Policy Document

Aboriginal and Torres Strait Islander Health Policy

Background

The Australian Medical Students' Association (AMSA) is the peak representative body of Australia's medical students. AMSA believes that all communities have the right to the best attainable health. Accordingly, AMSA advocates on issues that may impact health outcomes. AMSA acknowledges that the term "Indigenous" within the context of this policy is in reference to and respect of both Aboriginal and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander people are the First Australians, and today comprise 3% of the Australian population [1, 2]. Currently, Aboriginal and Torres Strait Islander people have significantly poorer health outcomes than the general Australian population. The projected life expectancy of Aboriginal and Torres Strait Islander peoples is 10 years lower than the Australian average; 69.1 and 73.7 years for males and females respectively born in 2010-2012 [3]. Almost all health indicators, including mortality or morbidity rates for specific diseases, or risk factors, are poorer in the Aboriginal and Torres Strait Islander population. Infant mortality, maternal mortality and age-standardised death rates from 2000-2010 are approximately 2-3 times higher than the non-Indigenous population [3].

Some of the most significant causes of death among Aboriginal and Torres Strait Islander people are chronic diseases. Chronic diseases include a wide range of disease states such as cardiovascular, respiratory, ophthalmic and endocrine diseases, cancer, physical or intellectual disabilities and mental illness. In 2012, cardiovascular disease was the leading cause of death among Aboriginal and Torres Strait Islanders people, responsible for 25% of deaths in NSW, QLD, WA, SA and NT, almost twice that of the non-Indigenous population [3]. Further striking differences exist in renal disease and diabetes; Aboriginal and Torres Strait Islander people died of diabetes at seven times the rate of the non-Indigenous population in 2012, and the notification rate for end-stage renal disease was 7.3 times higher [3]. These differences are multifactorial, but are in part due to the significant disparity in chronic disease risk factors.

Communicable diseases that are particularly prevalent among the Aboriginal and Torres Strait Islander population relative to the non-Indigenous population include hepatitis A, B and C, tuberculosis, HIV/AIDS, sexually transmitted infections, meningococcal disease and skin infections [4]. Furthermore, diseases typically found in developing countries, such as scabies, have been eradicated from all of Australia except Aboriginal and Torres Strait Islander populations, where up to 50% of children and 25% of adults are infected with the parasite [5]. Similarly, trachoma is endemic only among the Aboriginal and Torres Strait Islander populations in parts of the NT, SA and WA [6]. These diseases are closely correlated with socioeconomic status, sanitation, overcrowding, malnutrition, and pre-existing chronic diseases such as diabetes and renal disease [4].

These health inequities are the result of a number of complex and interrelated issues. European colonisation brought with it a number of foreign diseases as well as years of conflict, trauma and neglect, resulting in a socially disadvantaged community, with the generational effects still being felt today. Furthermore, Aboriginal and Torres Strait Islander people have a more holistic view of health, which includes a strong connection to the land, social, emotional and mental wellbeing. Thus, Aboriginal and Torres Strait Islanders require health care that acknowledges and supports this.

Social determinants of Aboriginal and Torres Strait Islander health include education, employment, income, unequal access to health care and an inferior standard of health infrastructure in Indigenous communities (housing, nutrition, sanitation, etc.) [7-9]. For example, the overall unemployment rate in the Aboriginal and Torres Strait Islander population is more than three times that of the non-Indigenous population, 17.2% compared to 5.5% [10]. Similarly, the average income for Aboriginal and Torres Strait Islander people is 62% of that of the non-Indigenous population [11].

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In recent years, the Australian Government has implemented numerous programs to improve Aboriginal and Torres Strait Islander health outcomes, targeting a wide variety of health behaviours including nutrition, alcohol and drug abuse, hygiene, physical activity and smoking [12]. However, the success of these programs has been varied, and many have been unsuccessful due to socio-cultural barriers, particularly intergenerational trauma, historical mistrust and low education rates [13]. Social interventions such as The Northern Territory Emergency Response (NTER) [14] and the Stolen Generation have caused profound, long-term damage to the health of Aboriginal and Torres Strait Islander people [15]. These traumas have resulted in a significant loss of identity and culture, with severe, ongoing consequences [16] on mental health, with high rates of suicide, psychological illness [16] and physical health.

Increases in government funding for Indigenous health services over recent years reflect the recognition of health inequality between Aboriginal and Torres Strait Islanders and the non-Indigenous population. From 2008-11, health expenditure per capita grew by 6.1% annually, versus a growth of only 2.6% for non-Indigenous Australians. Comparatively, national and state funding accounts for a much greater proportion of Aboriginal and Torres Strait Islander health care (91.4%) than for the non-Indigenous population (68.1%) [17-18]. While this is a positive indication of dedication to reducing health inequality for Aboriginal and Torres Strait Islander people, funding allocation remains an area of concern – the lapse of the National Partnership for Closing the Gap in Aboriginal and Torres Strait Islander Health in 2013 [19] means that there is no current guideline on funding coordination between the Australian and state governments. There are also concerns about the millions of dollars that have been cut from a wide range of health services, such as anti-smoking initiatives [20].

A considerable constraint with respect to monitoring and evaluating health outcomes and health programs is the unreliable identification of Aboriginal and Torres Strait Islander people [3]. Inaccuracy in both denominator data (overall Aboriginal and Torres Strait Islander population) and numerator data (events and outcomes) contributes to this problem. Data collection methodologies and comprehensiveness varies based on state and condition. For instance it has been estimated that Aboriginal and Torres Strait Islander identification in deaths was only 62% in 2011, compared to 96% of births correctly identified as Aboriginal and Torres Strait Islander over 2002-2006 [21, 22]. Although there have been improvements in recent years, particularly with the establishment of the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID), there is still much room for improvement [23].

Improving equity of access to healthcare services is imperative to bettering the health of Aboriginal and Torres Strait Islander people. In 2008, 26% of Aboriginal and Torres Strait Islander people in non-remote areas reported difficulty accessing health services, compared to only 2.6% of the general population [12]. Aboriginal Community Controlled Health Services (ACCHS), run by local Indigenous communities, are recognised as the main contributors to the effective delivery of primary health care [24], working in unison with the communities to give them ownership of their health at a local level. Currently, over 170 ACCHS provide over 2.4 million episodes of culturally-competent primary health care per annum [25], under the representation of National Aboriginal Community Controlled Health Organisation [26]. However, the majority of Aboriginal and Torres Strait Islander people still have limited access to Aboriginal-specific services [27]. Improving accessibility will necessitate addressing barriers universal to all primary healthcare services including physical availability, economic accessibility, cultural acceptability and appropriateness of the service to provide for the health requirements of Aboriginal and Torres Strait Islander people [12]. Research has indicated that the most successful strategies are those that motivate and engage communities in health programs [28].

Additionally, there is a chronic under-representation of Aboriginal and Torres Strait Islander people in the health workforce, with about 1% of health workers identifying as being Aboriginal and/or Torres Strait Islander [29]. 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 [29].

Current efforts to increase the numbers of Indigenous health professionals, include increasing the number of Aboriginal and Torres Strait Islander medical students. This was a key effort identified in the *Healthy Futures* report released by the Australian Indigenous Doctors Association (AIDA) [30]. This document recommended Aboriginal and Torres Strait Islander medical student recruitment and retention strategies, such as bridging programs, alternative entry pathways, mentoring and most significantly, establishing Indigenous Health Units (IHUs) at each university that are specifically responsible for these support services. Some universities have begun implementation and as a result of these efforts, first-year Aboriginal and Torres Strait Islander student numbers have reached a new high of 2.5% that matches

population parity (2011, 2012). While graduations remain below par at 0.5% of total domestic graduations [31], the uptake of the initiatives described above, are expected to increase this number in the coming years.

Position Statement

AMSA believes that:

1. Aboriginal and Torres Strait Islander people should be officially recognised within the Australian Constitution as the First Australians;
2. A national long-term plan to improve Aboriginal and Torres Strait Islander health involves collaboration with all levels of government, Aboriginal and Torres Strait Islander people and Indigenous and non-Indigenous organisations and communities;
3. Although the Australian government spends more (per capita) on Aboriginal and Torres Strait Islander people, the provision of extra funding alone is not sufficient to address the current health inequity, and must be applied in a more targeted, culturally appropriate manner;
4. Any effective action in improving Aboriginal and Torres Strait Islander health should aim to empower Aboriginal and Torres Strait Islander people to support their own needs by improving access to health services, supporting cultural continuity and increased employment, housing, transport services and education;
5. The Australian Government should have a long term funding commitment to empower communities, individuals and service providers such as ACCHS;
6. Health services provided specifically for Aboriginal and Torres Strait Islander people should be increasingly developed and controlled by Aboriginal and Torres Strait Islander communities;
7. The underlying social determinants of health that impact Indigenous communities such as income, education, employment, environment and housing need to be recognised and addressed by all stakeholders;
8. Health care should be delivered in a culturally appropriate manner, as described by AIDA's Cultural Safety Position Paper [32], taking into account physical, social and psychological determinants of health.
9. Developing and maintaining strong partnerships with Aboriginal and Torres Strait Islander advocacy groups, working collaboratively on projects that promote health and education is essential to improving Aboriginal and Torres Strait Islander health;
10. Aboriginal and Torres Strait Islander people have a strong connection to the land, which is part of their cultural identity and impacts upon their health. Recognition of this connection is essential in improving their health outcomes;
11. The development and delivery of Indigenous health education should be a key component of all medical curricula;
12. Aboriginal and Torres Strait Islander people should have greater representation in the health workforce, and should receive additional support to ensure student retention during training programs.

AMSA supports:

1. The Close the Gap campaign;
2. The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes;
3. Initiatives set out by the Department of Health in the National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023;
4. Initiatives set out to increase Indigenous Health Education (such as the CDAMS [Now MDANZ] *Indigenous Health Curriculum Framework*), as well as Indigenous participation in the health workforce (such as the AIDA *Healthy Futures* report);
5. Maintaining funding for Aboriginal-specific services such as ACCHS, NACCHO and other Indigenous health workforce peak organisations;

Policy

AMSA calls upon:

1. Australian Governments to:
    a. Follow a collaborative evidence-based policy approach to improving the health and status of Aboriginal and Torres Strait Islander people;

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b. Consult with relevant Indigenous groups in all policies affecting them, in a meaningful culturally appropriate manner;
c. Uphold the dignity and cultural integrity of Aboriginal and Torres Strait Islander people as a key consideration in their policy approach in order to prevent damage to their psychological and social wellbeing;
d. Use culturally appropriate and community developed programs to educate Indigenous communities on health and disease;
e. Require all state and territory governments to engage in accurate and consistent data collection regarding Indigenous status and all aspects of Aboriginal and Torres Strait Islander health and wellbeing;
f. To support development of a specific, and culturally appropriate national mental health plan for the Aboriginal and Torres Strait Islander population.

2. Medical Schools:
   a. To establish and maintain Indigenous Health Units (IHUs) at each university;
   b. To maintain relationships with their local Indigenous communities via the Indigenous units within each medical school, Aboriginal Community Controlled Health Services and outreach programs;
   c. To ensure that Medical Deans commit to development of locally relevant cultural awareness and orientation programs for all staff and students;
   d. To provide quality immersion learning experiences through practicum placements in an Indigenous health context, including area-specific cultural awareness/competency training prior to placement;
   e. To ensure a minimum adequate standard of Aboriginal and Torres Strait Islander health education is developed in conjunction with the CDAMS Indigenous Health Curriculum Framework guidelines [33];
   f. To increase the number of Aboriginal and Torres Strait Islander medical students;
   g. To implement the recommended strategies outlined in the Healthy Futures report as a method of ensuring adequate recruitment, retention and support of Aboriginal and Torres Strait Islander medical students;
   h. To follow up the initiatives put in place by providing data and statistical analysis for Indigenous medical student retention rates;
   i. To encourage the continued medical practice of Aboriginal and Torres Strait Islander medical professionals;
   j. To ensure education on cultural safety in the healthcare setting and promote a culturally safe learning environment for Aboriginal and Torres Strait Islander medical students.

3. Health professionals and students:
   a. To provide culturally appropriate services to Aboriginal and Torres Strait Islander people;
   b. To undertake ongoing cultural training facilitated by trained Indigenous health officers and ensure a appropriate standard is maintained

4. AMSA Executive:
   a. To build and maintain strong relationships with stakeholders relevant to the Aboriginal and Torres Strait Islander Health Policy.
   b. To actively advocate to improve the health outcomes of Aboriginal and Torres Strait Islander Australians where appropriate

5. Medical Students' Societies, global health groups, rural health groups and Indigenous health groups:
   a. To promote involvement of medical school societies for Aboriginal and Torres Strait Islander events and campaigns, such as Close the Gap, Indigenous festivals and days of significance.
   b. To appoint an Indigenous health officer position on medical student societies to advocate for and promote the welfare of Aboriginal and Torres Strait Islander students.

6. Aboriginal and Torres Strait Islander communities:
   a. To advocate for community-driven health programs, working in partnership with local and state government and medical schools to deliver health care that meets the specific needs of Aboriginal and Torres Strait Islander people in their locale.

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Policy Details

Name: Aboriginal and Torres Strait Islander Health Policy

Category: F – Medicine in Australia

History: Adopted 2015