Compendium to the Equity and Inclusion Strategy

2026 – 2030

Australasian College
for Emergency Medicine

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Contents

From principles to practice

Case studies, frameworks and evidence for equity and inclusion in emergency medicine

This compendium serves as the practical foundation and evidence base supporting the **ACEM Equity and Inclusion Strategy 2025-2030** and **ACEM Equity and Inclusion Action Plan 2026-2030**. While the strategy articulates our vision and high-level commitments, the materials gathered here translate those commitments into lived realities, practical applications and measurable imperatives for change.

Definitions

Compassion

Compassion is defined as 'the emotional response to another's pain or suffering, involving an authentic desire to help … compassion also involves taking action.'[5] Unlike other forms of caregiving, such as familial love or the moral and professional obligation of physicians to 'do no harm,' compassion is informed by empathy but avoids the emotional strain and cognitive load of empathy-without-action to provide scientifically verified benefits to patients, families/caregivers and clinicians.

Difference

When spelled with a capital 'D', Difference refers to those distinctions that affect how people are treated in society, as opposed to incidental differences that have little to no impact on privilege or hierarchy. People who diverge from the cultural norm with capital D Differences can be described as members of **non-dominant groups**, whether in terms of culture, Indigeneity, race, ethnic origin, religion, language, sexuality, gender or other criteria recognised core identity markers in Australian and Aotearoa New Zealand societies. For example, wearing glasses is a difference, while being a wheelchair user is a Difference; height is usually a difference, whereas race is a Difference.

Disability

The strategy and compendium draw on the World Health Organization's (WHO) social definition of disability, which states that 'disability results from the intersection between individuals with a health condition, such as cerebral palsy, Down Syndrome and depression, with personal and environmental factors including negative attitudes, inaccessible transportation and public buildings and limited social support.'[7] Disability may be permanent, fluctuating, episodic, situational, progressive or temporary, and may exist from birth or be acquired later in life. It can also be visible or hidden. This definition is not incompatible with the Australian Human Rights Commission, which follows the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) model and recognises disability as 'a natural aspect of human diversity and humanity.' [8] As with the Australian Human Rights Commission, the strategy and compendium emphasise 'respect for dignity, individual autonomy, non-discrimination, inclusion and participation in society, accessibility and equality of opportunity.'[8]

Diversity

Refers to the mix of people in an organisation or society, considering their social, professional and other identities, including sex, gender, sexuality, Indigenous status, religion, language, neuroprocessing, physical ability, age and ethnicity.[9]

Equity

The practice of treating people as individuals with different needs, requiring tailored strategies to achieve equal outcomes. This means addressing each person's specific needs and **not treating everyone the same or with complete impartiality**.[10]

Inclusion

The creation of a sense of belonging for everyone, recognising and valuing individual and group diversity, and ensuring equitable access to opportunities and resources. Inclusion encompasses both physical access and fostering a culture of respect and understanding for all.[11]

Intercultural adaptation

Milton Bennett's *Developmental Model of Intercultural Sensitivity*[2, 3] posits that Acceptance and Adaptation are the most advanced stages of intercultural development that organisations can achieve. Acceptance does not mean 'liking' every aspect of all cultures, but rather the recognition that each cultural group has its own internal logic, which is largely consistent with the whole. **Adaptation** refers to the actions taken to include others once this cognitive shift has occurred.

Using the Intercultural Development Inventory (IDI), ACEM's staff have identified **Acceptance and Adaptation** as the College's desired stages of intercultural development, which requires a shift from Minimisation, the less developed stage in which the College is currently working. The strategy and compendium calls for the IDI to be used with Fellows, trainees and other stakeholders to help define their developmental goals for the College.

Achieving these advanced intercultural stages, which involves navigating the most complex experiences of Difference or otherness, requires recognising fundamental Differences in cognition and behaviour across human groups and adjusting approaches to meet diverse needs, instead of relying on minimising bureaucratic or medical models that assume inherent sameness.

LGBTQIA+ITSB

Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual + Irawhiti, Takatāpui, Sistergirl, Brotherboy. The final four terms in this extended acronym represent Indigenous gender and sexuality categories that existed prior to colonisation – **Irawhiti** and **Takatāpui** in Māori communities; **Sistergirl** and **Brotherboy** in Aboriginal and Torres Strait Islander communities.

Irawhiti is an umbrella term for trans, non-binary and some intersex people and refers to gender. Takatāpuhi is an umbrella term for queer and refers to sexuality.

Sistergirl is a term for people who are born male and identify with a third gender that is more feminine than masculine. Brotherboy is a term for people who are born female and identify with a third gender that is more masculine than feminine.

Social Emergency Care

Defined as practicing medicine in a way that addresses not just clinical care but also the social determinants of health, as defined by the WHO (''conditions in which people are born, grow, live, work, and age'' that are in turn ''shaped by the distribution of money, power and resources at global, national and local levels''). [12, 13]

Appendices

Appendix 1 presents three detailed case studies, each corresponding to one of the strategic pillars – **Intercultural Adaptation**, the **Science of Compassion** and **Social Emergency Care**. These narratives draw on real-world scenarios from emergency departments in Australia and Aotearoa New Zealand, highlighting the challenges faced by Fellows, Associates, trainees staff, patients and families when systems are not adaptive, compassionate or cognisant of the social determinants of health. Through these stories, we see how institutional inflexibility, communication gaps and structural inequities can affect both clinical outcomes and the wellbeing of those who deliver and receive care.

Appendix 2 outlines the three overarching frameworks – **Centring Stories**, **Intersectionality** and **Strength-based Discourse** – that inform and guide the implementation of the strategy. These frameworks provide the ethical and conceptual scaffolding for change: **Centring Stories** underscores the centrality of listening and empathy as well as being able to formulate the clinician story; **Intersectionality** illuminates how overlapping identities shape experience; and **Strength-based Discourse** reframes challenges to emphasise capabilities, resilience and systemic responsibility rather than individual deficit. Together, they ensure that initiatives remain inclusive, informed and responsive to the diverse realities of our Fellows, Associates, trainees, staff and patients.

Appendix 3 provides life expectancy differentials across Australia and Aotearoa New Zealand, with attention to geographic, socioeconomic, disability, refugee and other equity-related factors. These data illustrate stark disparities in health outcomes and reinforce the urgency of embedding social emergency care principles into all facets of ACEM's work – training, policy, advocacy and clinical practice.

Collectively, these appendices move the strategy beyond abstract principles. They connect policy to practice, data to humanity and vision to action – equipping ACEM stakeholders with the insight, tools and moral clarity needed to advance equity and inclusion across emergency medicine.

Appendix 1: Case studies for each Strategic Pillar

Case study 1 – Complexity in the emergency department: A call for intercultural adaptation

Context

At a metropolitan emergency department (ED) in Australia, a senior trainee, Dr Amina*, who identifies as neurodivergent and culturally Muslim, is in the final phase of her ACEM training. Over several months, she has reported experiencing subtle but persistent barriers in the workplace. These range from inflexible expectations about verbal communication styles during handovers to culturally inappropriate feedback approaches that undermine her confidence and professional identity. Meanwhile, staff frequently default to standardised clinical processes that do not account for the needs of patients from culturally diverse or neurodivergent backgrounds.

The incident

During a high-pressure trauma case, Dr Amina's clinical decision-making was questioned by a FACEM in public in a tone and setting she found undermining. While the feedback was intended as constructive, it failed to consider her neuroprocessing differences and the impact of delivering complex information in an overstimulating environment. Her cultural and neurodivergent needs, often mistaken as a marker of competence, were invisible within the emergency department's dominant culture of high-speed, high-volume communication. This incident, layered on years of microaggressions and institutional rigidity, led her to take stress leave just months before sitting her fellowship exam.

On the same day, a non-verbal autistic teenage boy presented to the ED with escalating behavioural distress. The department, unprepared to adapt the clinical environment, defaulted to restraint and sedation instead of sensory-informed approaches. The teenager's family, deeply familiar with their child's needs, felt dismissed by staff unfamiliar with neurodivergent-informed care.

Systemic reflection

These two seemingly distinct experiences – one involving a trainee, the other a patient – share a common thread: institutional inflexibility in the face of Difference. Despite good intentions, this ED operates within a framework that prioritises expedience and uniformity over nuance, adaptability and cultural competence. Staff are trained to treat everyone 'equally,' but not necessarily equitably, and often without the tools to recognise how racial, cultural, gendered and other Differences shape the way people give, receive and interpret care.

Why intercultural adaptation is needed

This case illustrates the urgent need to move beyond performative inclusion and toward intercultural adaptation, as outlined by Bennett. It demands a shift in mindset that:

- Recognises Difference not as a challenge to overcome but as a fundamental aspect of how people engage with the world.
- Accepts that treating people 'the same' can in fact be deeply exclusionary if 'the same' is defined by the dominant norm.
- Embeds behavioural, bureaucratic and structural changes that give all staff and patients what they need to thrive and heal – not just what is standardised.

Key takeaways

- Trainees like Dr Amina require culturally and neuro-cognitively responsive supervision and learning environments to succeed.
- Patients with diverse communication or processing needs must be met with flexible protocols that do not default to containment or constraint.
- FACEMs and other staff must be supported to shift from rigid systems to adaptable practices through mindset, policy and structure change.

Conclusion

The ED must evolve from a place of monocultural efficiency to one of intercultural fluency. This includes revisiting feedback practices, retraining for sensory and both cultural safety for Indigenous patients and staff and cultural competency for all, adjusting workflow assumptions and building in relational, not just procedural, competence. Only then can emergency care deliver on its promise: to meet people at their most vulnerable, with the care that fits them – not just the care that fits the system.

**Name changed for privacy.*

Case study 2 – 'Are you listening?': The crucial role of compassion in emergency medicine

Context

In a busy metropolitan emergency department in Aotearoa New Zealand, Mereana*, a 52-year-old Māori woman, presented with escalating abdominal pain. She was triaged appropriately, seen promptly and had her observations recorded. But as her clinical workup began, something shifted: she grew visibly agitated, withdrawing from the conversation and eventually refusing to engage further with the care team.

The attending doctor, Dr Kingston*, believed she had followed all standard protocols – asking about her medical history, current medications and social circumstances. But her tone was brisk, her questions clinical and her body language distracted. She had five other patients waiting. When Mereana became distressed, she chalked it up to 'non-compliance.'

It was the nurse who discovered the missing piece: Mereana had a history of healthcare – related trauma and deep mistrust in clinical systems after prior experiences of stereotyping and dismissal. The way she was being spoken to – rushed, impersonal, transactional – echoed those past harms. She wasn't refusing care. She was protecting herself from it.

What was missing: Compassion

The science of compassion, increasingly cited in medical research, tells us that patients who feel seen, heard and respected are more likely to:

- Share crucial information that affects diagnosis and care;
- Engage with and participate in treatment plans;
- Have better short and long-term outcomes; and
- Return to necessary healthcare settings in the future with greater trust.

None of these outcomes were possible for Mereana in that moment – not because of a lack of skill, but because compassion was not integrated into the clinical interaction.

The trainee's parallel experience

In the same department, a non-binary trainee, Dr Nguyen*, regularly received negative feedback from senior staff. Despite performing well on clinical tasks, they were told to 'toughen up' and 'be more assertive.' These comments – though meant to be helpful – missed the mark. Dr Nguyen experienced them as a dismissal of their identity and more relational communication style.

When a trusted supervisor later asked, 'What support would help you feel more confident in high-pressure situations?' Dr Nguyen felt, for the first time, like someone was interested not just in their performance, but in **them**. That shift in approach, **a compassionate one**, changed everything.

Compassion is a clinical tool, not just a personal trait

The *ACEM Strategy 2025–2030* recognises that compassion must not be incidental to emergency care; it must be embedded in how we train, supervise, treat and lead. This includes:

- Compassion for patients, whose definitions of safety, dignity and healing may differ from our clinical assumptions.
- Compassion for trainees, Fellows and Associates whose experiences of gender, race, neurodivergence or other background, trait or identity shape how they learn and thrive.
- Compassion for ourselves and colleagues, especially in high-stress environments prone to burnout.

Compassion in practice means

- Asking not just 'What's the matter?' but 'What matters to you?'
- Making room in clinical protocols for cultural, emotional and identity-based needs.
- Recognising when standard procedures may unintentionally cause harm and adjusting with empathy.
- Being willing to create space for human connection. The common misperception is that this takes longer. But multiple studies show this is incorrect.

Conclusion

Emergency departments are defined by urgency, but **compassion cannot be optional** in that equation. It is as essential a piece in providing excellent care as diagnostic acumen and procedural skill. And it's not only for patients; **it must extend to how we engage with colleagues and trainees, too**.

By allowing the **science of compassion** to guide our decisions, we move closer to an emergency medicine system that doesn't just treat people, but truly cares for them.

**Names have been changed for confidentiality*

Case study 3 – 'More than a diagnosis': Extending social emergency care to all ACEM stakeholders

Context

Ali*, a 34-year-old refugee father of three, presented to an urban emergency department (ED) in Australia with severe chest pain and breathlessness. English was his second language, but he refused an interpreter. Although clinically stable, he appeared anxious and withdrawn. The team quickly initiated a standard chest pain pathway and ruled out a myocardial infarction. He was discharged with information and reassurance.

But what went undocumented, and unacknowledged, was his **ongoing trauma**. Ali had arrived in Australia just six months earlier, after fleeing violence. He was living in temporary accommodation, parenting alone and dealing with ongoing immigration stress. The chest pain was real, but so was his **social suffering**, which the ED workflow was not equipped to identify or respond to. **Clinical care was provided, but holistic care was not**.

Why social emergency care matters

Ali is one of many patients for whom medical presentations are deeply interwoven with social vulnerability. Traditional emergency medicine often separates the 'social' from the 'clinical,' but **social emergency care**, as described in ACEM's Traumatology Talks strategy, recognises that social context is not peripheral: **it is central to how patients experience illness, treatment and recovery**.

A missed training opportunity

Meanwhile, in the same department, a senior trainee named Joel*, who lives with moderate hearing loss, was preparing for his fellowship exams. Joel is highly capable and well-regarded for his diagnostic reasoning and calm presence in trauma situations. But in oral exam preparation he struggles to keep up, especially in noisy environments or when questioned rapidly without being able to face the speaker.

Despite disclosing his disability early on, adjustments were always inconsistent. His difficulty processing questions during high-speed mock vivas was misinterpreted by some as hesitation or lack of confidence. Feedback focused on 'speaking up' and 'projecting certainty,' without recognition of the listening fatigue and concentration burden Joel carried.

Had the department's teaching and assessment processes drawn on principles of **compassionate education and social emergency care**, Joel's needs might have been anticipated and accommodated, not treated as afterthoughts. This isn't about special treatment; it is about **equitable opportunity** to demonstrate his capabilities in a system not designed with him in mind.

From the bedside to the College: A needed expansion

These stories demonstrate why the science of compassion and social emergency care **must extend beyond clinical encounters and into training, policy, assessment and College structures**. Extending the work already undertaken in cultural safety to other populations is not only ethically urgent; it is **supported by mounting evidence**.

The *Traumatology Talks: Black Wounds, White Stitches* report notes that many patients would benefit from this approach and so would **our Fellows, Associates, trainees and staff**, many of whom live at those same intersections.

Embedding Social Emergency Care principles across all aspects of ACEM's work would mean:

- **Training:** Equipping educators and supervisors to understand how disability, culture and social experience affect learning and to adjust accordingly.
- **Assessment:** Ensuring fairness and accessibility are designed in from the start, not tacked on at the end.
- **Policy and advocacy:** Making visible the needs of people who aren't always represented in dominant models of care.
- **Membership and Fellowship:** Creating a culture of genuine belonging where equity is built into the structure, not left to individual goodwill.

Conclusion

Ali's pain was real. Joel's struggle was real. And in both cases, the care system responded with competence but not with compassion. Neither needed extraordinary accommodations, just **a system attuned to their humanity**.

If ACEM fully embraces the science of compassion and the breadth of social emergency care as envisioned in the strategy and action plan, emergency medicine will become not only more clinically effective but also more just, more humane and more sustainable.

**Names and identifying details changed for privacy.*

Appendix 2: Background on the supporting frameworks

Centring Stories: Listening

Every patient has a story …[14]

If you ask Dr Fiona Reilly, a senior paediatric emergency physician, what the key to good healthcare is, her first answer might be a little unexpected.

> *'The fundamental building block of medicine is stories,' Dr Reilly tells ABC Radio National's Life Matters program.*
>
> *'The care of the sick unfolds in stories.'*

But Dr Reilly says doctors often don't allow patients to share these stories, which could include the feelings, concerns and experiences they bring into a medical consultation that impact their medical interactions.

She points to a 2019 US study published in the Journal of General Internal Medicine that looked into the time it takes before a doctor interrupts a patient for the first time.

> *'It's devastatingly bad. It's 11 seconds,' she says.*

But when they are given that space, Dr Reilly says a patient's experience is vastly different – and so is the feeling they walk away with.

A worried mother's story

When patients visit a doctor, they bring 'complex and sometimes quite ambiguous problems', Dr Reilly says.

And these aren't always answered by a purely scientific approach to medicine.

Dr Reilly believes it's essential that health professionals also have skills in listening deeply to their patients.

Without those skills, they'll miss valuable information and a valuable opportunity to build trust and connect with their patients.

For example, Dr Reilly recalls meeting a family at her paediatric emergency department several years ago.

Their three-year-old daughter had a fever and doctors treating her believed it was likely a viral illness and that the child wasn't too unwell.

But the family remained highly anxious about the child's illness. It led the doctors to do a number of extra tests – including a urine test, chest X-ray and blood test – which were 'building up in terms of the complexity and cost, both to the patient and to the system', Dr Reilly says.

The tests returned as normal, but the family's concern was undiminished.

As a result, 'the doctors began to second guess themselves', wondering if they were missing something, Dr Reilly says. She was brought in to give a second opinion.

The first thing she did was speak with the child's mother, who was on the verge of tears.

'What transpired was a really important story,' Dr Reilly says.

The mother explained that years earlier, when she was 34 weeks pregnant, she sensed something was not right with her pregnancy and sought medical care. At the hospital, she'd been reassured that everything was okay after a number of tests. But, tragically, after she returned home the baby had died.

'It was as the mother told me this story that I understood how that story connected to the story of why she was so worried about this child today,' Dr Reilly says.

It meant all the doctors could approach the family with a greater understanding of their concern and a better chance of managing it.

Dr Reilly says the more patients feel listened to, the more likely they are to have closer and more productive relationships with their medical providers.

'When patients come to me, they come with a story about their illness, that narrative of their illness experience,' she says.

'That storyteller has power.'

Empathy doesn't need to take more time

Dr Reilly says it's a commonly held misconception that 'practising good listening in a medical context takes extra time'.

But if patients are given the space and time to speak, she says the average time it takes them to tell their story – 'the story that's important to them' – and explain what they need from the interaction with a doctor, 'is about a minute and a half'.

'So, this is not something that costs a lot of time. And it actually can save time, it can save money, it can save unnecessary investigations. And it can save a lot of stress and anxiety for patients and their families.'

...

A good doctor needs 'scientific knowledge and technical skill', she says.

'But they also need insight and the ability to interpret a story. And they need an ethical framework in which to situate that so that they can make a deep and important and trusting connection with their patients.'

Centring Stories: Telling

Three ways doctors can find the courage to tell their burnout stories[15]

If you had met Dr Jillian Horton, MD, six years ago, you would have thought she was at the pinnacle of her career. The reality was, Dr Horton had been cycling in and out of doctor burnout for her entire physician career. But what ultimately pulled her out of this burnout cycle was the ability to share her personal story.

'As clinicians and individuals who are dedicated to addressing the physician burnout crisis, we know that there are two other groups of stakeholders: patients and the organizations [sic] that we work for,' Dr Horton said during the closing keynote at the American Conference on Physician Health 2021 in Scottsdale, Arizona. She is associate chair of the internal medicine department at the University of Manitoba Max Rady College of Medicine, in Winnipeg, Canada.

If physicians only publish their writing in places where other doctors will see it, 'then we don't ever really give those other groups the information that they need to help us,' said Dr Horton, author of the national bestseller, *We Are All Perfectly Fine: A Memoir of Love, Medicine and Healing*. 'This is part of why I believe it is critical for all of us to … put our narratives in places where people aside from only physicians will read them and we will begin to get their buy-in, their feedback, their perspective and also their health.'

To find the courage to tell their own stories, Dr Horton outlined some steps that physicians can follow to do so.

Decide what you want to accomplish

'When we write about really deeply personal experience or trauma … we're not just doing it for catharsis,' she said. 'That's just downloading our difficult experiences, getting them out of our head and putting them on a piece of paper, but that's not writing with intent.'

Don't just write 'to exorcise demons,' but to 'elicit a response from someone to try to accomplish something,' said Dr Horton. 'As we become sophisticated in our skills, we develop intent, and we come to recognize [sic], hopefully, that when we write there's a purpose.'

Brace yourself first

'We all know that organizational [sic] factors are the primary driver of burnout, and that we don't have a resiliency deficit – we have a resiliency mismatch,' said Dr Horton. 'What has been so important for me is that this work fortifies me so that I can continue to do the work of changing the system.

Such writing is not meant 'to let the system off the hook. It gives me a way to continue to survive with minimal personal collateral damage so that I can keep doing the work that we must do,' she said. 'So brace yourself first. Do what you can to strengthen yourself so that you can feel that you have the courage and reserve to do this work.'

Be willing to rewrite the ending

Think about survivor bias.

'The narratives that we don't hear … are the people who we have lost tragically, unacceptably to completed suicide,' Dr Horton said. 'What we need to do is try to help normalize [sic] the experience of sharing narratives so that those people who sustain those other injuries – the ones that we don't normally talk about – feel able to share their narratives in a safe and supportive way.'

Intersectionality

Intersectionality is a term coined by American legal scholar Kimberlé Crenshaw in 1989.[16] She used it to explain how Black women often experience compounded forms of bias that aren't fully addressed by focusing on race or gender alone. The concept has come to refer to the interconnected nature of multiple social categories, such as race, gender, class, sexuality, Indigeneity, disability, neurodivergence and others, that overlap and interact to create unique dynamics of discrimination or privilege.

Intersectionality is a more complex approach to exploring discrimination and privilege than either single-axis approaches, which look at one form of disadvantage at a time (e.g. gender or race), or additive approaches, which look at multiple categories (e.g. gender and race) but don't account for how they interact.

In emergency medicine practice and education intersectionality helps us:

- Understand why certain groups (e.g., LGBTQIA+ITSB people with a disability who live rurally) face greater systemic barriers to training or care.
- Avoid 'one-size-fits-all' solutions that only address single-axis inequities (e.g., only Aboriginality or only rural residence).
- Develop equity-based policies that reflect the complex lived experiences of staff, trainees and patients.

Strength-based Discourse

Strength-based Discourse is a communication and concept framing approach used in many disciplines and practices to challenge deficit-based narratives that focus on what an individual or population lacks, struggle with or fail to do. It focuses on structures and systemic barriers instead of individuals, capabilities rather than limitations, potential instead of problems and assets instead of deficits. It's not about ignoring hardship but about changing who and what we see as the 'problem.'

For example, we can reframe the deficit discourse idea that 'marginalised groups struggle to succeed in medicine' with a lens on how 'marginalised groups have been systematically excluded, despite their strong contributions.' Or we can think about patient care rather than from a 'non-compliance' framework but with a focus on how a patient has unique, intersecting circumstances that require us to approach their case differently if we want to provide appropriate care. Finally, rather than thinking about a trainee's communication style as an indication of low confidence, we can hear them differently by listening to the indirect ways they provide leadership in a crisis.

Appendix 3: Life expectancy differentials – Why social emergency care matters

In both Australia and Aotearoa New Zealand, Indigenous people experience lower life expectancies than non-Indigenous people, which is one of the reasons that the *Traumatology Talks: Black Wounds, White Stitches*[13] report at ACEM called for a social emergency care platform to be initiated. As the action plan is borrowing the social emergency care concept from Indigenous health at ACEM, we present here the life expectancies for some of the other populations that we believe will benefit from social emergency care.

Australia

Australia's life expectancy in 2023 was one of the highest in the world (11th), men were expected to live an average of 82.1 years (second among countries with populations over 100,000) and women 85.7 years.[17] Nonetheless, significant differences are evident when the population is looked at by region, socioeconomic level and other aspects of advantage and disadvantage.

Remote females 77.4, males 73 vs metropolitan females 88.1, males 85.7.[18]

Lowest socioeconomic decile females 82.3, males 78 vs Highest socioeconomic decile females 87.3, males 84.7.[19]

Refugee females 70.5, males 60.[20]

People with intellectual disability in Australia die an average of 27 years younger than those without.[21]

The Australian Bureau of Statistics does not currently track life expectancy for the LGBTQIA+ITSB population but most research indicates that this population experiences poorer health outcomes, largely for sociocultural reasons such as homophobia and transphobia, exclusion and clinician ignorance.[22]

Aotearoa New Zealand

Aotearoa New Zealand's life expectancy data in 2022-24 were also very high: 80.3 years for males and 83.7 years for females.[23]

We cannot find a rural vs urban life expectancy statistic for Aotearoa New Zealand that categorises by sex. However, the life expectancy between the most urban and the most rural residents in the country is four years.[24]

Most deprived females 81, males 76.8 vs Least deprived females 86.2, males 83.5.[25]

Current data on life expectancy and refugee status for Aotearoa New Zealand is unavailable.

People with intellectual disability in Aotearoa New Zealand experience extremely poor life expectancy outcomes: 18 years fewer (for males) and 23 years fewer (for females).[26]

Stats NZ does not currently track life expectancy for the LGBTQIA+ITSB population.

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