Better Indigenous health—
Ken Wyatt

Aboriginal patient journey
mapping tools

Walk with us

Nutrition from first foods

Check today, see tomorrow

Close the Gap

The official magazine of the Australian Healthcare and Hospitals Association

ISSUE 46 / February 2018
no butts about it

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O
ver the past few years there has been a lot of discussion about ‘what works’ in delivering healthcare to Aboriginal and Torres Strait Islander communities. One thing has become clear—we need to put Indigenous Australians in the driver’s seat when it comes to improving their health outcomes. In the words of Malcolm Turnbull, we need to ‘do things with Aboriginal and Torres Strait Islander Australians, rather than doing things to them’.

The health outcomes of Indigenous Australians are impacted by a complex range of factors including differences in social determinants of health, differences in behavioural and biomedical risk factors and barriers to accessing affordable and culturally appropriate care that is close to home. This means mainstream approaches to healthcare are often inappropriate. Exploring new ways of working with Aboriginal and Torres Strait Islander patients is essential if we are going to make further progress is closing the gap. Our approach needs to focus on genuine engagement that gives Indigenous Australians a powerful say in any decisions that affect their communities.

Before any ground work is laid in developing new models of care, we need to involve representatives from Aboriginal organisations. Involving the right representatives from the get go will ensure we have the community’s consent before adopting or implementing anything that affects them. It’s about genuine, ongoing engagement at the highest level, not lip service or merely ticking the consumer engagement box. Relationships built on trust and integrity supported by formal engagement processes will help us carry out projects with, not for, Indigenous people.

We also need to ensure that any model of care gives the patient a voice in how their care is delivered along with ongoing, culturally-appropriate support. Providing a culturally safe process and environment is only possible if we embed cultural awareness within our organisations and appreciate the history and diversity of Indigenous communities.

After taking on the role of CEO of Dental Health Services Victoria (DHSV) in 2011, I realised we needed to gain the trust of the Indigenous population and better understand their needs if we had any chance of improving their oral health. At DHSV, we have developed wonderful relationships with representatives from Aboriginal Community Controlled Health Organisations (ACCHOs) over the years. In particular, our work with Jill Gallagher from the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) has been instrumental in shifting the design of oral healthcare delivery to Indigenous people in Victoria. Jill worked with us to develop new models of care that focused on supporting Indigenous patients to navigate an often complicated system while developing outreach programs that took care to the community.

DHSV signed a memorandum of understanding with VACCHO and our relationship strengthened by sharing power with the Aboriginal community through the decision-making process. As a result, the number of Indigenous people accessing public oral health services in Victoria has increased by 36%.

Another example of an approach that is improving the health outcomes of the Indigenous community is the Marrabinya model of care that was born out of a collaboration between the Western New South Wales (NSW) Primary Health Network and Aboriginal primary healthcare services operating in the region.

When the Western NSW PHN was established it incorporated two key Aboriginal health organisations in the region—Maari Ma Health Aboriginal Corporation and Bila Muuji Aboriginal Health Services. These two health organisations had a solid understanding of the local community’s needs as well as longstanding relationships with Aboriginal communities in the region. Integrating the Aboriginal Health Council into the PHN structure and ensuring representatives from the Aboriginal health organisations sat on the PHN’s board was a unique approach and demonstrated that Aboriginal health was the number 1 priority in the region.

As a result, a new model of care has been implemented delivering patient-centred, integrated care to Aboriginal communities in the area. Aboriginal people with a diagnosed chronic disease can now be referred to the Marrabinya Indigenous Health Support Service for assistance with specialist appointments, transport, accommodation and medical aids. These services are provided at no cost to the patient and all support is communicated back to the referring GP. Through this model, Aboriginal people are given the option of choosing their healthcare provider—either mainstream or through an ACCHO. In just four months of operation, the number of patients accessing care through the service doubled—a clear indication that the PHN’s collaborative approach was spot-on.

As healthcare leaders, we need to be open to working differently with Aboriginal and Torres Strait Islander people. A ‘one size fits all’ approach simply doesn’t cut it. We need genuine engagement and a genuine sharing of power with a strong focus on doing things with Indigenous Australians rather than to them.
The Lighthouse Project

Quality improvement to achieve lasting change in Aboriginal and Torres Strait Islander heart health.

In 2010, the Australian Healthcare and Hospitals Association, together with the Heart Foundation, published a report about the disparities in health outcomes experienced by Aboriginal and Torres Strait Islander patients with acute coronary syndrome.

We provided recommendations for achieving better care and support for Aboriginal and Torres Strait Islander peoples throughout the length and the breadth of the patient journey. The report acknowledged the pockets of good work and cases where quality care was being provided, and also highlighted the need for more research and comprehensive data collection. Together we advocated for Commonwealth funding to develop the Lighthouse Hospital Project, and were successful in receiving funding to support hospitals and communities over three phases of the project.

Eight years and 18 hospitals later, the toolkit jointly developed by our two organisations in partnership with participating hospitals is contributing to improved care and better health outcomes for Aboriginal and Torres Strait Islander patients across the country.

We join with participating hospital staff, patients and their communities in being very pleased with, and proud of, what has been achieved so far. But our job will not be done until the gap in health outcomes has been closed, not only for patients with acute coronary disease, but for all Aboriginal and Torres Strait Islander people who experience ill health.

Although quality improvement has been the main focus of Lighthouse, essentially it is a project about change: change in the way hospitals and health services are governed, organised, structured and staffed to address institutional racism; change in the way organisations and clinicians work with Aboriginal and Torres Strait Islander people to embed a co-design approach in our health services; and change that can be realised not only in an individual hospital, but across our health system.

It is gratifying to hear stories about the various quality improvement successes, the better care achieved, and support garnered for the project. And it has been particularly pleasing to see case studies from phase 2 of the project incorporated in the Australian Commission on Safety and Quality in Healthcare’s newly-released user guide to national standards related to better health care for Aboriginal and Torres Strait Islander people.

The generosity of many Aboriginal and Torres Strait Islander people in sharing their experiences, and the thoughtful way in which health leaders have engaged with the project over the past 8 years must be acknowledged as contributing to these markers of success.

While the successes are uplifting, it can be challenging and even dismaying at times to see how much work still needs to be done to really achieve change in the health system, and improvement in health outcomes for Aboriginal and Torres Strait Islander peoples. Nevertheless, at AHHA we will not lose hope nor give up on our vision of a health system that delivers outcomes for Aboriginal and Torres Strait Islander people that all Australians can be proud of.

For the hospitals, patients and communities participating in the Lighthouse project, their collective commitment to the project, and their continuing work in leading change and engaging in reflective practice, are crucial to achieving real system-wide change.
Better Indigenous health

“We know that over one-third of the average health gap between Indigenous and non-Indigenous people is the result of social determinants—the implications of housing, employment, justice and education.”
Understanding and respecting Aboriginal and Torres Strait Islander cultures—our strengths, traditions and our family, kinship, values and knowledge—is a fundamental foundation for better Indigenous health.

The Turnbull Government understands that significant factors contributing to higher rates of premature death and chronic illnesses among our people lie largely outside the traditional health system.

Consideration of the social and cultural determinants of health is vital, because a strong connection to culture correlates with good health, through strengthened identity, resilience and social and physical wellbeing.

We know that over one-third of the average health gap between Indigenous and non-Indigenous people is the result of social determinants—the implications of housing, employment, justice and education. This rises to over 50% when combined with risky behaviours such as tobacco and alcohol use, poor diet and physical inactivity.

In 2017, the Government led the My Life My Lead consultations across the nation, listening to people, and government and non-Government agencies, sharing their experiences around the social and cultural determinants of health, with around 600 attending 13 forums.

We heard that to make significant overall improvements in Indigenous lives, including their health, we need to:

• recognise the importance of culture, family and country;
• partner with communities to build capacity;
• recognise and address the impacts of underlying trauma; and
• lift access to health, education, employment and social services.

There is a need to address systemic racism and enhance cultural competency.

The 2017 Aboriginal and Torres Strait Islander Health Performance Framework highlighted some areas of success: There has been a 44% decline in Aboriginal circulatory disease death rates between 1998 and 2015, and a 47% decline in kidney deaths; there has been a longer term 33% decline (1998-2015) in child mortality and a recent 9% drop in smoking rates.

However, we can, and must, do better. Among my Aboriginal and Torres Strait Islander health priorities are:

• Renal health—reducing the incidence of kidney disease, with a strong focus on early intervention.
• Maternal and child health—making sure we give babies through to teenagers the best possible start in life by developing a 0-17 years approach to social, physical and emotional wellbeing.
• Men’s health—considering more of the social and cultural determinants of health.
• Eye and ear health—working on the causes of preventable blindness and hearing loss, including tackling otitis media.
• Preventable hospital admissions—with a strong focus on early intervention to keep people out of hospital.

Aboriginal and Torres Strait Islander men’s life expectancy is 10 years shorter than non-Indigenous males.

While smoking rates have improved significantly, they remain high and contribute to the largest burden of Indigenous ill health. The $116.8 million (2015-16 to 2017-18) Tackling Indigenous Smoking program aims to further reduce these rates.

The gap in the blindness rate in Aboriginal and Torres Strait Islander people over 40, compared to non-Indigenous Australians, has halved between 2008 and 2016. The Australian Government is investing $76 million from 2013-14 to 2020-21 to build on this improvement.

A comprehensive approach to childhood hearing loss is combining prevention, early treatment and management of ear infections, supported by an investment of $76.4 million from 2012-13 to 2021-22.

In addition, providing a culturally safe and respectful environment within mainstream health services can help improve access to health care, as well as the effectiveness of that care.

Between July 2013 and June 2015, Aboriginal and Torres Strait Islander peoples were discharged from hospital against medical advice at seven times the rate of non-Indigenous people and were more likely to leave the emergency department without waiting to be seen.

I am pleased to be partnering with organisations including the National Aboriginal Community Controlled Health Organisation, the Australian Indigenous Doctor’s Association and the Council of Presidents of Medical Colleges to help reduce the barriers to accessing health care.

The initial focus includes improving how the health system works with Aboriginal and Torres Strait Islander peoples, ranging from enhanced cultural awareness and training for staff, through to reducing any forms of institutionalised racism.

The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026, sponsored by the Australian Health Ministers’ Advisory Council, commits all state and territory governments to embedding the principles of cultural respect into the health system.

The next Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan, due in 2018, will recognise the importance of culture in finding solutions, and focus on the factors that promote resilience, foster a sense of identity and support good mental and physical health and wellbeing for individuals, families and communities.

In the words of the Prime Minister, we are committed to doing things with Aboriginal and Torres Strait Islander people, not to them, empowering local community solutions and better personal choices.

This will require the involvement of individuals, families, communities and Aboriginal organisations at all levels, in shaping the future and achieving improved health.

The Closing the Gap refresh and the next Implementation Plan will be important opportunities to build on what we have learned, and help ensure our people live better, longer and healthier lives and are able to achieve their full potential.
AHHA welcomes new national healthcare standards for Aboriginal and Torres Strait Islander patients

“We welcome the release of national healthcare standards that, for the first time, target safety and quality in services for Aboriginal and Torres Strait Islander people’, said Dr Chris Bourke, AHHA Strategic Programs Director.

The Australian Commission on Safety and Quality in Health Care Australian had issued its second edition of the National Safety and Quality Health Service Standards

‘As with the Safety and Quality Commission’s new standards, our own AHHA Position Statement on Aboriginal and Torres Strait Islander Health advocates incorporation of cultural competency into national standards for healthcare, including assessing and reporting on racism in all its forms’, Dr Bourke said.

‘We also support the “cultural safety” concepts contained in the guide to the new Standards. This is where health professionals examine their own beliefs, behaviours and practices, as well as issues such as institutional racism, in ensuring that their services are perceived as safe—by the patient rather than the provider.’

Going digital in hospitals better than ‘pin the tail on the donkey’, but benefits not fully understood

Research from Brisbane’s Princess Alexandra Hospital and its parent Metro South Hospital and Health Service highlights that eHealth technologies confer benefits in improving quality and safety in health care, without major hazards, said Australian Health Review (AHR) chief editor Professor Gary Day on publication of the December 2017 issue.

The Brisbane author team found that there were four basic types of eHealth technologies:

- Electronic Medical Records
- Computerised Provider/Physician Order Entry systems
- Electronic Prescribing (ePrescribing)
- Computerised Decision Support Systems

Computerised Decision Support Systems, especially those used at the point of care and integrated into workflows, attract the strongest evidence for substantially increasing clinician adherence to guidelines, the appropriateness of disease and treatment monitoring, and optimal medication use.

Public hospitals the only choice if you’re very sick, very young or old, or live in rural areas

‘A new report released by the Australian Institute of Health and Welfare shows that if you’re very sick, very young or very old, or live in rural areas, and you want to use your private health insurance and choose your doctor, public hospitals are your only real choice’, said Dr Linc Thurecht, Australian Healthcare and Hospitals Association (AHHA) Senior Research Director.

‘Much hullabaloo has been made about privately insured patients getting quicker access to care in public hospitals; however the data clearly show that those patients being funded by insurers in public hospitals for elective surgery were more likely to be in category 1 for clinical urgency (needing surgery within 30 days), and not surprisingly this was in highly complex areas of care which are often provided in large public teaching hospitals, such as neurosurgery.’
HAVE YOUR SAY...
We would like to hear your opinion on these or any other healthcare issues. Send your comments and article pitches to our media inbox: communications@ahha.asn.au

FROM THE AHHA DESK

7 DECEMBER 2017
Patient education and self-management key to successfully managing chronic pain

‘Empowering people to self-manage their pain on a daily basis is key to managing chronic pain, reducing pain-related disability and facilitating return-to-work,’ said Senior Research Director Dr Linc Thurecht when commenting on the latest Health Policy Evidence Brief, Power through knowledge: patient education and self-management keys to successfully managing chronic pain, published by the Australian Healthcare and Hospital Association’s Deeble Institute for Health Policy Research.

‘To date, our national response to more effectively prevent and manage our pain burden has been fragmented. ‘By making pain a national priority for policy change we can start to take steps to reducing the impact of pain towards a reinvigorated and longer term national pain strategy.’

18 DECEMBER 2017
Health Ministers receive early Christmas gift: blueprint maps out how to give Australians a 21st century health system

‘We’re giving Health Ministers an early Christmas gift’, said Australian Healthcare and Hospitals Association (AHHA) Chief Executive Alison Verhoeven.

‘Over the past nine months Australian health leaders mapped out how to transform our healthcare system into a fit-for-purpose 21st century system that will meet the needs and expectations of Australians.

‘Healthy people, healthy systems is a solid blueprint with a range of short, medium and long term recommendations on how to reorientate our healthcare system to focus on patient outcomes and value rather than throughput and vested interests.

‘In 2018 Health Ministers and First Ministers will negotiate and agree new public hospital funding arrangements—if Ministers are committed to a healthy Australia supported by the best possible healthcare system they simply need to direct their health departments to begin rolling out the recommendations found in the blueprint.

18 DECEMBER 2017
Government decisions on home visits overlook patient interests

‘Decisions by the Federal Government to restrict use of MBS items for urgent after-hours care are all about bowing to the interests of certain doctor groups and neglecting patient interests’, said Alison Verhoeven, Chief Executive of the Australian Healthcare and Hospitals Association (AHHA).

‘These decisions decisions affect mainly after-hours care in major cities and large regional centres.

‘They will reduce access to home doctor visits by restricting access to full MBS rebates to specialist GPs who work predominantly during business hours.’

‘After-hours deputising services provided by doctors with the same qualifications as you would find in a hospital emergency department will have their levels of Medicare rebate progressively reduced, which will potentially make such services financially unviable.’
Medicines funding in Australian hospitals—complex, fragmented, not patient-focused

‘Current funding arrangements for medicines in Australian hospitals are so complex and fragmented that they are difficult to navigate, and may result in unexpected costs or lack of timely and affordable access to optimal medicines’, says Alison Verhoeven, Chief Executive of the Australian Healthcare and Hospitals Association (AHHA).

The AHHA has released a Deeble Institute Issues Brief today, The impact of Australian hospital medicines funding on achieving the objectives of the National Medicines Policy, authored by Deeble Institute for Health Policy Research Summer Scholar Brock Delfante.

New toolkit helps health workers and patients to co-design a better healthcare experience

A new Australian-developed toolkit released today by the Australian Healthcare and Hospitals Association (AHHA) and the Consumers Health Forum (CHF) will help individual hospitals and healthcare services to provide better experiences of healthcare for both workers and patients.

Experience-Based Co-Design: a toolkit for Australia guides services in using the expertise and experiences of healthcare staff and patients in a genuine equal and reciprocal relationship to develop a better healthcare experience for all.

The toolkit is available at www.ahha.asn.au/experience-based-co-design-toolkit.

676 million federal cuts to remote housing will lift already-shocking rheumatic fever rates

‘We share the concern of state governments, the Close the Gap campaign and the National Congress of First Peoples at the recent cuts by the Australian Government to the National Partnership Agreement on Remote Housing’, Australian Healthcare and Hospitals Association Strategic Programs Director Dr Chris Bourke said.

The cut will see funding from the federal government drop from $776 million over two years to just $100 million, with that $100 million going only to the Northern Territory.

‘Our major concern is that overcrowded housing in remote Aboriginal and Torres Strait Islander communities is the primary cause of rheumatic fever in Australia.’

Sugary drinks tax remains a necessity to reduce obesity and improve health

Government action to curb the consumption of sugary drinks in Australia is still a priority, ‘over a year after we first raised this issue and released a position statement on it’, said the nation’s leading public healthcare body, the Australian Healthcare and Hospitals Association (AHHA).

‘We fully support the AMA and other health and healthcare organisations in continuing to advocate for a levy on sugar-sweetened drinks’, said AHHA Chief Executive Alison Verhoeven.

‘Our consumption of sugar-sweetened beverages remains among the highest in the world, with Australians and New Zealanders consuming an average of 76 litres of these drinks per person every year’, said AHHA Chief Executive Alison Verhoeven.

‘We are obviously not having these drinks as an occasional treat.’
Free Palliative Care Training Resource

Build skills in caring for people with a life-limiting illness—ideal for carers, clinicians, community and aged care workers and volunteers!

Evidence-based, interactive, easy to understand, and nationally recognised—over 35,000 people have completed the training and improved their practice. It is done completely online, can be completed in multiple sittings and requires no prior learning.

All modules are based on the PalliAGED evidence base, and may enable many participants to accrue Continuing Professional Development points.

The six training modules cover topics such as:

- needs of people and their families as they approach end-of-life
- assessment skills
- end-of-life conversations
- self-care and building resilience
- recognising deteriorating patients
- pain management

Get started NOW by visiting www.pallcaretraining.com.au

The Palliative Care Online Training Portal is funded by the Australian Government.
Six months ago, in the August 2017 edition of *The Health Advocate*, AHHA announced it had launched its inaugural Reconciliation Action Plan, a framework of objectives and deliverables designed to work with and support Aboriginal and Torres Strait Islander peoples in the development of health public policy through our programs of advocacy, research, education, publications and events.

We considered what was important to us as an organisation and as a health sector and arrived at a number of real, practical actions we could take to get there. Now, six months later, we want to take a moment to reflect on our progress, as well as to note the journey still ahead.

It’s common knowledge and accepted fact Aboriginal and Torres Strait Islander peoples face a number of concerning health challenges not faced by the population as a whole. These include higher burden of disease, lower life expectancy, poorer access to health services and the lack of culturally appropriate healthcare—to name just a few.

Institutional racism within our health system reinforces these and many other issues, resulting in poorer health outcomes for our First Peoples.

A nation that prides itself on the notion that everyone is entitled to a ‘fair go’ should act more forcefully to ensure that all Australians, including Aboriginal and Torres Strait Islander Australians, get a fair go at accessing quality healthcare and achieving the best possible health outcomes.

AHHA has undertaken several actions since August 2017 to demonstrate our commitment to reconciliation and to support the development and implementation of better health public policy.

The formal launch in September 2017 of the AHHA’s Reconciliation Action Plan in Sydney with Uncle Allen Madden was affirmation that we were away to a flying start.

Our Reconciliation Action Plan Working Group met twice in 2017 to oversee the timely meeting of our RAP deliverables. More meetings are scheduled for 2018.

We’ve reached out to peak bodies and associations representing the Aboriginal and Torres Strait Islander health sector, seeking better and more meaningful engagement.

We have also actively promoted cultural events and learning opportunities internally and have developed guidelines to assist staff when acknowledging traditional owners.

We have employed two full-time Aboriginal staff since the commencement of the RAP.

We have welcomed Associate Professor Carmen Parter from the University of Sydney as one of our Deeble Institute for Health Policy Research Summer Scholars. Carmen will write an issues brief on the relational interconnection between Indigenous culture and Indigenous knowledge, and its relevance to or implications for public health policies.

Looking forward, we continue to work with the National Heart Foundation as we roll out phase 3 of the Lighthouse Project, which aims to improve care and outcomes for Aboriginal and Torres Strait Islander peoples experiencing coronary heart disease, through to implementation of quality improvement activities.

This has included delivering a whole-day training workshop to develop the capacity of the Heart Foundation team to:
- support 18 hospital project sites;
- improve understanding of current developments in the Aboriginal and Torres Strait Islander policy environment; and
- advance quality improvement knowledge skills—including using the AHHA’s recently released experience-based co-design toolkit.

A particular focus of the workshop was measuring institutional racism in Australian hospitals.

AHHA has worked with our long-term partner HESTA (Health Employees Superannuation Trust Australia) to develop a scholarship that will support the attendance of two Indigenous students in the Bachelor of Health Science program at the University of Technology, Sydney. Experience-based co-design toolkit.
of an Aboriginal or Torres Strait Islander early-career health professional to attend the World Hospital Congress in Brisbane in October 2018. The call for applications will be released shortly.

Internally, we will support staff as we improve our knowledge and understanding of Aboriginal and Torres Strait Islander cultures, histories and achievements. Together we will continue to unpack institutional racism within our health system.

In 2018, AHHA staff will again have the opportunity to participate in National Reconciliation Week activities, following on from our 2017 participation in the Canberra Bridge Walk organised by Winnunga Nimmityjah Aboriginal Health Service.

AHHA’s Reconciliation Action Plan Working Group looks forward to reporting to Reconciliation Australia later in the year on our 2017-18 activities, as well as developing the next stage of our Reconciliation Action Plan, which will focus on innovation.

Reflection (the theme for the current Reconciliation Action Plan) and innovation are key starting points for AHHA on the path of reconciliation. We will continue to work to Close the Gap in health outcomes through advocacy, research, education, publications and events—and we encourage all of our members and stakeholders to work with us to achieve that vision.

When reconciliation is achieved in Australia, health outcomes will be equal for all Australians. We look forward to that day.

For more information or to get involved, please visit www.ahha.asn.au/governance.

“We considered what was important to us as an organisation and as a health sector and arrived at a number of real, practical actions we could take to get there.”

AHHA’s Reconciliation Action Plan artwork ‘Women Dreaming’ by Monica Napurrurla White was purchased as part of our commitment to reconciliation and is reproduced here with permission from the Warlukurlangu Artists Aboriginal Corporation, Yuendumu NT.
The Health Advocate  •  FEBRUARY 2018

The term ‘Aboriginal’ is used in this article to refer to both Aboriginal and Torres Strait Islander peoples, but with recognition of and respect for the autonomy of the two peoples.

The Australian Government has made a commitment to Closing the Gap in life expectancy between Indigenous and non-Indigenous Australians by 2030. This commitment includes halving the gap in mortality rates of Aboriginal children under five by 2018 through two key areas:

- reducing the number of babies born with low birthweight; and
- decreasing tobacco smoking during pregnancy.

Neither area is on track.¹

The gap in tobacco smoking during pregnancy has not only been slow to decline but has in fact widened between Aboriginal women and other Australians.²

One in two Aboriginal mothers are smoking during pregnancy, which is 4 times the rate of non-Indigenous mothers (47% vs 14%).

Rates of smoking in pregnancy have declined by 11.7% in the general population, but only by 1.4% for Aboriginal women. Babies born to Aboriginal women are twice as likely to be low birthweight.²

Between 2011 and 2015 we lost 610 Aboriginal children between the ages of 0 and 4 years of age—82% of these children were under the age of 1 year, with 42% of deaths being a result of conditions originating in the perinatal period.¹

Reducing the incidence of smoking during pregnancy is an urgent priority to influence long term outcomes for Aboriginal people. Maternal smoking is the most important modifiable risk factor for perinatal and infant mortality through reducing numbers of premature births and low birthweight babies. Babies born with low birthweight not only have an increased risk of perinatal morbidity and mortality, but a raised long-term risk of chronic diseases, including cardiovascular disease, chronic kidney disease and type 2 diabetes—all of which have a significant impact on the life expectancy of our Aboriginal people.

WHAT DO WE KNOW ABOUT SMOKING IN ABORIGINAL COMMUNITIES?

Smoking in our Aboriginal communities is declining, but is still 2.6 times the rate for other Australians.³ Aboriginal smokers experience multiple barriers to quitting, but most want to quit and 70% have made a quit attempt.³

Aboriginal people are more likely to make a quit attempt than their non-Aboriginal counterparts, but are less likely to succeed.³ This is telling us that there is a gap in the interventions and supports offered to Aboriginal smokers and that current practices may not be useful or meaningful to Aboriginal people.

HOW CAN WE CLOSE THE GAP IN MATERNAL SMOKING?

As outlined earlier, Aboriginal women have a high rate of smoking during pregnancy. To understand the current supports offered to Aboriginal women during pregnancy we
recently engaged in qualitative yarning with Aboriginal women who reported actively reducing cigarette consumption during pregnancy:

‘I’d only have probably three smokes a day if I was lucky.’ (Woman 1)

Aboriginal women have reported that they want and expect support from their health professionals to quit smoking during pregnancy. However, support and advice offered to Aboriginal women during pregnancy is inconsistent and often weak:

‘They asked was I still smoking, how many per day, we need to decrease it, you know, get it down to this amount.’ (Woman 6)

Health professionals have reported in previous research a lack of confidence in motivating Aboriginal women to quit smoking during pregnancy, amid feelings that reduction of cigarette consumption is a satisfactory outcome and concerns about the safety of Nicotine Replacement Therapy.

We believe that empowering interventions should be offered to all Aboriginal women during pregnancy regardless of healthcare providers’ assumptions of ‘readiness to quit’. Ongoing education about the risks of smoking, smoking cessation options and benefits of quitting should build on Aboriginal values of resilience, empowerment and trust, and offered through psychosocial interventions.

Aboriginal women are frequently reducing cigarette consumption during pregnancy—health professionals should focus on this phenomenon for intervention development and education, addressing the continued risks to mother and child at low consumption and empowering Aboriginal women to quit smoking completely during pregnancy.

Our Aboriginal communities are largely interested in quitting smoking, but the right interventions or supports are still not available across the country and/or not yet being measured and reported on. If we want to meet Close the Gap targets for infant mortality we need to implement enhanced support to Aboriginal women to stop smoking completely during pregnancy.

Michelle Bovill, Indigenous Scholar investigating culturally responsive approaches to smoking cessation care for Aboriginal and Torres Strait islander women.

References

THE PROBLEM
Everyone with diabetes is at risk of losing vision and going blind. Although good control of blood sugar, blood pressure and cholesterol will reduce the annual rate of developing eye disease and extend life, these actions will not change the overall lifetime risk of blindness. The good news is that up to 98% of blindness from diabetes can be prevented with timely detection and treatment.

Over 1 in 3 Aboriginal and Torres Strait Islander people over the age of 40 have diabetes—all need to have an eye exam every year to look for the early eye changes. But only one-half of Aboriginal and Torres Strait Islander people with diabetes actually have an eye check and one-quarter have never had an eye exam.

THE SOLUTIONS
A REGIONAL APPROACH
The Roadmap to Close the Gap for Vision provides a range of recommendations that need to be addressed in order to provide proper eye care to Indigenous Australians. The Roadmap includes recommendations specifically targeted to deliver eye care for people with diabetes.

A key element is developing appropriately resourced and properly coordinated regional programs for eye care services. These programs need to link services and to support patients from primary care to secondary specialist eye services, and then to hospital when this is required.

EMPOWERING ABORIGINAL MEDICAL SERVICES (AMSS)
One component has been to empower primary care clinics to check for eye changes.

A new Medicare Item number (12325) became available in late 2016 for annual retinal photography. As well, the Commonwealth is providing more than 100 retinal cameras to AMSs over the next 2 years.

If those with diabetes are found to have eye problems they need clear referral pathways to optometrists and ophthalmologists, sometimes for diabetic retinopathy, but maybe for a pair of glasses or for cataract surgery. Once established, these referral pathways can also be used by those who do not have diabetes but who require glasses or cataract surgery.

Furthermore, because Indigenous Australians with diabetes comprise three-quarters of those who need an eye exam each year, a strong focus on getting eye care right for those with diabetes helps all people needing eye care.

EMPOWERING COMMUNITIES
It is one thing to set up and organise a new service, but people need to know about it and understand it. To develop appropriate health promotion material we worked closely with three community groups:
• one remote—Looma, Western Australia
• one regional—the Grampians, Victoria
• one urban—Deception Bay, Queensland.
Creative agencies in art and music spent a week or so with each community to develop stories and messages, artwork and images, personal stories, songs and videos—all telling the story about diabetes eye disease and the need for regular eye exams.

The community response was amazing and resulted in the development of some very powerful material. This was developed into sets of posters, pamphlets and brochures, flipcharts, short community service announcements suitable for TV, longer videos for use in clinics and social media, T-shirts, and other material—all branded in the same way and all carrying the same message, ‘Check today, see tomorrow’.

These resources are targeted to those with diabetes, their families and communities to reinforce the importance of the annual eye exams to stop people with diabetes from losing their vision. The resources also target AMS staff to make sure they remember that their clients with diabetes need the regular eye exams, and how to do those exams.

The resources have been provided to many AMSs across the country and can also be downloaded for free from our website.

THE OUTCOME
The Roadmap identified 42 areas for change...
Eye health for Aboriginal and Torres Strait Islander people with diabetes.

to improve eye care for Indigenous people and Close the Gap for Vision, with the target of achieving this by 2020. This approach has broad sector support and endorsement. Good progress is being made—two-thirds of the intermediate steps have been completed and 16 recommendations have been fully implemented. Across the country, over 30 regions are implementing the Roadmap and this now represents over 60% of the Indigenous population. With this multi-pronged approach to improve eye care we aim to make sure that every Aboriginal and Torres Strait Islander person has access to top quality eye care as and when they need it. The focus on eye care for those with diabetes is a key component of this work.

The National Eye Health Survey reported in 2016 that the gap for blindness had been halved. In 2008 there was 6 times as much blindness in Indigenous people compared with non-Indigenous Australians, and by 2016 this had been reduced to 3 times. This is still not acceptable and there is more work to do, but good progress is being made.

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Example of a poster developed with community input to promote awareness of diabetes eye disease.
The Uluru Statement from the Heart

Rejecting minimalism will advance health and wellbeing.
From across Australia 250 Aboriginal and Torres Strait Islander people gathered at Uluru in May 2017 for an historic First Peoples Constitution Convention. They were the delegates from a series of 13 regional meetings held around the country where 1,200 Aboriginal and Torres Strait Islander people had debated and shared their ideas and aspirations for reform of the Australian constitution. The First Peoples Convention and the regional meetings were historic events; the most extensive series of discussions designed, led and supported by Aboriginal and Torres Strait Islander people in decades.

Each regional meeting was hosted by the local land council or other local organisation, which invited participants balanced by gender, demographic characteristics, key local individuals, traditional owners and local Aboriginal and Torres Strait Islander community organisations. Stolen Generations representation was also a focus.

This thoughtful gathering of Aboriginal and Torres Strait Islander views was consistent with the opinion of Patrick Dodson who, as co-chair of the Referendum Council, said ‘Strong support by Aboriginal and Torres Strait Islander peoples for the referendum proposal is absolutely essential. If Aboriginal and Torres Strait Islander peoples do not support the referendum proposal, there is little incentive to proceed to a referendum.’

The Convention at Uluru explicitly rejected the minimalism of an acknowledgement of Aboriginal and Torres Strait Islander people within the Constitution. Furthermore, delegates understood the complexity of excising the race power from the Constitution—section 51(26) enables the Commonwealth Parliament to make special laws for people of any race. The Uluru Convention acknowledged that deletion of this section, without a Treaty in place, would negate existing federal legislation that is beneficial for Aboriginal and Torres Strait Islander peoples such as the Native Title Act 1993 and the heritage protection of sacred sites. Therefore they decided not to call for removal of the race power at this time.

Interestingly, the final report of the Referendum Council, appointed by the Federal Parliament to enquire into constitutional change, recommended that an Aboriginal and Torres Strait Islander Voice to Parliament should be tasked with monitoring the use of the power in section 51(26). Racism is a major barrier to health equality and has a profound effect upon the social determinants of health. Providing oversight, by an elected Aboriginal and Torres Strait Islander Voice, would mitigate potentially negative uses of these race powers by the Parliament.

The outcome of the Convention was the Uluru Statement from the Heart. It called for:

- a Voice to Federal Parliament embedded in the Constitution; and
- a Makaratta Commission to supervise treaty-making and truth-telling about our history.

Representation, treaty-making and truth-telling would deliver not only justice and equity but also a foundation to deliver better policies and programs for Aboriginal and Torres Strait Islander peoples, including healthcare.

The Uluru Statement is the latest step in a long-running debate on constitutional reforms relating to Aboriginal and Torres Strait Islander people, and what such reforms might look like. The advocacy, for over a century, by past and present Aboriginal and Torres Strait Islander leaders has constantly focused on representation, treaty, and the telling the truth about Australia’s colonial history. These elements were embodied in William Cooper’s 1937 petition to King George V, Doug Nicholls’ 1949 letter to Prime Minister Chifley, the 1971 Larrakia petition, and the 1998 Kalkaringa Statement.

The consensus at Uluru that greeted the Statement from the Heart refreshes this work with a contemporary mandate. A First Peoples Voice to Federal Parliament, as elected representatives, would deliver national advocacy and contribute to self-determination by holding the Government to account for the delivery of programs and policy. It would give Aboriginal and Torres Strait Islander people a voice in laws that affect them. This is a key element in transforming the institutional racism that pervades many Australian organisations, particularly in health. Modifying the power imbalances within our society will enable challenges to laws, institutions and policies in Australia are currently constructed to ‘privilege the interests of the dominant cultural group’—the laws, organisations and policies that have been historically constructed to deliver disadvantage to Aboriginal and Torres Strait Islander peoples.

The continued advocacy for the Uluru Statement was entrusted to a Working Group, elected from the delegates at Uluru, to lead the campaign for the implementation of the Voice to Federal Parliament and the establishment of the Makaratta Commission. The Uluru Statement Working Group has taken up this work and meets regularly with politicians, business leaders, Aboriginal and Torres Strait Islander organisations, non-Indigenous supporters and community activists to advance the campaign for the Uluru Statement.

Dr Chris Bourke was Australia’s first Aboriginal dentist and the first Indigenous Australian elected to the ACT Legislative Assembly.

Dr Chris Bourke
Strategic Programs Director, Australian Healthcare and Hospitals Association

The Health Advocate • FEBRUARY 2018 19
Reflections on the Australian Physiotherapy Association’s reconciliation journey

The Close the Gap campaign has motivated and inspired many Australians from all walks of life to take the issue of poor health outcomes in Aboriginal and Torres Strait Islander communities very seriously, and act for equity in health.

Reconciliation Australia’s support for the development of Reconciliation Action Plans (RAPs) offers a way for many organisations to plan their own answers and contributions. Putting these plans into action helps drive positive change.

The Australian Physiotherapy Association (APA) recognises that there is an important role for allied health professionals to play in reducing Aboriginal and Torres Strait Islander health inequalities. One of the APA’s fundamental beliefs is that all Australians should have access to quality healthcare.

In 2009 the APA conducted a survey to establish what the level of engagement was between Aboriginal and Torres Strait Islander communities and the physiotherapy profession. The survey found that most staff and members were not engaged in Aboriginal health, that only a small number of Aboriginal people were entering the physiotherapy profession, and that the Aboriginal community generally did not access physiotherapy for managing their health and wellbeing. The APA also received some negative feedback from Aboriginal physiotherapists regarding the lack of support they felt from the APA and the profession more widely.

The APA National President at that time, Melissa Locke, took up the challenge to develop a RAP, and the first Reflect RAP was launched in 2012. Dr Liisa Laakso, APA RAP Champion, said in her reflections on this RAP:

‘By commencing at the core of the organisation (with its staff) the belief was that the organisational culture, once developed, could help drive a second RAP that was more outward-looking to its membership. The inaugural APA Reflect RAP was a lighthouse initiative that significantly contributed to reconciliation by alerting Australian physiotherapists to their potential role in closing the gap.’

From this RAP, the APA learned some valuable lessons. A RAP needs a structure that clearly identifies and allocates responsibility across the team to avoid burnout by relying on a few staff to do it all. Keeping the RAP goals fresh in staff and members’ minds, and maintaining momentum, provide challenges as other priorities emerge; and negative responses to some initiatives can affect morale. Starting with modest goals and having a clear focus on what is trying to be achieved helps an organisation stay on track, and strong support from all levels of leadership is crucial.

Oversight by the APA’s Aboriginal and Torres Strait Islander Health Committee (ATSIHC) played an important role in monitoring progress, advising on policy, and offering suggestions for implementing initiatives, such as ideas for articles in publications and guest speakers at conferences.

Since this first RAP, the APA has ensured that all policy decisions and advocacy priorities are considered through an Aboriginal health lens. Cultural training is now seen as an important facet of the organisation for all staff and members, whereas in the past it was seen as a time and money cost. Aboriginal health is featured in the APA’s Strategic Plan, and the National Advisory Council and Board meetings regularly discuss the progress of the RAP and Close the Gap campaign. The APA has also accepted a seat on the Close the Gap Steering Committee, which is both an honour and a responsibility.

In October 2017, the APA launched its second Innovate RAP at its biennial national
scientific conference. It celebrated the gains made to date, and acknowledged the challenges of pursuing reconciliation and improved health equity more strongly. Current APA National President Phil Calvert said:

‘The profession has a genuine opportunity to ensure that our professional practice is culturally safe, is aware and understands Indigenous cultures, and is focused on closing the gap in Aboriginal life expectancy.’

Indigenous media host Stan Grant officially launched Innovate RAP at the conference, reminding the 2000-strong audience of physiotherapists of progress to date as well as our nation’s unfinished journey towards reconciliation.

Understanding the role we, as physiotherapists, each play in achieving reconciliation with our nation’s First People is a crucial first step on the journey to effectively Closing the Gap. Ensuring the development of a culturally safe physiotherapy workforce, and creating opportunities for employment in the profession for Aboriginal and Torres Strait Islander people, are two of the actions that will help us get there.

NEW PHASE, NEW STANDARDS IN CULTURAL SAFETY

In coming months, public hospitals and other health services will embark upon a new phase in the journey towards improving the cultural safety of their organisations and services for Aboriginal and Torres Strait Islander clients and employees.

The second edition of the National Safety and Quality Health Service Standards will require health service leaders to ask some hard questions about their organisations and services.

For the first time, these standards, recently released by the Australian Commission on Safety and Quality in Health Care, will specifically address the needs of Aboriginal and Torres Strait Islander people.

The standards will be assessed in public and private hospitals and many other forms of health services from 1 January 2019.

One of the practical impacts of the standards is that health organisations and services will have to examine how institutional racism is embedded in governance structures and processes, as well as the delivery of services and workplaces.

The new standards and a supporting user guide provide many recommendations and practical examples for steps that organisations can take to address these concerns.

The standards will require services to implement six actions related to working in partnerships with local Aboriginal and Torres Strait Islander communities, reforming governance processes, and ensuring clients are routinely asked if they identify as Aboriginal and Torres Strait Islander and their responses documented in their clinical notes.

The user guide encourages health services to address the impact of racism upon the health outcomes of Aboriginal and Torres Strait Islander people, and says an intended outcome of the new standards is ‘a reduction in the number of Aboriginal and Torres Strait Islander people experiencing hospitals as sites of trauma’.

The guide also highlights the importance of ensuring a focus on trauma-informed care, and increasing employment and representation of Aboriginal and Torres Strait Islander people at all levels of health organisations.

NEW POTENTIAL GAINS

As Chief Executive Officer of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), I am excited by the potential for the new standards to improve the cultural safety of workplaces for our members, as well as for Indigenous clients.

Hopefully, this will bring direct benefits for our people’s health—Aboriginal and Torres Strait Islander people will be more likely to engage with health services, whether as clients or employees, if they are culturally safe.

But if we are to ensure the potential gains from these new standards are realised, it will take whole-of-system and whole-of-organisation efforts to transform attitudes, behaviours and practices.

At our CATSINaM conference last year, we heard from many speakers about the importance of addressing ‘whiteness’—which is not about skin colour or ethnicity, but about Western systems and world views that entrench inequality and injustice.

Addressing these health concerns takes commitment and determined work by non-Indigenous people and organisations to critically reflect upon themselves and their work and to be open to transformative change.
While cultural safety training is important (and something we offer at CATSINaM), the transformative changes that are needed require a commitment to cultural safety as an ongoing process of reflexive systemic change, rather than as simply a one-off training opportunity.

At CATSINaM, we stand ready to work with health services around the country as they embark upon this journey of change. We offer practical workshops to assist organisations and services in planning and implementing the new standards.

These hands-on workshops will assist health service leaders, clinicians and managers in embedding a focus on cultural safety right across their organisations, spanning the range of standards, including those relating to clinical governance, partnering with consumers and communicating for safety.

We encourage health services to ensure their planning for 2018 includes dedicated time for preparation to ensure the new standards are implemented appropriately.

**COMMITTING TO CULTURAL SAFETY—HOW CATSINAM CAN HELP**

The concept of cultural safety, developed by a Māori nurse, the late Dr Irihapeti Merenia Ramsden, puts the onus on health professionals to examine their own beliefs, behaviours and practices, as well as issues such as institutional racism. By contrast, transcultural concepts like cultural awareness can promote the ‘othering’ of people and what Dr Ramsden called ‘cultural voyeurism’.

A critically important point for health services and organisations is that one of the foundational elements of cultural safety is that it is up to the recipient of care—not the institution or service providers—to decide if care and services are culturally safe.

**CULTURAL SAFETY VS CULTURAL AWARENESS**

The terms ‘cultural safety’ and ‘cultural awareness’ are often used interchangeably, despite being quite different.

At CATSINaM we are also working on many other fronts as part of our commitment to improving the cultural safety of health services, including through:

- efforts to embed cultural safety into national health practitioner legislation;
- the new Leaders in Indigenous Nursing and Midwifery Education Network (LINMEN), and
- enactment of the National Aboriginal and Torres Strait Islander Health Plan.

We are also advocating for the establishment of a Racial Barometer in health services, at local and national levels, to measure the extent of racial discrimination and hopefully also to measure progress in tackling this.

We would be delighted to work with any organisations reading this article on developing such a barometer for your service.

We invite you to walk with us at CATSINaM on your journeys of transformation—which also offer exciting opportunities for innovation in the provision of services and care.

The implementation of these new standards offers a significant and important opportunity to improve the health of Aboriginal and Torres Strait Islander people—let’s all work to ensure we make the most of it.

Janine Mohamed is a Nurrunga Kaurna and is CEO of CATSINaM.
How can healthcare evolve to meet 21st century demands?

**WORLD HOSPITAL CONGRESS 2018**

In October 2018, health leaders from around the world will come to the 42nd World Hospital Congress in Brisbane to examine how healthcare needs to evolve to meet 21st century demands.

The World Hospital Congress is an annual event that brings health leaders, executives and managers together to engage in constructive dialogue on leadership best practice in hospital and healthcare management and delivery of services.

The Congress is returning to Australia after a 20-year absence, at a time when, globally, health systems are in transition.

**THREE THEMES**

Factors such as the impact of new technology, changing demographics and disease profiles, funding pressures, and new models of care are driving transformation in healthcare.

At the 2018 World Hospital Congress, presenters and delegates will examine the benefits and obstacles in transforming healthcare and health systems through three main themes:

- From volume to value
- From four walls to the neighbourhood
- From information to intelligence.

**FROM VOLUME TO VALUE**

A global movement is underway to change the focus of hospitals and health organisations from volume of services and activities to the value of the outcomes achieved. This theme will include discussions on: value-based care; patient-reported outcome and experience measures; transparency in reporting; preparing for transformational change; and achieving funding value.

**FROM FOUR WALLS TO THE NEIGHBOURHOOD**

Hospitals don’t exist in a vacuum—how can they be good citizens in a medical...
2018 World Hospital Congress to look at the transformation of health services around the globe.

neighbourhood where acute, primary and community care sectors all have a role to play? In this theme, discussions will investigate how the process of integrating care can be supported at funding, structural and clinical levels to provide better health outcomes, sustainable health services and universal health care.

FROM INFORMATION TO INTELLIGENCE
The information revolution has provided us with much greater capacity to collect data. From detailed clinical data to patient flows, we have more information than ever potentially at our fingertips. Transforming that information into intelligence can provide new opportunities for collaboration and enable administrators and clinicians to plan and deliver more reliable, efficient and effective patient-centred care. This theme will encourage discussion on how to achieve this while ensuring that security, privacy, workforce training and other aspects are properly covered.

A GLOBAL OPPORTUNITY
Around the world, hospital and healthcare issues related to value-based care, integrated care, and the information revolution are manifesting in different ways, leading to development and application of a wide range of responses.

The World Hospital Congress will bring these perspectives and solutions together for three days of engaging presentations and discussion.

Keynote speakers will include global leaders in the value-based care movement, international health service executives and creators of innovative new service models.

Opportunities to pause, think and consider the future in hospitals and healthcare are vital, yet hard to come by—especially in international company. We therefore encourage you to make the most of this once-in-20-years opportunity to attend and participate in the World Hospital Congress in Australia.
“Whether racism is experienced within, or outside of the health system, it impacts on people’s health and wellbeing. It impacts on our ability, as a nation, to Close the Gap.”
Racism: a barrier to lasting solutions

The Lowitja Institute is Australia’s national institute for Aboriginal and Torres Strait Islander health research. As such, we support and are actively engaged in work to deliver benefits to the health and wellbeing of Australia’s First Peoples.

The Lowitja Institute works with communities, researchers and policy makers to facilitate, generate and translate research. The voices of Aboriginal and Torres Strait Islander people inform all of our activities, whether we’re conducting community-based research or setting strategic direction. We put our peoples’ culture, knowledge and expertise at the heart of our research process. Our approach ensures that we are more likely to have research outcomes that make a positive difference on the ground and enable communities to identify priorities and develop their own solutions.

In recent years, Aboriginal and Torres Strait Islander health leaders and organisations have worked collaboratively with the Australian Government in the development of the:

• National Aboriginal and Torres Strait Islander Health Plan 2013-2023
• Implementation Plan for the National and Torres Strait Islander Health Plan 2013-2023

The vision for the Health plan is

“The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address social inequalities and determinants of health, this provides the necessary platform to realise health equality by 2031.”

The Health Plan and the Implementation Plan went a significant way in identifying racism as a social determinant for Aboriginal and Torres Strait Islander health.

The Hon. Ken Wyatt AM MP, Minister for Aged Care and Indigenous Health, said in 2016, ‘What a huge step forward to have racism recognised as a critical issue to be addressed in the Implementation Plan’.

Further, as an Aboriginal man and Minister responsible, he said ‘Our people need to feel culturally safe in the mainstream health system’.

Whether racism is experienced within, or outside of the health system, it impacts on people’s health and wellbeing. It impacts on our ability, as a nation, to Close the Gap. The Experiences of Racism 2010-2011 Survey was funded by the Lowitja Institute, and was undertaken in Victoria as part of a broader study. This project surveyed 755 Aboriginal Victorians aged 18 years and older, living in two rural and two metropolitan local government municipalities. Key findings included:

• Racism can occur in a range of settings, such as shops and public spaces, education and employment settings, and sports settings.
• 97% of those surveyed had experienced racism in the previous 12 months; and more than 70% of respondents experienced eight or more racist incidents in the period.
• 92% of those surveyed were called racist names, teased or had heard jokes or comments that relied on stereotypes about Aboriginal people; 85% were ignored, treated with suspicion or treated rudely because of their race; 84% were sworn at, verbally abused or treated rudely because of their race; 85% were ignored, treated with suspicion or treated rudely because of their race; 84% were sworn at, verbally abused or subjected to offensive gestures because of their race.

This survey also presented results which we always felt instinctively, but for which we didn’t have clear evidence—that there is a link between racism and health. Participants were assessed through a modified version of the Kessler 6 scale. The Kessler scale is a well-established assessment tool which screens for psychological distress. High psychological distress is an indicator of increased risk of mental illness.

Overall, this work found that
(a) racism does occur, in every circumstance, for Aboriginal and Torres Strait Islander people; and
(b) that there is a link between racism and health.

Until we make structural and widespread changes to address racism in health, and racism across the entire spectrum of society, our health will suffer—we will not improve the health and wellbeing outcomes of Aboriginal and Torres Strait Islander people in any significant or lasting way.

References
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Healthy people, healthy systems

7 March 2018, Old Parliament House, Canberra
Join us for a Town Hall style event to identify case studies that pursue outcomes-focused and value-based healthcare based on AHHA’s blueprint for a post-2020 National Health Agreement

YOU CAN CLOSE THE GAP

We all deserve the chance to be healthy; and you can help make this happen.

Ten years into the campaign for Indigenous health equality, Aboriginal and Torres Strait Islander health outcomes are improving. The support of people like you is helping make that difference. But we still have a long way to go to close the gap entirely by 2030.

National Close the Gap Day is your opportunity to keep the pressure on government and ensure we achieve health equality within a generation.

Find out more and register your activity in support of health equality for all Australians.

oxfam.org.au/closethegapday
A combined approach to the elimination of trachoma by 2020

WHAT IS TRACHOMA?
Trachoma is a blinding eye infection that is spread between children by infected eye and nose secretions. Repeated episodes of infection cause increasing damage which leads to severe scarring, in-turned eye lashes (trichiasis), and finally, blindness. Some 150 to 200 episodes of infection are needed to lead to blindness. As most of this infection occurs in the first few years of life, children may be infected 2 or 3 times a month!

Trachoma was a problem in Australia in the 19th century and was called sandy blight. It disappeared from mainstream Australia 100 years ago mainly due to improved sanitation and living standards. However, Australia remains the only developed country to still have trachoma, as it still occurs in Aboriginal people living in remote communities.

In 2009 Australia made the commitment to eliminate trachoma by 2020. Australia follows the WHO ‘SAFE’ Strategy for trachoma elimination—this stands for Surgery to correct the in-turned lashes, Antibiotic treatment to reduce infection, Facial cleanliness and Environmental improvement.

CURRENT ACTIVITIES

SURGERY
Routine screening for trichiasis should be undertaken in primary health care as a routine part of the Health Adult Check (MBS 715), or opportunistically as required for those presenting with plucked eyelashes, or sore or watery eyes.

All people identified with trichiasis should be referred to an ophthalmologist for consideration for surgery.

Although these systems are essentially in place for all this to happen, there are still many gaps that patients fall through.

ANTIBIOTIC TREATMENT
Screening and treatment programs are performed by jurisdictional teams. Depending on the rates of trachoma, mass treatment with Azithromycin is given either community-wide or to the affected households. Particular attention needs to be given to communities and households that are ‘hot spots’.

FACIAL CLEANLINESS
Improving and maintaining clean faces is the key to stopping transmission: ‘Every child with a dirty face is a health hazard’. Clean faces (without eye or nose secretions) need to become the community’s ‘social norm’.

Working closely with communities, Indigenous Eye Health (IEH) at the University of Melbourne coordinated the development of a suite of material around the program mascot, Milpa the trachoma goanna, and the key message of ‘Clean faces, strong eyes’.

Extensive health promotion and hygiene messaging has been effective at raising community awareness, and benefits from being coordinated with other hygiene-related health interventions. Consistent health promotion messages for behaviour change need to be continuous and delivered in
multiple ways, such as through community and sporting events, TV, radio and social media. Health education materials provide the motivation, modelling and resources needed to prompt memory and reinforcement, particularly when they feature local culture, country and language. Community and household ‘hotspots’ need to be specifically targeted for hygiene messages—‘Treat the family, treat the house’.

ENVIRONMENTAL IMPROVEMENT
Addressing the broader social determinants of health is of course important for many reasons. However, to stop the transmission and re-emergence of trachoma, one needs the provision of safe and functional washing facilities for children, an immediate and simple action.

Maintenance and repair programs often do not work well in many communities—families can wait for months to have simple repairs done. The message for policy-makers and staff therefore becomes ‘Clean faces, safe bathrooms’. Cross-portfolio cooperation and referral are required between public health, environmental health, education and housing sectors to make sure that washing facilities are properly maintained in houses, schools, preschools, clinics, sporting areas and other community settings. These washing facilities need to have functional troughs, soap, paper towels, and child-height mirrors—and all require proper maintenance.

PROGRESS
Overall, good progress is being made in controlling trachoma. Rates in children in endemic areas have fallen from 21% in 2008 to below 5% in 2015. Rates have been brought down by the combined use of antibiotics and health promotion, but without good hygiene (clean faces) they will bounce up again when antibiotics are stopped. Clearly, more work is needed to make sure children can access safe and functional washing facilities to wash their faces.

THE CHALLENGE AHEAD
We need to maintain the good work being done on screening, treatment and health promotion. We need to make sure that data reporting is timely to identify hotspots for more intense and coordinated attention.

Screening and referral for trichiasis needs to be strengthened so people do not fall through the cracks. Further, jurisdictional departments of health, housing and education need to commit to work across portfolios to reduce or eliminate delays in repair and maintenance of basic hygiene infrastructure—that is, ‘fix the taps’ in houses, schools, community spaces and targeted hotspots.

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Indigenous health education in physiotherapy

Using Indigenous knowledges to guide physiotherapy students towards culturally safe practice.

There is an ancient spirit of learning in Aboriginal ways which is as much about how we learn as what we learn. It is embedded in song, story, ceremony and country. Our approach to teaching Aboriginal health to physiotherapy students captures the sentiment of lifelong learning, while acknowledging that Aboriginal knowledges offer much to western pedagogy. Our approach is grounded in an engagement with Aboriginal people built on an understanding of place and being open to different ways of doing.

Students and teachers alike are invited to undertake a series of structured and supported learning activities that progressively aim to cultivate deep understanding of key Indigenous health issues, as well as fostering ambition for change in current health practices.

Framed by the Australian Physiotherapy Association’s (APA) professional standards and Reconciliation Action Plan (RAP), along with the university’s Aboriginal curriculum frameworks, our teaching places an emphasis on cultural safety, reflexive practice and critical understandings. This, as a starting point, asks of both staff and students ‘What is your place in this narrative?’.

Our aspiration, shared with many educators, is for students to have the capability to be widely critical thinkers, willing and able to be active in contributing to and shaping best practice in healthcare. Our imperative is for graduates to be thought and action leaders. Such an agenda for transformative learning asks students to:

- engage deeply with knowledge of the contextual factors that shape our experience of health and wellbeing;
- examine personal bias and stance on race and Indigenous history, past and current; and
- understand how to create a culturally safe environment that listens to and respects Indigenous clients.

Our team includes both Aboriginal and non-Aboriginal educators, who together have built a tiered curriculum that fosters deep learning of Indigenous health perspectives, while aiming to ensure cultural and value-based safety for both students and staff.

We recognise the importance of creating a safe space for our students so that they feel comfortable engaging critically with their personal values and history, as well as those of their peers and teachers, and the broader community.

Using a scaffolded approach across the three years of the physiotherapy program, we aim to support, grow and challenge responses to Aboriginal health teaching within the discipline of physiotherapy. The approach is guided by a growing body of research in Indigenous health education.

In Year 1, students and staff are asked to connect with the University’s own Indigenous cultural heritage by walking where Billibellary (Wurundjeri Ngurungaeta) and his people walked—seeing, hearing and understanding the university landscape as ‘place’ through a different lens. This supported, self-guided tour permits students time to reflect privately on their current level of knowledge about Indigenous issues and consider how past
history inevitably defines the present and influences the future. Students engage with this activity independently and at their own level of understanding, opening a connection with their University and with local Indigenous community and history.

In Year 2 our students progress from private self-guided reflection to classroom and online teacher-facilitated conversations. An online discussion-based assessment task drives the key learning activity, where students work in small groups to connect Indigenous health perspectives more explicitly with physiotherapy clinical practice. On-campus lectures and tutorials are complemented by a class excursion to the Indigenous permanent exhibition at Melbourne Museum, Bunjilaka, to learn from the voices and stories of the Victorian Koori community.

Year 3’s final semester of studies sees students actively participate in a ‘respect morning’ during which they learn about the APA’s and the University of Melbourne’s Reconciliation Action Plans, as well as the physiotherapy profession’s ambition to actively respond to the Indigenous experience of healthcare.

A reflection assignment on the APA’s RAP follows, asking students to critique their own and the profession’s role in Indigenous wellbeing. In this assignment, students pay attention to their role in closing the health gap, scrutinise their position within the current narrative, and consider their professional identity as they prepare to graduate. Our hope is that they leave us as more conscious critical beings, perceiving more deeply their connection to the land, their position in Indigenous (Australian) history and Indigenous ways of knowing and learning—with capacity to advocate for change in the current Indigenous health narrative.

As educators we value the creation of a culturally safe environment for our students and teachers that invites critical engagement with their own beliefs, values and politics, as well as those of their profession and health systems. Our evolving teaching practices highlight key elements of, and merge, Indigenous ways of knowing and doing with western pedagogical practices. Our ambitious aim is to produce physiotherapy graduates with great capacity to engage and create positive change in the Indigenous health experience.

Louisa Remedios, Shawana Andrews, Joanne Bolton and Tamara Clements, Department of Physiotherapy, University of Melbourne

Billibellary’s Walk is named after the Ngurungaeta, or clan head, of the Wurundjeri people at the time of Melbourne’s settlement. The walk is a cultural interpretation of the University of Melbourne Parkville campus landscape. More information is available at http://murrupbarak.unimelb.edu.au/engage/billibellarys-walk. Self-guided tours of the walk are available as an Apple smartphone application and/or downloadable map and narrative.

“Lying within the University of Melbourne’s built environment are the whispers and songs of the Wurundjeri people. Imagine the time is 1830 and the place is Wurundjeri Country, Billibellary’s Country…” (Billibellary’s Walk, University of Melbourne)
WHAT WE DID
From May 2010 to May 2012, The Fred Hollows Foundation led work to trial the Early Childhood Nutrition and Anaemia Prevention Project (ECNAPP), designed to promote good nutrition and prevent anaemia among young children in remote Aboriginal communities. A nutritious diet supports healthy growth and development in early childhood but also has long term benefits, with reduced risk of chronic disease and improved education achievements. Australian recommendations for infant feeding emphasise exclusive breastfeeding to around 6 months, then continued breastfeeding with nutritious solid foods. Solid foods are needed from 6 months of age to ‘complement’ breast milk (or infant formula). Recommended first foods include lean meat, fortified cereals, cheese/yoghurt, and fruit and vegetables. High sugar foods and drinks, and high salt choices are not recommended.

Six remote Aboriginal communities across northern Australia participated in the ECNAPP project. Local community-based workers met with parents and carers to ask for their consent for their children to participate. The community-based workers completed food records with the parents and also recorded how many people lived in each household, and whether it was ‘pay week’ or not. This report describes the diet on the previous day of 227 babies and young children aged from 6 months up to 24 months of age, based on information collected by the community-based workers.

WHAT WE FOUND
As has been reported previously in remote Australian settings, breastfeeding rates were high. Most of the 227 babies and young children (67.4%) were breastfed, especially those under 12 months (80.3%). Nearly all the babies and young children (98.2%) had solid food as well as breast milk. However, fruit and vegetable intake was low. Close to one-third (32.6%) had neither fruit nor vegetables on the previous day. In fact, only 30 children (13.2%) had had fruit on the previous day.

In contrast, sweet drinks were reported for about one in four (24.7%) and processed meats for about one in five (20.3%).

WHAT THIS MEANS
There were positive aspects reported for the diets of these infants and young children, not least the high breastfeeding rates. Breastfeeding provides health and economic advantages that are especially important for people who are disadvantaged. Breastfeeding is a core traditional practice for optimal...
Poor Nutrition from First Foods—its effect on childhood health and development that has to be promoted and protected.

Other findings—insufficient fruit and vegetables and consumption of less nutritious foods and drinks—are not so good. These dietary patterns are not unusual in Australia, but they are unusual to the extent reported here. For example, one recent study of dietary intake of 551 children, aged 12 months to 16 months, reported diets that included sweet drinks and other nutritionally poor choices.4 However among the metropolitan children, only 4% missed out on both fruit and vegetables on the previous day compared to nearly one-third of the remote community infants and young children studied as part of the ECNAPP project.

WHERE TO FROM HERE?
The results in our study in relation to household size and ‘pay week’ highlight the need to focus on availability, affordability and accessibility of nutritious foods—in short, food security. Issues of food security as well as nutrition for mothers and young children are flagged in the National Aboriginal and Torres Strait Islander Health Plan, but have not yet made it into the companion implementation plan. Nutrition is still the ‘gap’ in ‘Closing the Gap’!

Improved food security would mean that fruit and vegetables can become daily foods, not pay-day luxuries. But food security, while essential, may not be sufficient. The ready availability, low cost and intensive marketing of less-nutritious choices are real barriers to making healthy choices.4 Initiatives to improve food security need to be partnered with strategies to preserve breastfeeding, and behaviour change initiatives for nutritious foods from around 6 months of age. Combined food security and nutrition promotion initiatives could substantially improve the diet and health of young Aboriginal and Torres Strait Islander children—and help to close the gap in health, education and employment between Aboriginal and Torres Strait Islander peoples and other Australians.

References
Looking forward, looking back

BEGINNINGS

I was born and grew up in country Victoria in a home where my parents were committed to lifelong learning. During the 1960s and early 1970s my father, a school teacher, studied part-time and completed degrees in commerce and education at Melbourne University. My mother, who had only received a primary education to grade 8, undertook and completed a teaching degree.

From an early age I was immersed in a home where education, achievement and community service were highly prized, and there was no doubt that I would be going on to university after school. It was in high school that I was attracted to science and I enjoyed working with my hands. Coupled with a strong desire to help others, these interests led me to dentistry. And looking back, after more than 40 years that decision was extremely sound.

DENTISTRY

When I began dentistry at Melbourne University in 1977, the environment was very different to my father's time at teachers college in the 1950s. By this time it had been recognised that education, and in particular tertiary education, was essential to the sharing of Australia's wealth and opportunity between Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Support for Aboriginal and Torres Strait Islander tertiary education had been instigated by the National Union of Students in the mid-1960s in a program called Abschol. I was able to benefit from these initiatives and with hard work and determination completed my dental degree in 1982, becoming the first Aboriginal dentist in Australia.

FIRST JOB—AND POLITICAL AWARENESS

My first job as a dentist was with the Victorian Aboriginal Dental Service, travelling country Victoria and southern New South Wales with a dental caravan. It was the beginning of 10 years in public dentistry working in Aboriginal dental services, school dental services and public dental clinics.

I also involved myself in community work on Aboriginal education committees and community health. I wanted to capitalise on this experience with additional qualifications, so I completed a graduate diploma in public health at Adelaide University.

My unease about the career potential of public dentistry and my developing political awareness were heightened during this postgraduate study. This led to two key decisions—I decided to seek employment in private practice dentistry and I joined the Australian Labor Party.

GROOTE EYLANDT

In 1991 I travelled to Groote Eylandt in the Northern Territory for a two-year contract providing a private dental practice to the manganese miners and their families, and public dentistry to the Andilyakwa people.

The contrast between the dental surgeries provided for the mining community (predominantly non-Aboriginal) and the Andilyakwa people was stark. In the Aboriginal communities the equipment was old and dilapidated; the emphasis was on ‘blood and acrylic’—that is, extractions and dentures. It was outrageous, and a situation which I complained about loudly. I am proud to say that the Northern Territory health department was able to refit these clinics with proper equipment during my contract.
AFTER POLITICS

Life after politics has also been satisfying.

Last year I was able to complete an MBA at the University of Canberra whilst providing dental locum services around Australia.

In August 2017 I was delighted to join AHHA in the role of Strategic Programs Director, where I lead and implement AHHA work programs, in particular for the Lighthouse Project and the National Oral Health Alliance.

I am also responsible for analyses and responses to policy issues and proposals arising from AHHA members, governments, and other organisations, including oral health, Aboriginal and Torres Strait Islander health, and cross-jurisdictional relations.

This year, among these other projects, I am currently focused on developing the management of institutional racism, as well as methods to improve the recruitment of Aboriginal and Torres Strait Islander staff. And I still work as a dentist, although very much part-time right now!

Chris Bourke was Australia’s first Aboriginal dentist and the first Indigenous Australian elected to the ACT Legislative Assembly

MEMBER OF THE ACT LEGISLATIVE ASSEMBLY

In 2011 I was elected to the ACT Legislative Assembly representing the Australian Labor Party for the electorate of Ginninderra. I was very proud to have been elected during Reconciliation Week as the first Aboriginal member of the ACT parliament. In my 5½ years in politics I held various ministerial portfolios including Aboriginal and Torres Strait Islander Affairs, Children and Young People, Disability, Corrections, and Education and Training, and there were many highlights, including:

- Continued improvement in the performance of the ACT Youth Justice System, with a 47% reduction in Aboriginal and Torres Strait Islander young people in detention.
- The transition of Disability ACT and Therapy Services out of service delivery and the implementation of major change for community organisations in the NDIS environment, including the smooth transition of 400 ACT public servants.
- Community consultation for a Reconciliation Day public holiday and then successfully moving in the Assembly for the renaming of an existing ACT public holiday in 2018.
- Trauma-informed care embedded into the out-of-home care system for children.
- An inquiry into Aboriginal and Torres Strait Islander employment in the ACT Public Service; a consensus report with recommended procedural changes to better achieve the desired outcomes of the ACT Government’s Aboriginal and Torres Strait Islander employment policy.
- The largest election commitment to the arts since self-government, including $17 million for Stage 2 of the Belconnen Arts Centre, additional ongoing funding for grants to artists, community arts festivals, and an annual DESIGN Canberra Festival.

In 1993 I bought a dental practice in Canberra to be closer to family. This financial commitment sharpened my appreciation of the ups and downs of running a business, including aspects such as employee relations, overdraft financing and cash flow management.

Outside business, my community involvement in Canberra was initially with the ACT branch of the Public Health Association. In 1997 the ACT government, under Kate Carnell, decided to establish an Indigenous education consultative body. I applied to join this body because of my commitment to the improvement of educational outcomes for Aboriginal and Torres Strait Islander children. I was elected as the inaugural chairperson.

During my term as chairperson the consultative body signed a compact between ACT Aboriginal and Torres Strait Islander families and the Department of Education and Community Services. This agreement acknowledged the past and set out significant commitments by families and the department to achieve better educational outcomes.

I was a founding member of the Indigenous Dentists Association of Australia in 2004 and its inaugural president. The principal objective was the promotion of good oral health for Aboriginal and Torres Strait Islander people through supporting Aboriginal or Torres Strait Islander dentists and dental students. With no resources, other than the personal sacrifice of its members, the association was able to influence policy development at the highest level.

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Aboriginal patient journey mapping tools
improving coordination and care

ABORIGINAL COMPLEX JOURNEYS
Aboriginal people often undergo very complex and disjointed patient journeys as they move between primary health care, and acute and outpatient services. When Aboriginal patients live in rural and remote areas, their journeys become even more complex, and may require travel across vast distances, with escort support.

Receiving good care relies on effective communication and coordination among mainstream and Aboriginal community controlled primary care services, General Practitioners, hospitals, and patients and family members. A patient may find that they are interacting with 30 or more different health care providers across a single health care journey. Understandably, undergoing entire patient journeys across diverse health services can be very confusing for patients and families. It is also often confusing for health care providers, and this has a significant impact on the quality of care, discharge planning and follow-up provided.

RESPONDING TO THE COMPLEXITIES
In South Australia (SA), the Managing Two Worlds Together (MTWT) project worked with SA Health sites, and Aboriginal community controlled health and aged care services. It aimed to better understand the barriers and enablers, gaps and strategies to care for Aboriginal people.

The project involved analysing admissions data and conducting interviews and focus group sessions with patients, families and staff in urban, rural and remote locations. Mapping tools with flexible adaptations were co-developed with renal, maternity, cardiac and other healthcare professionals, and healthcare sites. The tools enabled journeys to be accurately mapped with individual patient needs and priorities highlighted.

The underlying factors having an impact on access to and quality of care in a range of locations (illness, language and communication, financial resources, cultural safety) were identified. The tools were then used to bring together the perspectives of patients, family members and staff chronologically across the entire journey, identifying health care priorities and gaps, and responsive strategies. These were then compared with relevant clinical standards. An accurate and realistic action plan could then be developed.

ONE EXAMPLE—A RENAL RESPONSE
Renal units in South Australia have used the tools to improve inter-hospital transfers, discharge planning and end of life journeys back to remote areas.

Level 3 nurses converted recent journeys of concern into case studies and used these in management and planning meetings to change policy and practice. They found that the mapping process enabled them to translate professional concerns and strategies into formalised ‘evidence’ that could then be responded to.

The case studies were also used by other staff as localised resources that provided step-by-step information on how to arrange an end-of-life journey quickly and effectively when the Level 3 nurse was on leave.

This renal unit also was able to arrange for an Aboriginal coordinator to be positioned within their unit to assist with patient journey planning and coordination. This is now having a direct and positive impact on Aboriginal patient journey experiences, staff workloads and continuity of care.

The tools and case studies have also been used across healthcare sites, sharing knowledge and strategies among healthcare professionals. One ‘near-miss’ incident was mapped between a city and regional site, leading to a policy change to avoid Friday night discharges for Aboriginal rural patients with few personal resources.

The renal case studies are also being used by clinical and academic educators as localised educational resources, as most renal textbooks only provide UK and USA examples of patient care.

QUALITY AND SAFETY
When one of the renal units was audited recently, unit staff were able to produce the case studies as evidence of working closely with patients and families, collaborating with other health services and enacting culturally safe care. With six new Aboriginal and Torres Strait Islander National Safety and Quality Health Service Standards being released in
2017–18, the mapping tools provide another avenue for health services to identify and record how they are responding Aboriginal patient needs.

SUMMARY AND NEXT STEPS
Collaboration between a range of health services and the research team enabled a flexible set of patient journey mapping tools to be developed. These are now being used for quality improvement and education. Work is continuing to further develop the mapping tools into a patient self-management and decision-making tool.

This project was based at Flinders University, and funded by SA Health and the Lowitja Institute. Further collaborative work with renal services is continuing with the University of Adelaide Nursing School.

Bibliography
Closing the Indigenous health gap requires a deep understanding of the health challenges Indigenous communities in Australia face.

Endorsed Enrolled Nurse Tamika Elvin knows this well—her family comes from the Guringai-Wonnarua people in the Hunter Valley and she has worked on the frontline as a nurse in these communities.

Motivated to continue to improve health outcomes for Indigenous people in Australia, Tamika recently attended the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) national conference with support from HESTA, as a key action of HESTA’s Reconciliation Action Plan.

Here Tamika shares her insights and experience on what needs to be done to help close the Indigenous health gap.

What was your motivation to become a nurse?
My motivation came from my family and my husband. I was in between jobs and my husband suggested I should apply for a nursing course—and happily I did. Also, my family is full of nurses and my grandfather did a lot for Aboriginal adolescents in mental health.

What was it that triggered your awareness of the Indigenous health gap in Australia?
My Aunty (a nurse practitioner) and grandfather (now passed) have both done a lot of work to help Close the Gap for Indigenous health. Their work raised my awareness of the importance of Indigenous Close the Gap programs.

As an Aboriginal nurse, what do you think are the biggest challenges impacting Indigenous health in Australia?
The biggest challenges are location, funds, access to healthcare and socioeconomic disadvantage. A lot of Indigenous Australians still live in rural and remote areas, where there is usually limited access to healthcare. Funds and support are lacking in these areas where they need to be a priority. It is not just Aboriginal people that are affected by funding cuts, but all Australians. Just because people choose to live in remote areas or
because Aboriginal people choose to live on their sacred land doesn’t mean they shouldn’t receive the same healthcare as those who live in suburban areas or in the city.

Aboriginal people are let down time after time by the healthcare system. Aboriginal Medical Services around the country continue to be either closed down or funding is cut so resources are taken away. I recently did a placement at an Aboriginal Medical Service where the chronic diseases clinic, which did house calls, was scrapped.

Following this I witnessed how an Aboriginal community reacts when there is a big change. Key members of the healthcare team were no longer working there, and the nurse practitioner had been away. This greatly affected the community—patients stopped coming into the clinic, resulting in patient numbers being at an all-time low, putting people’s health at risk.

When the nurse practitioner returned to work, the patients came back because they knew and trusted her—and she, like them, is Aboriginal.

What do you think needs to be done to help close the Indigenous health gap in Australia?

We need increased health education, especially for people living in rural and remote areas. There also need to be more Indigenous health workers, nurses and midwives in addition to more job opportunities for these positions.

The Aboriginal community also needs to start caring about their health. It’s all well and good for us to get the above things into practice, but there needs to be teamwork on both ends. With the help of rural and remote communities the word will spread, and the younger generation will care about their own health as well as their children’s.

You were recently sponsored by HESTA to attend the 2017 Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) national conference. What did you get out this experience?

I’m really thankful to HESTA for the great opportunity to attend the CATSINaM 2017 conference.

I got a lot of knowledge on how important our people’s healthcare is and how Australia is lacking in education about our health. Dr Chris Sarra really inspired me and taught me a lot.

I also learnt what areas of Aboriginal healthcare are lacking and as a mental health nurse (studying for my Bachelor of Nursing to further my nursing career) this gave me the ambition and passion to go further with mental health.

Your attendance at the conference was part of an initiative in HESTA’s Reconciliation Action Plan (RAP). What role do you think corporate organisations and industry partnerships have in helping to close the Indigenous health gap?

The more big organisations are a part of closing the gap, the more Aboriginal people will know that they are here to help. It is also a good way to help show it is time to move forward and stop living in the past. It is 2017 and help is here: we need to unite to close the gap and make our voices heard.

Through your work as a nurse how do you plan on using your knowledge to help close the Indigenous health gap?

By furthering my own education about Aboriginal health and mental health. I’ll be able to pass my knowledge onto the people I work with, and work united to close the gap.

There are only so many Aboriginal nurses and doctors out there, so we need to work with everyone in the healthcare system. We’re all in our jobs to help people, no matter what age, gender or race.
The Mind the Gap project

The National Disability Insurance Scheme and psychosocial disability.
This project, a partnership between the University of Sydney and Community Mental Health Australia, engaged 58 expert stakeholders across the country. Stakeholders included consumer, provider and advocacy organisations involved in psychosocial disability aspects of the National Disability Insurance Scheme (NDIS).

Stakeholders identified existing and emerging gaps in relation to:
1. experiences of the NDIS for people with psychosocial disability, and
2. the broader community-based mental health sector serving all Australians living with severe mental illness, whether eligible for the NDIS or not.

Stakeholders then proposed policy solutions to address identified gaps.

“Gaps also exist for carers and families, including lack of inclusion at the assessment and pre-planning stages, and multiple barriers to carer needs being included in a plan.”

GAPS WITHIN THE NDIS FOR PEOPLE LIVING WITH PSYCHOSOCIAL DISABILITY

Many Australians with psychosocial disability are not engaging or applying for NDIA support at all, and others are withdrawing mid-way through the application process. The reasons identified were consistent across all regions:
- lack of understanding or knowledge of the NDIS;
- lack of support to navigate complex access and planning processes and requirements; and
- poor psychosocial disability alignment of NDIS processes and language.

Support to access the scheme is particularly lacking for Aboriginal and Torres Strait Islander people, people from Culturally and Linguistically Diverse (CALD) backgrounds, and people in rural and remote areas.

The process of proving that someone met NDIS eligibility criteria created particular barriers and challenges. Stakeholders across the country spoke of the complexity of collecting the evidence required by the National Disability Insurance Agency (NDIA—the agency implementing the NDIS) to prove that people living with psychosocial disability had a permanent, functional disability and met NDIS eligibility criteria.

Evidence was particularly hard to obtain for people who:
- were disconnected from or disengaging with services and supports
- were transient and/or homeless
- faced difficulties in accessing services and information, such as people with language barriers.

Major gaps also exist in processes surrounding planning meetings (for NDIS plan development for individuals), including: inappropriate NDIA tools; planners having poor psychosocial disability expertise and knowledge; lack of cultural competency; and inadequate support or advocacy available to people with psychosocial disability.

Importantly, however, NDIS plans have been very positive and life-changing for many people living with psychosocial disability—for some people this was the first time that they had access to the services and resources they needed. The gaps that have emerged in this instance relate to difficulties in the enactment of the plan.

Gaps also exist for carers and families, including lack of inclusion at the assessment and pre-planning stages, and multiple barriers to carer needs being included in a plan.

For providers, the NDIS is creating a system described by some as being ‘on the brink of collapse’.

SOLUTIONS

Central to solutions proposed by stakeholders is the need for the NDIA to listen and learn from those with lived experience and expertise in psychosocial disability, and to engage with this expertise through genuine co-production and collaboration.

Strategies identified included:
- a separate NDIS stream for psychosocial disability with recovery-oriented language and a practice foundation
- all participants provided with support coordination in the first instance unless they opt out
- accessible guides produced in multiple languages translating psychosocial disability functional impacts into disability language, and clarifying the evidence required by the NDIA
- Information Linkages and Capacity (ILC) funding used to provide services to people not eligible for NDIS, and to resource CALD and Aboriginal and Torres Strait Islander communities to build capacity of communities to engage with the NDIS
- specialised Aboriginal and Torres Strait Islander support teams established, co-designed and led by Aboriginal and Torres Strait Islander organisations, consumers and carers
- regular information and Q&A sessions prior to and during NDIS roll-out in a region
- carers and families automatically a part of NDIS processes, in agreement with consumers.

GAPS BEYOND THE NDIS

The method of funding the NDIS has created major issues beyond the NDIS—specifically for a significant number of people with severe mental illness who are not, and will not be, eligible.

Limited and inconsistent data exists regarding the number of people with psychosocial disability applying for the NDIS and those deemed eligible.

While the NDIS was not meant to replace the broader mental health system, funding from this system has been shifted into the NDIS without a clear understanding of the impact on people not eligible. This has turned out to be a very short-sighted method of funding the NDIS, resulting in critical service and support gaps for the vast majority of Australians living with a mental health condition.

What was clear from the project was that the Australian Government should continue to fund low-barrier-to-entry, flexible support programs while the states and territories must continue to fund the community-managed mental health system. Without immediate, coordinated government funding responses, Australians living with a psychosocial disability will increasingly end up in acute, crisis care. This will not only prove to be financially costly, it will increasingly impact on the quality of people’s lives.

University of Sydney and Community Mental Health Australia

The Health Advocate • FEBRUARY 2018 43
MENTAL ILLNESS AND RURAL AND REGIONAL AREAS

Mental illness is a major health and social policy issue in Australia. One in five Australians aged 16 to 85 years will experience a mental disorder each year. In addition, almost one in seven young people (aged 4 to 17 years) have been assessed as having a mental disorder in the previous 12 months.

Unfortunately, less than one-half of all people living with mental health issues access treatment each year. In addition, there is a high level of mental distress in rural and regional areas. Suicide rates in rural areas are consistently 40% higher than the rates in metropolitan regions.

THE STRONG MINDS INITIATIVE

Marathon Health is working with two regional Primary Health Networks (PHNs) in New South Wales to provide psychological services to underserviced and hard-to-reach groups, in an initiative Marathon Health has called ‘Strong Minds’.

Marathon Health is a profit-for-purpose organisation that aims to see country Australians accessing the best health care. The organisation has around 200 staff working to improve the physical and mental health of people living in rural and remote NSW.

The program provides access to psychological support for people experiencing mild to moderate mental illness. The total population is over 550,000, including 37,000 Aboriginal people.

The Strong Minds service operates in over 60 communities, ranging from large regional centres with populations of 60,000, to small and isolated towns of 200 people. The total area covered is 558,000 square kilometres.

FEATURES

Marathon Health delivers Strong Minds across such a large and diverse geographic area through a mix of face-to-face and telehealth services, including telehealth directly into people’s homes in remote communities. The service is free and not intended to duplicate or replace existing services—rather, it is targeting gaps in the system for underserviced groups.

A key component of the Strong Minds service is a comprehensive, client-centred intake and triage system. This ensures that any person seeking support is able to access the right service, at the right time, and that the intervention offered to them will be the most effective at addressing their immediate concern.

The central intake enables a clinical triage, person-centred engagement, follow-up, and linkage to other services. It is also a key enabler for understanding demand across the region, understanding where people are in the care process, and outcomes for clients. This information supports the building of a regional picture of need and gaps, and assists with the allocation of resources to areas of high demand.

CHALLENGES

A very large geographic region and workforce limitations are big challenges to providing an effective and efficient service.
For example, for face-to-face services, the amount of travel time for staff creates fatigue and limits the number of services that can be delivered each day. The Strong Minds team has also faced challenges in determining an equitable spread of services in an environment where demand far exceeds available resources—in particular, the demand for mental health services for children is extremely high in rural and remote NSW. It is also challenging to operate in communities where there are so few other mental health services. Referrals can be of a severity beyond the service’s capacity to manage safely, with limited pathways available to more appropriate care.

**SOLUTIONS**
To address workforce limitations Marathon Health has set up a program of supervision for provisional psychologists, which has already attracted seven new interns. This is part of a longer-term strategy of increasing the skills and capacity of mental health professionals in the region.

Marathon Health has also implemented a mix of face-to-face services with telehealth follow-ups, allowing a readily accessible service for people in need while reducing travel and fatigue risks for clinicians.

Strong links have also been developed with Local Health Networks, General Practices, Aboriginal Medical Services and other NGOs providing mental health services. Every community the Strong Minds service works with is unique. Therefore local and regional partnerships are critical to ensuring effective pathways are established for referrals and crises if and when required.

**RESULTS**
The services across Murrumbidgee and Western NSW received almost 1,000 referrals between July and October 2017 inclusive, and this is steadily increasing.

Approximately 13% of those referrals have been for Aboriginal people, who comprise 7% of the region’s population. The delivery of culturally safe mental health support is of critical importance to the service and we ensure that our staff are trained in cultural awareness so they can provide a culturally appropriate service.

**REWARDS**
Mental health support for disadvantaged and underserviced groups is the key concern of the Strong Minds service, as mental illness does not discriminate, affects all sectors of the community and has far-reaching impacts on families and carers.

Although challenging, it is rewarding to deliver mental health support across such an expansive region in NSW where the opportunities for positive change at both individual and community levels are enormous.

Marathon Health is a profit-for-purpose organisation that aims to see country Australians accessing the best health care. The organisation has around 200 staff working to improve the physical and mental health of people living in rural and remote NSW.
The Australian Healthcare and Hospitals Association (AHHA) is an independent national peak body advocating for universal and equitable access to high quality healthcare in Australia. With 70 years of engagement and experience with the acute, primary and community health sectors, the AHHA is an authoritative voice providing: strong advocacy before Ministers and senior officials; an independent, respected and knowledgeable voice in the media; and a valued voice in inquiries and committees.

By becoming a member of the AHHA, you will gain access to AHHA’s knowledge and expertise through a range of research and business services.

The Deeble Institute for Health Policy Research was established by the AHHA to bring together policy makers, practitioners and researchers to inform the development of health policy. In joint collaboration with our university partners and health service members, the Institute: undertakes rigorous, independent research on important national health policy issues; publishes health policy Evidence Briefs and Issue Briefs; conducts conferences, seminars, policy think-tanks and workshops; and helps policymakers, researchers and practitioners connect when they need expert advice.

The AHHA’s JustHealth Consultants is a consultancy service exclusively dedicated to supporting Australian healthcare organisations. Drawing on the AHHA’s comprehensive knowledge of the health sector, JustHealth Consultants provides expert skills and knowledge in areas including: corporate and clinical governance training; strategy and business planning advice; organisation design and improvement; health services planning and program evaluation; and board induction training.

In partnership with the LEI Group, the AHHA also provides training in “Lean” healthcare which delivers direct savings to service provider and better outcomes for customers and patients.

To help share important developments across these various health research, policy and training spheres, the AHHA publishes its own peer-reviewed academic journal (Australian Health Review), as well as this health services magazine (The Health Advocate).

To learn more about these and other benefits of membership, visit www.ahha.asn.au/membership.
More about the AHHA

Who we are, what we do, and where you can go to find out more information.

AHHA Board

The AHHA Board has overall responsibility for governance including the strategic direction and operational efficiency of the organisation, the protection of its assets and the quality of its services. The 2016-2017 Board is:

- Dr Deborah Cole (Chair) Dental Health Services Victoria
- Dr Michael Brydon Sydney Children’s Hospital Network
- Dr Paul Burgess NT Health
- Ms Gaylene Coulton Capital Health Network
- Ms Jill Davidson CEO SHine South Australia
- Dr Paul Dugdale ACT Health
- Mr Nigel Fidgeon Merri Community Services, Vic
- Mr Walter Kmet WentWest, NSW
- Mr Adrian Pennington Wide Bay Health and Hospital Service, Qld

AHHA National Council

The AHHA National Council oversees our policy development program. It includes the AHHA Board as well as a range of members. The full list of Council members can be found at: ahha.asn.au/governance

Secretariat

- Ms Alison Verhoeven Chief Executive
- Mr Murray Mansell Chief Operating Officer
- Dr Linc Thurecht Research Director, Acting Deeble Institute Director
- Mr Krister Partel Advocacy Director
- Ms Lisa Robey Engagement and Business Director
- Ms Kylie Woolcock Policy Director
- Dr Chris Bourke Strategic Programs Director
- Dr Rebecca Haddock Deeble Institute Manager
- Mr Nigel Harding Public Affairs Manager
- Ms Kate Silk Integration and Innovation Manager
- Ms Sue Wright Office Manager
- Mr Daniel Holloway Web/Project Officer
- Ms Freda Lu Assistant Accountant
- Ms Suhi Sudhakar Administration Officer
- Mr Matthew Tabur Executive Officer
- Ms Odette Fuller Administration Officer

Australian Health Review

Australian Health Review is the journal of the AHHA. It explores healthcare delivery, financing and policy. Those involved in the publication of the AHR are:

- Prof Gary Day Editor in Chief
- Dr Simon Barracough Associate Editor, Policy
- Prof Christian Gericke Associate Editor, Models of Care
- Prof Sonj Hall Associate Editor, Health Systems
- Dr Linc Thurecht Associate Editor, Financing and Utilisation
- Ms Danielle Zigomanis Production Editor (CSIRO Publishing)

AHHA Sponsors

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- HESTA Super Fund
- Good Health Care
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- Price Waterhouse Cooper

Other organisations support the AHHA with Corporate, Academic, and Associate Membership and via project and program support.

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