

**The Royal Australasian College of
Physicians**

**Indigenous child health in Australia and
Aotearoa New Zealand**

May
2020

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Ehara taku toa i te toa takitahi engari he toa takitini

My accomplishments aren't those of the individual, but of the many.

When we have power over our destiny our children will flourish

Uluru Statement from the heart

The RACP Indigenous Child Health Working Group

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About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand. The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Note about terminology

In this position statement, the terms *child* and *children* are used to describe all young people that paediatricians provide care for, including infants and adolescents. Notes about other terms used in this statement can be found in the *Glossary*.

Introduction

Aboriginal, Torres Strait Island and Māori children should enjoy the same high standard of health as other children in Australia and Aotearoa New Zealand. Even though many of the factors that contribute to poorer health for Indigenous children have been identified and are preventable, neither country would claim to be close to achieving equitable outcomes.

Some of the factors that contribute to inequity are deeply embedded in our society and our history, but some are present right at the point where healthcare is delivered, where a child and a family interact with a healthcare professional. The RACP recognises that as an organisation it has a responsibility and an opportunity to make a major contribution to eliminating health inequity for Indigenous children. Whether it be through influencing wider society with education and advocacy, or through enabling paediatricians to provide equitable care in their everyday practice.

There is strength and resilience in the Indigenous people of Australia and Aotearoa New Zealand even in the face of great and ongoing adversity. There is knowledge and beauty in Aboriginal, Torres Strait Island and Maori cultures that all Australians and Aotearoa New Zealanders can share in and learn from.

This position statement presents what we know about the current state of Indigenous child health and why it differs from the health of other children. It provides the RACP and its members with a guide to understanding our role in the elimination of health inequity. There is no child health issue more important in Australia and Aotearoa New Zealand.

This position statement builds on issues discussed in the RACP Inequities in Child Health statement.

Key messages of this position statement

1. The RACP regards the inequitable health outcomes experienced by Indigenous children as unacceptable and affirms that it is committed to taking action to eliminate those inequities.
2. Indigenous children have a right to the same standard of health as other Australian and Aotearoa New Zealand Children.
3. Indigenous Child Health is *everyone's* responsibility.
4. In their day-to-day practice of medicine, every paediatrician influences Indigenous Child Health
5. Paediatricians should be able to openly discuss and teach about how implicit bias, institutional racism, colonisation and privilege impact on the health of children.
6. Indigenous Child Health works best when designed and delivered by Indigenous people.

7. Paediatricians improve Indigenous child health when they support and work with Indigenous communities.
8. The RACP is committed to the development of an Indigenous physician workforce that mirrors the population.
9. The RACP will routinely and deliberately consider the impact on Indigenous health in all of its activities and decision-making.

Priorities for the RACP

1. Develop an Indigenous physician workforce that, at the least, mirrors the general population.

This is the most effective means by which the RACP can contribute to the health and well-being of Indigenous people and it is of the highest priority. Attracting Aboriginal, Torres Strait Island and Māori doctors requires a culturally competent and culturally safe College. A model of social justice should be applied to the selection process and ongoing support of Indigenous trainees.

2. Prioritise Indigenous health in its training, assessment, supervision, mentoring, continuing professional development requirements and education activities.

Paediatricians should be able to openly discuss and teach about how implicit bias, institutional racism, colonisation and privilege impact on the health of children. The RACP will promote this through the education offered to fellows and through the expectations it sets in its continuing professional development requirements.

3. Recognise that in the past and present Indigenous people in Australia and Aotearoa New Zealand have frequently been unable to fully realise their human rights, that there is an urgent need to respect and promote these rights¹ and that Indigenous children have a right to the same standard of health as other Australian and Aotearoa New Zealand Children
4. In its Indigenous Strategic Framework and eventually in its Constitution, the RACP will recognise and endorse the rights of Indigenous People.

The United Nations Declaration on the Rights of Indigenous Peoples which includes the right to self-determination (article 3); the right to be free from discrimination (article 2); the right to be respected as distinct people (article 5); and collective, as well as individual human rights (article 1).² The RACP will recognise and endorse the unique rights of Māori in Aotearoa New Zealand under the Treaty of Waitangi.

5. Routinely and deliberately consider the issue of health equity for Indigenous people in any and all College activities, publications, statements, initiatives, functions and decisions and keep records of those deliberations so that they available for review and audit.
6. Work towards a College that is culturally safe and free of institutional racism.

This requires formal training of staff, employment of cultural advisors and regular review and audit of college activities.

7. Advocate for governments to implement policies that address inequitable health outcomes for Indigenous Children.

Policies include those that influence the social determinants of health, such as poverty, employment and housing. Other policies should address issues such as; youth suicide, children and young people in detention or in the care of the state, protection of children from neglect and abuse, healthy eating and healthy living and the prevention of childhood obesity.

8. Prioritise research about Indigenous Health, especially by Indigenous doctors, with appropriate allocation of funding.

Priorities for Paediatricians and Paediatric Trainees

1. Form relationships with people and organisations that work in Indigenous Child Health.

This will allow you to support them, and them to support you.

2. Learn about Indigenous culture and language in your country and your area.

Including meeting Indigenous people by being involved in community activities; be humble enough to learn new ways of thinking about the world that will enhance your own; recognise the many strengths Indigenous cultures possess and utilise them when your care for Indigenous children.

3. Be open to recognising, naming and controlling unconscious biases and institutional racism in our practice and our professional environments.

Understand the meaning and significance of the terms privilege, colonisation and institutional racism and be comfortable explaining those meanings to others, as well as teaching others about them.

Understand that the development of cultural competency and cultural safety is a career-long process

4. Incorporate cultural competency and Indigenous Health into your teaching, training, supervision and mentorship of trainees and medical students.

5. Learn about the colonial history of your country and encourage colleagues to do the same.

It is *not possible* to understand the current health status of Indigenous people, including children, if you don't know about the history of your country.

6. Examine how well Indigenous children are served by your practice and your organisation and develop plans to achieve equitable outcomes.

7. Consider equity in all the decisions you and your colleagues make about the day-to-day operations, governance and quality management of your service.

Clinical audit, data collection and comparison, peer review, patient satisfaction studies and research are some examples of tools through which achievement of equity can be assessed.³

8. Promote behaviours that are respectful of Indigenous customs and beliefs and, where possible, the use of Indigenous language in your workplace and your clinical interactions.

Indigenous Models of Health

To make special mention of Indigenous Models of Health would seem to suggest that they are distinct from 'normal' models of health. In fact, the idea of health including the well-being of a person as a whole and in the context of the well-being of a social group has probably been normal in most of the world for most of its history. We describe it mainly to provide a contrast with the modern Western model of health, which has tended to place an emphasis on disease, biology⁴, and an individual's responsibility for his or her own health^{5,6}.

Indigenous models of health in Australia and Aotearoa New Zealand have a wide focus that includes the well-being of people within their families and communities, and generally a shared responsibility for the health of the individuals within a group. Physical health, psychological health, spiritual health and the health of the family and community are linked and interdependent.

The relative collectivism seen in traditional Indigenous Australian and Aotearoa New Zealand societies contrasts with the strong emphasis on individualism in contemporary mainstream society in both countries. Individualism is at the heart of modern economic policies that assume a level playing field of opportunity, and assume that humans are individuals who make decisions based on maximising material wealth.^{7,8} Not only do these policies disadvantage Indigenous societies, but they also tend to lead to assignment of blame to those who are disadvantaged, since responsibility for any lack of success is directed at the behaviour of individuals rather than systems and institutions.^{9,10,11}

Māori models of Health

Māori models of health are holistic and reflect fundamental elements that contribute to realising and sustaining a state of well-being. Whānau, hapū and iwi are best placed to decide what this means to them, in accordance with their own values and their own rangatiratanga (autonomy). Models of Māori health,¹² defined by Durie and Pere, set out to describe commonalities premised on a kaupapa Māori worldview. The conceptual framework they provide is frequently used in the development of health education curricula, health policy and health services in Aotearoa New Zealand.

Whare Tapa Wha, or the four cornerstones of health, demonstrates that health and well-being is dependent upon an equilibrium of four walls: tinana (physical), hinengaro (mind), wairua (spiritual) and whānau - hapū - iwi (family, subtribe, tribe, kinship). Each of these elements are equally critical for Māori health and well-being to flourish and thrive.

Te Wheke, uses the octopus as a metaphor, the head of the octopus represents whānau and each of the tentacles represent: waiora (total wellbeing for the individual and family), wairuatanga (spirituality), hinengaro (mind), tinana (physical), whānaungatanga (family), mauri (life force in people and objects), mana ake (unique identity of individuals and family), hā a koro ma, a kui ma (breath of life from

forbearers) and whatumanawa (the open and healthy expression of emotion). The elements are interwoven, each are required for Māori health and well-being to flourish and thrive.

Aboriginal and Torres Strait Island Models of Health

“To us health is so much more than simply not being sick. It’s about getting a balance between physical, mental, emotional, cultural and spiritual health. Health and healing are interwoven, which means that one can’t be separated from the other.”

Dr Tamara Mackean

Chairperson 2013-2018, RACP Aboriginal and Torres Strait Islander Health Committee

Aboriginal and Torres Strait Islander peoples view health in a broad inclusive way that highlights the central importance of culture, identity and connection to family, country, language and traditions.¹³

“Aboriginal health” means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life.”

National Aboriginal Health Strategy, 1989

Social and emotional wellbeing recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these impact on the individual¹⁴. Within Aboriginal and Torres Strait Islander communities, ‘family’ is defined more broadly than for many other Australians and comprises extended family members and significant others¹⁵. Social and emotional wellbeing includes acknowledging the impact of trauma, grief and life stressors, which are reported at higher rates for Aboriginal and Torres Strait Islander people¹⁶.

The Current State of the Health of Indigenous Children

Australia

Aboriginal and Torres Strait Islander children in Australia experience a higher burden of disease and have poorer health outcomes than their non-Indigenous peers. The reasons for this disparity are multiple, and complex. The impact in terms of increased morbidity and mortality is seen during childhood, and also in adulthood where the long-term sequelae of childhood illness can result in chronic diseases and early death¹⁷.

Gaps in health outcomes between Aboriginal and Torres Strait Islander people are often quantified based on analyses which group all Aboriginal and Torres Strait Islander people together. This approach can obscure the wide spectrum of health outcomes that exist in this diverse cohort; health outcomes that are influenced by other factors such as socioeconomic status, geographic location and other barriers to healthcare.

Antenatal factors play a very important role in the health of children. Whilst the majority of Aboriginal and Torres Strait Islander mothers in Australia access antenatal care, this tends to occur less often

and later in pregnancy, compared to other mothers¹⁸. Rates of tobacco smoking are higher amongst Aboriginal and Torres Strait Islander mothers than non-Indigenous mothers.¹⁹ Nineteen to 44 per cent of Aboriginal women drink alcohol during pregnancy.²⁰ Of babies born to Aboriginal and Torres Strait Islander mothers, 11.8% are low birth weight, almost twice the rate for babies of non-Indigenous mothers²¹. Low birth weight is associated with increased risk of death and neurodevelopmental disability in the first year of life and can have life-long impact on morbidity.

Aboriginal and Torres Strait Islander infant mortality rates have been reducing over time, with a narrowing of the gap between Indigenous and non-Indigenous infants. Despite this, the rate (6.1 per 1,000 live births) remains almost twice the rate for non-Indigenous infants.²² In the Northern Territory, the Indigenous infant mortality rate is 12.5 per 1,000 live births.²³

Under-five years old mortality trends reflect infant mortality trends in both Indigenous and non-Indigenous children and, while there was a decrease for Indigenous children between 1998 and 2014, the rate remains higher than the non-Indigenous rate.²⁴ Aboriginal and Torres Strait Islander children aged less than 5 years are hospitalised at 1.5 times the rate of non-Indigenous children.²⁵

Mortality differences persist into adolescence, when all-cause mortality is more than twice that of non-Indigenous adolescents. The majority of deaths in Indigenous adolescents are due to intentional self-harm or road traffic injury²⁶. Aboriginal and Torres Strait Islander teenagers are far more likely than non-Indigenous to be affected by sexually transmitted infections, including chlamydia, gonorrhoea and syphilis²⁷. In 2016, notification rates for gonorrhoea in people aged between 15 and 19 years was 2202 per 100 000 compared with 93 in the non-Indigenous population.²⁸

Rates of invasive bacterial infections and severe sepsis are significantly higher in Indigenous children²⁹. Invasive infections with *Staphylococcus aureus* and group A *Streptococcus* are particularly common in Northern Australia^{30,31}. Non-infectious sequelae of group A Streptococcal infection disproportionately affect Aboriginal and Torres Strait Islander children by large orders of magnitude. Post streptococcal glomerulonephritis rates are 50 times higher in Aboriginal and Torres Strait Islander people, and acute rheumatic fever and rheumatic heart disease rates are more than 60 times that seen in non-Indigenous people.^{32,33} Australian Indigenous children have almost three times the rate of middle ear disease than their non-Indigenous counterparts, and rates of hearing loss are also higher.^{34,35}

Indigenous Australians have 1.5 times the rate of disability of non-Indigenous Australians³⁶. Indigenous children in Australia are more at risk of developmental vulnerabilities: the Australian Early Development Census in 2015 (based on a teacher's assessment of a child's development in their first year of school, across five domains) found that 42.1 per cent of Indigenous children were developmentally vulnerable on at least one domain compared with 22 per cent of all Australian children.³⁷

Aboriginal and Torres Strait Islander children are placed in out of home care at higher rates than non-Indigenous children³⁸. The Aboriginal and Torres Strait Islander Child and Young Person Placement Principles outline that where possible, Aboriginal and Torres Strait Islander Children should be placed in extended family networks, kin or the broader Aboriginal community to maintain connection to family, community, country and culture³⁹.

The over-representation in detention of Aboriginal and Torres Strait Islander young people relative to non-Indigenous young people is significant and is more extreme than for the adult population⁴⁰. Incarcerated adolescents are more likely to experience poorer health and life outcomes and disproportionately high levels of disadvantage than the general population, and it is increasingly recognised that their health needs are greater than young people in non-custodial settings⁴¹.

High rates of mental health issues and stress are a significant public health issue for Aboriginal and Torres Strait Islander children. Aboriginal and Torres Strait Islander children experience higher incidences of life stressors, the death of a family member being the most common⁴². Poor mental health and high stress levels are influenced by biological, social, psychological factors and the collective impact of life stressors. Between 2013-2017 Aboriginal and Torres Strait Islander children made up 25 per cent of suicide fatalities for the under 17 age group⁴³. Preventative responses to address suicidal behaviour include reducing the number of life stressors experienced by children, a healthy, safe, supportive environment and a strong connection to culture, community and school.

Figure 1. Infant mortality rates in Australia and Aotearoa New Zealand

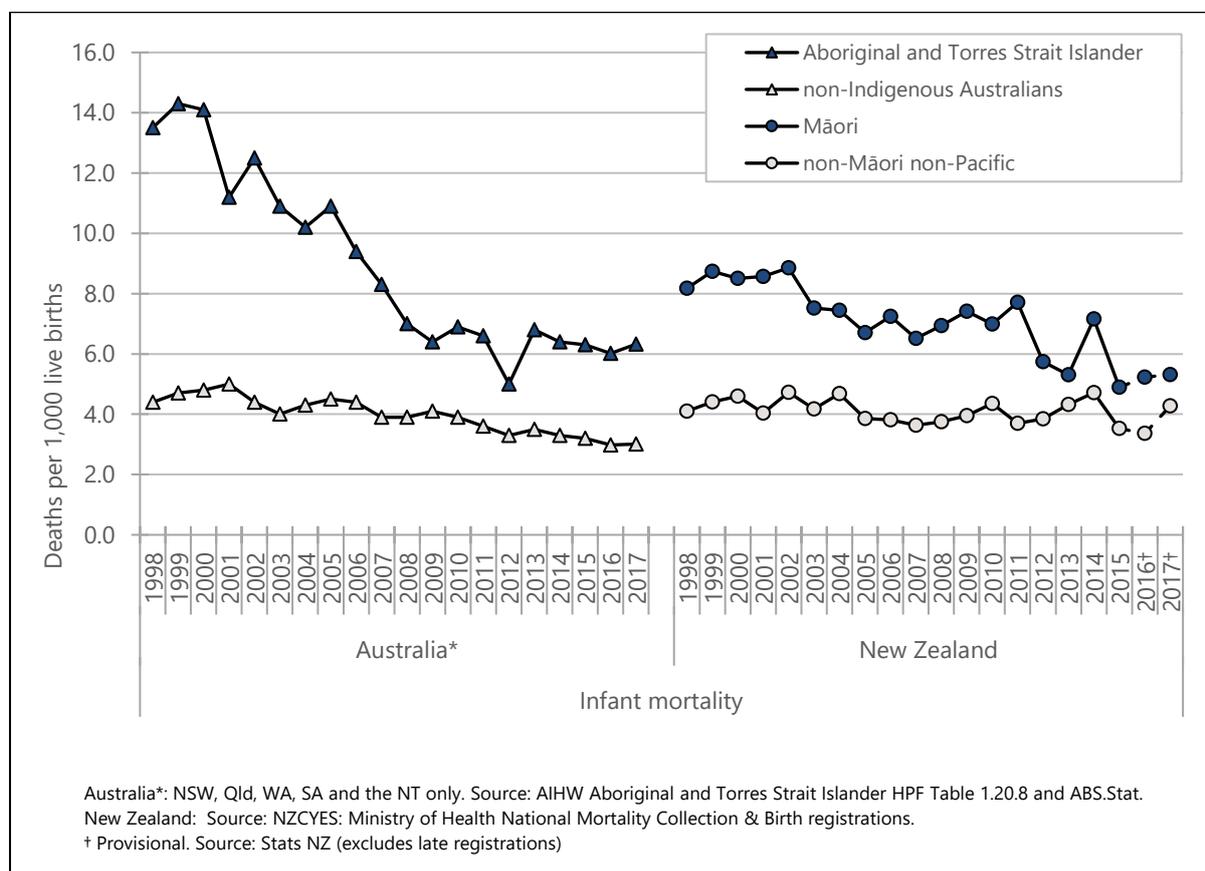
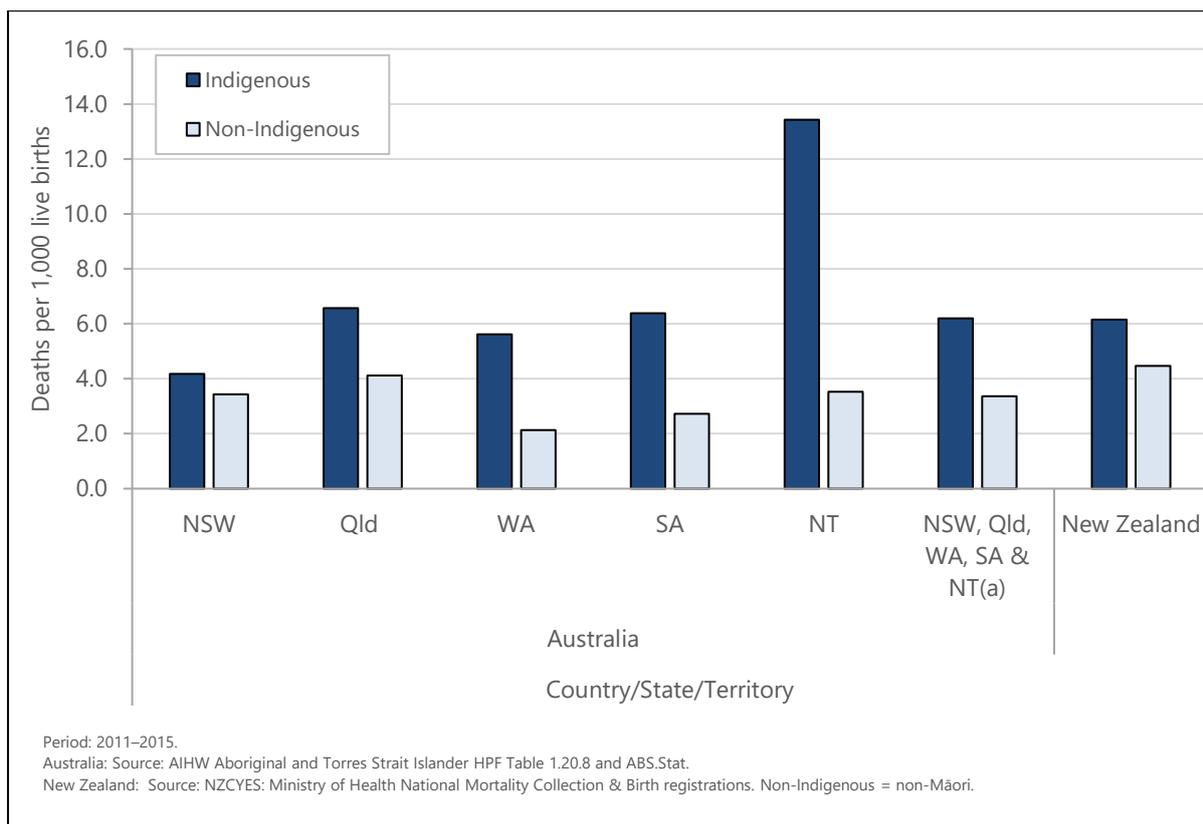


Figure 2. Infant mortality rates by State and Territory.



Aotearoa New Zealand

The health status of children in Aotearoa New Zealand has been improving over time. For example, the rate of infant mortality among Māori almost halved between 1996 and 2012.⁴⁴

Despite the improvements, the health of Māori children lags well behind the health of other children. In an imagined Aotearoa New Zealand where Māori children enjoy the same health as other children (where other children are non-Māori non-Pacific), each year there would be 38 fewer Māori infant deaths, 20 fewer Māori Sudden Unexpected Death in Infancy cases, 1608 fewer hospital admissions for bronchiolitis in Māori children, 75 fewer hospital admissions for acute rheumatic fever in Māori children and 28 fewer suicides among Māori young people aged 0-24 years.

Disability rates in children age 0-14 years are 1.6 times higher in Māori (14.9%) than non-Māori (9.2%).⁴⁵ Māori children are more than 1.5 times as likely as non-Māori to have any teeth extracted due to decay, abscess or infection in the past 12 months.⁴⁶ Māori children 0-14 years old are 1.43 times more likely to have unmet need for primary care (due cost, lack of transport, lack of childcare or to lack of an available appointment within 24 hours) than non-Māori children.⁴⁷

Māori children are placed in the custody of Oranga Tamariki (Ministry for Children), Aotearoa New Zealand's State child welfare agency, at higher rates than other children. Of 5708 children in Oranga Tamariki custody in the year ending 30 June 2017, 3518 were Māori.⁴⁸

In Aotearoa New Zealand there are twice as many Māori children living in poverty as pakeha children.⁴⁹ Māori children are more likely to be in categories associated with health risks: rates of exclusive breast feeding at age four months 0.7 times those of non-Māori, rates introduction of solids

before age four months are 2.28 times those of non-Māori, and there are higher rates of television watching.⁵⁰

The New Zealand Health survey 2017/18 shows Māori children are more likely to be in categories associated with health risks in many indicators⁵¹, summarised in table 1.

Table 1. The New Zealand Health Survey 2017/18 (selected results displayed, see reference for full results).

	Rate Māori to non-Māori
Exclusively breastfed until at least 4 months old (among children aged 4 months to < 5 years)	0.70
Given solids before 4 months (among children aged 4 months to < 5 years)	2.28
Meets vegetable intake guidelines (2-3 servings per day, depending on age (2-14 years))	0.88
Breakfast at home every day in the past week (2-14 years)	0.91
Fizzy drink at least three times in the past week (2-14 years)	1.86
Ate fast food three or more times in past week (2-14 years)	1.81
Children (aged 6 months-14 years) who met screen time recommendations for their age group	0.55
Asthma diagnosed and medicated (2-14 years)	1.87
Eczema diagnosed and medicated (0-14 years)	1.37
Experienced one or more types of unmet need for primary health care in the past 12 months (0-14 years)	1.43
Teeth extracted due to decay abscess or infection in lifetime (1-14 years)	1.50

*An adjusted ratio of 1.50 for Māori means that the indicator is 1.5 times as likely in Māori than non-Māori, after adjusting for differences in gender and age.

A list of other important indicators for health status for Māori children and young people are summarised in table 2.

Table 2 Rates ratios for indicators for the health status for Māori children and young people age 0-14 years compared to non-Māori non-Pacific.

	Māori cases annual average	Rate ratio Māori to non-Māori non-Pacific
Infant mortality, 2011-2015	108	1.53
Sudden unexpected death in infancy, 2011-2015	25	4.87

Ambulatory sensitive hospitalisation 0-4-year olds^{b*}, 2013-2017	6065	1.38
Otitis media 0-14-year olds^{b*}, 2013-2017	156	1.21
Bronchiolitis in infants^{b*}, 2012-2016	2374	3.10
Pneumonia 0-24-year olds^{b*}, 2013-2017	1051	1.72
Asthma 0-24-year olds^{b*}, 2013-2017	2420	2.05
Bronchiectasis 0-24-year olds^{b*}, 2013-2017	146	6.79
Pertussis in under 1-year olds^{b*}, 2012-2016	57	2.70
Meningococcal disease in 0-24-year olds^{b*}, 2013-2017	23	2.32
Acute rheumatic fever 0-24-year olds^{b*}, 2013-2017	84	36.31
Rheumatic heart disease 0-24-year olds^{b*†}, 2013-2017	82	11.22
Serious skin infection 0-24-year olds^{b*}, 2013-2017	1613	1.93
Gastroenteritis 0-24-year olds^{b*}, 2013-2017	1146	0.85
Unintentional injury hospitalisations 0-24-year olds^{b* ‡}, 2013-2017	4305	1.25
Teenage births^c, 2012-2016	1696	5.55
Mental health hospitalisations 0-24-year olds^{b*}, 2013-2017	1849	1.29
Suicide 0-24-year olds^a, 2011-2015	50	2.29
Unmet need for primary health care 0-14-year olds^{dΦ}, 2016/2017	n/a	1.33
Obesity in 2-14-year olds^{dΦ}, 2016/2017	n/a	1.74
Age-appropriate immunisations at 2 years old^e, 2017/2018	2666	0.96
Children aged 0-17 years in custody of Oranga Tamariki – Ministry for Children^{2016/2017}	3518	5.12

Source: NZYCES. Data sources: ^a National Mortality Collection. ^b National Minimum Dataset (acute and arranged admissions). ^c Birth registrations dataset. ^d NZ Health Survey. ^e National Immunisation Register. ^f Oranga Tamariki. *RR = Rate ratio (Māori vs non-Māori non-Pacific); aRR = Adjusted Rate Ratio (Māori vs non-Māori). †Diagnosis in any of the first 15 diagnosis. ‡Excludes ED cases

Why is the health of Indigenous Children different from other children?

Some of the reasons for the difference between the health of Indigenous children and other children are deeply embedded in Australian and Aotearoa New Zealand societies. Others are at play in the interactions that health professionals have with children and their families and therefore can be directly influenced by paediatricians. All childhood health inequities are preventable.

Social Determinants of Health

Several studies have shown that inequalities in health are caused by and reflect social and economic factors.⁵² These social inequalities in the conditions into which children are born, grown, live and work

and age affect not only material resources and access to health care, but also their relationship to power structures and the control that they have over their lives. All of these factors have a direct and profound influence in health outcomes, mediated by complex processes that influence health along the life course. Those with higher socioeconomic positions have better health outcomes on average, and that there is a gradient in the relationship between socioeconomic position and health.⁵³

The social inequalities affecting health far outweigh the impact of other determinants of health, such as genes, biology or medical care.^{54,55} Socioeconomic position accounts for between one-third to one-half of the health gaps between Indigenous and non-Indigenous Australians.⁵⁶ An analysis of the Australian Institute of Health and Welfare (AIHW) 2011-13 Health survey showed that specific social determinants including education, employment status, overcrowding and household income accounted for over one-third of the gap in health outcomes.⁵⁷ Socioeconomic position affects a number of factors that are involved in good health: access to adequate housing and material needs, access to preventative health care, exposure to adverse childhood events, and exposure to behavioural risk factors such as smoking, substance use and poor diet. AIHW data from 2012-13 shows that Indigenous Australians who were unemployed were more likely to smoke and to have substances misuse issues.⁵⁸ Indigenous Australians who live in remote areas are further disadvantaged by social circumstances that are linked to their remote location including access to safe housing, access to water and sanitation, access to health care and early childhood education.⁵⁹ Māori people constitute a larger percentage of Aotearoa New Zealand's rural population and distance to services is an acknowledged by-product of rural living.⁶⁰ Māori adults are more likely to report difficulty accessing primary health care due to cost.⁶¹

In addition, social inequalities for Indigenous Australians influences health through a mechanism described by Marmot as the “marginal position in relation to mainstream society”.⁶² Marmot's work in the Whitehall studies have been critical in understanding the fundamental role of having control over one's life in determining health outcomes and he encourages Australia to, “apply the findings from research on the social determinants of health...(to) enable Indigenous Australians to lead more flourishing lives that they would have reason to value”. Many Indigenous Australians experience racism. Several studies have examined the adverse relationship between racism and health for children and young people.⁶³ The WA Aboriginal Child Health Study found that 22 per cent of the surveyed children aged 12 to 17 years reported experiencing racism.⁶⁴ Racism is a societal factor which can affect health in many ways and is a “fundamental driver of health” for Indigenous people⁶⁵. Paradies outlines the pathways from racism to ill-health, including, “reduced and unequal access to societal resources for health, increased exposure to risk factors, direct impacts of racism on health via racially motivated physical assault, stress and negative emotion reactions that contribute to mental ill health, and negative responses to racism such as smoking and alcohol use”.⁶⁶

Early childhood, a period during which many factors affecting lifelong health are present, can be strongly influenced by social determinants such as access to good antenatal care, maternal and child nutrition, exposure to adverse childhood events, exposure to unhealthy environments and access to early childhood education. The work by Shonkoff and others has illustrated the neurobiology of chronic stress on the developing brain, and the long-lasting effects that this can have on a child's development and learning, their wellbeing and physical health.^{67,68} The adverse childhood experiences (ACE) studies have added to the weight of scientific knowledge about the impact of early childhood trauma on adult health, including mental health, metabolic health and chronic disease.^{69, 70} Several studies have illustrated the burden of significant life stressors on Indigenous children in

Australia. Twenty-five percent of Indigenous children aged 4-14 years reported experiencing the death of a family member or friend in the past year in 2014-15.⁷¹ Forty per cent of Indigenous children aged 4-14 years reported being bullied at school, and nine per cent reported being treated unfairly at school because they were Aboriginal and/or Torres Strait Islander.⁷² This exposure to adverse childhood events, and early childhood trauma, can have a profound influence on that child's early childhood cognitive and emotional development, and which have a lasting influence on health into adult life. In addition, there is emerging evidence for the role of intergenerational trauma on health outcomes, through epigenetic changes which can be inherited.⁷³

Improvements in the health of Indigenous children lags behind their non- Indigenous counterparts in both Australia and Aotearoa New Zealand. The social determinants of health are responsible for a large portion of this gap in health outcomes. In both Australia and Aotearoa New Zealand, Indigenous populations are more likely to have a lower socioeconomic position, and the factors underlying these inequalities need to be addressed in a fair society. Addressing the root causes of these inequalities is the most effective way to achieve health equity. This requires sustained political and economic policy changes, and an intersectoral approach. The principles of proportionate universalism – reducing the steepness of the social gradient in health with action that is universal but proportionate to the level of disadvantage – address the tendency for good medical care to vary inversely with the need for it in the population served. These principles are described in the RACP Inequities in Child Health Position Statement.⁷⁴ Marmot outlines six domains to target: (i) give every child the best start in life, (ii) improve education and life-long learning, (iii) create fair employment and jobs, (iv) ensure a minimum income for a healthy standard of living, (v) build healthy and sustainable communities, and (vi) apply a social determinants' approach to prevention⁷⁵.

Health Systems

Although the social determinants of health are a major contributor, significant health inequalities can exist between people of different ethnicities even with adjustments for socioeconomic factors like employment status, income, education, marital status and household size.^{76, 77}

Māori, Aboriginal and Torres Strait Island people receive poorer quality health care than non-Indigenous people.^{78, 79, 80, 81} Health professional factors play a role in creating and maintaining inequitable health care and health professionals can have a major role in their elimination.^{82, 83}

Unconscious Bias

Bias may be present at different levels in health system, including at an inter-personal level. Doctors, like other people, interact more positively with patients who are similar to themselves.⁸⁴ Each of us tends to believe that we are fairer and less prejudiced than the average person⁸⁵. We have both a positive bias towards people in our group – the people we are more familiar with – and a negative bias towards outside of our group – the people we are less familiar with⁸⁶. Generalisations and assumptions can make patient interactions faster and easier, but they can also exacerbate disadvantage. Clinician bias has been found to contribute to racial inequities in medical care⁸⁷

Unconscious bias influences our decision-making and judgements in ways that, by definition, we aren't aware of. It is bias that comes from our past experiences, the culture we grow up in, our assumptions or interpretations and our deeply embedded thought patterns.^{88 89} We underestimate the influence of unconscious bias on our behaviour. As Howard Ross describes, "Ultimately, we believe

our decisions are consistent with our conscious beliefs, when in fact, our unconscious is running the show”.⁹⁰

When the unconscious brain sees two things that go together often (for example, many male Chief Executive Officers or many female nurses) it begins to expect to see those things together. This can lead to a feeling that those combinations are ‘normal’ and other combinations aren’t. If not recognised, these associations can lead us to (at best) lazy stereotypes and (at worst) prejudice and discrimination.⁹¹ We are all affected by unconscious bias⁹², but we are far more likely to be able to recognise bias in others than in ourselves.⁹³

Unconscious bias may lead some people to not be concerned that there are very few Indigenous paediatricians, because they are so familiar and comfortable with paediatricians being non-Indigenous. This acceptance of the familiar can be present even in centres where a high proportion of the children who require paediatric care are Indigenous.

Institutional Racism

The term racism is confronting. When most people hear the word, they think of interpersonal racism, referring to prejudice based on assumptions about the abilities, motives and intentions of others according to their race.⁹⁴ Although there is evidence that interpersonal racism occurs within the delivery of healthcare in Australia and Aotearoa New Zealand, institutional racism is also present⁹⁵. Institutional Racism is defined by Jones as “differential access to goods, services, and opportunities of society by race”.⁹⁶ Others have described it as “an entrenched pattern of differential access to material resources and state power determined by ethnicity and culture, which advantaged one population while disadvantaging another”⁹⁷ and “requirements, conditions and practices, policies or processes that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups”⁹⁸ Institutional racism results when institutions are created and evolve around the values and systems of the dominant culture. Those values and systems become normalised, while those of other cultures are excluded. To participate those in the minority cultures are then required to subjugate their own values and systems in favour of those of the majority.⁹⁹

As a consequence of institutional racism Indigenous people receive less healthcare and lower quality healthcare. In Aotearoa New Zealand Māori receive shorter interview times, fewer referrals, fewer diagnostic tests and fewer treatments from their doctors than non-Māori.¹⁰⁰ Disparities persist even with adjustments or control for socioeconomic and demographic variables.¹⁰¹ Even when they are aware of the inequalities between Māori and non-Māori, there is a tendency for non-Māori doctors to blame Māori for their own condition rather than identify deficiencies in the care they provide or to acknowledge historical socio-political factors.¹⁰²

There is growing evidence of the negative health effects of racism and colonisation^{103 104 105 106 107 108} Institutional racism leads to a systemic failure of health services in Australia and Aotearoa New Zealand to meet the health needs of Indigenous children. It can be present in workplaces staffed by well-meaning and intelligent healthcare professionals, even when they have taken measures to eliminate interpersonal racism. Institutional racism influences health outcomes not just through the social determinants of health, but also in the way healthcare is delivered to patients by health services and by health care professionals.

Privilege

If one group is experiencing lower quality health outcomes, then there must be higher quality outcomes for another group¹⁰⁹. Privilege is a preferred status or rank that is conferred rather than earned through effort or talent^{110,111} but it is perpetuated in society by the notion that individuals receive what they deserve: if you are wealthy and powerful you must have worked hard or been smart; if you are powerless and poor you didn't work hard enough and you weren't smart enough.¹¹²¹¹³¹¹⁴¹¹⁵¹¹⁶ This idea is predicated on an assumption that everyone has equal opportunities in society, but the perception of an 'equal playing field' can be an illusion; for the privileged group it can *seem* like the opportunities afforded to them are universally available.¹¹⁷ Those in the privileged group have more power in society¹¹⁸ and in this way privilege protects itself, even when the privileged aren't aware they possess it. To those belonging to the dominant culture, the established practices that support and privilege them in all domains of society are so natural that they are invisible.¹¹⁹ A Privilege Model helps to explain inequitable outcomes in health because health systems inherently favour the group in society who design, control and deliver the healthcare.

Approaching issues of equity with a Privilege Model has the advantage of placing obligation on the privileged to examine their role in the origins of inequity and the part they play in achieving equitable outcomes. This contrasts with the Deficit Model¹²⁰ where the focus is on the roles and responsibilities of those that are experiencing lower health outcomes.

Colonisation

Colonisation has been identified as an underlying determinant of Indigenous Health.^{121,122,123} The process of colonisation in Australia and Aotearoa New Zealand has been built on a presumption that the language, traditions and knowledge of the colonisers is superior to those of the colonised.¹²⁴ Ethnocentrism, the act of evaluating other cultures according to preconceptions originating in the standards and values of one's own culture, lies at the core of the colonisation process.^{125,126} The negative impacts of this devaluation of a culture within societies can be seen on Indigenous populations around the world.¹²⁷ Colonisation sees decision-making and resource allocation transfer from the Indigenous people to the colonisers. This is reflected in the structure of the institutions such as Education, Justice and Health. Indigenous language may be suppressed or eradicated. The Indigenous Children's Health Report describes historic and *ongoing* government policies in Australia, Aotearoa New Zealand, Canada and the United States as contributing to and perpetuating the dislocation of Indigenous people from their homelands; the disenfranchisement of Indigenous people from their rights to self-determination; the undermining of economic and social development; and the fragmentation of families, communities, and nations.¹²⁸ It is common to think of colonisation as inadvertent and historical, but it is more accurate to describe it as a continual, active and deliberate process.^{129,130}

Intergenerational trauma

Historical trauma, which transmits through generations and is separate from contemporary stressors, may impact on the health of Indigenous people.¹³¹ The trauma of colonisation may be experienced by subsequent generations with lifelong health, psychological and social impacts.¹³²¹³³ There are established links between violence, grief and substance use, as symptoms of traumatic stress.¹³⁴

Trauma-informed services respond to how people, families and communities have been impacted by trauma.¹³⁵ Values and principles of trauma-informed services can include: awareness of trauma impacts, patient safety, cultural competency, enabling an individual's control, enabling healing and provide integrated care.¹³⁶ Paediatricians should understand and be comfortable working in trauma-informed models of care.

Culture and healthcare

All of us have a culture. Culture isn't so much something people have or belong to, but rather it relates to shared meaning and how people see their own identity and the identity of others. Its many influences include ethnicity, age, gender, sexual orientation, beliefs, values, the friends you have, the pastimes you enjoy, your employment and the environment you were raised in.

Health systems and healthcare environments also have a culture; one that reflects the culture of the people who design, manage and work in them.¹³⁷

It's easy for health care professionals to give little thought to their own culture and the culture of their workplaces because they are so familiar and comfortable with them. Commonly doctors perceive the care they provide to be culturally 'neutral' and therefore equally available to all their patients. Cultural competence is largely about recognising how your own culture, including the implicit biases that affect your thinking and behaviour, and the factors that drive those biases, influence the interactions you have with those around you.¹³⁸ Cultural competency is a life-long learning process that can be continually developed, in the same way that one continually develops their communication skills or teaching ability.

Cultural safety focuses on the patient experience to define and improve the quality of care.¹³⁹ Part of cultural safety is making sure that your system is not set up to favour one racial group over another.¹⁴⁰ A system that is racist asks one group to conform to the requirements of the system that is designed and delivered by another group.¹⁴¹ It sends the message that you can be just as successful in this system as long as you think, behave and share the values of the advantaged group¹⁴². In this sort of biased system unequal health outcomes tend to be addressed by focusing on the capacity of the disadvantaged group rather than the failings of the systems and institutions.

Cultural safety provides patients with the power to be involved in their own health care.¹⁴³

Understanding how differences in culture impact on interactions between people is necessary for doctors to provide effective health care to all patients and to reduce the inequities that exist between Indigenous and non-Indigenous children.

Indigenous Rights

Indigenous children face significant challenges to achieve the best possible health and well-being through childhood and into adulthood. Adverse experiences that predict a person's future health and wellbeing - including risk of smoking, drug dependency, obesity, depression, anxiety, cardiovascular disease, cancer, non-completion of high school, unemployment, lower income, poverty and shortened

Trauma is generally understood as a persons' response to a major catastrophic event that's so overwhelming it leaves that person unable to come to terms with it. This trauma can be passed on to future generations through parenting practices, behavioural problems, violence, harmful substance use and mental health issues.
Intergenerational trauma. Australians Together australianstogether.org.au

lifespan - are present during childhood, before a child is old enough to make decisions about their own health.^{144, 145, 146} Inequitable exposure of Indigenous people to the negative social determinants of health and societal systems and institutions that produce inequitable outcomes are breaches of the rights and protections afforded to them by the United Nations Declaration of the Rights of the Child, Declaration on the Rights of Indigenous Peoples, Universal Declaration of Human Rights and, in Aotearoa New Zealand, the Treaty of Waitangi.¹⁴⁷

The United Nations Declaration on the rights of Indigenous Peoples, adopted by the United Nations General Assembly in 2007, recognises that Indigenous people have not always been able to fully realise their human rights and that there is an urgent need to respect and promote the rights of Indigenous peoples.¹⁴⁸ The Declaration includes articles that affirm that Indigenous Peoples have the right to:

- Self-determination
- A nationality, autonomy or self-government, and their own institutions
- Participation in decisions that affect them
- Equality and non-discrimination
- Protection from cultural destruction or assimilation
- Their culture, customs and language

More details about the United Nations Declaration on the Rights of Indigenous Peoples and other protections are summarised in Appendix 1.

The Treaty of Waitangi

The Treaty of Waitangi (the Treaty) is often referred to as the founding document of New Zealand. Signed in 1840, the Treaty¹⁴⁹:

1. Bound Māori and the Crown in partnership
2. Enabled Māori control and management over their resources (article two)
3. Made clear the Crown's protective role over Māori and conferred citizenship rights to Māori (article three)

The Treaty forms the basis of the partnership between Māori and the New Zealand Government. Under the principles of the Treaty Māori have the right to make decisions about the planning, development and delivery of health services; to expect to enjoy at least the same level of health as non-Māori; and to have Māori cultural concepts safeguarded.¹⁵⁰

See appendix 1 for recommended reading about the Treaty of Waitangi

The Uluru Statement of the Heart and a Treaty for Australia

The RACP supports the Uluru Statement of the Heart,¹⁵¹ which calls for:

- A Makarrata Commission – a truth telling process about colonisation and Australian history
- Legislative change – develop agreements with Australian governments
- Constitutional change - enshrining a First Nations Voice in the Australian Constitution empowers Aboriginal and Torres Strait Islander people

Equity and Equality

Child health inequities are unequal outcomes in children's health and well-being that are unjust, unnecessary, systematic and preventable. Health inequalities are observed differences in health status between groups, not all of which can be judged to be inequitable^{152,153}.

Health inequities exist between Indigenous and non-Indigenous children in Australia and Aotearoa New Zealand. These inequities are large, pervasive, and persist across the lifespan and over time.¹⁵⁴

The RACP has published a position statement on Inequities in Child Health which describes the problem in Australia and Aotearoa New Zealand and makes recommendations about how the RACP and its members can eliminate them.¹⁵⁵

The Economic Cost of Health Inequity

If well-being and good health benefit society, unnecessary and preventable absence of well-being and health is a burden. The existence of persistent and unfair health inequities has been described as '...a substantial loss of human potential, a loss of talent and productivity that might otherwise have contributed to the betterment of society'.¹⁵⁶ In the United States it has been estimated that elimination of health disparities for ethnic/racial minorities between the years 2003 and 2006 would have reduced direct medical costs by US\$229.4 billion and indirect costs associated with illness and premature death by more than US\$1 trillion.¹⁵⁷ A study in the United Kingdom examined the costs imposed by health inequalities by comparing the population in 2010 to a population in which everyone has the same health outcomes as the richest 10%. Productivity losses were estimated at £31-33 billion per year, lost taxes and higher welfare payments were estimated to be between £20-32 billion per year and direct healthcare costs at £5.5 billion per year.¹⁵⁸ Inequality related losses to health in the EU have been estimated to account for 20% of the total costs of healthcare and 15% of the total costs of social security benefits.¹⁵⁹ An Australian study estimated that racial discrimination cost the economy AU\$37.9 billion per annum, equating to 3% of gross domestic product over 2001-11.¹⁶⁰

The economic costs of health inequity may be substantial. Social justice reasons aside, these results suggest there are compelling incentives for countries like Australia and Aotearoa New Zealand to eliminate health inequities.

Approaches to Indigenous Child Health

If inequitable Indigenous child health outcomes have their origins in the social determinants of health, colonisation, institutional racism and privilege, then physicians have not just the opportunity but also the responsibility to reduce them. The RACP and its members can work towards child health equity in many ways and at all levels.

Addressing bias

Training in the recognition and management of cognitive bias is increasing in medical education. The expectation that individual clinicians understand how bias impacts on their clinical practice can come from the individuals themselves, from the departments they work in, and from the larger organisations in which they work.

Every doctor should recognise that they have cognitive biases and that it is human nature to categorise other humans.¹⁶¹ Taking the time to see a person as a unique individual and not a stereotype is even more difficult when you are fatigued, time-pressured or dealing with complex cognitive information.¹⁶²

Health organisations, including the RACP, can develop their own resources and training. Training about bias can form part of cultural competency and safety training requirements.

Additional information and training resources about bias are listed in Appendix 2.

Addressing racism

If racism and discrimination are to be eliminated, they need to be recognised, named and understood. This action must be part of medical education as well as institutional policy.¹⁶³ In its educational programmes, publications and policies the RACP should refer to racism by name. There should be an expectation that fellows and trainees participate in educational activities that arm them with the knowledge and skills to combat racism in their institutions and their practice. This would include regular cultural competence/safety and Indigenous Health training. Cultural competence and cultural safety are processes for doctors to continually develop throughout their careers, in much the same way they continually improve their communication skills and their teaching ability. Understanding and reflecting on the concept of privilege is an important part of this training. When one has the capacity to reflect on one's own privilege this facilitates greater commitment to equitable action.¹⁶⁴ Physicians and paediatricians should be familiar enough with the concepts of institutional racism, privilege, cultural competence and Indigenous health that they can talk about them and teach them to others.

The responsibility for dealing with racism lies with those who are perpetuating it, not with those who are subject to it.¹⁶⁵

Addressing Colonisation

A requirement for the reversal of the negative effects of colonisation is self-determination.¹⁶⁶ In the 1994 Whaiora report Mason Durie affirms that Māori health development is essentially about Māori defining their own priorities rather than being passive bystanders, and that 'development' means using an approach in which Māori have control over the strategies used, take a preventative and integrated approach to managing and delivering their own services and work in partnership with the State.¹⁶⁷

Understanding the health status of Indigenous People in Australia and Aotearoa New Zealand requires an understanding of the colonial histories of these countries.¹⁶⁸ Contemporary colonisation is not widely recognised or reported but unequal power distribution, loss of land, language and culture continue to have significant adverse effects on Indigenous People in Australia and Aotearoa New Zealand.¹⁶⁹

If Indigenous people continue to be subject to the adverse effects of colonisation, and non-Indigenous people continue to benefit, then responsibility for reversing colonisation falls on everyone: Industry, Government, health systems and health care professionals alike.

Approaches Paediatricians can take to reverse the effects of colonisation:

1. In their language and behaviour, demonstrate that they highly value the place of Indigenous culture in their workplaces and in the work, including being knowledgeable about and respectful of Indigenous traditions, values and languages.
2. Learn about the colonial history of their country
3. Be able to discuss and teach about unconscious bias, institutional racism, privilege and the effects of colonisation with colleagues and trainees
4. Understand the difference between treating patients 'equally' and treating patients 'equitably'.
5. Develop strategies that make their services welcoming and appropriate for Indigenous families
6. Support strategies for the training and recruitment of Indigenous health care professionals, including paediatricians.

Appendix 4 lists suggested resources for paediatricians who want to learn more about the story of their country.

Indigenous health by Indigenous people

If self-determination is a fundamental requirement for the reversal of the effects of colonisation on Indigenous people, then Indigenous health services designed and delivered by Indigenous people is a fundamental requirement for health equity. This approach challenges the prevailing model in Australia and Aotearoa New Zealand that has focused on deficiencies in Indigenous people's ability and willingness to use existing services, rather than the deficiencies in the existing services.

Historically, health professionals and experts have been non-Indigenous people. Unconscious bias can lead to the notion that health experts *should be* non-Indigenous people, because non-Indigenous health experts seem familiar and normal.

Indigenous health professionals are best placed to produce effective Indigenous health services. Health systems that counter the effects of colonisation would have Aboriginal, Torres Strait Island and Māori in all roles: doctors, nurses, allied health professionals, social workers, managers, executives, laboratory scientists, administrators, funders, planners and information technologists. At present, Indigenous people make up a disproportionately small number of healthcare professionals in Australia and Aotearoa New Zealand; well below a figure that would mirror the population. Table 3 lists the percentage of Health Care Workers who are Indigenous by selected professions^{170, 171}, and compares the current number of Indigenous Health Care Professionals in those professions to the number that would represent population parity, expressed as a percentage. Population parity means the same percentage of Indigenous Health Care Workers in the health speciality as the percentage of Indigenous people in the population; 3.3% in Australia¹⁷² and 15% in Aotearoa New Zealand¹⁷³.

Table 3. Percentage of selected Health Care Professionals who are Indigenous

	Australia		Aotearoa New Zealand	
	Indigenous as a percentage of total number	Current number as a percentage of the number that would achieve population parity	Indigenous as a percentage of total number	Current number as a percentage of the number that would achieve population parity
Medical Practitioners	0.44%	13%	3.1%	21%

Paediatricians	0.17%	5.7%	3.2%	21.6%
Adult Physicians	0.16%	5.3%	2%	13.8%
Nurses	1.0%	30%	6.3%	42%
Midwives	0.96%	29%	7.1%	47%
Dentists	0.27%	8.2%	4.6%	31%
Medical Radiation Technologists	0.42%	13%	3.5%	23%
Psychologists	0.57%	17%	5.3%	35%
Pharmacists	0.32%	9.7%	1.5%	10%
Physiotherapists	0.51%	15%	3.9%	26%
Occupational Therapists	0.45%	14%	3.8%	28%
Dietitians	0.28%	9.5%	3.4%	23%
Optometrists	0.1%	3.5%	2.2%	15%
Medical Laboratory Scientists	n/a	n/a	1.7%	11%

Notes: Australia data 2014-2015. Aotearoa NZ data 2009-2010. Australian Dietitian 2011, Australian Optometrist 2018 NZ Occupational therapist 2017. n/a = not available.

A Strengths-based approach

Strengths-based approaches to healthcare seek to recognise and utilise the assets and resilience found in individuals and communities. This contrasts with deficit models that frame and represent people in a narrative of negativity, deficiency and failure.¹⁷⁴ Deficit discourse focuses on the roles and responsibilities of the affected individuals or communities, overlooking the larger socio-economic structures in which they are embedded.¹⁷⁵ A deficit mode of thinking might prompt a healthcare provider to ask themselves “how can I change or educate this person so that they better understand and better utilise the health service we provide?” A strengths-based approach might lead that same healthcare provider to ask themselves “how can I change my practice to allow me to better work with this person and the resources they have?”

“Connection to culture and language is a great strength for many Māori whānau, but it is a strength often overlooked by mainstream health services. I’ve been learning te reo Māori as a way to break down barriers and open the door to better relationships. I’ve found whānau are more willing to share their frustrations with me and to work with me to find solutions when I can demonstrate that Māori ways of doing things are important to me”

Dr Sonja Crone, Paediatrician

General approaches to Indigenous Health in Australia

Indigenous leadership and community-controlled health sector

In Australia, Aboriginal Community Controlled Health Services (ACCHSs) have their origins in Aboriginal peoples’ right to self-determination. This includes the right to be involved in health service delivery and decision making according to procedures determined by Aboriginal communities based on how they define health.¹⁷⁶ ACCHSs exist in a framework of a comprehensive primary health care (CPHC) service, addressing health inequities, and provide health services addressing needs identified

by Aboriginal people . ACCHSs have a high rate of Aboriginal employment, training and development which supports cultural security, as well as addressing employment as a social determinant of health.¹⁷⁷

Paediatricians who work in partnership with ACCHSs can have a significant impact. Providing paediatric services onsite in a culturally safe environment, within a multidisciplinary team inclusive of Aboriginal Family Support Workers, improves the access Aboriginal families have to paediatric services.¹⁷⁸ Paediatricians and health services can collaborate with ACCHSs to develop integrated pathways and partnerships.¹⁷⁹

Principles of equitable delivery of specialist medical care to Aboriginal and Torres Strait Islander people

The RACP Medical Specialist Access Framework outlines seven principles identified by the Indigenous health sector for the specialist care of Aboriginal and Torres Strait Islander people: Indigenous Leadership, Culturally Safe and Equitable Services, Person-Centred and Family-Orientated, Flexibility and Innovation, Sustainable and Feasible, Integration and Continuity of Care, and Quality and Accountability. These principles apply to all models of care for Aboriginal and Torres Strait Islander children.¹⁸⁰

Culturally Safe & Equitable Services

A culturally appropriate health service is one which considers language(s), beliefs, gender and kinship systems, delivers care in a manner which respects these factors, is free of discrimination and takes account of the need for trauma-informed care.^{181,182} The embedding of culturally safe practices into clinical and health care environments across the health system is critical to address disparate health access and outcomes for Aboriginal and Torres Strait Islander peoples.¹⁸³ Culturally inappropriate services are a barrier to a patient's access to care.¹⁸⁴

Cultural safety is built through trust and long-term relationships with communities and local health practitioners (of all kinds) and is vital to delivering quality specialist health care. Trust relies on empathy, effective communication, and demonstrated commitment over time. Building trust can take time; for this reason, long-term services with permanent, staff are an important investment. Strong relationships with communities allow health practitioners to have an improved appreciation of a community's culture family priorities and for services to be responsive to community needs.^{185 186}

Family-oriented

Family-oriented care is based on an understanding of family and kinship structures. The health of Aboriginal and Torres Strait Islander children requires the health system and health professionals to be responsive to the individual nature of families, communities and individuals.¹⁸⁷ Health professionals can help identify and strengthen 'protective factors' including values, kinship structures and cultural practices that promote child and family wellbeing.¹⁸⁸ Culture is a source of strength and resilience for Aboriginal and Torres Strait Islander children and families.¹⁸⁹ Western models of care need to be moulded to the principle of person-centred and family orientated care.¹⁹⁰

The National Framework for Health Services for Aboriginal and Torres Strait Islander children and their families highlighted an approach is needed that recognises:

"The different child-rearing and parenting practices of many Aboriginal and Torres Strait Islander

communities and families. Within Aboriginal and Torres Strait Islander communities, 'family' is defined more broadly than for many other Australians and comprises extended family members and significant others. Understanding and respecting different child-rearing practices is important for planning and delivering services that reflect individual parenting choices and styles".¹⁹¹

General approaches to Indigenous Health in Aotearoa New Zealand

Whānau Ora philosophy

In Aotearoa New Zealand the health initiative Whānau Ora, launched in 2010, is jointly implemented by Te Puni Kōkiri (the Ministry for Māori Development), the Ministry of Social Development and the Ministry of Health. The aim of Whānau Ora is to empower whānau (family) rather than focusing on individuals and their problems.¹⁹² Services use a Māori concept of health and well-being to work with whānau to identify their aspirations in health, education, housing, employment, standards of living and cultural identity. A strengths-based approach that puts the whānau at the centre of decision-making underpins the Whānau Ora philosophy. In this model, whakawhānaungatanga (building relationships) relies upon trust, shared experiences and mutual respect. Services are delivered through Non-Government Organisations that are community-based, while Whānau Ora provides staff who act as Navigators and advocates for whanau.¹⁹³

A Model of Social Justice to develop the Indigenous medical workforce

The number of Indigenous physicians and physician trainees in Australia and Aotearoa New Zealand is low relative to the proportion of the population that is Indigenous. Training more Indigenous physicians, with the aim of achieving at least population parity (3.3% in Australia and 15% in Aotearoa New Zealand) is a high priority for the RACP.¹⁹⁴ The College also acknowledges the additional pressures and barriers faced by Indigenous doctors and the need for support and mentoring in their training.¹⁹⁵

That Indigenous people experience disadvantage in the education system is evident in the makeup of the medical workforces in Australia and Aotearoa New Zealand. Cultural and social barriers limit the access Indigenous young people have to medical school. In response to this, many medical schools in Australasia have invested in programmes that aim to level the playing field for Indigenous students who aspire to enter and be successful in medical training. These programmes are based on a model of social justice; they are not intended to 'privilege' Indigenous students, but they do acknowledge the relative privilege already experienced by non-Indigenous students.¹⁹⁶

The RACP has a role to play in the development of an Indigenous medical workforce, not because Indigenous physicians are needed, but because Aboriginal, Torres Strait Island and Māori people have as much right to be doctors as other people. Indigenous children should grow up believing they have the same career opportunities as other children, including the opportunity to go to medical school.¹⁹⁷

Medical colleges that want to incorporate a model of social justice into their selection and training processes should first decide on what they want their cohort of trainees to look like, then create a selection and training process that allows them to achieve it. They need to examine themselves as an organisation to understand how attractive they are to Indigenous doctors. Rather than focus on trying to shape Indigenous doctors to fit into the college they should focus on transforming their college into one that Indigenous doctors want to belong to.¹⁹⁸

A culturally competent, culturally safe College

To attract Indigenous doctors into physician training:

1. Indigenous physicians must be visible as role models and mentors; currently a difficult task when their numbers are so few
2. The College must be seen to value and respect Indigenous cultures
3. The College must be seen to give the achievement of health equity for Indigenous people its highest priority.

The most effective way for the RACP to attract young Indigenous doctors into physician training is to have RACP Fellows who demonstrate their commitment to culturally appropriate care and to the elimination of health inequities in the day-to-day practice they model to those they work with and train. Culturally appropriate behaviour by College staff in their interactions with potential and current trainees is also crucial. The requirement for training in cultural safety applies to staff just as it does to Fellows. Employment of Indigenous people onto College staff and participation of Indigenous people in College decision making at all levels are two critically important strategies for the College as it seeks to become a culturally safe organisation.

Training and Continuing Professional Development for Paediatricians

The RACP has developed Cultural Competency e-learning modules that have a focus on Indigenous Health¹⁹⁹. Other online cultural competency resources are listed in Appendix 3. Paediatricians and trainees should also participate in cultural competency and cultural safety training that is available to them through their employers.

The Continuing Professional Development programme (myCPD) requirements are a means by which the RACP signals its priorities and sets its expectations of Fellows. The myCPD points credit system should reflect the high value the College places on cultural competency, cultural safety and Indigenous Health training and the expectation that Paediatricians continually development their understanding, skills and abilities in these areas. Cultural competency and safety components could also be included in the RACP Supervisor Professional Development Program.

Participate in the transformation of health institutions

Paediatricians and trainees have influence in the health institutions in which they work. They can examine the processes in their workplaces that may be contributing to inequitable outcomes, and institute measures to correct them. Achievement of equitable health outcomes can be something a paediatrician considers in all areas of his or her clinical practice, including continuing education, teaching, quality assurance, peer review, clinical audit and health policy development. Paediatricians can also be involved with the design and delivery of specific programmes within health organisations that address cultural competency and cultural safety. Just as developing cultural competence is a career-long process, building culturally safe organisations is a long and complex undertaking.²⁰⁰

Research

In undertaking research in child health, improving the outcomes for Indigenous children should be a priority. The approach to research involving Indigenous children needs consideration.

Mason Durie (2004) summarised this:

*“Indigenous knowledge cannot be verified by scientific criteria nor can science be adequately assessed according to the tenets of Indigenous knowledge. Each is built on distinctive philosophies, methodologies, and criteria. While there is considerable debate around their relative merits, contests about the validities of the two systems tend to serve as distractions from explorations of the interface, and the subsequent opportunities for creating new knowledge that reflects the dual persuasions. Māori researchers in Aotearoa/New Zealand have been able to apply the methods and values of both systems in order to reach more comprehensive understandings of health and illness”.*²⁰¹

In the paper “Achieving health equity in Aotearoa: strengthening responsiveness to Māori in health research” the authors state that:

*“Health research should build towards equity and in doing so ensure that no one is left behind... However, many health researchers have a narrow view of responsiveness to Māori and how it might be relevant to their work.” They “provide an overview of existing frameworks that can be used to develop thinking and positioning in relation to the Treaty of Waitangi and responsiveness to Māori. We also describe an equity-based approach to responsiveness to Māori and highlight four key areas that require careful consideration, namely: (1) relevance to Māori; (2) Māori as participants; (3) promoting the Māori voice, and; (4) human tissue. Finally, we argue for greater engagement with responsiveness to Māori activities as part of our commitment to achieving equitable health outcomes”.*²⁰²

Furthering research into Indigenous child health is also a key component of the New Zealand National Science Challenge – “A better start – E tipu e rea” and draws on the He Awa Whiria - Braided Rivers model described by Professor Angus Macfarlane.^{203 204}

Reliable data on the health status of Indigenous children is needed to monitor the reduction in health inequities. Only with active monitoring of levels of inequity can health services and government be held to account.²⁰⁵

Research about Indigenous people in Australia should follow the Aboriginal Health and Medical Research Councils five principles:²⁰⁶

1. Net benefits for Aboriginal people and communities
2. Aboriginal Community Control of Research
3. Cultural Sensitivity
4. Reimbursement of costs
5. Enhancing Aboriginal skills and knowledge

Research about Māori should observe kaupapa Māori approaches, which can be described as seeing the world from a Māori perspective, unconstrained by western values, attitudes or social structures²⁰⁷ Research should reflect Māori health needs and priorities.²⁰⁸ Paediatricians should seek out advisors in this area when planning research involving Māori.

Advocacy

The RACP has a strong role to play in advocacy for the health and well-being of children and young people. In Aotearoa New Zealand there have been several government – initiated reviews which have a Māori framework or emphasis in response to the disproportionately number of Māori affected by a mental health issue, addiction, suicide, and who are interacting with and supported by the welfare system.

For policy traction to occur three factors need to align:

1. The problem needs to be recognised e.g. data on child health inequities
2. Potential solutions need to be identified e.g. income needed for essentials
3. Political imperative needs to exist e.g. public opinion²⁰⁹

Health policies do not usually change on evidence alone, changing public opinion is vital.²¹⁰

The RACP has developed comprehensive child health advocacy recommendations in the following statements:

1. [Inequities in Child Health 2018](#)²¹¹
2. [Early Childhood: The Importance of the Early Years 2019](#)²¹²
3. [Health of Children in “Out-Of-Home” Care 2008](#)²¹³
4. [Action to prevent obesity and reduce its impact across the life course - RACP Position Statement on Obesity 2018](#)²¹⁴

This Indigenous Child Health statement endorses the recommendations of the aforementioned statements and recommends the following additional areas for Indigenous child health advocacy:

Youth suicide, mental health and addiction.

This Indigenous Child Health Statement endorses the recommendations of the [He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction](#)²¹⁵ and the [Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report](#)²¹⁶. We recommend long-term investment in Indigenous-developed local solutions to mental health and addiction health issues.

Child poverty

This Indigenous Child Health Statement endorses the recommendations of the Whakamana Ngā Tāngata: Report of the Welfare Expert Advisory Group.²¹⁷ Australian and New Zealand governments must commit to and achieve the reduction of poverty.

Housing

This Indigenous Child Health Statement endorses the recommendations of the New South Wales Health [Housing for Health priorities](#).²¹⁸ Housing solutions must be informed by Indigenous communities.

Promotion of Indigenous peoples’ leadership and self-determination²¹⁹

Australian and New Zealand governments and health systems must appropriately recognise and support Indigenous self-determination and leadership. The RACP supports the calls in the Uluru Statement from the Heart, including constitutional recognition.

The RACP acknowledges the implementation of the Australian government National Action Plan for the Health of Children and Young People: 2020-2030 as an opportunity for advocacy.

Case study: Paediatricians and community-driven Indigenous healthcare in Aotearoa

Tipu Ora is a primary health, social and education service based in Rotorua, Aotearoa New Zealand. Services provided include monitoring of growth and developmental milestones for children, parenting support and education, dental services, and primary maternity care.

The Tipu Ora Māori Child and Mother Service was co-founded in 1990 by Inez Kingi, a Rotorua and Te Arawa kuia and leader, and Dr Jacqueline Allan, a General Practitioner.²²⁰ The programme involved kuia from the local community acting as kaitiaki to deliver health education to parents until children reached school age. Nowadays, kaitiaki work alongside Registered Nurses and social workers to provide well-child health care and promotion, including via home visits.

Dr Johan Morreau, a Paediatrician in Rotorua, has had a long association with Tipu Ora. He says that paediatricians must make themselves available to provide education for community-based services, build relationships with Māori community leaders and advocate for investment in services that can reach “the families that need them the most”.

“The message of valuing others’ culture is critical. To learn to understand and value another culture, you have to become familiar with it. Spend time with and get to know people in your community. When you become part of that community it enriches your work and your life. Listen to what people from the community are telling you, work with them, not do to them. Use a strengths-based aspirational approach, because a deficit-based model doesn’t work”.

Johan also believes that “growing the Māori workforce, with Māori people designing and delivering or facilitating access to healthcare for Māori is critical”.

[photo of Johan. Photo of Hingatu. Photo of Tipu Ora building]

The Tumu Whakarae of Manaaki Ora Trust, which oversees Tipu Ora, is Hingatu Thompson of Ngāti Rangiwewehi and Te Aitanga-a-Hauiti. Hingatu sees Tipu Ora providing a Te Arawa kaupapa service that national services cannot duplicate.

“The Crown has obligations under Te Tiriti o Waitangi including to ensure Māori: exercise their authority; participate in health service delivery; and achieve equity in health outcomes. In Rotorua this means working with Te Arawa based organisations”

“Tipu Ora was initially set up to help young parents who had become isolated from their whānau. Each hapū in Te Arawa was asked to nominate a kuia to work in the community. The aim was to combine the traditional role and knowledge of Kuia with the strengths of Western medicine, through training developed by Dr Allan. It is an intergenerational approach to whānau ora”.

“Paediatricians are often working with whānau that are under stress. Real gains can be made when clinical and community expertise are valued and they work side-by-side.”

Case study: Paediatrician, Dr Mark de Souza provides clinics at South Coast NSW Aboriginal Health Services

When Dr Mark de Souza, a general paediatrician, began delivering a regular paediatric clinic at a South Coast New South Wales Aboriginal Medical Service, the word spread and Dr de Souza was invited to established clinics at other Aboriginal Medical Services in the area. Currently, Dr de Souza holds regular paediatric clinics between Nowra, Batemans Bay and Narooma, in addition to continuing his private practice service.

Providing services to Indigenous communities is satisfying work for Dr de Souza not just because of health inequities but also because of our collective responsibility to the First Nations people on whose land we live.

Dr de Souza believes that the clinics are successful because they are local, in a culturally welcoming environment, free and regular – usually held every one to two months. Patients are bulk-billed and the hosting Aboriginal Medical Service offers assistance with patient transportation.

Dr de Souza: *“It’s important work, that we have an obligation to do...It’s satisfying work, to provide care where it’s really needed”*

For paediatricians who would like to improve or increase their services to Aboriginal and Torres Strait Islander children, Dr de Souza advises reaching out to local Aboriginal health services:

“Speak to local Indigenous health services, ask what their needs are and how your services can assist”

For more information about Aboriginal health services in your area please visit:

<https://www.naccho.org.au/member-services/naccho-member-services/>

Appendix 1 Indigenous Rights Agreements, Laws and Policies

Aotearoa New Zealand

Te Tiriti o Waitangi (The Treaty of Waitangi)

The Treaty of Waitangi (the Treaty) forms the basis of the partnership between Māori and the government of New Zealand; it is often referred to as New Zealand's founding document. Under the principles of the Treaty Māori have the right to make decisions about the planning, development and delivery of health services; to expect to enjoy at least the same level of health as non-Māori; and to have Māori cultural concepts safeguarded.²²¹

New Zealand Public Health and Disability Act 2000

The New Zealand Public Health and Disability Act (2000) provides for the public funding and provision of health services, and disability support services. It provides a statutory link between Te Tiriti and Māori health by requiring District Health Boards to work with and be responsive to Māori when developing, planning, managing and investing in services that impact on Māori communities.²²² The first two stated objectives of the Act are:

- (a) to achieve for New Zealanders-
 - (i) the improvement, promotion, and protection of their health:
 - (ii) the promotion of the inclusion and participation in society and independence of people with disabilities:
 - (iii) the best care or support for those in need of services.
- (b) to reduce health disparities by improving the health outcomes of Māori and other population groups.

The Human Rights Act 1993 makes it unlawful to discriminate on the basis of race/ethnicity in key areas of public life.

He Korowai Oranga, New Zealand Ministry of Health Māori Health Strategy

Published in 2002 and updated in 2014, He Korowai Oranga outlines four implementation pathways to achieve the objectives of the New Zealand Public Health and Disability Act (2000)²²³:

- Supporting whānau, hapū, iwi and community development
- Supporting Māori participation at all levels in the health and disability sector
- Ensuring effective health service delivery
- Working across sectors.

Australian agreements

Under the *Human Rights and Equal Opportunity Commission Act 1986* (Cth), the Australian Human Rights Commission has an official role to protect and promote children's rights²²⁴.

Family Law Act 1975 (Cth)

"focuses on the rights of children and the responsibilities that each parent has towards their children,

rather than on parental rights. The Act aims to ensure that children can enjoy a meaningful relationship with each of their parents and are protected from harm”²²⁵.

The Racial Discrimination Act 1975, based on the United Nations Convention of the Elimination of Racial Discrimination, made it unlawful to commit a racist act that impinges upon a human right.

There are numerous state and territory legislation relating to the child protection.²²⁶

International agreements

United Nations Declaration on the Rights of Indigenous Peoples

The United Nations Declaration on the Rights of Indigenous Peoples was adopted by the United Nations General Assembly in 2007.²²⁷ It was supported by Australia in 2009 and New Zealand in 2010.^{228,229} The Declaration recognises the rights of Indigenous people to self-determination, to maintain their own languages and cultures, to protect their natural and cultural heritage and manage their own affairs.²³⁰

The articles contained in the Declaration have been summarised by the Aotearoa New Zealand Human Rights Commission²³¹:

Indigenous peoples have the right to:

1. All human rights, including collective rights
2. Equality and non-discrimination
3. Self-determination
4. Autonomy or self-government
5. Their own institutions
6. A nationality
7. Life, liberty and security
8. Protection from cultural destruction or assimilation
9. Belong to Indigenous communities or nations
10. Freedom from forced removal from their lands
11. Their culture and cultural property
12. Their spiritual and religious customs
13. Their languages, stories and names
14. Education, including in their own language
15. The dignity and diversity of their culture
16. Their own media and equal access to all other media
17. Protection in employment
18. Participation in decisions that affect them
19. Good faith consultation on laws and policies that affect them
20. Their own political, social and economic institutions and activities
21. Improvement of their economic and social conditions

22. Particular attention to the needs of elders, women, youth, children and disabled people
23. Development
24. Health, and to their traditional medicinal resources and health practices
25. Their spiritual relationship with their lands and resources
26. Recognition and protection of their lands and resources
27. Fair processes for dealing with their rights to lands and resources
28. Redress for lands and resources taken or damaged without consent
29. Environmental protection
30. Consultation before their lands are used for military activities
31. Their cultural and intellectual property
32. Use and develop their lands and resources, and consultation on projects that would affect these
33. Determine their own identity and membership
34. Their own institutions, laws and customs
35. Determine the responsibilities of individuals to their communities
36. Maintain and develop contacts across borders
37. Observance of their treaties with States

United Nations Convention on the Rights of the Child

The *Convention on the Rights of the Child* (CROC) was adopted by the United Nations General Assembly in 1989. CROC has core principles on the rights of children, including: the right to survival and development, the right to express their views freely on all matters affecting them, respect for the best interests of the child as a primary consideration in all decisions affecting them²³². Australia ratified CROC in 1990²³³ and New Zealand in 1993²³⁴.

Universal Declaration of Human Rights

The WHO identifies health as a human right.²³⁵

Jackson proposes that rather than considering unequal Māori health outcomes in terms of higher Māori health needs, it is more appropriate to frame Māori health needs as a consequence of breaches of Indigenous right.^{236,237}

The right to a 'standard of living adequate for... health and wellbeing' was established as a basic human right in Article 25.1 of the **Universal Declaration of Human Rights** adopted by the United Nations General Assembly in 1948

A right to a health is enshrined in Article 12.1 of the **International Covenant on Economic, Social and Cultural Rights 1966**, which has been ratified by both Australia and Aotearoa New Zealand

Appendix 2 Resources for addressing bias

RACP Pomegranate Health Ep 32: Diagnostic Error Part 1-Cognitive Bias

<https://www.racp.edu.au/pomegranate/View/ep32-diagnostic-error-1> Also available on Apple Podcasts, Spotify or any Android podcasting app

How Can Providers Reduce Unconscious Bias? David R. Williams. Professor of Public Health at the Harvard T.H. Chan School of Public Health.

<http://www.ihl.org/education/IHIOpenSchool/resources/Pages/AudioAndVideo/David-Williams-Don-Berwick-How-Can-Providers-Reduce-Unconscious-Bias.aspx>

Unconscious bias the Royal Society Briefing 2015

<https://royalsociety.org/~media/policy/Publications/2015/unconscious-bias-briefing-2015.pdf>

We all have implicit biases. So what can we do about it? Dushaw Hockett. TEDxMidAtlanticSalon

<https://www.youtube.com/watch?v=kKHSJHkPeLY>

Project Implicit <https://implicit.harvard.edu/implicit/takeatest.html>

Exploring Unconscious Bias. Howard Ross. 2008

<https://www.cookcross.com/docs/UnconsciousBias.pdf>

Decolonising Medical Education and Practice to Advance Indigenous Health. Rhys Jones. Redfern Oration, RACP Congress 2014 https://www.youtube.com/watch?v=0DuiS_cWUFA

Appendix 3 Resources for cultural competency and cultural safety

RACP Cultural competency online training: Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence training – available at Online Learning Resources @ RACP for RACP members and the general public by logging in <https://elearning.racp.edu.au/>

Mauriora Health Education Research Foundation Course in Cultural Competency (Māori)

<https://members.mauriora.co.nz/mauriora-courses/>

eCALD Cultural Competency Courses online (Aotearoa New Zealand, eligibility criteria apply)

<https://www.ecald.com/>

Australasian College for Emergency Medicine Indigenous Health and Cultural Competency online course <https://acem.org.au/>

The privilege walk <https://www.buzzfeed.com/nicolaharvey/what-is-privilege>

Morris T. On a Plate [Internet]. The Wireless, RNZ 2015. [cited April 2018]. Available at

<https://www.radionz.co.nz/news/the-wireless/373065/the-pencilsword-on-a-plate>

Statement on cultural safety [Internet]. Medical Council of New Zealand [updated October 2019, cited 2 Feb 2020]. Available from <https://www.mcnz.org.nz/our-standards/current-standards/cultural-safety/>

Appendix 4 Resources for learning about the history of Australia/Aotearoa New Zealand

Australia

Bruce Pascoe, Dark Emu: Aboriginal Australia and the Birth of Agriculture

Bruce Pascoe A real history of Aboriginal Australians, the first agriculturalists TEDxSydney:
<https://www.youtube.com/watch?v=fqgrSSz7Htw>

ABC: Educational resources about Aboriginal and Torres Strait Islander histories and culture:
<http://education.abc.net.au/newsandarticles/blog/-/b/3233160/educational-resources-about-aboriginal-and-torres-strait-islander-histories-and-culture>

Marcia Langton: Welcome to Country: A Travel Guide to Indigenous Australia 2018

Larissa Behrendt, Indigenous Australia for Dummies, Wiley Publishing Australia 2012

John Harris "Hiding the Bodies: the myth of the humane colonisation of Australia", in Journal of Aboriginal History 2003

Australian Institute of Aboriginal and Torres Strait Islander Studies: <https://aiatsis.gov.au/>

Aotearoa New Zealand

Anderson A, Binney J, Harris A. Tangata Whenua. Bridget Williams Books; 2014.

King M. Māori – A Photographic and Social History. Penguin Group (NZ); 2008

King M. The Penguin History of New Zealand. Penguin Group (NZ); 2013

Orange C. The Treaty of Waitangi. 2nd ed. Bridget Williams Books; 2013

Orange C. An Illustrated History of The Treaty of Waitangi. Wellington: Bridget Williams Books; 2004

Orange C. The Story of a Treaty. Bridget Williams Books; 2013

O'Malley V. The New Zealand Wars | Ngā Pakanga o Aotearoa. Bridget Williams Books; 2019

Calman R, Derby M, Walker P, Morris T. Te Tiriti o Waitangi/The Treaty of Waitangi. Lift Education; 2019.

Te Mana i Waitangi – Human Rights & the Treaty of Waitangi. Booklet and resources produced by the Human Rights Commission [Internet]. Available from <https://www.hrc.co.nz/our-work/indigenous-rights/our-work/human-rights-and-treaty-waitangi/>

The Treaty in Brief. New Zealand History [Internet]. Available from <https://nzhistory.govt.nz/politics/treaty/the-treaty-in-brief>

Story: Treaty of Waitangi. Te Ara The Encyclopaedia of New Zealand [Internet]. Available from <https://teara.govt.nz/en/treaty-of-waitangi>

Appendix 5 Resources for te reo Māori

Morrison S. Māori Made Easy. Auckland: Penguin; 2015.

Morrison S. Māori Made Easy 2. Auckland: Penguin Random House; 2018.

Morrison S, Morrison S. Māori at Home. Auckland: Penguin Random House; 2017.

Morrison S. Māori at Work. Auckland: Penguin Group (NZ); 2019

Morrison S. The Raupo Phrasebook of Modern Māori: Auckland; Penguin; 2011.

Moorfield JC. Te Kākano. 2nd ed. Pearson; 2001.

Cormack I. He Pā Auroa - A Dictionary and Language Guide for Students of Māori. Auckland: Cengage Learning New Zealand; 2000.

Jansen D. He Pukapuka Reo Hauora Māori. Kirikiriroa: Ahuru Press; 2008.

Kelly H. A Māori Word a Day. Penguin Group (NZ); 2018.

Kelly H. A Māori Phrase a Day. Penguin Group (NZ); 2020

Aki-Hauora (app). Available on Android and Apple platforms.

Māori Dictionary (online) <https://Māoridictionary.co.nz/>

Ōpaki. Television series. Māori Television on Demand. <https://www.Māoritelevision.com/>

Tōku Reo. Television series. Māori Television on Demand. <https://www.Māoritelevision.com/>

Kōrero Mai. Television series. Māori Television on Demand. <https://www.Māoritelevision.com/>

Appendix 6 Aboriginal and Torres Strait Islander Models of Care

Kimberly Aboriginal Medical Service Model of Care: <https://kams.org.au/remote/acchs-model-of-care/>

IUIH System Of Care: <https://www.youtube.com/watch?v=voyx1CAAa6c&t=127s>

Glossary of terms

Aotearoa

The original name for New Zealand.

Cultural competency

Definitions for this term have evolved over time. In broad terms, cultural competency describes one's ability to understand the influence that differences in culture have on interactions between people. While older definitions placed emphasis on learning about 'other' cultures, modern definitions emphasise self-reflection on the biases, prejudices, attitudes and assumptions that exist within one's own cultural identity. Some experts use the term *cultural safety* as a replacement for *cultural competency*.

Cultural safety

In the healthcare setting the term cultural safety is sometimes used to describe the patient's *experience* of the behaviour and attitudes of health professionals towards them. Some experts have

replaced the term *cultural competency* with *cultural safety* because of the historical association the former term has with focusing on knowledge about 'other' cultures rather than examining and reflecting on oneself. Cultural safety provides patients with the power to be involved in their own health care.²³⁸

Ethnocentrism

The evaluation of other cultures according to preconceptions originating in the standards and customs of one's own culture. Often associated with the belief that the people, customs, and traditions of your own race or nationality are superior to those of other races.

Explicit Bias

Prejudices and attitudes toward certain groups that an individual has and is consciously aware of.²³⁹

Hapū

Sub-tribe

Implicit Bias

Another term for *unconscious bias*

Inequity

Inequality that is that is unjust, unnecessary, systematic and preventable.

Institutional racism

Requirements, conditions, practices, policies or processes that maintain and reproduce avoidable and unfair inequalities.²⁴⁰

Internalised racism

Acceptance of attitudes, beliefs or ideologies by members of stigmatised ethnic/racial groups about the inferiority of one's own ethnic/racial group.²⁴¹ For example, an Indigenous person believing that Indigenous people are naturally less intelligent than non-Indigenous people.

Interpersonal racism

Interactions between people that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups.²⁴²

Iwi

Tribe, extended kinship group

Kaitiaki

Guardian, caregiver, protector

Kaupapa Māori

An approach that uses Māori ideology and principles

Kuia

Female elder, grandmother

Othering

Classifying another person or group into a category outside of the 'normal' category to which you belong. see *Ethnocentrism*, above.

Privilege

A preferred status or rank that is conferred rather than earned through effort or talent ^{243,244}.

Tino rangatiratanga

Self-determination, autonomy

Social Determinants of Health

An individual's health is shaped by socioeconomic factors, which can be broadly defined as the conditions in which people are born, grow, live, work and age. These social characteristics are influenced by political and economic systems, social and economic policies, and development agendas which shape the conditions of daily life. These influences are collectively known as the social determinants of health.²⁴⁵

Systemic racism

Another term for institutional racism

Tāonga

Treasure, things that are prized or valued.

Te Arawa

A group of Maori tribes descended from the crew of the Te Arawa canoe.

Te reo

Language. Often used as an abbreviation for *te reo Māori* (Māori language).

Te Tiriti o Waitangi

The Treaty of Waitangi. Sometimes refers specifically to the version written in te reo. Sometimes abbreviated to *Te Tiriti*.

Tumu Whakarae

Chief Executive

Unconscious bias

Bias that comes from internalised schemas that individuals are unaware, leading them to discriminate against others without conscious intent.²⁴⁶

Whānau

Family

Whānau ora

The well-being of families

¹ New Zealand College of Public Health Medicine, Māori Health Policy statement, 2015

² United Nations, Declaration on the rights of Indigenous peoples, 2007 New York, available from:

<http://www.ohchr.org/EN/Issues/IPeoples/Pages/Declaration.aspx>

³ Note that data of Indigenous people must be governed by Indigenous data sovereignty principles and processes.

⁴ Anand R, Lahiri I. Intercultural Competence in Health Care – Developing Skills for Interculturally Competent Care. In: Deardorff D. The Sage Handbook of Intercultural Competence. 2009.

⁵ Baum F, Fisher M. Why behavioural health promotion endures despite its failure to reduce health inequities. *Sociology of Health & Illness* Vol. 36 No.2 2014: 213-225.

⁶ Navarro, V. What we mean by social determinants of health. *International Journal of Health Services*. 2009; 39 (3): 423–41

⁷ Wade R. Inequality A New Zealand Crisis. In: Rashbrooke M. Inequality and the West. 2013.

⁸ Altman JC. Beyond closing the gap: valuing diversity in Indigenous Australia. Canberra (AU): Centre for Aboriginal Economic Policy Research, Australian National University 2009. 24. CAEPR working paper no. 54

⁹ Borrell B, Gregory S, McCreanor T. “It’s hard at the top but it’s a whole lot easier than being at the bottom”: The role of privilege in understanding disparities in Aotearoa/New Zealand. *Race/Ethnicity: Multidisciplinary Global Contexts*. 2009 3(1): 29-50

¹⁰ Black, L., and D. Stone. Expanding the definition of privilege: The concept of social privilege. *Journal of Multicultural Counseling and Development*. 2005 33: 243-55.

¹¹ Reid P, Robson B. Understanding health inequities. In: Robson B, Harris R. editors. *Hauora: Māori Standards of Health IV: A study of the years 2000-2005*. Wellington, New Zealand: Te Rōpū Rangahau Hauora a Eru Pōmare, School of Medicine and Health Sciences, University of Otago; 2007.

¹² Durie M, Ministry of Health New Zealand. Māori health models – Te Whare Tapa Whā. Available from: <http://www.health.govt.nz/our-work/populations/Māori-health/Māori-health-models/Māori-health-models-te-whare-tapa-wha>

¹³ The Royal Australasian College of Physicians, Indigenous Strategic Framework 2018-2028, 2018.

¹⁴ The Royal Australasian College of Physicians, Indigenous Strategic Framework 2018-2028, 2018.

¹⁵ Department of Health, Australian Government. National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families. Canberra (AU): Australian Government; 2016.

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- ¹⁷ Australian Institute of Health and Welfare. Australia's Health 2014. Canberra (AU): Australian Institute of Health and Welfare; 2014. Australia's health series no. 14 (178).
- ¹⁸ Gilligan C, Sanson-Fisher RW, D'Este C, Eades S, Wenitong M. Knowledge and attitudes regarding smoking during pregnancy among Aboriginal and Torres Strait Islander women. *Med J Aust.* 2009;190(10):557-61.
- ¹⁹ Australian Institute of Health and Welfare. Alcohol, tobacco & other drugs in Australia. Canberra (AU): Australian Institute of Health and Welfare; 2019.
- ²⁰ National Health and Medical Research Council, Australian Guidelines to reduce health risks from drinking alcohol 2009
- ²¹ Australian Health Ministers' Advisory Council. Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report. Canberra (AU): Commonwealth of Australia; 2017.
- ²² Australian Health Ministers' Advisory Council. Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report. Canberra (AU): Commonwealth of Australia; 2017.
- ²³ Department of Prime Minister and Cabinet, Aboriginal and Torres Strait Islander Health Performance Framework 2014. Canberra (AU): Commonwealth of Australia; 2015.
- ²⁴ Australian Institute of Health and Welfare. Australia's health 2016. Canberra (AU): Australian Institute of Health and Welfare; 2016. Australia's health series no. 15. Cat. no. AUS 199.
- ²⁵ Australian Institute of Health and Welfare. Australia's welfare 2015. Canberra (AU): Australian Institute of Health and Welfare; 2015. Australia's welfare series no. 12. Cat. no. AUS 189.
- ²⁶ Azzopardi PS, Sawyer SM, Carlin JB, Degenhardt L, Brown N, Brown AD, et al. Health and wellbeing of Indigenous adolescents in Australia: a systematic synthesis of population data. *Lancet.* 2018 Feb 24;391(10122):766-782.
- ²⁷ Kirby Institute. Bloodborne viral and sexually transmissible infections in Aboriginal and Torres Strait Islander people: annual surveillance report 2017. Sydney: Kirby Institute, UNSW Sydney; 2017.
- ²⁸ Commonwealth of Australia as represented by the Department of Health, Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2018-2022 5, 2018.
- ²⁹ Ostrowski JA, MacLaren G, Alexander J, Stewart P, Gune S, Francis JR, et al. The burden of invasive infections in critically ill Indigenous children in Australia. *Med J Aust.* 2017;206(2):78-84.
- ³⁰ Boyd R, Patel M, Currie BJ, Holt DC, Harris T, Krause V. High burden of invasive group A streptococcal disease in the Northern Territory of Australia. *Epidemiol Infect.* 2016;144(5):1018-27.
- ³¹ Engelman D, Hofer A, Davis JS, Carapetis JR, Baird RW, Giffard PM, et al. Invasive *Staphylococcus aureus* Infections in Children in Tropical Northern Australia. *J Pediatric Infect Dis Soc.* 2014;3(4):304-11.
- ³² Marshall CS, Cheng AC, Markey PG, Towers RJ, Richardson LJ, Fagan PK, et al. Acute post-streptococcal glomerulonephritis in the Northern Territory of Australia: a review of 16 years data and comparison with the literature. *Am J Trop Med Hyg.* 2011;85(4):703-10.
- ³³ Australian Institute of Health and Welfare. Rheumatic heart disease and acute rheumatic fever in Australia: 1996–2012. Canberra (AU): AIHW; 2013. Cardiovascular disease series. Cat. no. CVD 60.

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- ³⁴ Morris PS, Leach AJ, Halpinac S, Mellon G, Gadila G et al 2007. An overview of acute otitis media in Australian Aboriginal children living in remote communities. *Vaccine* [Internet]. 2007; vol 25(13): 2389-2393.
- ³⁵ Australian Health Ministers' Advisory Council. Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report. Canberra (AU): Commonwealth of Australia; 2017.
- ³⁶ Australian Bureau of Statistics, Aboriginal and Torres Strait Islander People with a Disability, 2012 [Internet]. Canberra (AU): ABS; 2017. Available from: <http://abs.gov.au/ausstats/abs@.nsf/mf/4433.0.55.005>
- ³⁷ Australian Government, Australian Early Development Census National Report 2015. Canberra (AU): Department of Education and Training; 2016.
- ³⁸ Aboriginal Child, Family and Community Care State Secretariat, Delivering better outcomes for Aboriginal children and families in NSW. Sydney (AU): Aboriginal Child, Family and Community Care State Secretariat; 2018.
- ³⁹ Children And Young Persons (Care And Protection) Act 1998 (NSW) S13. Available from: <https://www.legislation.nsw.gov.au/#/view/act/1998/157/chap2/part2/sec13>
- ⁴⁰ The Royal Australasian College of Physicians, The Health and Well-being of Incarcerated Adolescents. Sydney (AU): The Royal Australasian College of Physicians; 2011.
- ⁴¹ The Royal Australasian College of Physicians, Submission to the Royal Commission into the Protection and Detention of Children in the Northern Territory. Sydney (AU): The Royal Australasian College of Physicians; 2016.
- ⁴² Australian Bureau of Statistics and Australian Institute of Health and Welfare. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples. Canberra (AU): Australian Bureau of Statistics; 2008.
- ⁴³ Australian Bureau of Statistics. Causes of Death, Australia, 2017. Canberra (AU): Australian Bureau of Statistics; 2018.
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