2018-2028

Indigenous Strategic Framework

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The RACP is commissioning Aboriginal, Torres Strait Islander and Maori art for this Framework. This process is being undertaken in a culturally appropriate manner, in consultation with the RACP Aboriginal and Torres Strait Islander Health Committee and the RACP Maori Health Committee. This Framework will be updated with Aboriginal, Torres Strait Islander and Maori art.

Acknowledgment

The RACP would like to thank all those who contributed to the development of this strategic framework; the RACP members involved and external Indigenous leaders and organisations who gave generously of both their time and their expertise.

In particular, we acknowledge and are grateful for the leadership and commitment of the RACP's Aboriginal and Torres Strait Islander Health Committee and Māori Health Committee members. Their guidance, hard work and enthusiasm is pivotal to the RACP's work to contribute to improved health and equity for Australia and New Zealand's Indigenous peoples, and in growing and supporting the Indigenous medical workforce.

Aboriginal and Torres Strait Islander Committee

Dr Tamara Mackean (Chair)

Professor Noel Hayman (Deputy Chair)

Dawn Casey (NACCHO)

Dr Angela Dos Santos

Dr Andrew Hutchinson

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Dr Jonathan Newchurch (AIDA)

Dr Naru Pal

Dr Simon Quilty

Dr Angela Titmuss

Māori Health Committee

Dr George Laking (Chair)

Dr Denise Bennett

Dr Danny de Lore

Dr Liza Edmonds

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Dr Myra Ruka

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We would also like to acknowledge the invaluable contribution made by Associate Professor Wendy Edmondson to both the consultation process and the drafting of this document. Her advice, insights and strategic approach provided a robust, constructive and meaningful foundation to this work.

Foreword

On behalf of the Board, it is my pleasure to present the RACP's Indigenous Strategic Framework which will guide the work of the College in this area in the coming years. The College has a strong commitment to equitable health outcomes for Indigenous peoples in Australia and Aotearoa/New Zealand, and this Framework serves to consolidate and strengthen our work in this vital area. The Framework reflects key priorities developed through a comprehensive engagement process with members, including Indigenous leadership both within the College and with external peak Indigenous health bodies.

Aboriginal and Torres Strait Islander peoples and Māori experience significantly higher burdens of ill-health, and shorter life expectancies, in comparison to non-Indigenous populations. A focus on early life experiences and environments is key to reducing adverse health outcomes; from childhood mortality, early and ongoing poor health, through to improved life expectancy. Although some gains have been made, health disparities remain unacceptable when compared with continued improvements in non-Indigenous health. Complex factors have contributed to the current situation including the ongoing effects of colonisation, dispossession, and loss of identity, culture and land. Social determinants of health also impact on Indigenous people's health; poverty, housing, environment, education, employment, social capital; and racism, discrimination, and culturally unsafe health services all contribute to poor health outcomes.

We recognise the disparity in opportunity and the non-Indigenous privilege that exists in our countries. We see one result of this in the low numbers of Indigenous doctors in our health system. The RACP has a core responsibility to work to grow the Indigenous physician workforce.

We also have a vital role to play ensuring the broader membership is educated and equipped with both clinical and cultural competencies required to serve the health needs of Aboriginal and Torres Strait Islander peoples and Maori.

We have the capability to support these strategic priorities become embedded across the Australian and New Zealand's health system to contribute to culturally appropriate and safe health services for Indigenous peoples.

This Strategic Framework provides the RACP with the opportunity to reflect on its work, its approach and its own culture. It provides a platform for the RACP to consider and act on available evidence and what's needed to move these strategic priorities forward within the parameters of the College's role and accelerate our contribution to achieving equity for our nations' First Peoples. In short it commits to driving the following priorities:

- Contributing to addressing Indigenous health inequities
- Growing the Indigenous physician workforce
- Educating and equipping the physician workforce on Indigenous health and culturally safe clinical practice
- Fostering a culturally safe and competent College
- Meeting the regulatory standards and requirements of the Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ).

For the Framework to achieve the shared vision and strategic directions contained herein, the Board, broader membership, and staff of the RACP, led by the Indigenous leadership, will need to commit to working collaboratively to produce effective and sustainable outcomes. I am confident that the level of enthusiasm and dedication already demonstrated for this Framework will result in improved contributions by the College to achieving Indigenous health equity.

Dr Catherine Yelland PSM
RACP President 2016-2018

We recognise the disparity in opportunity and the non-Indigenous privilege that exists in our countries. We see one result of this in the low numbers of Indigenous doctors in our health system. The RACP has a core responsibility to work to grow the Indigenous physician workforce.

Aboriginal and Torres Strait Islander Statement

> “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
Chair, RACP Aboriginal and
Torres Strait Islander Health Committee

Aboriginal and Torres Strait Islander peoples are the First Peoples of this country and have been for millennia prior to the arrival of European peoples. At the time of first contact, there were between 300,000 to 950,000 First Peoples, and approximately 260 distinct language groups and 500 dialects. First People’s societies are founded on highly developed and complex social, cultural and spiritual beliefs with ecosystems created by ‘Dreaming’ energy and creation ancestors who travelled across the land to create living and non-living entities. To First Peoples the land is both deeply symbolic and spiritual, and inextricably linked to First peoples collective and individual identity.

From 1788, Australia was regarded as a British Colony which utilised the fiction of ‘terra nullius’. Even though the governors and managers of the first settlements were aware of a significant First peoples’ population they did not amend the terms of British sovereignty or attempt to negotiate treaties with the people. This remains the case today despite the express wish of Indigenous peoples, in the Uluru Statement of 2017, for a treaty to recognise sovereignty and for constitutional reform. This wish has its roots in the strength and tenacity of First Peoples to continue to survive and evolve in the face of prejudice and oppression. The call for a Makarrata in the Uluru Statement embodies the aspirations by Indigenous peoples for collaborative and structural reforms to create a more fair and equitable society in which the rights of Indigenous peoples are realised.

Our country’s shared history is critical to understanding the contemporary status of our national health and well-being. Australia has the privilege of being a part of the cradle of humanity with our First Peoples being the oldest, continuous living cultures in the world, however, the impact of colonisation and resultant dispossession and exclusion continues with disparities in health and social outcomes for First Peoples. Our nation’s health inequities are closely related to powerlessness, racism and a slow process of reconciliation alongside limited recognition of human, land and sovereign rights. This is of deep concern to health professionals and health organisations who strive for healing and contentment in the families and communities they serve as well as their own families and communities. It is this common goal of wellness that provides a way forward to actively redress disparities and do so in a manner that upholds social justice and firm nation building.

Uluru Statement from the Heart (excerpt)

“Our Aboriginal and Torres Strait Islander tribes were the first sovereign Nations of the Australian continent and its adjacent islands, and possessed it under our own laws and customs. This our ancestors did, according to the reckoning of our culture, from the Creation, according to the common law from ‘time immemorial’, and according to science more than 60,000 years ago.

This sovereignty is ***a spiritual notion: the ancestral tie between the land, or ‘mother nature’, and the Aboriginal and Torres Strait Islander peoples who were born therefrom, remain attached thereto, and must one day return thither to be united with our ancestors. This link is the basis of the ownership of the soil, or better, of sovereignty.*** It has never been ceded or extinguished,

With substantive constitutional change and structural reform, we believe this ancient sovereignty can shine through as a fuller expression of Australia’s nationhood.

We seek constitutional reforms to empower our people and take ***a rightful place*** in our own country. When we have power over our destiny our children will flourish. They will walk in two worlds and their culture will be a gift to their country.

We call for the establishment of a First Nations Voice enshrined in the Constitution.

Makarrata* is the culmination of our agenda: ***the coming together after a struggle***. It captures our aspirations for a fair and truthful relationship with the people of Australia and a better future for our children based on justice and self-determination. We seek a Makarrata Commission to supervise a process of agreement-making between governments and First Nations and truth-telling about our history.”

First Nations National Constitutional Convention
Uluru, Australia, 2017

* Makarrata is much more than just a synonym for treaty. It is a complex Yolngu (Indigenous people from Arnhem Land) word describing a process of conflict resolution, peace-making and justice.

Māori Statement

The Treaty of Waitangi

The World Health Organisation identifies health as a human right. In Aotearoa./New Zealand the health of Māori is also a right guaranteed by Te Tiriti o Waitangi, The Treaty of Waitangi. Te Tiriti o Waitangi was signed on 6 February 1840 by representatives of the British Crown and various Māori leaders from the North Island of New Zealand. The Treaty principles are enacted through the NZ Public Health and Disability Act 2000, and implemented through the Ministry of Health's Māori Health Strategy, He Korowai Oranga. Its underpinning principles are

- **Partnership** involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services
- **Participation** requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services
- **Protection** involves the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices

The RACP supports the moral and ethical responsibilities enshrined in Te Tiriti o Waitangi, and is committed to incorporating them into this Framework and its ongoing work.

Themes of *Ko Aotearoa Tēnei*

The Wai 262 claim concerns the place of Māori intellectual property in New Zealand's laws, policies and practices. It covers the certain claims of six iwi (tribal groups) Ngāti Wai (Whangarei) Ngāti Kurī (Parengarenga and Rerenga Wairua); Te Rawara (North Hokianga); Ngāti Kahungunu (Hawke's Bay and Wairarapa); and Ngāti Koata (northern South Island). Wai 262 does not concern territorial claims, but who owns or controls the following:

1. Mātauranga Māori – the Māori world view, including traditional culture and knowledge
2. The tangible properties of mātauranga Māori – artistic and cultural expressions often referred to as taonga works (treasures)
3. Things which are important to mātauranga Māori, including the unique characteristics of indigenous flora and fauna (taonga species) and the New Zealand environment.

While the claim was bought by six iwi, all iwi have an interest in the claim's outcome. The claim is broadly about the ownership and rights of control of Māori intellectual and cultural property, as well as the physical and spiritual wellbeing of the environment in their traditional territories.

Ko Aotearoa Tēnei

(This is Aotearoa/This is New Zealand) – a 2011 report from the Waitangi Tribunal – considers a post-settlement Aotearoa/New Zealand, where the country is poised to move beyond grievance and transition to a unique identity and culture. The Māori Health Committee notes that beyond the legal responsibilities and obligations, there are ethical and moral responsibilities that can encourage rethinking and inform new approaches.

Health (hauora) is a taonga (treasure) that must be protected. Health is multidimensional and is considered in terms of whare tapa wha – the house with four cornerstones. Total health and wellbeing is only possible where all four elements are in balance: taha tinana (physical health), taha hinengaro (mental health), taha whānau (family health) and taha wairua (spiritual health).

Ko Aotearoa Tēnei identifies rongoā Māori as a system of knowledge which needs the protection of the Crown under te Tiriti ō Waitangi. The Crown recognises that rongoā Māori has significant potential as a weapon in the fight to improve Māori health. This will require the Crown to see the philosophical importance of holism in Māori health, and to be willing to draw on ***both*** of this country's two founding systems of knowledge.

One of the key impacts of an Indigenous strategy is achieving health equity and positive wellbeing for Indigenous peoples in Aotearoa/New Zealand and Australia. While one pathway to achieve this outcome is training more Indigenous physicians and paediatricians, Wai 262 would require the incorporation of traditional practices drawing from Indigenous traditions in Aotearoa NZ and Australia, particularly in terms of taha wairua (spiritual wellbeing) which has "not simply been replaced by clinical, Western biomedical practices"[1].

Māori ethical principles (as part of Mātauranga Māori) including manaakitanga (kindness), whanaungatanga (sense of belonging), rangatiratanga (self-determination) and kaitiakitanga (guardianship, reciprocity) would also inform connections between the organisation, Māori, te Tiriti and Wai 262.

There are parallels between the reasons and rationale for the WAI 262 claim and the development of an Indigenous strategy for the RACP, which have led the Māori Health Committee to begin to explore the opportunity for the Strategy to be informed by the findings in Ko Aotearoa Tēnei.

[1] New Zealand. Waitangi Tribunal. Ko Aotearoa Tēnei : a report into claims concerning New Zealand law and policy affecting Māori culture and identity. Te taumata tuatahi. (Waitangi Tribunal report) 2011

RACP Indigenous Strategic Framework

The Royal Australasian College of Physicians (RACP) is the professional medical College of over 16,500 physicians and 8,000 trainee physicians, often referred to as specialists, in Australia and Aotearoa/New Zealand. The RACP has a key commitment to develop and implement strategic initiatives that effectively contribute to improved health outcomes for Aboriginal and Torres Strait Islander peoples, and Māori, through the following priorities, which are to:

- Contribute to addressing Indigenous health equity differences;
- Grow the Indigenous physician workforce;
- Equip and educate the broader physician workforce to improve Indigenous health;
- Foster a culturally safe and competent College;
- Meet the new regulatory standards and requirements of the AMC and MCNZ.

The RACP recognises the evidence that the health and wellbeing of Indigenous peoples in Australia and Aotearoa/New Zealand has been adversely affected as the result of colonisation, and that physical and spiritual health outcomes have been and continue to be compromised leading to a gap in life expectancy and health outcomes between Indigenous and non-Indigenous peoples. The RACP is fully committed to making a positive difference. This document is a roadmap for the RACP to address these priorities, through short, medium and long-term strategies, with dedicated support and resources. It is a vehicle to support the RACP in reflecting on what's needed to shape a College, a physician workforce, and health system which values and encompasses Indigenous perspectives on health and wellbeing. It's an opportunity to ensure we are effective and unstinting in our work to bring about an Australia and Aotearoa/New Zealand that honours and draws upon its Indigenous cultures, knowledge and histories; that roots out and does not tolerate racism or discrimination; and that drives equitable access to healthcare, equitable health outcomes and equitable opportunities for Indigenous physicians.

The development of this Framework

The Framework has been developed in close consultation with key stakeholders including the Aboriginal and Torres Strait Islander Health Committee (ATSIHC) and the Māori Health Committee (MHC), RACP Board Directors, senior management, as well as consultations with leading Indigenous health organisations to whom we express our sincere thanks.

The ATSIHC and MHC have broad responsibilities in the RACP in relation to Indigenous health. The Committees will provide the cultural knowledge and leadership required in the ongoing implementation and evaluation of the Framework.

Strategic initiatives in this area are more likely to be successful if based on Indigenous aspirations and priorities, fitting within an Indigenous framework and process, and placed in the context of Indigenous self-determination. Indigenous leadership, agency and decision making is critical from the beginning of the process, and throughout the implementation and evaluation of the Framework. The implementation will follow agreed cultural protocols, drawing on Indigenous strengths and assets, in an empowering process for Indigenous leadership both internal and external to the RACP.

Aboriginal and Torres Strait Islander peoples and Māori have unique and diverse cultures, belief systems and world views. Indigenous knowledges and ways of working, expressed through stories, histories, ceremonies, language, and family and community relationships. These beliefs and practices have informed the development of the Framework and will continue to inform its implementation.

Ways of working, such as the established biennial Hui and other forums, support effective engagement and collaboration with Indigenous health stakeholders including community members, Indigenous partner organisations, RACP leaders, and Aboriginal and Torres Strait Islander and Māori health leaders, to discuss key issues and develop a joint platform for change through the Framework, whilst respecting the needs of each group.

Within the context of the work of the ATSIHC, the MHC, and the Framework, it is also crucial to recognise that, while Australia and Aotearoa/New Zealand have experienced similar impacts of colonisation, the Indigenous peoples of each country have unique political, social, cultural, and historical differences in relation to issues of Indigenous agency and engagement, treaty, diversity, land rights, language, government policies, and historical trauma. The shared legacies of colonisation such as loss of land, culture and identity are perpetuated in contemporary Indigenous societies, and manifest in intergenerational trauma which continues to affect the health and wellbeing of Indigenous peoples. Postcolonial scholars have argued that 'settler' countries such as Australia and Aotearoa/New Zealand are either colonial or neo-colonial, rather than postcolonial, and are still subject to ongoing discrimination and dominant systems of power. In this context, Indigenous peoples are not only affected by intergenerational trauma, but are also repeatedly impacted by structures that continue to marginalise their human and legal rights and fail to address the social determinants of health. These factors need to be recognised, respected, and incorporated into the planning and implementation of the Framework's strategies and in all College work related to Indigenous health.

It needs to be noted that although the Framework relates to Aboriginal and Torres Strait Islander peoples and Māori, the College has Pasifika members and that, as a result, there are three spheres of indigeneity.

To be successful the Framework will require the commitment of all members of the College, through the process of a shared vision and commitment to achieving the strategies contained therein. The College will need to reflect and adopt new ways of working, including new policies and practices, to ensure collaborative and effective outcomes.

A broad range of social determinants influence the physical, emotional, mental and spiritual dimensions of health among Aboriginal and Torres Strait Islander peoples and Maori. These include circumstances and environments as well as structures, systems and institutions that affect the development and maintenance of health. Social determinants of health are categorised as distal (e.g. historic, political, social and economic contexts), intermediate (e.g. community infrastructure, resources, systems and capacities), and proximal (e.g. health behaviours, physical and social environment, poverty).

Determinants in relation to Indigenous peoples also include racism, exclusion, culture, and self-determination and resilience, as contributors to health outcomes in the context of ongoing colonisation. Although there have been some positive, albeit limited, outcomes in relation to Indigenous health, data and qualitative evidence clearly demonstrate that Aboriginal and Torres Strait Islander peoples and Māori continue to experience significant disparity in health outcomes and in equitable access to health services.

RACP Indigenous Strategic Framework

The Australian Context

Aboriginal and Torres Strait Islander peoples view health in a broad inclusive way; as not just the physical well-being of an individual but 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. This view highlights the central importance of culture, identity and connection to family, country, language and traditions to their definition and understanding of health.

In Australia, although progress has been made in some areas including access to medicines, health checks, and reducing childhood mortality, it is the continuing disparity in life expectancy where there has been little change, with the gap remaining at just over a decade. A contributing factor to the health gap is the lower use of specialist services by Indigenous people due to a range of factors but irrespective of geographic location. Addressing this is the priority policy & advocacy work for the College's ATSIHC. Last year the College was successful in its advocacy to have this issue included in the government's Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP), and work is continuing with a wide range of engaged and supportive Indigenous health stakeholders to develop a framework to support nationally consistent and appropriate access to specialist care.

> "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.
>
> Health care services should strive to achieve the state where every individual is able to achieve their full potential as a human being and this bring about the total well-being of their community."

National Aboriginal Health Strategy, 1989

The New Zealand Context

The most prominent understanding of Māori health and wellbeing was described by Professor Sir Mason Durie. This model, known as Te Whare Tapa Whā/ health as a whare (house), draws on the symbolism of a four-sided house to illustrate the four dimensions of Māori well-being:

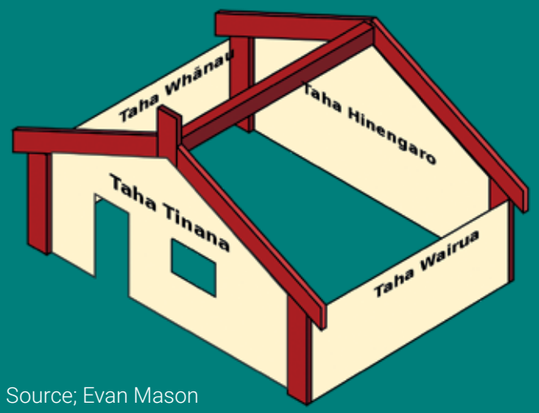
Taha tinana /
physical health: the body

Taha hinengaro /
mental health: the mind

Taha whānau /
family health: close relationships

Taha wairua /
spiritual health: meaning and purpose

Figure 2:



Source; Evan Mason

Whānau is understood as the extended network of close personal relationships not necessarily defined by biological kinship. The spiritual dimension is not as well characterised in the biopsychosocial model, though is showing some resurgence in Western medicine especially in palliative care. Although these different health perspectives have been long and widely recognised, and in many instances highly valued, many healthcare providers and the mainstream health system as-a-whole, still struggle with these different knowledge systems relating to health and healing, and with providing health services and health care that collaborates, spans and respects the values and benefits of the western biomedical model and the Indigenous holistic approach.

In New Zealand disparities in overall Māori health persist even when confounding factors such as poverty, education and location are eliminated, demonstrating that indigeneity is an independent determinant of health status. The New Zealand Public Health and Disability Act 2000 requires District Health Boards to address Māori health and reduce health disparities, and for Treaty principles to be embedded in all government policy through the New Zealand Health Strategy, New Zealand Disability Strategy and Māori Health Strategy. This ensures the health sector develops services that are relevant to Māori by involving Māori at all levels of the strategic and operational planning and delivery of healthcare services. A number of Māori health providers are contracted to District Health Boards throughout Aotearoa/New Zealand and tend to deliver health and disability services to predominantly, although not exclusively, to Māori clients. What does distinguish the service is the kaupapa (policy) and the delivery framework which is distinctively Māori. In addition to contracted Māori health providers, there are also health providers who are significant providers of health and disability services to Māori. Health services are required to recognise and safeguard Māori cultural concepts, values, and practices.

RACP Indigenous Strategic Framework

RACP's Indigenous Health Committees

The ATSIHC and the MHC provide leadership, guidance, and facilitation in relation to the Indigenous Strategic Framework. Both committees possess the cultural and clinical knowledge and competence to strategically direct the work of the Indigenous Strategic Framework, with appropriate internal support and resources. The Framework requires a whole-of-College approach, and strong partnerships with Indigenous organisations and communities, to ensure its objectives are met.

The current roles and responsibilities of the ATSIHC and the MHC are outlined below. The purpose of the committees is to strengthen the College's capacity to develop a coordinated College approach to improving the health and social outcomes for Aboriginal and Torres Strait Islander peoples and Māori.

ATSIHC Terms of Reference (ToR)

- The responsibilities of the Committee will have a strong focus on coordinating issues of immediate interest to the College and its Fellows, specifically:
- Providing advice to the College Policy and Advisory Council (CPAC) on matters relating to Aboriginal and Torres Strait Islander health and social policy and advocacy;
- Providing advice to the CPAC on matters relating to workforce development and education and training;
- Representing the College on Government, professional and community groups and other forums related to Aboriginal and Torres Strait Islander health;
- Facilitating the development and maintenance of partnerships, relationships and linkages with key stakeholders;
- Leading, advising and supporting the development of policies and positions that address matters concerning Aboriginal and Torres Strait Islander health.

The principles that underpin ATSIHC Terms of Reference are as follows:

- The acknowledgement of Aboriginal and Torres Strait Islander peoples as first peoples and the recognition of Aboriginal and Torres Strait Islander peoples' rights as Indigenous people;
- The College supports the Constitutional recognition of Australia's first peoples and recognises the health benefits of genuine reconciliation;
- The acknowledgement of the value and strength of Aboriginal and Torres Strait leadership to the Australian health system;
- The importance of human rights for Aboriginal and Torres Strait Islander peoples' advancement;
- The recognition and honouring of Aboriginal and Torres Strait Islander worldviews in relation to health and wellbeing;
- The necessity for partnership with Aboriginal and Torres Strait Islander communities; and
- The ongoing support to help close the gap between Aboriginal and Torres Strait Islander and non-Indigenous life-expectancy and health outcomes.

Māori Health Committee Terms of Reference

- Assist in the education and training of physicians and paediatricians in facilitating their understanding, knowledge and skills when dealing with patients / whānau (family);
- Contribute to the development of College policy relating to cultural competence in training, educating and assessment;
- Takes an active role in the development of all College policies in respect to Māori Health;
- Inform and advise the College of the inequalities that exist with indigenous populations and ensure that College works towards promoting the highest standard of indigenous health in New Zealand/ Aotearoa and Australia.
- Promote an increase in Māori participation and retention in the New Zealand physician and paediatric workforce.

RACP Strategic Priorities

Priority 1. Contribute to addressing Indigenous health equity differences

The health and wellbeing of Aboriginal and Torres Strait Islanders and Māori has been adversely affected by ongoing colonisation through structural oppression, racism, disruption to cultural practices, family structures, traditional lifestyles, and historical trauma. Loss of agency, identity and powerlessness, and the impact of the social determinants of health, has contributed to compromised physical, social, mental and spiritual health for Indigenous peoples. Although some positive gains have been made in recent years, it is unacceptable that the current average life expectancy gap for Aboriginal and Torres Strait Islander peoples is 10 years, and 7 years for Māori.

It has been demonstrated that health strategies that involve Indigenous peoples in leadership, decision-making, and management roles, are most likely to result in improved outcomes, due to Indigenous empowerment and control. There is a growing body of evidence that indicates a strengths-based, human rights approach, focussing on resilience, Indigenous culture and positive identity, rather than problems and deficits, will lead to measures being more effective according to Indigenous priorities and definitions of success. 'Bottom-up' rather than 'top-down' approaches, in which Indigenous culture is a key theme from the outset, and which incorporate holistic world views on health and well-being, have been shown to gain more Indigenous community support and lead to better outcomes.

Features of policies and programs that deliver on community priorities and health improvements, include Indigenous governance and staff, long-term sustainable funding and support, flexibility, and program development which is based on Indigenous capacity, strengths and cultural considerations.

Benefits of such programs not only include improved physical health, but also increased social, emotional, and spiritual health. The recognition of protective factors in program design and implementation, such as family, resilience, culture and community, leads to increased self-esteem, empowerment, cultural identity, and agency and control, for Indigenous peoples. This focus recognises the important role that healthy communities play in providing a healthy and safe childhood which in turn mediates whole of life health gains from reduced childhood mortality through to reduced health morbidities and increased life expectancy.

Health professionals play a vital role in working with Indigenous communities, particularly in programs which are Indigenous-led, and where Indigenous world views and ways of working are respected. Practitioners who listen, learn, reflect on their own values and assumptions, and address power differentials, are well placed to make a positive contribution to Indigenous health. There is evidence that suggests that those who possess clinical competence, and who engage in culturally safe practices, and develop relationships based on trust, are most effective in making a long-term difference to Indigenous health.

The RACP currently undertakes a range of initiatives designed to address Indigenous health equity differences. The College is aiming to expand its efforts through this Strategic Framework. Policy and advocacy, cultural competence training, curriculum development and training, will be strengthened through internal collaboration and by working in partnership with local, state and national Indigenous leaders and organisations. Organisations such as Te Ora, AIDA, and NACCHO and its approximately 150-member organisations, have considerable expertise in Indigenous health. They have Indigenous governance, leadership, cultural knowledges, extensive networks, and work at grass-roots community levels. As strong advocacy, policy and community engagement bodies, it is critical that the RACP partner with these organisations, and form collaborative relationships with key Indigenous leaders to better inform and deliver on the RACP's work.

Priority 2. Grow the Indigenous physician workforce;

There is currently a disproportionately low percentage of physician members who identify as Aboriginal and/or Torres Strait Islander or Māori. Encouraging the development of an increasingly diverse physician population is a strategic priority for the College. There is growing evidence that Indigenous doctors, whether in mainstream or Indigenous community controlled services, contribute to improved access to appropriate health care services, culturally safe patient experiences, and improved health outcomes for Indigenous people.

Although Indigenous doctors come from diverse backgrounds, they bring a shared understanding of cultural themes such as family, community, world views and concepts of indigenous health. They also possess lived experience of Indigenous social determinants of health, and often have a strong commitment to serving their communities no matter whether they work in a remote community or in a large urban teaching hospital. Indigenous doctors play strong advocacy roles in addressing racism, system changes, and the need for cultural competence training for other staff. That said, there is also a need to be mindful of the additional pressures and barriers faced by Indigenous medical practitioners, and the need to provide appropriate supports for Indigenous doctors. It is not the responsibility of Indigenous people to challenge and hold people to account for behaviours or policies that are racist, discriminatory or culturally unsafe; that is something that every one of us must do. Additionally, the RACP needs to be aware of challenges facing Indigenous trainees and Fellows and have in place effective processes and mechanisms that recognise these challenges and provide appropriate support.

The Australian Indigenous Doctors Association and Te ORA have called for their countries to achieve population parity with their Indigenous medical workforces. Population parity means that the ratio of non-Indigenous and Indigenous doctors is reflective of the percentage makeup of the general population. In practical terms, this means that approximately 3% of Australian doctors would be Aboriginal and Torres Strait Islander and 15.5% of New Zealand doctors would be Māori. The RACP New Zealand Committee formally adopted the output of the 2015 Hui that parity for trainee numbers should be the aim.

In relation to the RACP, it would be useful to consider what constitutes optimal representation within each specialty given the health profiles and needs of Indigenous populations. For example, child health, chronic conditions such as diabetes, renal disease, cardiovascular disease, and cancer, as well as care for older people, are priority areas for Indigenous health and could result in the most significant short and medium-term benefits from increased Indigenous physician numbers.

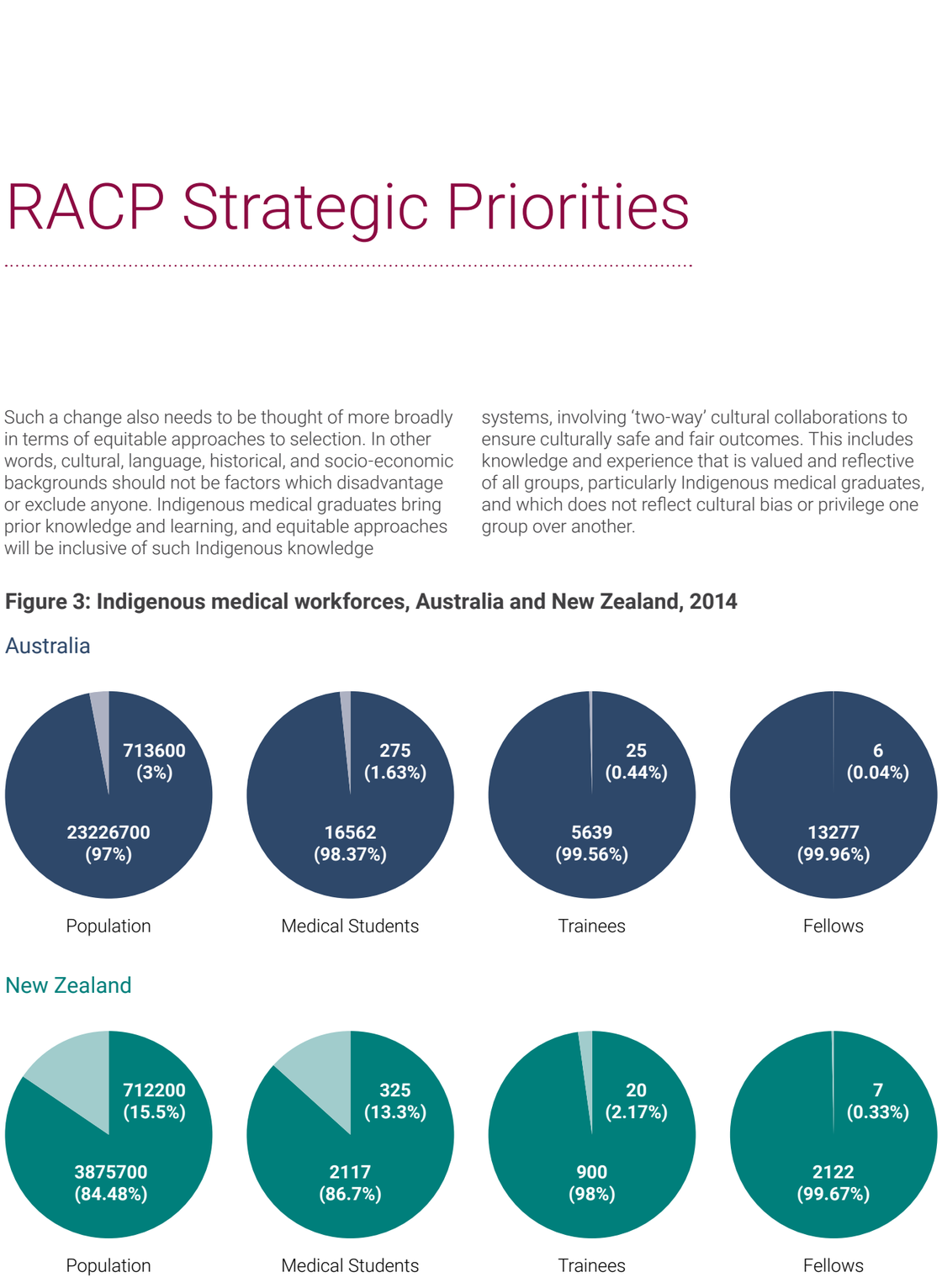
There is also an opportunity to draw on lessons learnt from the medical school experience, many of which have already achieved population parity in their intake of students, to inform our own strategies to growing the Indigenous physician workforce. The Framework should promote the recruitment and retention of Indigenous medical graduates by ensuring that the College is a competitive, culturally safe organisation which is recognised for prioritising and advocating for Indigenous health. There is an opportunity to improve the retention of trainees by reviewing current strategies, consulting with current and past Indigenous trainees and Fellows, and strengthening and developing new initiatives in response to this feedback. The RACP will also seek to work with health services to encourage them to recognise cultural considerations, including the provision of cultural competency and cultural safety training for their staff.

A key principle of the RACP's newly developed Selection into Training Policy will involve seeking and embracing diversity; and a key element will be supporting the increased selection of Aboriginal and Torres Strait Islander and Māori physician trainees, working in partnership with training workplace organisations.

RACP Strategic Priorities

Such a change also needs to be thought of more broadly in terms of equitable approaches to selection. In other words, cultural, language, historical, and socio-economic backgrounds should not be factors which disadvantage or exclude anyone. Indigenous medical graduates bring prior knowledge and learning, and equitable approaches will be inclusive of such Indigenous knowledge systems, involving 'two-way' cultural collaborations to ensure culturally safe and fair outcomes. This includes knowledge and experience that is valued and reflective of all groups, particularly Indigenous medical graduates, and which does not reflect cultural bias or privilege one group over another.

Figure 3: Indigenous medical workforces, Australia and New Zealand, 2014



Data from: ABS, Statistics New Zealand, RACP Reports to the AMC/ MCNZ and Medical Training and Review Panel Reports.

Priority 3 Equip and educate the broader physician workforce to improve Indigenous health

The RACP has an important role to play in ensuring physicians are culturally aware, competent and safe, and are clinically competent in relation to Indigenous health matters. There is a need for specifically targeted professional development to equip all physicians with competencies to provide high quality, safe and accessible care for Indigenous patients in Australia and Aotearoa/New Zealand.

Although some good work has been done, there remains a need within the physician workforce for education, upskilling and engagement of many more physicians to focus on a strengths-based approach to improving Indigenous health through recognising the unique cultural and historical position of Aboriginal and Torres Strait islander peoples, and Maori, and the impacts of colonisation and historical trauma, as well as resilience and survival.

The RACP is in the process of renewing its education programs to suit the changing environment for physician practice. Throughout this period of renewal, the College is undertaking a suite of projects underpinned by a competency-based approach to training, split across three broad strategy domains, educational renewal strategy, new curricula, and better infrastructure and support strategies.

This educational renewal is an opportunity for the RACP to make strategic changes to drive towards equity for Indigenous peoples. These changes will include a commitment to incorporate Indigenous competencies, cultural priorities and knowledges where appropriate; as well as ensuring an inclusive and equitable approach to educational renewal, and curriculum content and development. Infrastructure and support strategies should be reflective of Indigenous perspectives in a changing physician practice environment.

Priority 4 Foster a culturally safe and competent College

Competence in Indigenous health matters is not the same as Indigenous cultural competence. In Aotearoa/ New Zealand cultural competence is recognised as a key professional skill required to address health disparities for Māori, as enshrined in legislation through the Health Practitioner's Competence Assurance Act 2003. Both the MHC and ATSIHC consider that clinical competence is not possible without cultural competence; and it provides the foundation for equity and collaboration. Both committees are guardians of cultural competence in the RACP. They articulate the values of cultural competence, and mediate their translation into RACP systems and processes.

Cultural competence is a central skillset and a key area for the College to work consistently to achieve the principles of the Te Tiriti o Waitangi (the Treaty of Waitangi). Cultural competence is also a core component of the RACP's accreditation processes and assessed by the regulators, the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ).

Being culturally safe means that we recognise and ameliorate the impact that our own beliefs, assumptions, and behaviours have on others; and, for health care practitioners, recognising the serious adverse impacts on patients and whānau (family) of practicing in a culturally unsafe way. The impacts can be long-term and widespread, reaching far beyond any one specific incident.

Within the RACP, cultural competence is implicit in all aspects of physician and paediatrician education, training, professional development, and practice. Cultural competence requires awareness of cultural diversity, understanding of issues faced by different populations, and the skills to function effectively and respectfully when working with people of different cultural backgrounds.

RACP Strategic Priorities

It is in these key areas that Indigenous cultural competence is differentiated from broader definitions of this concept. It is within the power of the College to lead the way in delivering culturally competent health care to Aboriginal and Torres Strait Islander peoples, Maori, and Pacific peoples.

The RACP must train doctors to be culturally competent so they have the skills, knowledge, understanding, and practices to work in a safe and effective way with patients and whānau (family), to improve health equity and health outcomes. Culturally competent doctors understand that:

1. Populations are culturally diverse
2. The doctor's own culture and belief systems influence their interactions with patients and whānau (family), who may have a different perspective
3. Positive outcomes are achieved when people's experiences are acknowledged and when doctors treat patients and whānau (family) with respect.

The RACP has a key responsibility to provide access to role models, mentors, and teachers that can help equip doctors meet the needs of populations, and it is important that the RACP systematically record the ethnicity of its members through targeted resources and support. There are many examples whereby the cultures of health care and hospital systems have worked as a barrier to cultural competency. The RACP can change health and hospital culture for the better. The RACP can use its Curriculum Framework to set standards for culturally diverse praxis, in constructive critique of Western biomedical and biopsychosocial models. The RACP's peak Indigenous health bodies, the MHC and ATSIHC, will be key facilitators for these changes.

Cultural safety is a correspondingly key attribute at the level of the organisation. Cultural safety is a concept that emerged in the late 1980s as a framework for the delivery of more effective health services for the Māori in New Zealand. Culturally safe practices include actions which recognise and respect the cultural identities of others, and safely meet their needs, expectations and rights. Conversely, culturally unsafe practices are those that "diminish, demean or disempower the cultural identity and well-being of an individual" (Nursing Council of New Zealand 2002, p. 9). There has been an increased uptake of cultural safety in medical schools in growing recognition of the value of the principles to medical practice that are contained in the framework, and their applicability to systems levels, i.e. culturally safe health services, and to the individual, whānau/family and community members Historically, health services have not been seen as safe places for indigenous people as a result of racism, cultural insensitivity, poor communication, disempowerment and historical practices, such as the removal of children.

An important principle of cultural safety is that it doesn't ask people to focus on the cultural dimensions of any culture other than their own. Instead, cultural safety is primarily about examining the health professional's own cultural identities and attitudes, and being open-minded and flexible in attitudes towards people from cultures other than their own.

Both cultural competence and cultural safety needs to be incorporated across all aspects of physician education, training, professional development, and practice. Training will require participants to examine their own implicit biases and to be mindful of power differentials, and have the opportunity to develop reflective practice, undertake 'transformative' unlearning, and contribute to a decolonisation of health services for Indigenous peoples. The RACP is in a position to develop and adopt its own Indigenous cultural competence/ cultural safety framework based on the incorporation of the principles from both concepts which most clearly reflect the priorities of the RACP and its Indigenous health committees.

Figure 4: A framework for understanding Indigenous culture, health and cultural competence (originally developed by Dr Tamara Mackean, FAFPHM)

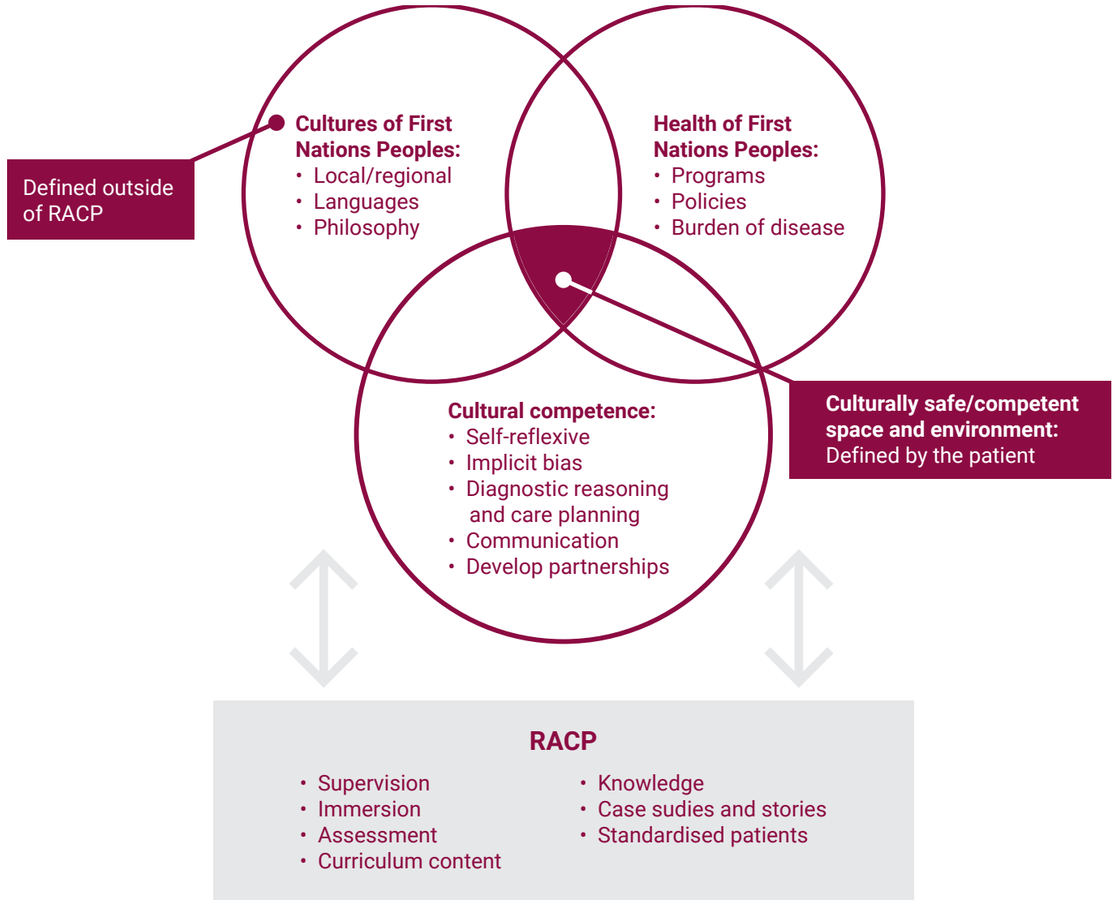


Figure 4 examines the generation of a culturally safe space for Indigenous Peoples, their families and their broader communities. It highlights the importance of acknowledging Indigenous world views and history, and ways the College can foster the generation of safe environments in healthcare settings throughout Australia and New Zealand.

RACP Strategic Priorities

Priority 5. To meet the new regulatory standards and requirements of the Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ).

In recent years, regulators of medical colleges have increased their monitoring of Indigenous health activities. New Indigenous health standards for Specialist Medical Programs and Professional Development Programs came into effect in 2016 and these build on the standards in the earlier phases of medical education. The RACP must meet the AMC and MCNZ standards relating to Indigenous health in order to be accredited.

The RACP's 2014 reaccreditation report from the AMC/MCNZ requires that the RACP report annually against progress in the following two areas:

Condition 3: Develop and implement strategies to engage more broadly with organisations such as Aboriginal and Torres Strait Islander and Māori health groups, not for profit heath organisations, public health organisations, jurisdictional health bodies and other key health providers in the development of education policy and curricula.

Recommendation FF(ii): Develop robust cultural competence outcomes and associated training resources for trainees and supervisors.

AMC and MCNZ standards

Standard 1 - The context of training and education

Standard 1.6.4 The education provider has effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to support specialist training and education.

Standard 2 - The outcomes of specialist training and education

Standard 2.1.2 The education provider's purpose addresses Aboriginal and Torres Strait Islander peoples of Australia and/or Māori of New Zealand and their health.

Standard 3 - The specialist medical training and education framework

Standard 3.2.9 The curriculum develops a substantive understanding of Aboriginal and Torres Strait Islander health, history and cultures in Australia and Māori health, history and cultures in New Zealand as relevant to the specialty(s).

Standard 3.2.10 The curriculum develops an understanding of the relationship between culture and health. Specialists are expected to be aware of their own cultural values and beliefs, and to be able to interact with people in a manner appropriate to that person's culture.

Standard 7 – Trainees

Standard 7.1.3 The education provider supports increased recruitment and selection of Aboriginal and Torres Strait Islander and/or Māori trainees.

Standard 8 - Implementing the program: delivery of education and accreditation of training sites

Standard 8.2.2 The education provider's criteria for accreditation of training sites link to the outcomes of the specialist medical program and support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of health care to Aboriginal and Torres Strait Islander peoples in Australia and/or Māori in New Zealand.

Additional accreditation criteria from the MCNZ

The Training Program should demonstrate that the education provider has respect for cultural competence and identifies formal components of the training program that contribute to the cultural competence of trainees.

Strategies

Priority 1: Contribute to addressing Indigenous health equity differences

Strategy	Outcome / progress indicators	Timeframe
Continue to advocate and support the health policy priorities of the College's ATSIHC and MHC; in particular advocacy to improve access to medical specialist care by Indigenous peoples, and secure the active support and engagement of key Indigenous health organisations in a collaborative effort to close the gap on access to specialist care, and the #MakeItTheNorm campaign in NZ focused on health equity	ATSIHC & MHC agreed objectives; deliver on workplans; Engagement with key indigenous health organisations Positive feedback from stakeholders	Ongoing In annual ATSIHC & MHC workplans Feedback and engagement activity reviewed annually Requested annually
Develop policies and procedures, and undertake advocacy for systemic change that will facilitate the implementation of the Indigenous Strategic Framework;	Able to identify and monitor instances where these actions have been undertaken	Ongoing; report annually
Undertake policy and advocacy work to raise awareness of Indigenous specific issues in senior health forums, including with government and senior health stakeholders; for example with the Indigenous National Health Leaders Forum and in meetings with government Ministers;	Able to identify and monitor instances where these actions have been undertaken	Ongoing; report annually
Review and update the College's Indigenous Health Position Statement(s)	Approved by ATSIHC & MHC	End 2018 review at least every 5 years

Priority 1: Contribute to addressing Indigenous health equity differences

Strategy	Outcome / progress indicators	Timeframe
Advocate on Indigenous health matters that are priorities of other College Bodies, with input and collaboration from ATSIHC and MHC;	Identified indigenous health matters included in workplans Deliver on workplans	Progress reviewed annually
Raise the profile and awareness of Indigenous health issues through relevant social media and RACP publications;	Regular RACP communications on Indigenous health issues	Ongoing; report annually
Work in partnership with key Indigenous peak organisations (including AIDA, Te ORA and NACCHO) and, where appropriate, governments, to develop and progress strategies that address Indigenous health equity differences and support culturally competent and safe experiences for Indigenous patients	Identified shared initiatives;	Ongoing; report annually

Strategies

Priority 2: Grow and support the Indigenous physician workforce

Strategy	Outcome / progress indicators	Timeframe
Develop and implement strategies to increase intake and completion rates for the Indigenous medical workforce with the aim of future population parity, including: • Gaining a clear understanding of their needs and the barriers they face; • Developing strategies to overcome identified barriers and meet needs • Engaging with Indigenous medical students, graduates and young doctors • Connecting with medical schools and other relevant organisations • Incorporate into RACP Selection into Training	Research on issues and barriers Strategies in place & effectiveness assessed Opportunities to engage with potential new trainees planned and delivered on Organisations identified, plans in place Incorporated into selection process	Initial research completed by March 2018; repeated every 3 years Report annually Annually 2018; review 2020 2019 Review every 3 years
Review strategies adopted by medical schools that were successful in increasing their intake and completion rates for Indigenous students, assess their applicability to the RACP and incorporate best practice elements;	Review undertaken and reported on Best practice elements incorporated into recruitment and retention strategies	2019 Review every 3 years
Investigate current support and mentoring services and implement a process of continuous improvement;	Review completed Revised plan and budget Regular review in place	Mid 2018 2019 implement 2020

Priority 2: Grow and support the Indigenous physician workforce

Strategy	Outcome / progress indicators	Timeframe
Investigate models to improve connections between Fellow mentors, Supervisors and trainees	Report on investigation Recommended model approved and in 2020 budget	2019 End 2019
Provide career development support and counselling to trainees and Fellows;	System in place	2020; Report annually
Undertake a review of the current scholarships model and terms to assess their effectiveness, including the potential to increase the number;	Review undertaken and reported on; improvements identified	2018; implement 2019
Provide scholarships for Indigenous trainees and Fellows to undertake Indigenous health research, particularly as early career researchers; implement ongoing review/improvement cycle to ensure effectiveness	Scholarships awarded; strong response to EOIs; positive feedback from recipients	Annual monitoring and reporting; reviewed every 3 years
Develop and implement specific Health and Wellbeing strategies for Indigenous trainees and Fellows.	Program in place; strong awareness by Indigenous members; positive feedback	Program in place 2019; annual monitoring and reporting; review every 3 years

Strategies

Priority 3: Equip and educate the broader physician workforce to improve Indigenous health

Strategy	Outcome / progress indicators	Timeframe
Incorporate Indigenous health content and cultural competency into • new RACP training curricula (including learning, teaching and assessment programs) • Supervisor training programs and materials • Continuing Professional Development programs and materials	In BT curriculum In AT curricula In Supervisor training materials Able to identify new and/or updated resources	2019 Ongoing; report annually In relevant workshop content and agendas by end 2018; in all relevant materials by end 2019 Report annually
Incorporate cultural competency into the Selection into Training processes;	In initial pilot In roll-out version	2018 2019
Advocate opportunities for non-Indigenous physician workforce to undertake placements in areas with significant Aboriginal and Torres Strait Islander and Māori populations	Able to identify instances	Ongoing; report annually
Where appropriate, work in collaboration with health services (where physicians work) to support initiatives to educate the physician workforce to improve Indigenous health and cultural competency	Able to identify instances	Ongoing; report annually

Priority 4: Foster a culturally safe and competent College

Strategy	Outcome / progress indicators	Timeframe
Develop an Indigenous cultural competence framework to inform College policy and practice	Framework in place	2019
Update the RACP's Reconciliation Action Plan (RAP) and regularly monitor its progress;	New RAP approved by Board	2018; report annually; update every 5 years
Review and develop systems and policies to facilitate a culturally safe organisation;	Review undertaken Able to identify instances Undertake regular processes to secure feedback	2018 report annually 2020
Encourage and support Indigenous member representation within the committee structure of the College;	Report to Board	Ongoing; report annually
Incorporate Indigenous acknowledgements, artwork and imagery within College offices and, where appropriate, materials;	Positive feedback from ATSIHC and MHC, members, and external stakeholders	Ongoing; report annually

Strategies

Priority 5: Meet the new regulatory standards and requirements of the Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ)

Strategy	Outcome / progress indicators	Timeframe
• Incorporate relevant processes to ensure the College meets AMC and MCNZ accreditation standards relating to Indigenous health	Positive feedback from AMC regarding progress against new standards, conditions and recommendations AMC condition 3 closed	Ongoing; reported on annually

It is within the power of the College to lead the way in delivering culturally competent health care to Aboriginal and Torres Strait Islander peoples, Maori, and Pacific peoples.

Electronic version available at:

https://www.racp.edu.au/docs/default-source/default-document-library/indigenous-strategic-framework.pdf

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