

## Policy Document

# Aboriginal and Torres Strait Islander Health

### Position Statement

AMSA believes that:

1. The health of Aboriginal and Torres Strait Islander people is impacted by underlying social determinants such as historic and ongoing systemic racism, income, education, employment and housing, as well as the Country<sup>1</sup>, languages and cultural identity to which they are connected. The importance of these connections must be recognised by all stakeholders for meaningful improvement of health outcomes;
2. Action towards improving Aboriginal and Torres Strait Islander health should aim to empower Aboriginal and Torres Strait Islander communities to support their own needs by improving access to health services, facilitating continued connection to and expression of culture, and increasing employment, housing, transport services and educational opportunities;
3. Strong representation of Aboriginal and Torres Strait Islander people within health professions is essential to improving health outcomes. Support mechanisms should be established for Aboriginal and Torres Strait Islander people in all medical schools, hospitals and specialist training programs, should they require additional support to ensure retention and representation;
4. Reducing the inequity in health will require collaboration between both Indigenous and non-Indigenous health professionals;
5. Aboriginal and Torres Strait Islander health education should be developed and implemented at every level of education and employment.

1: Aboriginal people use the term "Country" to describe the geographical border of their communities land and all the natural resources, culture and history associated with it.

### Policy

AMSA calls upon:

1. Australian Government to:
  - a. Actively seek and follow guidance from Indigenous communities and organisations regarding all policy decisions that affect them;
  - b. Support the continuation of research by Aboriginal and Torres Strait Islander-led organisations to facilitate an evidence-based policy approach to improving the health and wellbeing of Aboriginal and Torres Strait Islander people;
  - c. To recognise that factors contributing to the health and wellbeing of Aboriginal and Torres Strait Islander people are often beyond the traditionally accepted responsibility of the health sector, therefore an intersectoral approach addressing primordial and primary prevention needs to be undertaken to effectively close the health and wellbeing gap;
  - d. To ensure that funding provided for Aboriginal and Torres Strait Islander health is used appropriately to support communities;
  - e. To support Indigenous communities to develop mental health plans aligned with their needs and culture;
  - f. Establish and support community-developed, community-run, and community-controlled programs with the express goal of promoting health literacy.

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2. Medical Schools:
  - a. To ensure that Medical Deans commit to facilitating locally developed up-to-date cultural awareness and orientation programs by Indigenous community members for all staff and students;
  - b. To provide meaningful learning experiences through placements in an Indigenous health context;
    - i. Cultural awareness/competency training should be completed by students prior to placement, regarding the local context in which they will be placed as well as the diversity of Indigenous health contexts they may be working in during their education and career;
    - ii. All students must demonstrate competence in cultural safety prior to commencing placement;
  - c. To increase the number of Aboriginal and Torres Strait Islander medical students beginning and completing their degree (refer to AMSA Aboriginal and Torres Strait Islander Medical Student Recruitment and Retention Policy).
3. Australian Medical Council:
  - a. To develop specific guidelines and expectations for Aboriginal and Torres Strait Islander medical education which must be fulfilled to meet accreditation standards. (Refer to AMSA Aboriginal and Torres Strait Islander Medical Curriculum Policy).
  - b. To work with Indigenous communities and organisations to define culturally safe practice, and to produce specific guidelines for medical students and educators which outlines acceptable standards of culturally safe practice.
4. Health professionals:
  - a. To recognise the importance of the continuation of culture as a health determinant for Aboriginal and Torres Strait Islander people;
  - b. To recognise the individual, clinical, and public health benefits of accurate identification of Aboriginal and Torres Strait Islander patients;
    - i. Promote opportunities for Aboriginal and Torres Strait Islander patients to self-identify by asking every patient "Are you of Aboriginal and Torres Strait Islander origin?" as recommended in the Australian Institute of Health and Welfare Best Practice Guidelines;
    - ii. Ensure identification of Aboriginal and Torres Strait Islander patients is based on self-identification rather than governmental definitions, historical definitions, physical appearance or stereotypes;
    - iii. Respect Aboriginal and Torres Strait Islander individuals' right to not identify within a clinical setting;
    - iv. Be competent in delivering culturally safe healthcare and be aware of the services available to Aboriginal and Torres Strait Islander people;
  - c. To undertake ongoing cultural training facilitated by Aboriginal and Torres Strait Islander organisations and ensure an appropriate standard of cultural safety is maintained;
  - d. To recognise that health authorities were complicit in the Stolen Generations legislation that allowed for the forcible removal of Indigenous children from their families and communities;
  - e. To recognise that children who are separated from their families and placed in out of home care today suffer through the loss of cultural identity and exacerbation of intergenerational trauma.
  - f. To recognise how implicit bias, power dynamics and subconscious discrimination lead to poorer health outcomes for Indigenous people.
5. AMSA Executive:
  - a. To continue their relationship with the Australian Indigenous Doctors Association (AIDA) through annual renewal of the Memorandum of Understanding;
  - b. Seek leadership from the Australian Indigenous Doctors Association or associated students on all matters affecting Aboriginal and Torres Strait Islander people;

- c. Create opportunities for Aboriginal and Torres Strait Islander AMSA volunteers to advocate on topics regarding Aboriginal and Torres Strait Islander health and community wellbeing;
  - d. Continue support for the AMSA Indigenous Health Project as a permanent collaborative endeavour between Indigenous and non-Indigenous AMSA volunteers and the Australian Indigenous Doctors Association, specifically collaborating with the Student Representative Council and the Student Director.
6. Medical Student Societies:
- a. To promote involvement in Aboriginal and Torres Strait Islander events of cultural or community significance, including but not limited to: Invasion Day<sup>2</sup>, NAIDOC week and Mabo Day<sup>3</sup>;
  - b. To appoint an Indigenous Health Officer position, separate to the AIDA Student Representative, to advocate for the welfare of Aboriginal and Torres Strait Islander students.
    - i. The position of Indigenous Health Officer should be preferentially appointed to an Aboriginal and/or Torres Strait Islander medical student. Where this is not possible, a non-Indigenous medical student may be appointed with demonstrated experience and passion iAboriginal and Torres Strait Islander health.
7. Hospitals and specialty colleges:
- a. To act proactively against racism, discrimination and bullying, with a clear code of conduct and accessible mechanisms to report and resolve instances of behaviour not complying with the code of conduct;
  - b. To establish support mechanisms for Aboriginal and Torres Strait Islander people at all medical schools, and in all hospitals and specialist training programs, to ensure retention and representation;
  - c. To mandate ongoing training for all hospital staff, irrespective of their position, in cultural awareness and cultural safety.

2: "Invasion Day" is the term given to describe the events of the 26th January 1788 which marks the arrival of the First Fleet of British Ships to Port Jackson in New South Wales, and thus is the anniversary of the invasion and colonisation of Aboriginal Country. This represents a day of mourning to some Aboriginal and Torres Strait Islander communities.

3: "Mabo Day" is an event which commemorates Eddie Koiki Mabo, a Torres Strait Islander man who campaigned for legal recognition of Indigenous land rights and eventually overturned the legal fiction of Terra Nullius.

## Background

*Aboriginal and Torres Strait Islander people, please be advised that the following texts includes contextual information regarding colonisation, the Stolen Generations, intergenerational trauma and other historical and cultural topics.*

Australia's medical students are primarily represented through the Australian Medical Students Association (AMSA). AMSA believes that all individuals within Australia should be able to access culturally safe and equitable healthcare. Aboriginal and Torres Strait Islander people are members of the longest continuing culture and are the First Nations people of Australia. Today, Aboriginal and Torres Strait Islander people account for 3.1% of the Australian population - almost 800,000 people [1]. Within Indigenous communities, 91% identify as Aboriginal, 5% as Torres Strait Islander and 4% identify as both Aboriginal and Torres Strait Islander [1]. As Aboriginal and Torres Strait Islander people are valued members of the Australian community, AMSA must prioritise Aboriginal and Torres Strait Islander health.

## The Importance of Culture For Health

Aboriginal and Torres Strait Islander communities view on health is largely defined as "holistic" from a Western perspective as it encompasses the spiritual, social and physical aspects of a person's wellbeing and extends beyond the biomedical description of health [2]. This attempts to encapsulate an individual's wellbeing as intrinsically connected to their environment, community and family. There is an increasing evidence base suggesting the protection, promotion and practice of Aboriginal and Torres Strait Islander traditional knowledge, culture

and kinship systems contributes to personal and community resilience, in addition to improving health outcomes [2].

A systematic review of the link between Indigenous cultures and health and wellbeing was published in the International Journal of Health, Wellness and Society. It suggests a positive association between health, wellbeing and cultural factors within the Indigenous community including Country, knowledge and beliefs, language, self-determination, family and kinship as well as cultural expression [2]. In the “Health Benefits of Going on Country<sup>4</sup>” report published by the Lowitja Institute, five potential benefits were identified of going on Country, including a healthier diet, more frequent exercise, continuation and learning of local culture, increased time spent with family and overall increased spiritual connectedness [3]. Acknowledgment of these important factors recognises that Aboriginal and Torres Strait Islander culture has developed over millennia to utilise best practice methods for their own community's health [4].

*4: Going on Country” is a phrase used to describe Aboriginal people returning to their home Country or land to engage in traditional activities or cultural protocol.*

## Overview Of Aboriginal And Torres Strait Islander Health

Indigenous Australians experience poorer health outcomes than non-Indigenous Australians, an issue significantly caused by a lack of accessible and appropriate healthcare [5]. This health inequity is based in a long history of exclusion and negligence from the medical community, culminating in a lack of accessible healthcare and growing distrust of Western medicine [6-8]. Despite recent efforts to create a cohesive public policy and the recent 10th anniversary of the Close the Gap campaign, Indigenous health outcomes have consistently fallen below target levels [1].

Aboriginal and Torres Strait Islander people are almost half as likely than their non-Indigenous counterparts to report their health as very good or excellent, which is reflective of the high burden of disease the community experiences [9]. The leading cause of death among Indigenous Australians is coronary heart disease (CHD) at 24% of deaths, based on ABS data from NSW, QLD, WA, SA and the NT in 2017, with a mortality rate of 1.8 times the non-Indigenous population [1]. Other leading causes of death include cancer, external causes/injury and diabetes, affecting Indigenous Australians at 1.4, 2.1 and 5.6 times the rate of non-Indigenous Australians [1]. This is also reflected in the leading avoidable causes of death, which were CHD (22%), diabetes (12%) and suicide (11%) [1]. There are also striking differences in hospitalisation rates, with Aboriginal and Torres Strait Islander people being hospitalised at 2.6 times the rate of non-Indigenous people, 80% of which is attributable to dialysis and differential rates of chronic kidney disease [1]. These statistics should not be used to characterise Indigenous populations but rather as a guide for targeted interventions to improve the health of Australia's First Nations peoples.

## The Health of The Stolen Generations

The Stolen Generations are the most disadvantaged groups within the Aboriginal and Torres Strait Islander population, due to the forced removal and assimilation legislation which lead to disconnection from culture, family, community and Country [10]. In 2015, Stolen Generations members represented 13.5% of the Indigenous population aged 42 and over, with 56% being women and 44% being men [10]. Among Stolen Generations members, 79% live in non-remote areas with three quarters living in either New South Wales, Western Australia or Queensland [10]. Likewise, 84% of descendants lived in non-remote areas and represented 33% of the Aboriginal and Torres Strait Islander community who are older than 18 [10]. The Bringing them Home report estimated that between 1 in 3 and 1 in 10 Indigenous children were forcibly removed from their families and communities, stating that “in that time not one Indigenous family has escaped the effects of forcible removal” [4].

Aboriginal people were removed from their traditional Country and relocated to reserves or missions. In every state and territory, with the notable exception of Tasmania, a “Chief Protector of Aborigines” was appointed who had extensive power of Aboriginal peoples lives including their ability to move off missions, seek employment or marry [11]. In the 1950's Australia adopted an assimilation policy, aiming to eradicate Indigenous culture from Australia [11]. Children were forcibly removed from their communities and families, being placed into foster homes or institutions and often told that their families have given them up as they were unwanted and unloved [11]. The traumatic impacts of legislation during this period are still being felt today by survivors and their descendants [10]. The details of this widespread devastation is documented in the Human Rights and Equal Opportunity Commission's Bringing them Home Report published in 1997, a document which details the stories of survival and described the extent of harm and



burden suffered by this discriminatory legislation of both Stolen Generations members and their descendants [4].

The members of the Stolen Generations experience higher rates of adverse health, cultural and socioeconomic outcomes when compared with the Aboriginal and Torres Strait Islander population which had not been removed [10]. In 2018, members of the Stolen Generations were:

- 3.3 times more likely to be incarcerated in the last five years
- 1.8 times more likely to have government payments as their main source of income
- 1.7 times more likely to have experienced violence in the last 12 months
- 1.6 times more likely to be unemployed and/or homeless in the last 10 years
- 1.5 times more likely to have experienced discrimination in the last 12 months
- 1.5 times more likely to have poor mental health and 1.6 more likely to have poorer general health

when compared to the general Aboriginal and Torres Strait Islander population who are already more likely to experience these issues than the general Australian population [10].

Stolen Generations descendants also experience significant intergenerational effects. They are 2 times as likely to be discriminated against, 2 times less likely to speak their language, 1.9 times as likely to experience threatened or physical violence and 1.5 times as likely to have been arrested in the last five years compared to the general Aboriginal and Torres Strait Islander population [10].

It is particularly important to recognise that health authorities, including hospitals and health professionals were complicit in the forcible removal and assimilation policies during this time leading to a mistrust in health professionals and health services [12,13]. There are many particularly harrowing aspects of our history as a medical profession. One example which is infrequently discussed is the development of “Lock Hospitals”, a form of racially based medical incarceration of Aboriginal and Torres Strait Islander people across Australia [14-16]. Inmates of lock hospitals were subjected to experimental and invasive interventions [15,16]. Research suggests that Aboriginal and Torres Strait Islander people want their history with the medical system to be more widely understood and acknowledged [14-16].

## Intergenerational Trauma

Intergenerational trauma is a form of historical trauma which is transmitted or “handed down” through the generations [17]. For Aboriginal and Torres Strait Islander people, trauma and its associated health and wellbeing effects did not occur within a single generation, instead it is the product of generations of frontier violence, massacres, forcible removal from Country and obstruction of cultural practices [18]. Trauma, in an Indigenous context is not restricted to the individual, but instead shared throughout the complex kinship and generational system meaning that whole families and communities are affected [18]. Consideration of the traumatising experiences Stolen Generations survivors and their descendants have had once removed from their communities is essential to providing tailored, mindful and culturally appropriate care.

The continuation of child removal from Aboriginal and Torres Strait Islander families is an ongoing problem, with the number of Aboriginal and Torres Strait Islander children in out-of-home care increasing since the Bringing Them Home report was published [19]. Whilst the intention behind the child removal practices today can be perceived to be different, the outcome is inevitably the same, with loss of cultural identity and exacerbation of intergenerational trauma [19].

## Mental Health

The burden of mental illness is considerable in Australia, and is again an area where Indigenous and non-Indigenous Australians experience different burdens of disease. However, populations differ not only in prevalence of conditions, but also in causes, manifestations and lived experiences. In terms of prevalence, the most recent Australian Aboriginal and Torres Strait Islander Health Survey revealed that 30% of Indigenous adults had experienced high or very high levels of psychological distress in a four week period, representing a rate 2.7 times an age-standardised rate in non-Indigenous adults [20]. Diagnosable conditions are also thought to be more prevalent in Aboriginal and Torres Strait Islander people than non-Indigenous people, for example, depression is estimated to affect 12% of Indigenous Australians compared to 9.6% of non-Indigenous Australians [5]. The diagnosis of certain psychological conditions is hindered by

using culturally incompatible assessment tools, which decreases confidence in current statistics and highlights the importance of using the widening array of culturally validated assessment tools [21].

A salient manifestation of mental illness, suicide, affects Indigenous Australians at almost twice the rate (1.9 times) that of their non-Indigenous counterparts [5]. The difference becomes more striking when considering youth suicide, as analysis of Queensland's suicide register revealed Indigenous children under 15 are over 12 times as likely than non-Indigenous children to die by suicide [22]. It should be noted that there can be significant variations in suicide rates both geographically and temporally, with many suicides being clustered [23]. With even the youngest Aboriginal and Torres Strait Islander people suffering the effects of poverty, racism, intergenerational trauma and the socioeconomic legacies of colonisation, a comprehensive life course approach is necessary for meaningful change in the social and emotional wellbeing of Indigenous Australians.

While it cannot fully explain the striking differences described above, one potent factor contributing to social and emotional wellbeing is the alarmingly high rates of Indigenous youth detention. Despite only 5% of 10-17 year old Australians being Indigenous, they represent 59% of young people in detention [24]. This correlates with Indigenous youth experiencing detention at 26 times the rate as non-Indigenous youth [24]. It should be emphasised that these rates are as a result of social disadvantage, lack of supportive formative environments, punitive courts and insufficient diversion strategies rather than any inherent criminality [25]. The 2017 Royal Commission into the Protection and Detention of Children in the Northern Territory found that the living circumstances were clearly unfit for youth requiring rehabilitation; furthermore, humiliation, verbal and physical abuse and isolation were used liberally and punitively [26]. Considering that 100% of the youth detention population in the Northern Territory is Aboriginal, these findings are evidence that the Northern Territory and federal government are failing in their duty to care for and protect at risk children [26].

### **Communicable Disease and Addressing the Poverty Gap**

Communicable diseases are overrepresented in the Indigenous community, including hepatitis A, B and C, HIV/AIDS, sexually transmitted infections, meningococcal disease and skin infections [1]. There are several communicable diseases that persist within the Indigenous communities despite being eradicated in the non-Indigenous population and developing nations around the world such as trachoma, scabies, tuberculosis and rheumatic fever [1], many of which have persisted since their introduction during colonisation of the land we now call Australia [27].

During consideration of these modifiable risk factors it is important to recognise the role that forcible removal and assimilation legislation played in the prevalence of these socioeconomic risk factors within the community [27]. The overrepresentation of communicable disease can be attributed to socioeconomic factors including poor hygiene, sanitation, access to clean water and overcrowding of homes in addition to inaccessibility of health care services to ensure prophylaxis and appropriate treatment before progression to chronic irreversible disease [28]. The social and cultural determinants of health model recognises that there are many factors of development of communicable diseases that are outside the traditionally recognised domain and responsibility of the health sector, therefore a collaborative intersectoral approach addressing primordial and primary prevention needs to be undertaken to effectively address these issues [29].

### **Concerns Regarding the Close the Gap Strategy**

The seeds of the Close the Gap campaign and subsequent Closing the Gap strategy were sown by the 2005 Social Justice Report from the Aboriginal and Torres Strait Islander Social Justice Commission [30]. The key recommendations to achieve health equality within a generation involved a bipartisan commitment from federal and state governments, and leadership and partnership with Indigenous Australians [30]. This spurred a campaign led by a coalition of over 40 non-governmental organisations, both Indigenous and non-Indigenous, health-related and human rights-related, with widespread grassroots support, coined the Close the Gap campaign [31]. The shift from the pluralistic, collaborative and consultative Close the Gap campaign to what would become a top-down governmental Closing the Gap strategy began with the late 2008 National Indigenous reform agreement (NIRA) by the Council of Australian Governments (COAG) [31]. The NIRA set six targets, namely:

- Close the gap in life expectancy by 2031;
- Halve the gap in child mortality by 2018;

- Ensure 95 percent of Aboriginal and Torres Strait Islander four-years-olds are enrolled in early childhood education by 2025;
- Halve the gap in reading, writing and numeracy by 2018;
- Halve the gap in year 12 attainment by 2020;
- Halve the gap in employment by 2018 [31];

A seventh target, to close the gap in school attendance by 2018, was added in 2014 [31].

Many Indigenous and non-Indigenous people have critiqued these targets, including school enrolment and attendance, for being more related to compliance than to outcomes; the priorities of the government are privileged over those of the community [32]. As Dr Chelsea Bond, a Munanjali and South Sea Islander woman and academic at the University of Queensland comments, the discourses of Closing the Gap “remind us that the Black body is to be regulated and remedied by the health system,” rather than people with a right to agency and control over their own affairs [32]. Strategic and human rights concerns were expressed promptly, for example regarding the “First Four Hours” policy in the Northern Territory which reversed 30 years of bilingual teaching in remote schools in 2008, coinciding with the beginning of the Closing the Gap strategy [33]. This policy of enforcing that English be used exclusively for the first four hours of each school day, relegating Indigenous languages to a maximum of two afternoon hours, directly impinged on the rights of Aboriginal students to be taught in their own language, blocked cultural education and necessitated non-attendance to achieve community priorities [33]. The Australian Human Rights Commission condemned this policy, stating that it endangers remaining Indigenous languages and bilingual education should be reinstated [34]. Aside from human rights concerns, the policy had a detrimental effect on attendance and enrolment rates [33], and has caused an increasing disconnection from culture and language which is likely to be detrimental to health when these elements are considered as protective factors. Although this policy was later repealed in 2012, it is a clear example that COAG was not united in considering Aboriginal and Torres Strait Islander people’s perspectives, priorities and praxis in ameliorating their community’s health and educational attainment [35].

Early on, concerns were voiced by the National Congress of Australia’s First Peoples that a new relationship must be forged to ensure “genuine” engagement which emphasises self-determination and a “shared journey” [36]. Additionally, they repeated that the governments must be held to account for their performance and a new target relating to criminal justice should be added, which has not occurred [36]. The 2016 Redfern Statement similarly asserted concerns that insufficient commitment was being given to Aboriginal and Torres Strait Islander led solutions and the unfinished business of reconciliation [37].

These critics of the Closing the Gap strategy were unsurprised when the Closing the Gap Report 2019 asserted that only two of the seven targets, early childhood education and Year 12 attainment, are on track to be met [38]. The target to halve the gap in child mortality rates by 2018 failed as the non-Indigenous rates declined faster than Indigenous rates, resulting in a widening of the gap [38]. The target to close the gap in school attendance by 2018 also failed, as school attendance rates remain unchanged [38]. The life expectancy estimates of Indigenous males for 2015-17 has increased from 2010-12 estimates by 2.5 years to 71.6 years, which is 8.6 years less than non-Indigenous males [38]. Similarly, life expectancy of Indigenous females has increased by 1.9 years over the same period to 75.6 years, which is 7.8 years less than non-Indigenous females [38]. While these statistics represent a modest decrease in the gap of life expectancy, however they are not statistically significant and are insufficient to meet the target by 2031 [38]. Targets to halve the gap in reading and numeracy by 2018 and to halve the gap in employment by 2018 failed to be achieved, prompting consideration of a Closing the Gap Refresh [38]. Although reconsideration and revision are necessary, many of the underlying issues are yet to be addressed [35].

The Closing the Gap strategy has been largely unsuccessful, attributable to the limited continued stakeholder involvement throughout the process and lack of consideration of Indigenous praxis, philosophies and priorities [35]. Overall, the problems with many government strategies historically is that “what is repeatedly missing in officialese accounts of what lies behind ‘disadvantage’ is the very thing that everyone in such circles is usually quick to say needs proper recognition - Indigenous tradition, social values and culture” [39]. There is also insufficient emphasis on upstream causes of ill health, notably the social determinants of health which contribute to at least 34% of the gap in health outcomes [40]. The common rhetoric of excessive spending on Indigenous health is quickly nullified upon further analysis of funding. While compared to the non-Indigenous population, Indigenous people receive 1.47 times the funding per capita, the health burden is considerably larger, currently standing at 2.3 times that

of non-Indigenous Australians [41,42]. Further analysis shows that of the funding allocations, Indigenous people receive less in primary health care services, through the pharmaceutical benefits scheme and private insurance [43]. For instance, the government allocates nearly 10% of the health budget to private insurance, the benefit of which is reaped by 55% of the non-Indigenous population but only 17% of Indigenous people [43]. Furthermore, 6 times more funding is spent on hospital-based care for Indigenous people than on prevention and primary care [43].

## **Aboriginal and Torres Strait Islander Health Research**

When evaluating the research upon which the Closing the Gap strategy and similar health initiatives are founded upon, the process of assigning structures, cultures, and histories is one which has been driven primarily by non-Indigenous Australian authors; it has emerged independent of Indigenous voices [44]. Regarding Indigenous health, research often serves to identify or highlight differences in health, social, or economic status between Indigenous and non-Indigenous population and to identify underlying social, environmental, economic, or biological factors which underlie these health differences [45]. The lack of Indigenous perspective in this research, however, has resulted in the representation of Indigenous communities and Indigenous health issues through a primarily Western lens [46], and has led to a discourse of deficiency, blame, and a focus on 'health choices' [47,48]. Some have argued that this approach to research on Indigenous health has led to asymmetry in epistemic power between non-Indigenous and Indigenous Australians, limiting the productive exchange of knowledge. This is of direct relevance to Indigenous health in that the downstream effects of this epistemic asymmetry are misaligned policy, the positioning of differing cultural values as negative, and oppression via the usurpation of the Indigenous voice [49,50]. This perspective is the foundation of the call for a strengths based approach to Indigenous Health, where differences in culture and ideas are valued.

Nakata [51], through his concept of the cultural interface has proposed a means of ameliorating some of the issues intrinsic with non-Indigenous research on Indigenous people, and the development of policy which is targeted towards Indigenous people. Nakata describes the cultural interface as a space where two cultures meet (in this case Indigenous cultures and the cultures of non-Indigenous researchers) and where complex bilateral exchanges of knowledge and understanding take place. It facilitates questioning of what is known, or thought to be known, how that knowledge was derived, what knowledge needs to be derived, and how best to generate that knowledge. It fosters the development of suitable and culturally responsive epistemologies grounded in pragmatism. The utilisation of indigenist theoretical frameworks, such as the cultural interface, alongside participatory research and policy development methodologies will aid in bridging the divide between Western researchers, policy makers, and Indigenous communities, facilitating the development of good policy which is aligned with community needs, values, and cultures. This intercultural collaboration and discussion is evidently essential in the development of a growing Indigenous health publications base, as well as the development of future health initiatives targeted at Indigenous communities [51].

## **Patient Identification**

Significant concerns have been raised regarding underidentification of Indigenous people, the impact this has on obtaining accurate data and the healthcare system's ability to monitor health outcomes and the efficacy of targeted initiatives such as the "Closing the Gap" strategy [52]. The identification of Aboriginal and Torres Strait Islander patients within the healthcare system is essential to the development of policy and tailored services to improve the healthcare outcomes for Indigenous communities [52]. Despite publications discussing issues and solutions regarding the identification of Aboriginal and Torres Strait Islander patients being circulated since 2010, this continues to be an issue in 2019 [53].

From a governmental and health care system perspective, Aboriginal and Torres Strait Islander identification generally utilises the accepted definition of an Indigenous person as implemented by the Australian Commonwealth government in the 1983 Aboriginal Land Rights Act as "a person of Aboriginal and Torres Strait Islander descent who identified as Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives" [54]. Importantly, an individual who self identifies as Aboriginal and/or Torres Strait Islander should not have their cultural identity questioned based on possession of a "Confirmation of Aboriginality", "Statutory Declaration", historical definitions of Aboriginality or their Country of birth, age, appearance, clothing, language, education or socioeconomic status [52,53].



The United Nations Permanent Forum on Indigenous Issues states that “the most fruitful approach is to identify rather than define Indigenous peoples. This is based on a fundamental criterion of self-identification as underlined in a number of human rights documents” [55]. The language individuals use when self-identifying varies between individuals based on historical, social and cultural experience of the individual [55,56]. Some individuals will identify as “Aboriginal” or “Torres Strait Islander” or “both Aboriginal and Torres Strait Islander”, while others will refer to themselves by the title given to all communities in a certain area<sup>1</sup> or by their community or language group [56]. It is important that medical professionals recognise that Aboriginal and Torres Strait Islander people have unique culture laws and customs to determine group membership which may not match the governmentally recognised definition [56]. Thus, health professionals should recognise variation in the terms used to self identify as an Indigenous person to increase the accuracy of identification.

<sup>1</sup>Certain areas of Australia use certain terms to refer to all Indigenous communities within that area. For example, Koori is a term used for Indigenous Australians in Victoria and the southern part of New South Wales. In addition, Murri is used for Queensland and north west New South Wales. Similarly Nyoongar refer to communities in the south west of Western Australia.

In April 2010, the Australian Institute of Health and Welfare published the “National Best Practice Guidelines for Collecting Indigenous Status in Health Data Sets”. This report suggested a standard national question of “Are you of Aboriginal or Torres Strait Islander origin” to ensure consistency in reporting of Aboriginal and Torres Strait Islander status [50]. This approach is supported by the Australian Indigenous Doctors Association, who suggests that this question should not be altered in any way, as changing the wording can vary the meaning of the question and therefore may result in inconsistency in response from the patient [51].

It is also essential to recognise that to maintain cultural safety for Aboriginal and Torres Strait Islander people, an individual has the right to not identify as an Indigenous person due to historical, cultural or personal reasons [51].

Recognising that an individual is an Aboriginal or Torres Strait Islander person is important from both a clinical and public health standpoint [50]. From a clinician’s perspective, identification as Indigenous in association with socioeconomic and geographical location is a clinical risk factor for several communicable and chronic illnesses [57]. This is an important clinical consideration when generating differential lists, investigating illness, discussing preventative health and deciding treatment protocols as there are PBS subsidies, vaccinations and specific medications available to Aboriginal and Torres Strait Islander patients [57]. In addition, Indigenous patients are eligible for Aboriginal and Torres Strait Islander health checks such as the MBS 715 “Aboriginal and Torres Strait Islander health assessment” which generates referrals to allied health professionals and specialists [57]. From a public health perspective, the development of more accurate data on the health concerns influencing Indigenous peoples’ quality of life ensure appropriate redirection of policy, health care initiatives and funding [51].

Barriers to identification include:

- Staff members’ discomfort when clarifying how an individual identifies due to:
  - A lack of confidence or experience
  - A desire to treat all patients equally; or
  - Feeling it is unnecessary due to few Indigenous individuals in their patient demographic [50]
- Aboriginal and Torres Strait Islander patients and clinicians being unaware of the individual and community based benefits of identifying [50]
- Staff members assumption that identity could be confirmed by appearance [50]

## Implicit Bias and Racial Stereotyping of Indigenous Patients

Implicit bias and stereotypes of Aboriginal and Torres Strait Islander people continue to have an impact on the care they receive within a medical context, as demonstrated by the coronial inquest into the death of Naomi Williams [58]. On the 29<sup>th</sup> of July 2019, the NSW state coroner released the findings from an inquest into the death of Naomi Williams, a Wiradjuri woman, who died from septicaemia secondary to a *Neisseria meningitidis* infection [58]. It was found that, on the basis of the clinical information known at the time, Naomi’s presentation should have been investigated further and that Naomi was discharged earlier than was clinically indicated [58]. Throughout the inquest it was also noted that Naomi had made multiple presentations to the emergency department in the months preceding her death, but was provided only with

symptomatic treatments for her complaints, leading her to have reduced expectations of care, delaying or perhaps preventing her presentation following the rapid decline in her health [58].

Implicit bias was also identified as a contributing factor in reducing the level of care provided to Naomi [58]. In the months prior to her death, Naomi was referred to drug and alcohol services multiple times, and her symptoms were attributed to 'withdrawal from marijuana' [58]. Naomi's mother communicated that this led her daughter to feel that she was being 'stereotyped as some sort of drug addict' [58]. A specialist referral was requested by Naomi's family; however, this was not actioned by medical staff [58]. Several witness statements were presented to the courts which outlined the perception of racism and racial stereotyping at the hospital as well as the provision of substandard care to Indigenous patients at the hospital, external to Naomi's specific case [58]. It was noted that Aboriginal people 'feel they cannot go up to the hospital as they won't get the treatment they need' [58].

This case highlights two key issues in relation to Indigenous health. The direct impact on health outcomes which arise when patients are stereotyped, and the wider effects of bias on the engagement of Indigenous patients with the health care system. Ongoing training is needed to ensure that medical staff are conscious of, and actively seek to remedy their biases in regards to Indigenous patients to ensure that their practice is inclusive, comprehensive and culturally appropriate.

## **Underrepresentation of Aboriginal and Torres Strait Islander Health Professionals**

There is a chronic underrepresentation of Aboriginal and Torres Strait Islander people in the health workforce, with about 1% of health workers identifying as Aboriginal and/or Torres Strait Islander [59]. Aboriginal and Torres Strait Islander medical personnel are a key part of the healthcare system, as they have invaluable knowledge, allowing them to offer perspective, advocacy and leadership in areas of Indigenous health. In 2008, there were 153 medical practitioners in Australia who identified as Aboriginal and/or Torres Strait Islander, making up approximately 0.2% of employed practitioners; this figure was approximately 0.6% for nurses [59].

In addition to the overall underrepresentation in health workers, there is a shortfall of of Aboriginal and Torres Strait Islander doctors in the specialist medical colleges. In 2015, the specialist employment rate for Aboriginal and Torres Strait Islander doctors was 14.8 per 100,000 people, compared to 128.3 per 100,000 people for non-Indigenous doctors [60]. As healthcare of Aboriginal and Torres Strait Islander people is not exclusively limited to primary care in the setting of Aboriginal Community Controlled Health Services, there is a need for increased training and employment of Aboriginal and Torres Strait Islander specialist registrars and fellows to address health inequities in all aspects of medicine. Some key barriers to the training and education of Aboriginal and Torres Strait Islander registrars and fellows have been identified by an AIDA survey report, which identified that bullying and racism are prevalent in health care, causing unsafe working environments [62], with the perpetrators of bullying and racism often being senior colleagues, reinforcing a common power dynamic in the registrar-consultant relationship [62]. This was echoed recently by reports of bullying and racism occurring in specialist medical training colleges [61]. The consequence of racism and bullying from superiors can directly affect a registrar's progression through a training program, having further consequences on the doctor's future career [61]. Being the victim of continued bullying and racism can also have significant impacts on the health and wellbeing of Aboriginal and Torres Strait Islander doctors, above and beyond the stressors all doctors face [62].

The existence of racism and bullying in a relationship with a power imbalance can result in the victim feeling reluctant to report such behaviour, leaving the victim to feel powerless and unable to defend themselves [61]. An inability to stop such behaviour creates a culture of institutionalised racism within the medical colleges. Further work is needed to extinguish institutionalised racism from the medical training colleges. AIDA supports mandatory cultural safety training across all areas of the health system, including specialist medical training colleges [63]. Further barriers to specialist training for Aboriginal and Torres Strait Islander doctors include a lack of knowledge about the options available for training, lack of access and contact with key individuals, and isolation from colleagues [64]. Some strategies have been suggested to counteract these barriers, including mentorship for Aboriginal and Torres Strait Islander doctors, support and assistance regarding the entry into college training programs and the establishment of flexible training opportunities [64]. Some progress has been made in this area, with pathways and opportunities opening up for Aboriginal and Torres Strait Islander medical students and junior doctors. For example, the Australasian College of Sports and

Exercise Medicine [65] and the Royal Australasian College of Surgeons [66] have numerous awards and scholarships available to Aboriginal and Torres Strait Islander students and junior doctors.

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