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Acting for Equity in the COVID-19 crisis: a statement from the Indigenous Health Committee of the Royal Australasian College of Surgeons

Tena koutou katoa.

The COVID-19 pandemic has brought about a drastic change in the way health practitioners practise medicine in both Aotearoa New Zealand and Australia. As surgeons, we have been required to reduce operating capacity, prioritise patients who receive surgery, restrict endoscopy, instigate non-operative management and perform the majority of our clinics virtually.

While restrictions placed by both the New Zealand and Australian governments are necessary to gain control of the spread of the virus, there will be inevitable adverse consequences to society. Although the virus is not selective about whom it infects, the impact of this pandemic will ultimately have greater adverse outcomes for those who are already disadvantaged.

It is important to remember that in times of resource constraint, inequities will develop as services are prioritised and redirected. Māori and Aboriginal and Torres Strait Islander peoples already experience significant health inequities in non-pandemic times. In a rapidly developing crisis these inequities will be exacerbated. Not only will Indigenous groups experience inequities in terms of the virus itself, but also due to the secondary impact on non-COVID-19 illnesses and disease.

Māori and Aboriginal and Torres Strait Islander peoples have experiences of inequitable treatment with pandemic conditions. The Spanish Flu pandemic of 1918 resulted in a mortality rate for Māori at least seven times that of non-Māori, while the number of Aboriginal and Torres Strait Islander peoples lost to the pandemic will never be known as their deaths were not recorded by Australian health authorities. In some communities there were not enough people to remove the dead. Health care delivery was denied to Indigenous communities and Indigenous people were routinely turned away from hospitals.

In the context of the COVID-19 pandemic Māori and Aboriginal and Torres Strait Islander peoples have an acute sense of the threat of devastation of their communities, language, customs and particularly their elders as holders of Indigenous knowledge. They have lived experiences of current and historical impacts of colonisation and resultant social, economic and health disparities.

In response, Indigenous leaders and communities in both countries have taken action to combat the impact of COVID-19 and protect Māori and Aboriginal and Torres Strait Islander peoples' right to health and wellbeing as guaranteed under the United Nations' Declaration of the Rights of Indigenous People (2007), Te Tiriti o Waitangi etc (e.g. www.uruta.maori.nz and many others).

It is imperative that we learn from the lessons of the past and take into account best practices and evidence to avoid widening already significant health inequities for Indigenous people. The current COVID-19 environment is rapidly changing and evolving in both our countries. The future is uncertain, however we can



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act now to mitigate inevitable worsening of health inequities for Māori and Aboriginal and Torres Strait Islander peoples.

We can do this by ensuring equity is centred in all COVID-19 responses from the beginning and not retrofitted or added on at a later date. We must centre Indigenous expertise in decision making and strategic planning and demand the collection of high quality ethnicity based data. Monitoring data collection and tailoring responses against best practice is an essential part of this pandemic response.

In Aotearoa New Zealand, Te Tiriti o Waitangi is critical to any framework developed around clinical care impacted by resource constraints.

Some broad concepts for equity around surgical decision making during the COVID-19 pandemic include:

1. Ensuring equity principles are embedded in initiatives, responses and systems from the outset.
2. Inclusion of Indigenous voices and perspectives in COVID-19 pandemic responses, initiatives and decision making. In Aotearoa New Zealand this involves embedding the principles of Te Tiriti o Waitangi as a structuring framework for all strategic decisions.
3. High quality ethnicity data based on Indigenous Data Sovereignty is essential to inform and evaluate the impact of interventions, but also ensure accountability from health boards and government.
4. Balance risk of COVID-19 with delayed cancer care. Due to multigenerational living situations, higher comorbidities and barriers to access to care, including institutional racism, Indigenous patients and communities will suffer disproportionately if the virus is contracted. There must be a balance between the risk of cancer not being treated optimally with the risk of illness and spread of COVID-19. This risk will depend on local and national COVID-19 virus prevalence which may differ between different regions and communities. Ensure all services have robust COVID-19 screening and testing when appropriate for patients receiving diagnostic investigations and surgical care in order to protect patients, whanau/family and staff. Ensure adequate PPE and up to date guidelines and training for its use.
5. Principles around delayed cancer diagnosis and treatment. Indigenous communities experience multiple and disproportionate barriers to access for cancer treatment and care. Consequently, these population groups are frequently diagnosed and receive treatment at a later stage, at a more advanced stage of disease and have worse cancer-related outcomes. Indigenous people have poorer access to early diagnosis of many forms of cancer ¹and the types of cancer commonly diagnosed in Indigenous populations differ from that of non-Indigenous groups, e.g. gastric and lung cancer is three to six times more common in Māori. Strategies should be developed to provide minimum standards of diagnostic and surgical treatment services which focus on investigations in areas more likely to disproportionately impact Indigenous groups such as gastroscopy and bronchoscopy for lung and gastric cancer. Ensure if minimum treatment standards are required for different COVID-19 alert levels that Indigenous people are not allocated inappropriately to levels of care that will be discontinued early.
6. Consider accelerated diagnostic and treatment pathways specifically for Indigenous patients. Accelerated pathways adjust for the delays experienced in diagnosis and treatment so that outcomes are comparable to non-Indigenous populations. Additional resources may be required to achieve equitable outcomes. This should not create

¹ Gurney J, Stanley J, Jackson C, Sarfati D. Stage at diagnosis for Maori cancer patients: disparities, similarities and data limitations. New Zealand Medical Journal 2020; **In Press**

discomfort for clinicians and health managers as the “one size fits all approach” of the current health system already fails to provide equitable outcomes in the pre-COVID-19 era. Resources and initiatives should be directed to Indigenous groups who require it in order to achieve the same outcomes as non-Indigenous populations.

7. Consider the long term, intergenerational and social impact of not treating certain surgical conditions, e.g. grommets in children, and set in place infrastructure to accelerate surgical services as soon as appropriate.
8. Advocate for screening programs to have an equity focus when screening is able to resume e.g. reduced age of bowel and breast screening for Maori, lung cancer screening programs etc.

Equity principles for surgery have been developed in Aotearoa New Zealand and are under review and will be able to be shared when finalised. The COVID-19 Management Plan for Aboriginal and Torres Strait Islander Populations is available on the Australian Government Department of Health website.

RACS has precedents in prioritising Indigenous health equity (Strategic Plan 2019-2021, Māori and Aboriginal and Torres Strait Islander Peoples Action plans, Reconciliation Action Plan 2019). We can and must act now to continue the aspirations of RACS to ensure that the pandemic response achieves equitable outcomes for Indigenous people in both our countries. As surgical leaders we have a responsibility and the ability to advocate for a response which guarantees surgical conditions and procedures are delivered to Indigenous people equitably.

If we can do that, we will contribute to ensuring that all communities emerge from this global humanitarian and health crisis side by side.

He waka eke noa

We are all in this together

Dr Maxine Ronald FRACS

Chair