginal and Torres Strait Islander peak bodies and service providers to redress inequitable health outcomes and life expectancy

between Aboriginal and Torres Strait Islander people, and non-Aboriginal and Torres Strait Islander people in Australia. The CPMC’s agreement is an important measure for delivering the Government’s Health Plan. The CPMC Chair noted in a media release that CPMC members “will work together with our respective partners to develop measurable improvements at all three tiers of the Plan, each taking a lead in areas ranging from enhanced cultural awareness training for staff through to reducing any form of institutionalised racism”.

#### 4.1.2 New Zealand

##### **The Treaty of Waitangi (Te Tiriti o Waitangi) and its place in New Zealand**

A key difference between Australia and New Zealand is that New Zealand has a treaty between the Crown and Māori. The Treaty of Waitangi was signed on February 6, 1840, between representatives of the British Crown, and a number of Māori chiefs. It is New Zealand’s founding document, and allowed government to be established in New Zealand, and migration to New Zealand to continue. The purpose of the treaty was to protect the rights and property of Māori; secure peace and good order for Māori; and to establish civil government<sup>20</sup>.

The treaty is seen as a constitutional document, though only has status in New Zealand law where a statute or act refers to the treaty specifically. However, the treaty is fundamentally important in guiding the relationship between the Crown and Māori, and its intent and principles are a core consideration in government policy. Non-government organisations also have a responsibility to consider the treaty, and ANZCA’s New Zealand office contains a plaque stating ANZCA’s commitment to upholding the principles of the Treaty of Waitangi.

In health policy documents such as Māori health strategies from government agencies, commitment to the Treaty of Waitangi is framed by three key principles of the treaty. These are:

**Partnership:** Working together with iwi, hapu, whanau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.

**Participation:** Requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.

**Protection:** Working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

The three principles provide a useful framework for applying the Treaty of Waitangi in a health setting.

##### **Māori health strategies from government agencies**

Crown agencies have a responsibility to the Treaty of Waitangi, and health organisations that ANZCA works with have had Māori health strategies in place for a number of years, such as the Ministry of Health<sup>21</sup>, the Health Quality and Safety Commission<sup>22</sup>, Pharmac<sup>15</sup>, and the Accident Compensation Corporation<sup>14</sup>. The ministry’s strategy, He Korowai Oranga is the overarching national strategy and implementation is the responsibility of the whole health and disability sector, of which ANZCA is a part. He Korowai Oranga has the overall aim of Pae ora – healthy futures for Māori, where Māori can live with good health and wellbeing in an environment that supports a good quality of life. Pae ora is a holistic concept made up of three elements: Mauri ora (healthy individuals); whanau ora (healthy families) and wai ora (healthy environments). The

strategy emphasises the importance of family, ability to participate in Te Ao Māori (the Māori world) and in society, and addressing the social determinants of health.

The strategies from the Ministry of Health; the HQSC and Pharmac are all structured differently, but are based on the principles of partnership, participation and protection. For example, the ministry's He Korowai Oranga encapsulates partnership by supporting Māori communities to develop programs incorporating Māori models of health and to build services based on the needs of Māori families. The HQSC and Pharmac focus on partnership as developing strong links between their organisations and key Māori groups and individuals. For the HQSC, building partnerships involves ensuring their own staff are culturally competent and sensitive to the cultural aspects of interagency relationships, for example using key phrases in Te Reo Māori for phone and email greetings, and understanding appropriate meeting tikanga.

For participation, He Korowai Oranga refers to Māori participating in decision-making and service delivery, to make sure services are appropriate and effective for Māori. It also focuses on building the Māori health workforce, by increasing the number of Māori in the health workforce; expanding the skill base of Māori in the health workforce; and ensuring equitable access to training opportunities for Māori. The HQSC focuses on strengthening the link between its Māori advisory group and the HQSC Board to ensure a Māori perspective is provided on strategic issues, and supporting its Māori staff to strengthen their own cultural aspirations.

Protection is strongly embedded across all three strategies as a responsibility to protect Māori health by ensuring equitable health outcomes. He Korowai Oranga explains that the health system must demonstrate it is achieving as much for Māori as it is for non-Māori, and emphasises the importance of quality improvement, research, resourcing, and monitoring health outcomes. The HQSC includes protection by making a commitment to be an intelligent commentator on Māori health inequity, including advocating for action on disparities; ensuring quality collection of ethnicity data; and assessing how its planned work will impact Māori.

#### **4.2 What the Australian Medical Council and Medical Council of New Zealand expect of the colleges**

The AMC and MCNZ are both committed to Indigenous health, and have set a number of accreditation criteria for colleges, requiring colleges to ensure their members are able to operate with cultural competence and cultural safety (defined below). The accreditation standards are not confined to cultural competence and cultural safety in clinical practice, they also establish broader expectations of the colleges in making a commitment to Indigenous health. Many of these criteria were introduced by the AMC in 2015, so are reasonably new requirements that ANZCA must meet for accreditation. They include expectations that medical colleges will:

- Allow relevant internal and external groups to be represented in decision-making in the governance structure of the college, including Aboriginal and Torres Strait Islander peoples of Australia, and Māori in New Zealand.
- Have effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to support specialist training and education and recognise and address the unique challenges faced by this sector.
- Address Aboriginal and Torres Strait Islander peoples of Australia, and Māori of New Zealand and their health, in the *educational purpose* of the college. Colleges have a community responsibility to improving health outcomes for Māori, Aboriginal and Torres Strait Islander people, through improving the education of practitioners in Indigenous

health. The AMC and MCNZ expect that medical specialists will demonstrate cultural competence in their practice of medicine.

- Develop curriculums with a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia, and Māori health, history and cultures in New Zealand as relevant to the specialty.
- Support increased recruitment and selection of Aboriginal and Torres Strait Islander and Māori trainees, complemented by retention policies.
- Consider the needs of groups of trainees that may require additional support to complete training, such as Aboriginal and Torres Strait Islander and/or Māori trainees.
- Support training and education opportunities in settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and Māori in New Zealand, in criteria for accreditation of training sites.

The Australian Medical Council uses the following definitions of cultural competence and cultural safety:

### **Cultural competence**

Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Being culturally competent means the medical practitioner has the professional qualities, skills and knowledge needed to achieve this.

A culturally competent medical practitioner will acknowledge that:

- Australia and New Zealand both have culturally diverse populations.
- A medical practitioner's culture and belief systems influence his or her interactions with patients, and accepts this may impact on the doctor-patient relationship.
- A positive patient outcome is achieved when a medical practitioner and patient have mutual respect and understanding.

### **Cultural safety**

Cultural safety is "an outcome of health practice and education that enables safe service to be defined by those who receive the service". Strategies aim to create an environment that is "safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need", where there is "shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening" .



Similarly, the Medical Council has additional criteria specific to New Zealand that the college must meet for accreditation. It includes a requirement for the training program to demonstrate that the education provider has respect for cultural competence and identify formal components of the training program that contribute to the cultural competence of trainees. encourages developing cultural competence resources and assessment tools; establishing links with Māori organisations; having Māori representation in the governance structure; providing extra support for Māori; nominating cultural competence workshops and courses fellows and trainees could do; and embedding assessment of cultural competence into the training program.

## 5 Workforce challenges

It is well recognised in government policies across Australia and New Zealand, and in expectations of the colleges outlined by the AMC and MCNZ, that a key component of addressing inequities in Indigenous health is to develop a workforce better able to meet the needs of Indigenous populations. Medical workforces that are more representative of Indigenous communities are more likely to understand and be responsive to the needs of these communities, and to deliver culturally appropriate care. Workforce development involves increasing recruitment, retention and support of Indigenous health practitioners. It also involves ensuring that non-Indigenous health practitioners are equipped to practice in a culturally safe and responsive manner, to improve the ability of mainstream care to meet the needs of Indigenous people.

In both countries, Indigenous medical practitioners are currently under-represented. This section summarises the Aboriginal, Torres Strait Islander and Māori medical workforces, in terms of size, contribution to Indigenous health, and the types of challenges faced as medical practitioners. It also discusses cultural safety.

### 5.1 Aboriginal and Torres Strait Islander medical workforce

In Australia, opportunities for Aboriginal and Torres Strait islander people to pursue careers in health are increasing. However, Indigenous health practitioners are still under-represented in the workforce<sup>23</sup>. For example, approximately 2.5 per cent of the Australian population identifies as Aboriginal and Torres Strait Islander<sup>24</sup> yet in 2011 Aboriginal and Torres Strait Islanders represented only 0.2 per cent of medical practitioners; 0.8 per cent of registered nurses; and 0.2 per cent of dental practitioners<sup>25</sup>. In relation to ANZCA membership, Aboriginal and Torres Strait Islanders represented only 0.08 per cent of fellows and 0.33 per cent of trainees. There are a number of barriers to entering the health workforce, including financial hardship, reduced access to secondary and tertiary education, lack of access to information about higher education, and policies that focus on enrolment rather than graduation quotas<sup>26</sup>.

Doctors who are Aboriginal or Torres Strait Islander often face extra challenges in the workplace, such as discrimination. A recent AIDA member survey found that of the Aboriginal and Torres Strait Islander respondents more than 48 per cent had experienced either a few incidents per month, or daily incidents of bullying, racism and lateral violence in their workplaces. Only 43 per cent of those who experienced these incidents reported them. The survey also found that about half of Aboriginal and Torres Strait Islander respondents reported that colleagues had a negative reaction to their cultural identity, with misconceptions about perceived privileges and easier pathways into and through medicine for Indigenous Australians being the most commonly cited reaction, indicating a large gap in cultural education and understanding<sup>27</sup>.

Aboriginal and Torres Strait Islander medical practitioners may also face greater personal, social and cultural pressures than most of their peers, which can impact on day-to-day work and training requirements when needing to balance the often competing pressures

surrounding cultural obligations and obligations to employers and work colleagues. Aboriginal and Torres Strait Islander health practitioners may also suffer the impact of vicarious trauma more than non-Indigenous health workers, because as Aboriginal community members as well as workers, they may be more deeply affected by trauma affecting the Aboriginal community and at times can be dealing with situations affecting people they know, including family members and friends.

## 5.2 The Māori medical workforce

Māori are under-represented in the medical workforce, with Medical Council data from 2014 showing 3.2 per cent of New Zealand medical practitioners identified as Māori, compared to 14.9 per cent of the general population. Numbers of Māori medical students are increasing however, as a result of initiatives from New Zealand's medical schools. In 2016, Otago University had 45 Māori medical graduates – matching the proportion of Māori in the general population for the first time.

Māori medical practitioners make a significant contribution to Māori health. Barnett surveyed Māori medical practitioners who had graduated from the University of Otago, to establish the nature and level of contribution Māori medical practitioners make to Māori health. Of the 70 Māori medical practitioners who responded, at least half either worked in areas with a high Māori population, or directly for Māori health providers. Senior Māori doctors often took on multiple roles, with 50 per cent having 4.5 roles on average, and 25 per cent having eight roles on average in Māori health. Roles included teaching in Māori health; mentoring Māori practitioners; Māori health promotion; governance; committee work; and advisory to government<sup>28</sup>.

Barnett also looked at the expectations placed on Māori doctors by themselves and others, and found that there were high expectations to have knowledge, expertise and experience in Māori health. These expectations were considered to be greater on Māori doctors than non-Māori doctors, and one-third of respondents reported it was difficult to balance day-to-day work with expectations as a Māori doctor. Some respondents reported having challenges as they were still learning about Māori health and culture themselves, and had not necessarily had the opportunity to do this previously. Other challenges included often being the only Māori medical practitioner in a setting, fighting to get Māori health on the agenda.

The majority of Māori medical practitioners surveyed agreed that colleges and training programs should take into account the particular training needs and support required by Māori doctors. In terms of skills required by Māori doctors, a high degree of importance was placed on ability to communicate in Te Reo Māori, a good understanding of tikanga, high levels of knowledge, skills and experience in Māori health, and high levels of clinical competence, as well as advocacy and leadership skills. This reflects that Māori doctors may have additional training and support needs.

## 5.3 Te ORA and AIDA

Australia and New Zealand both have Indigenous medical practitioner associations that support Indigenous medical students and doctors. The Australian Indigenous Doctors' Association (AIDA) promotes medical careers for Aboriginal and Torres Strait Islander people; and provides support and mentoring to medical students; junior doctors; trainees and consultants. In New Zealand Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA), represents Māori medical students and doctors working as clinicians, researchers and teachers. Both organisations host conferences that ANZCA sponsors and engages with.

#### 5.4 Cultural awareness and competency in Indigenous health

As described above, developing cultural awareness and competency in non-Indigenous medical practitioners is a key part of developing a workforce better able to meet the needs of Indigenous communities, and is a requirement from the AMC and MCNZ. Racism can have a negative impact on the overall health, wellbeing and employment of Indigenous people and significantly hinders access to healthcare<sup>29</sup>. In Australia, the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 explicitly aims for all healthcare to be free of racism, and to deliver clinically appropriate care that is culturally safe, high quality, responsive and accessible for all Aboriginal and Torres Strait Islander people. Culturally responsive care is an extension of patient centred-care focussing on social and cultural factors<sup>30</sup>. It involves obtaining a knowledge base, personal and professional self-awareness, and open discussion about cultural diversity<sup>31</sup>.

ANZCA already recognises the importance of cultural competence, and has this embedded within its curriculum. However, cultural safety is a concept that moves beyond cultural competence, and involves self-reflection and an understanding of one's culture, an acknowledgment of difference, and a requirement that caregivers are actively mindful and respectful of difference(s). It is informed by the theory of power relations and includes an appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on Indigenous people's wellbeing, both in the present and past<sup>31</sup>. According to Papps & Ramsden (1996) cultural safety is not defined by the health or human services professional, but is defined by the health consumer's experience – the individual's experience of care they are given, ability to access services, and to raise concerns<sup>32</sup>.

“A culturally safe environment does not ignore, challenge or deny cultural identity. Because a culturally safe environment is about shared respect, knowledge and understandings, it empowers people, enabling them to contribute and feel safe to be themselves.”

“Cultural safety is an outcome based on respectful engagement that recognises and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.”

## 6 What do other educational institutions do to support Indigenous health?

### 6.1 Medical Deans of Australia and New Zealand

#### Indigenous health curriculum

Indigenous health needs to be embedded in curriculum frameworks<sup>33</sup> to ensure Indigenous people have access to high-quality, culturally responsive care. In 2004, the Medical Deans of Australia and New Zealand (MDANZ) released the Indigenous Health Curriculum Framework to provide medical schools with a set of guidelines to develop their Indigenous health curriculum<sup>34</sup>. This framework highlighted the diversity of Indigenous communities and the importance of a holistic approach when working with Indigenous people. There are eight areas of learning in Indigenous health that have been set out by MDANZ including history; culture, self and diversity; population health; and communication skills<sup>34</sup>. In 2012 AIDA, in partnership with MDANZ, released a National Medical Education Review (NMER) which assessed how Aboriginal and Torres Strait Islander health was being incorporated as part of the curriculum in Australian medical schools. The NMER found that Australian medical schools had generally increased the amount of Indigenous health content since 2004;

however, there is a great deal of variation between the different medical schools<sup>35</sup>. The recommendations which emerged from the NMER included:

- The development of an Indigenous Health Unit within each medical school.
- Increased Indigenous staff numbers.
- Better relationships with local Indigenous communities and organisations.
- Improved development and implementation of Indigenous health curriculum.
- Relevant cultural awareness programs.
- Greater access to immersion experiences for students<sup>34</sup>.

The former Health Workforce Australia (HWA) had funded Curtin University to develop a culturally inclusive, interdisciplinary, Aboriginal and Torres Strait Islander Curriculum Framework for tertiary health professional training and considerable work on this was completed prior to the abolition of HWA in 2014<sup>36</sup>.

### **LIME Network**

MDANZ also has a program called the Leaders in Indigenous Medical Education (LIME) Network. It is funded by the Australian Department of Health, and supports collaboration between medical schools in Australia and New Zealand to support quality Indigenous health content in medical education.

## **6.2 Medical schools**

### **6.2.1 Australia**

The majority of medical schools in Australia offer an Indigenous entry pathway into medicine. These pathways differ between universities and include allocating a percentage of places to Indigenous applicants, entry without having to sit the UMAT and Dean's Indigenous List.

Universities in Australia offering medicine provide assistance to Indigenous students through education, engagement and support centres. The centres provide components such as a meeting place for students, tutoring, mentoring, advice on scholarships, financial support, orientation programs and general advice<sup>37</sup>.

### **6.2.2 New Zealand**

Both Otago and Auckland medical schools have programs to reach out to Māori at secondary school level and encourage health as a career, involving components such as scholarships; introductory programs and university visits; advice on academic pathways; and networking with Māori tertiary students in health subjects. Otago provides scholarships for Māori into its Foundation Year health science program, including support with fees and accommodation, academic support, pastoral care in the form of personal and social support, mentoring, and establishing networks with other Māori students. Otago also has a Māori strategic framework that outlines its commitment to achieving equitable Māori participation and success rates in tertiary education.

Auckland's Faculty of Medical and Health Sciences has Vision 20:20, a commitment to increasing the number of Māori and Pacific health practitioners to 10 per cent of the workforce by 2020. It has a Māori and Pacific Admission scheme providing admission, academic and pastoral support for Māori students. This involves extra tutorials and workshops, study space, pastoral support around accommodation, financial, personal, family or work issues, cultural development through workshops, and peer support. Auckland also has Te Kupenga Hauora Māori, a unit that coordinates teaching in Māori health. This involves learning outcomes such as understanding health inequities between Māori and non-Māori, social determinants that contribute to these, the role

health professionals can play in Māori health, and skills to enable health professionals to monitor personal and institutional contributions to Māori health outcomes.

### 6.3 Medical colleges

#### 6.3.1 Australia

In Australia RACS and ACEM have developed reconciliation action plans (RAP). A RAP is a business plan that documents what an organisation commits to do to contribute to reconciliation in Australia. RAPs provide a framework for organisations to commit to implementing and measuring practical actions that build respectful relationships and create opportunities for Aboriginal and Torres Strait Islander peoples. Both RACS and ACEM action plans are set out under the headings of relationships, respect, opportunities and tracking progress and reporting. Although RACS and ACEM are the only specialist college that have a current RAP, others colleges have in place a number of actions that fall under the principles of relationships, respect and opportunities.

**Relationships** is addressed through the building of relationships with Aboriginal and Torres Strait Islander peoples, communities and organisations and the promotion of reconciliation across college members. Colleges are currently doing this at various levels, from establishing and maintaining relationships with medical organisations such as AIDA and LIME to appointing an elder in residence.

**Respect** is addressed by the majority of specialist colleges through initiatives to enhance cultural competency amongst their workforce. Although not specific to Indigenous populations, colleges have developed cultural competency policies and position statements that in broad terms address how their members can understand and best manage the health needs of diverse communities within Australia's multicultural society. Further to this, most specialist colleges have online cultural competency eLearning modules or cultural competency/awareness courses.

**Opportunities** is addressed by workforce development. Colleges are undertaking initiatives to promote recruitment and retention of Aboriginal and Torres Strait Islander trainees including promoting their specialties at the annual AIDA conference; providing scholarships for junior doctors to attend ASMs; establishing support networks and mentoring programs for trainees to assist with the additional demands; and establishing scholarships to help with fees for exams, training, conferences and professional development.

#### 6.3.2 New Zealand

A number of medical colleges in New Zealand, including trans-Tasman colleges such as RACS and RACP, have specific strategies and action plans for Māori health, often based on the principles of partnership, participation and protection. RACS addresses partnership by establishing a meaningful relationship with Te ORA, including Te ORA representation on its Indigenous health committee; financial support for Te ORA activities such as its annual hui; and participation in Te ORA activities. Similar to the HQSC, RACS is also ensuring Te Ao Māori (the Māori world) is visible in the college, including developing a Māori name for the college and New Zealand Board; ensuring staff and fellows understand meeting tikanga; and implementing cultural competence training for staff. The RNZCGP addressed partnership by establishing Te Akoranga a Maui; a Māori representative group with over 150 members that the RNZCGP partners with to ensure Māori are involved in decision-making, and are represented across governance, advisory, and operational levels of the college.

Participation is addressed by various colleges by ensuring Māori are represented in the governance and organisational structures of colleges. RACP, RANZCP and RANZCOG

all have Māori health committees within their college structure to provide policy advice, promote Māori health, coordinate college relationships with Māori groups, support Māori registrars, and promote Māori views to their boards. RANZCOG has two kaumatua (Māori elders, from outside the college) on its New Zealand National Committee. RACS is also promoting wider Māori representation on its training boards, and ensuring Māori views are represented on its New Zealand National Board. Several colleges have employed dedicated Māori staff such as Māori policy advisers or project managers, to implement Māori health initiatives across the college.

Participation is also addressed by workforce development. Colleges in New Zealand are undertaking initiatives to promote recruitment and retention of Māori trainees including promoting their specialties at the annual Te ORA hui; providing scholarships for junior doctors to attend ASMs; establishing support networks and mentoring programs for trainees to assist with the additional demands; and establishing scholarships to help with fees for exams, training, conferences and professional development. RACS is also looking at barriers to entering the training program for Māori; and has committed to collecting and reporting ethnicity data for trainees and fellows. The RNZCGP has a specific strategic goal of increasing the number of Māori GPs by 50 per cent by 2021. It also aims to increase the number of Māori GP teachers, medical educators, and examiners within the college by 50 per cent. RACS and NZCPHM specifically aim to support Māori fellows with the additional demands placed on them, and to play a full role in college activities.

Protection of Māori health is addressed by activities including advocacy, research, and ensuring trainees and fellows are culturally competent. Several colleges have strong advocacy platforms promoting equitable health outcomes for Māori, with initiatives including policy statements for Māori health equity; advocating to government; and expecting Fellows to take leadership in Māori health advocacy. RACS and the RNZCGP have also published a Māori Action Plan and a Māori strategy respectively, and the RACP intends to publish an Indigenous strategy with specific reference to Māori health initiatives later this year. Many colleges also support research into achieving equitable health outcomes for Māori, including initiatives such as providing funding for research on Māori health equity; encouraging fellows and trainees to research Māori health issues; establishing prizes in Māori health research; and developing research-based relationships with iwi (Māori communities or tribes). RACS also expects its fellows to include ethnicity in their audit data, and to use peer reviewed audit of Māori health outcomes to inform their future practice. Colleges are promoting cultural competence in a number of ways, including developing tools and e-resources in Māori health; identifying appropriate external courses on Māori health, the Treaty of Waitangi and cultural safety; and embedding Māori health in curriculums with components such as equity analysis, advocacy, health promotion and managing high quality health data. RACS will also set the expectation that Māori health will be a topic of its Annual Scientific Conference and all New Zealand conferences; and will also require its training boards to formally assess trainees' cultural competence throughout training.

## **7 Stakeholder feedback**

Policy unit staff sought feedback from a number of health organisations (other medical colleges, HQSC, and Te ORA in New Zealand; and AIDA and NATSIHWA in Australia), and had feedback from Aboriginal, Torres Strait Islander and Māori ANZCA trainees, interens and residents; members of ANZCA's Indigenous Health Committee; and Indigenous medical students attending the AIDA conference.

A number of themes emerged, as follows:

**Recruitment:**

- Alternative pathways; scholarships to help with training and examination fees; and having identified training positions for Indigenous doctors were identified as ways colleges can attract and recruit Indigenous doctors.
- Highlighting Indigenous role models in anaesthesia was considered important, as a way to demonstrate anaesthesia is a specialty Indigenous doctors can engage in.
- Face-to-face communication was considered likely to have the most impact; including initiatives such as anaesthetists attending Indigenous conferences (e.g. Te ORA and AIDA) to promote the specialty, talk to medical students, and put forward abstracts.
- Networks were recommended, for example facilitating ways for Indigenous medical students interested in anaesthesia to meet with Indigenous ANZCA trainees and fellows, for example through partnerships with Indigenous medical student groups.
- Demonstrating support for Aboriginal, Torres Strait Islander and Māori world views by using correct pronunciation and language, acknowledging local tribes, openly acknowledging health inequities, and being familiar with appropriate customs would demonstrate the college's commitment to Indigenous health, and make the college a more attractive place for Indigenous doctors.

**Retention:**

- Mentoring and support groups to assist with issues such as scholarships, welfare, training issues, dealing with institutional racism, and staying engaged in Indigenous health were considered likely to be helpful.
- Many Indigenous trainees may have had limited opportunity to engage with their culture previously, so offering support to attend conferences or participate in groups that connect them with their culture was seen as important (for example, Te ORA). Similarly, supporting Indigenous trainees to engage in their communities was important, such as allowing Māori trainees leave to attend Tangi (Māori funeral rites).
- Supporting trainees to go to Indigenous health conferences, and approving courses in Indigenous health and cultural competence that could contribute to scholar role requirements were suggested as helpful.
- The college should help hospital departments understand participation in Indigenous health groups (such as journal clubs) is important for Indigenous trainees, even if the content is not always anaesthesia specific.

**Cultural safety:**

- Racism was identified as an issue affecting trainees, doctors, other staff and Indigenous patients in hospitals. Trainees identified that the racism seen or experienced was not explicit or overt, but implicit and unconscious. Cultural safety training was identified as being particularly important for Supervisors of Training, as they are often the support person a trainee would approach if experiencing racism, and also need to be comfortable discussing Indigenous teaching and learning cases in the curriculum.
- It was recommended cultural safety training should be mandatory for ANZCA staff, trainees and fellows, and that it should address racism and be embedded in the curriculum.
- It was recommended that cultural safety and cultural competence should be assessed as part of training, as trainees will prioritise examinable material.
- It was considered that more cultural safety education and resources would be useful, with specific reference to Aboriginal, Torres Strait Islander, and Māori health. This should include information on existing inequities and their causes (for example, impact of colonisation).

**Advocacy:**

- It was felt important that ANZCA should have a prominent position statement recognising the traditional owners of the land; that inequity exists; that ANZCA does not tolerate racism; and that ANZCA is committed to increasing the Indigenous medical workforce.

- It was recommended ANZCA should facilitate and support research in Indigenous health.
- A Reconciliation Action Plan was identified as a good framework for advocacy in Australia.

## **8 Taking action: next steps for ANZCA**

ANZCA's Indigenous Health Committee already supports several important initiatives, such as engaging with AIDA and Te ORA; developing Indigenous health learning resources; implementing collection of ethnicity data for fellows and trainees; and awarding scholarships for Indigenous medical students and junior doctors to attend ANZCA's ASM.

This review of how other organisations are taking steps to address health inequities demonstrates there is a broad range of options that ANZCA could consider implementing across its organisational structure, that would align with government and community expectations and evolve ANZCA's approach to Indigenous health.

A number of common themes emerged from reviewing the policy context and action plans of organisations in both countries. These included:

- The importance of enabling Indigenous representation within governance structures and in high-level decision making.
- Developing meaningful partnerships with Indigenous groups.
- Supporting increased recruitment and retention of Indigenous doctors.
- Strengthening doctors' abilities to practice with cultural competence and cultural safety.
- Acknowledging the challenges Indigenous trainees and doctors may face and providing support such as mentoring, networks, pastoral care, and support with cultural development.
- Advocating for Indigenous health equity through action plans and policy statements.
- Encouraging research into redressing health inequities.

Based on these themes, a strategy has been developed, underpinned by the principles of partnership; participation; equity and accountability. The strategy acknowledges health inequity is a safety and quality issue, and is supported by four key pillars of governance, partnership; workforce and advocacy.



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