STATEMENT ON THE HEALTH OF THE INDIGENOUS PEOPLES OF AUSTRALIA AND NEW ZEALAND

1. PURPOSE

This document is a statement of the Australasian College for Emergency Medicine (ACEM), and outlines the College's commitment to address the gross inequities in health outcomes for Aboriginal and Torres Strait Islander peoples in Australia, and Māori in Aotearoa/New Zealand.

2. SCOPE

This statement recognises the need for adequate resources and training to improve the cultural safety and health care of First Nations peoples, and provides a framework to address this need.

This statement is applicable to all EDs in Australia and Aotearoa/New Zealand.

3. RELATED DOCUMENTS

- (S63) Statement on Culturally Competent Care and Cultural Safety In Emergency Medicine.

4. BACKGROUND

ACEM recognises that improving the health of First Nations peoples is a priority for both Australia and Aotearoa/New Zealand. As the peak professional organisation for emergency medicine in Australasia, ACEM also has a vital interest in improving the quality and safety of health care of Aboriginal and Torres Strait Islander peoples and Māori.

5. ACEM POSITION

5.1 Acknowledgements

ACEM recognises:

a) The Wurundjeri people as the Traditional Owners of the land upon which the ACEM office in Melbourne resides

b) Aboriginal and Torres Strait Islanders as the traditional owners of the original nations now known as Australia.

c) Māori as the tangata whenua (original people of the land) of Aotearoa/New Zealand. As such, ACEM is committed to acting in accordance with the principles of Te Tiriti o Waitangi (The Treaty of Waitangi).

5.2 Statement of Aboriginal and Torres Strait Islander and Māori Health Status

Aboriginal, Torres Strait Islander peoples and Māori have a broad range of poor health outcomes as demonstrated in a number of population health measures. In particular, there is an unacceptable disparity in life expectancy between Indigenous and non-Indigenous people[1, 2]. Furthermore, there is an over-representation of a number of illnesses such as ischaemic heart disease, diabetes mellitus, chronic kidney disease, pulmonary diseases, communicable disease, and alarming rates of injury, substance dependence, self-harm and suicide[1]. Indigenous people of both countries are also more likely to be affected by poverty, overcrowded housing, low educational attainment, unemployment and poor access to health care and community services. These are well recognised determinants of health.[3]

ACEM acknowledges the ongoing health disparities for Aboriginal, Torres Strait Islander people and Māori are inseparably linked to economic and social disadvantage stemming from the historical impact of colonisation, and subsequent intergenerational trauma. In Australia this has partially been the result of assimilation practices and the delayed recognition of First Nations peoples as citizens of their own country. In Aotearoa/New Zealand many issues stem from different interpretations of the Treaty of Waitangi, as well as subsequent dishonouring of the Treaty, particularly relating to the loss of land, cultural traditions, language and the right to self-determination.

5.3 Statement of Aboriginal and Torres Strait Islander and Māori Healthcare in Relation to Emergency Medicine

Emergency departments are uniquely positioned as a first-point-of-call access point to healthcare, and play a vital role in providing targeted quality acute medical care. In addition, EDs provide opportunities to identify comorbidities that may need addressing, and to provide coordination of care between the inpatient and community systems.

The current burden of disease for Aboriginal, Torres Strait Islander people and Māori is substantial. The immediate need to manage chronic and acute illnesses will mean that hospitals and their EDs, as the front door to this healthcare system, will be a significant care provider into the foreseeable future. Diseases of the circulatory system and injury due to external causes (predominantly accidents, self-harm and assault) are not only leading causes of mortality for Indigenous peoples but result in a significant number of presentations to the ED, which are resource intensive, time costly and often present emergently. Therefore, it is important that cultural safety is afforded to all Indigenous patients and their families seeking care and treatment in the busy and often resource stretched ED.

In the context of emergency medicine, access and equity, and appropriate discharge and follow-up systems are important components of high quality patient care. To achieve this for Indigenous patients, it is essential to engage in partnerships with local communities and Aboriginal or Māori Health Services to ensure that the care provided is culturally appropriate and effective. Furthermore EDs, as a key contact point to the mainstream healthcare/hospital system for Indigenous patients, can provide a potential linkage point for health promotion activities; comprehensive primary health care; allied health and specialist services; mental health, drug and alcohol services; and care for the frail and aged.

6. RECOMMENDATIONS

ACEM is committed to:

6.1 Measures to address Aboriginal and Torres Strait Islander and Māori health disparities

Strategies to address health disparities are multi-faceted.

Foremost, the Committee of Presidents of Medical Colleges (CPMC) and the Australian Indigenous Doctors' Association (AIDA) Collaboration Agreement[4], outline increasing the Aboriginal and Torres Strait Islander and Māori Medical Workforce, especially within specialty fields, is pivotal to closing the gap. ACEM will work to expand the workforce accordingly within the field of Emergency Medicine.

This includes identifying and addressing barriers to recruitment, training and retention for Aboriginal, Torres Strait Islander peoples and Māori. This will be achieved through close professional collaborations with significant medical organisations already undertaking this work, such as AIDA, Te Ohu Rata o Aotearoa/Māori Medical Practitioners

Association (Te ORA), the CPMC Indigenous Health Subcommittee, and the Māori Ora Associates for the Medical Council of New Zealand[5]. We acknowledge significant steps already undertaken in New Zealand to achieve key partnered stakeholder governance on health issues concerning Māori people. The New Zealand Public Health and Disability Act 2000 increases Māori empowerment by mandating Māori representation (at least two members) within each District Health Board offering direct, regional Māori governance input[6].

A unified approach to achieve this needed workforce influx has been exacted through a number of proposed measures. These include:

a) Incorporating and providing combined stewardship of all nineteen recommendations of the CPMC National Aboriginal and Torres Strait Islander Medical Specialist Framework Project[7]. ACEM considers the recommendations relating to medical specialist training in Australia to be particularly important, including:

   i. identifying the status of Indigenous trainees and fellows, to provide information regarding access to various specialist programs,

   ii. the provision of cross-cultural training in Indigenous issues and cultural competency training in Indigenous Health to specialist staff, fellows and trainees,

   iii. the development of cultural competence curricula and online learning modules, and

   iv. performing a cyclical quality performance review.

b) Providing culturally appropriate education and training on Aboriginal and Torres Strait Islander and Māori health in accredited vocational training, non-specialist training pathways and Continuing Professional Development programs. This includes improving the skills, knowledge and cultural competency of physicians as a mechanism for improving patient outcomes. This statement is supported by the ACEM Statement on Culturally Competent Care and Cultural Safety in Emergency Medicine (S63).

c) Making EDs throughout Australia and New Zealand more accessible to Aboriginal, Torres Strait Islander peoples and Māori through the maintenance of standards relating to cultural awareness, advocacy and provision of cultural safety. This includes:

   i. Cultural competence as a key component of clinical practice to ensure improved care for First Nations peoples.

   ii. Acknowledging that the health and well-being of an individual Aboriginal or Torres Strait Islander person is only possible in the broader context of the family and community, and this often involves complex relationships and responsibilities

   iii. Acknowledging the importance of whānau (extended family or group of related families) for Māori health and wellbeing

   iv. Recruitment and support of Indigenous nursing and allied health staff such as Aboriginal Liaison Officers, Māori Health Care Providers, and interpreters.

   v. Ergonomic design of the building to embrace cultural values and artistry of First Nations peoples relevant to local communities

   vi. (In Australia) respect of Women's and Men's business through the designation of separate areas.

   vii. Collaborating with Aboriginal or Torres Strait Islander community leaders and Māori advisory boards to address disparities in health and improve Indigenous patient care

d) Promoting cultural safety of EDs, through the:

viii. Provision of health education materials in Indigenous languages, including audio

ix. Availability of interpreter services, professional support for Indigenous staff and their clear identification to patients

x. Clear visibility of posters with images relevant to (local) Indigenous people making transparent the presence of formal partnership with Indigenous community organisations.

xi. Promoting stronger linkages with all primary health care providers that care for Indigenous people. In Australia, this is in particular reference to the Aboriginal Medical Service, Aboriginal Community Controlled Health Organisation (ACCHO) and Aboriginal health workers. In Aotearoa/New Zealand the work of Māori Health Care Providers is also acknowledged.

6.2 The Role of Advocacy

ACEM is committed to promoting Aboriginal and Torres Strait Islander and Māori health. ACEM acknowledges there are a number influences that can adversely impact the health of Indigenous people. These include racism, poverty, overcrowded housing and limited access to health and community services, education and employment. ACEM is committed to advocating for strategies which will address these issues.

ACEM supports culturally appropriate strategies seeking to address other more direct causes of poor health such as smoking, diet, exercise, mental and sexual health and health literacy. ACEM also acknowledges the impacts of colonisation and assimilation, and is committed to supporting efforts which seek to assert self-determination.

ACEM supports its members advocating for individual patients on issues such as access to adequate health care and services.

7. REFERENCES

1. Australian Institute of Health and Welfare 2013. Aboriginal and Torres Strait Islander Health Performance Framework 2012: detailed analyses. Cat. no. IHW 94. Canberra: AIHW.

2. Statistics New Zealand 2013. New Zealand Period of Life Tables: 2010-12, accessed 31 July 2013, http://www.stats.govt.nz/browse_for_stats/health/life_expectancy/NZLifeTables_HOTP10-12.aspx

3. Social Determinants of Health Alliance (SDOHA). What are the social determinants of health? http://socialdeterminants.org.au/

4. Australian Indigenous Doctor's Association and Committee of Presidents of Medical Colleges Colloboration Agreement 2013-2015 (2013)

5. Medical Council of New Zealand 2008 Best health outcomes for Māori: Practice implications http://www.mcnz.org.nz/assets/News-and-Publications/Statements/best-health-Māoricomplete.pdf

6. New Zealand Public Health and Disability Act 2000. Accessed 18th September 2013, http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80051.html

7. VicHealth Koori Health Unit, Centre for Health and Society Melbourne School of Population Health 2011. National Aboriginal and Torres Strait Islander Medical Specialist Framework for Action and Report. Accessed 31 July 2013, http://www.limenetwork.net.au/files/lime/Ewen%202010%20CPMC.pdf

8. DOCUMENT REVIEW

Timeframe for review: every two (2) years, or earlier if required.

8.1 Responsibilities

Document authorisation: Council for Advocacy, Practice and Partnership
Document implementation: Indigenous Health Subcommittee
Document maintenance: ACEM Policy Unit

8.2 Revision History

Version	Date of Version	Pages revised / Brief Explanation of Revision
V01	2007	Approved by Council
V02	2014	Additional content added in consultation with relevant committees
V03	2017	Proofed for readability