



# The Health Advocate

Your voice in healthcare

## CLOSE THE GAP

Strategies and activities for improving the health and life expectancy of Aboriginal and Torres Strait Islander peoples

Are the gaps closing?

Aboriginal resilience and child health

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DEBORAH COLE

Chair of the Australian Healthcare and Hospitals Association (AHHA)

## Picking up the baton

### Moving forward in an ever-changing healthcare landscape.

**T**his is my first *View from the Chair* since being appointed Chair of AHHA's National Board late last year, and I look forward to working over the next two years with the Board and secretariat to build a healthy Australia supported by the best possible health system where health outcomes are equal for all Australians.

I want to thank AHHA's immediate past Board Chair, Dr Paul Dugdale, who has provided significant leadership to the AHHA in bringing together members from across all parts of the health sector, including primary and acute care, to represent their interests, and repay their investment and trust as we continue to advocate for best practice, efficient, universal healthcare, supported by adequate and ongoing funding.

It is now my job to pick up the baton and move forwards in an ever-changing healthcare landscape—an ageing population, the rise of chronic diseases, the increasing cost of medical technology, a new focus on person-centred care, and an increasing overlap of aged care, disability and health care services that needs a better health outcome focus, funding reform and better integration.

As health advocates, policymakers, researchers, administrators and practitioners, our goal must be the best possible health system where health outcomes are equal for all Australians. A high quality healthcare

system is key to a healthy population, a strong economy and true reconciliation with Australia's First Peoples.

This brings me to the theme of this first issue of *The Health Advocate* for 2017.

Consistent with our vision, mission and guiding principles, AHHA works with and supports Aboriginal and Torres Strait Islander peoples in the development and delivery of public health policy and care that will Close the Gap in health status between Australia's First Peoples and the general population.

We seek to do this through our key functions of advocacy, research, education, publications and events.

Accordingly AHHA has worked with its members, stakeholders and the broader Aboriginal and Torres Strait Islander community to publish this February 2017 edition of *The Health Advocate*, which follows on from our February 2016 edition in highlighting health programs aimed at Closing the Gap and what the data say.

We covers issues such as: practical yet meaningful activities by hospitals, other service providers and peak bodies to Close the Gap through training and employing more First Peoples in the health sector; partnering with Aboriginal and Torres Strait Islander

communities in the design and delivery of culturally appropriate care; and showing how the development and implementation of Reconciliation Action Plans ensure more meaningful engagement with First Australians.

This edition also looks at recent data and research, including research by AHHA's 2014 Deeble Institute Summer Scholar Katherine Thurber on how improving food security is critical if we are to Close the Gap.

I have also written an article myself, arguing that the limited information we have in Australia on the oral health status of Aboriginal children makes it difficult to guide appropriate

policy development and improvements in oral health outcomes.

We need more data on Aboriginal children living in metropolitan and regional areas of Australia, with consistency in the reporting of caries data with regard to age, study location and fluoridation status. We also need more sophisticated studies examining oral health inequities that include risk factor analysis and go further than simply describing oral disease by exploring the issues involved and possible solutions in more depth. **ha**

**"It is now my job to pick up the baton and move forwards in an ever-changing healthcare landscape..."**



**ALISON VERHOEVEN**  
Chief Executive  
AHA

# Lighthouse flame burns brightly in 2017 for First Australians

Phase 3 of **Heart Foundation/AHA** cardiac care project funded for 3 years.

**H**appy New Year to all of our members and readers! After a very busy 2016, we are hitting the ground running in 2017 with a new Board Chair, Dr Deborah Cole (see 'View from the Chair'), and with *The Health Advocate*.

We are focusing this first issue of the year on Aboriginal and Torres Strait Islander health, and the national Close the Gap campaign.

Among the good news in this sphere was a message received just before Christmas that the Australian Government had approved \$7.9 million in funding over 3 years for Phase 3 of the Lighthouse Indigenous cardiac care project.

Lighthouse is a project jointly sponsored by the Heart Foundation and ourselves. Its aim is to drive change in acute care settings that improve care and outcomes for Aboriginal and Torres Strait Islander peoples experiencing coronary heart disease.

The case for change is certainly compelling. Coronary heart disease is the leading cause of death among Indigenous Australians—they are 1.6 times as likely to die from it as non-Indigenous Australians. Aboriginal and Torres Strait Islander people are also more likely to be admitted to hospital for Acute Coronary Syndrome (ACS) episodes—heart attack or angina—and are more likely to die in hospital as a result of these episodes.

Paradoxically, while in hospital, Indigenous Australians are *less* likely than non-Indigenous Australians to undergo coronary tests and procedures. And they are also *more* likely to leave hospital against medical advice.

Hospitals have a critical role to play in improving access to evidence-based care, and reducing disparities in care. This is the main reason why Lighthouse has focused on care in hospitals. Together with reducing self-discharge rates, improvements in care will lead to better individual outcomes and significant overall savings to hospitals and the health care system.

The Lighthouse project began in 2012.

Phase 1 was about documenting best practice, and building an industry-based quality matrix for care improvement that could be incorporated into hospital accreditation.

Phase 2 involved developing a quality improvement toolkit and implementing the improvements in eight pilot hospitals across the five mainland states.

Phase 3 extends the project to 18 hospitals across Australia, capturing around 50% of all cardiac condition admissions for Indigenous Australians. We hope this will then lead to systemic change across all hospitals.

Cardiac care has made enormous strides over the last three decades or more, resulting

in lower mortality and increased life expectancy. We and our partners at the Heart Foundation are keen that Indigenous Australians benefit as much as possible from these care improvements.

Getting the improvements is about more than straight cardiac care, however. It's also about integrating services and improving communication among

hospitals, local Community Controlled Health Organisations, Indigenous patients and communities, Primary Health Networks, and health professionals.

If we can reduce the death rate from cardiovascular disease for Indigenous Australians to the same as for the total population, life expectancy would rise by nearly 7 years on average for all Indigenous Australians. **na**

**“Lighthouse is a project jointly sponsored by the Heart Foundation and ourselves. Its aim is to drive change in acute care settings that improve care and outcomes for Aboriginal and Torres Strait Islander peoples experiencing coronary heart disease.”**



# AHHA in the news

## 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](mailto:communications@ahha.asn.au)

## 76 litres a year of sugary drinks is 'way too much'

Government action is urgently needed to curb the consumption of sugary drinks in Australia. In late November 2016 AHHA released a position statement on sugar-sweetened drinks.

'Our consumption of sugar-sweetened beverages is among the highest in the world, with Australians and New Zealanders consuming an average of 76 litres of these drinks per person every year—that's simply way too much', said AHHA Chief Executive Alison Verhoeven.

'Obesity is now the leading cause of preventable death or illness in Australia, even more so than smoking.

'Sugar-sweetened drinks such as cordials, soft drinks, energy drinks, sports drinks, fruit and vegetable drinks, and fortified waters, are a major source of sugar in Australian diets, while not being of essential nutritional benefit. Consumption of these drinks has been clearly associated with obesity, type 2 diabetes, cardiovascular disease, tooth erosion and decay, and bone density problems.

'We therefore call on the Australian Government and the state and territory governments, as a matter of urgency, to develop and fund evidence based measures aimed at reducing consumption of these drinks', said Ms Verhoeven.

This could include taxing sugar-sweetened beverages; restricting sales in hospitals and schools; stronger advertising restrictions, especially during children's television viewing times; mandatory front of package 'healthy star' labelling; and public awareness campaigns.

Sugar-sweetened drink taxes have already been introduced in Mexico, France, Norway, Chile, Finland, Hungary, St Helena, Mauritius, French Polynesia, Samoa, Tonga and 33 states in the USA. The UK is introducing a 20% sugar tax in April 2018.



## Dr Deborah Cole appointed Chair of AHHA Board

Dr Deborah Cole was appointed Chair of the Board of AHHA in the last week of November 2016.

Dr Cole is currently Chief Executive Officer of Dental Health Services Victoria (DHSV), a position she has held since February 2011. Since joining DHSV Dr Cole has worked to significantly improve the community's access to quality and equitable dental care.

Prior to joining DHSV, Deborah held CEO positions at Calvary Health Care and Yarra City Council, as well as senior executive positions at Mercy Health and St Vincent's Health and the Dental Practice Board of Victoria.

Dr Cole is a Board Director for the Hessel Care Foundation and HESTA (Health Employees Superannuation Trust Australia). She holds qualifications in dentistry, health administration, business administration, and leadership. She is a Fellow of the Australian Institute of Company Directors and a Fellow of the Australian Institute of Management.

'I am very much looking forward to working with the AHHA Board and AHHA Chief Executive Alison Verhoeven towards a healthy Australia supported by the best possible health system', Dr Cole said.

'AHHA plays leading and influential roles in health advocacy, education and research, so that the healthcare system achieves better outcomes, better patient and provider experiences, and greater equity and sustainability. AHHA truly is the "voice of public healthcare", and, as we like to say, we start conversations rather than commenting on them.

## New online 'Australia's Health Tracker by Area' a welcome step forward

A new online interactive map of health in Australia, 'Australia's Health Tracker by Area' is a welcome step forward in highlighting areas for attention in health, as well as areas that could act as examples to follow.

'Australia's Health Tracker by Area' was released by the Australian Health Policy Collaboration at Victoria University, Melbourne, which developed the product with the Public Health Information Development Unit at Torrens University, South Australia.

'This new digital platform provides instant mapping and localised data on deaths, for example from cancer, cardiovascular disease, and suicide, as well as localised estimates of chronic diseases such as diabetes, and health risk factors such as overweight and obesity, high blood pressure and risky alcohol consumption', said AHHA Chief Executive Alison Verhoeven.

## "This new digital platform provides instant mapping and localised data on deaths..."

The usefulness of data like these is that we can focus on areas where, for instance, the prevalence of chronic diseases like diabetes is unexpectedly high, and then look into reasons why this might be occurring in that area and similar locations. From this, governments and other stakeholders can make informed policy choices in terms of fixing this population health issue.

This kind of data mapping can also be used by Primary Health Networks to determine, at quite a fine geographic level, what is going on health-wise in various communities within their overall areas of responsibility, so that they can take appropriate action from an informed perspective, including where to target their various services.

## December 2016 issue of *Australian Health Review* is 'topicality plus'

The latest edition of AHHA's peer-reviewed academic journal *Australian Health Review* (AHR) is 'topicality plus', said the AHR's chief editor, Professor Gary Day, in early December 2016

The journal covers many topical, and sometimes controversial issues—from seclusion and restraint in mental health care settings to the management and care of refugees in Australian hospitals.

'The article on caring for refugees in hospitals surveyed both a rural and an urban hospital. Refugees are a vulnerable group, often with complex health needs—and these needs are often unmet because of, for example, language issues and cultural barriers.'

'The research certainly highlighted that caring for refugees in Australian hospitals is a significant challenge, and that healthcare professionals require more support, more information about available services, and better access to interpreter services. These issues were more pronounced in the rural setting.'

Another interesting study included is on home enteral nutrition (feeding through a tube, outside of the hospital setting).

Other (selected) topics covered in AHR include: The care perceptions of orthopaedic trauma patients; health-related quality of life in people with Parkinson's disease receiving comprehensive care; medical record-keeping and system performance in orthopaedic trauma patients; implementing the National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Strategy in Queensland; National Broadband Network-enabled Telehealth trials for older people with chronic disease, and how rural placements affect junior doctors' perceptions of working in a rural area.



## End-of-life care 'needs a rethink'

'End-of-life care in Australia needs a rethink in order to improve it', AHHA Chief Executive Alison Verhoeven said in mid-December 2016.

Ms Verhoeven was commenting on AHHA's release of an Improving end-of-life care in Australia issues brief by the Deeble Institute for Health Policy Research, and the release of an AHHA position statement on the same topic.

End-of-life care should relieve suffering, preserve dignity, be accessible and enable people to die in a place of their choice. In practice, this is not happening—for example, most people, when asked, say they would prefer to die at home, but only 14% achieve this.

We are facing increasing demand for end-of-life care due to an ageing population, increasing rates of chronic disease, and the availability of aggressive therapies for the frail elderly that often extend life but can also cause harm.

As a nation we have been slow to adapt to these changes. Most people have clear preferences for the care they want at the end of their life, but rarely do they have open conversations that lead to effective end-of-life care plans for them.

On the healthcare side, it becomes difficult for medical professionals to know how far to pursue treatment and to understand at what point treatment becomes futile. The pressure to prolong life is enormous, and there is strong evidence that medical staff continue to provide futile care—indeed it is counter-intuitive for doctors not to do so.

## Affordability and equity must be balanced against competition, contestability and choice in human services

'Affordability and equity should not be forgotten in the rush to the "three Cs" of competition, contestability and choice in human services', AHHA Chief Executive Alison Verhoeven said in early December 2016.

Ms Verhoeven was responding to the release of the Productivity Commission study report, *Introducing competition and informed consumer choice into human services: identifying sectors for reform*.

The Commission named public hospital services, public dental services and end-of-life care as three of its six areas best suited to reform.

### "Affordability and equity should not be forgotten..."

'While the three Cs have their place in these services, and may deliver improvements in the 'E's of efficiency, effectiveness, and even equality, it should not be at the expense of the fourth 'E' of Equity', Ms Verhoeven said.

'If a group of people were trying to see over the crowd to watch a footy match, it's not necessarily the right thing to make sure everyone has the same size box to stand on, which is equality. Some people need only a small box, while others will need a much bigger box in order to see the match—that's equity.'

'The same principle should be applied to affordability and access to human services. In particular we should remember to 'keep it real in rural settings'—the principles of competition, contestability, and choice do not work out in the bush in the same way as in urban centres. Indeed, sometimes there is effectively no choice at all.'



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- St John of God Bendigo Redevelopment
- Northern Beaches Hospital Project
- The Epworth Geelong Hospital Project
- The New South East Regional Hospital and Redevelopment of the Goulburn Base Hospital
- The Redevelopment of the Lismore Base Hospital



For more information, visit [www.austhealthweek.com.au](http://www.austhealthweek.com.au)



# AHHA 2017 Events Calendar

AHHA is pleased to present another year of events aimed to inform, inspire, connect and showcase the Australian healthcare sector.

Along with topical Think Tanks and focused roundtable discussions, 2017 will see the continuation of AHHA's popular collaboration networks which aim to provide forums for ideas and discussion, promote collaboration and share best practice. The networks are:

## Data Collaboration Network

The Data Collaboration Network seeks opportunities for better use of health data in Australia, including promoting the potential for cross-sector collaboration.

## Innovation Collaboration Network

The Innovation Collaboration Network provides an opportunity to promote innovation and innovative ideas in the health sector and exposes participants to new ideas, technologies and techniques.

## Mental Health Network

The Mental Health Network provides opportunities to share information and expertise around mental health initiatives with a focus on primary health care.

Membership of the networks is open to all AHHA stakeholders with an interest in the relevant area.

## Partnering with Consumers

AHHA will also partner with the Consumers Health Forum of Australia throughout 2017 to deliver a series of skills development workshops to build the skills required for effective partnering with consumers.

## Events Calendar: March - June

### March

- 22 Data Collaboration Network Meeting
- 22 Innovation Collaboration Network Meeting

### April

- 4 Partnering with Consumers: Skills Development Workshop

### May

- 3 Think Tank: Deeble Discovery
- 4 Palliative Care Roundtable

### June

- 20 Data Collaboration Network Meeting
- 20 Innovation Collaboration Network Meeting
- 20 Health Law Seminar
- 21 Mental Health Network Meeting
- 22 Partnering with Consumers: Skills Development Workshop

For further information on these or any of AHHA's other events visit [www.ahha.asn.au/events](http://www.ahha.asn.au/events)

# People profile

Co-Chairs, **Close the Gap** Campaign Steering Committee.

Since 2006, Australia's peak Indigenous and non-Indigenous health bodies, NGOs and human rights organisations have worked together to achieve health and life expectation equality for Australia's Aboriginal and Torres Strait Islander peoples. This is known as the Close the Gap Campaign.

Jackie Huggins and Pat Turner are Co-Chairs of the Close the Gap Campaign Steering Committee, focused on closing the health and life expectancy gap within a generation—by 2030.

Here we take a short look at where they came from and what drives them.



## JACKIE HUGGINS: Four decades in Aboriginal affairs

Dr Jackie Huggins AM, FAHA has been a long-term advocate for the prevention of domestic and family violence, commencing in the early 1990s as Chair of the Queensland Domestic Violence Ministerial Council.

Her lifetime work has spanned many of the social determinants of health—Jackie takes an holistic approach to her work and life in addressing the many concerns confronting the Aboriginal and Torres Strait Islander communities she seeks to serve.

‘Close the Gap is a vital instrument in measuring outcomes of the health status and life expectancy of Indigenous

Australians’, she says. ‘There is a long road to travel to bring the aspirations and goals of CTG in addressing disadvantage in line with that of the wider population.’

Jackie was born in Ayr, North Queensland, and moved to Brisbane early in life when her father died in 1958 at the age of 38 as a result of his Prisoner of War World War 2 experience, when his people were not yet citizens of their own country. Her mother remained a war widow and Jackie led the typical life of an

Aboriginal child in the 1960s, materially poor but rich in family and community.

Her school years were spent in Inala, Brisbane, where she left at the age of 15.

Later she would excel at university, contrary to her schooling, which at the time had such low expectations of Aboriginals.

Having experienced this Jackie wanted to prove that a deficit model of her people served no purpose and was incorrect—so she embarked on a lifelong mission to dispel the often negative stereotypes that abound.

One of Jackie’s favourite quotes is from Maya Angelou—‘Nothing can dim the light which shines from within’.

*Jackie Huggins is a Birri-Gubba Juru and Bidjara woman from Queensland. She has had over four decades involvement in Aboriginal affairs, having worked across government, non-government and community sectors. As part of her role as Co-Chair National Congress of Australia’s First Peoples, she has been the Co-Chair of the Close the Gap campaign since November 2015.*

**“There is a long road to travel to bring the aspirations and goals of Close the Gap in addressing disadvantage in line with that of the wider population.”**

## PAT TURNER: Committed to Closing the Gap

Pat Turner knows all too well why improving life expectancy and the overall health status for Aboriginal and Torres Strait Islander peoples throughout our country is so important. Over the years she has attended far too many funerals and witnessed the grief and pain of too many families due to the premature loss of their loved ones for far too long.

‘The health disadvantage statistics for Aboriginal people speak for themselves’, she says. ‘We now know that the social and cultural determinants of health matter and I continue to advocate for a fully resourced package from governments to redress these inequalities.’

Pat believes there is no agenda more critical to Australia than enabling Aboriginal and Torres Strait Islander people to live good quality lives while enjoying all their rights and fulfilling their responsibilities to themselves, their families and communities.

‘Aboriginal people should feel safe in their strong cultural knowledge being freely practised and acknowledged across the

country. This should include the daily use of our languages, in connection with our lands and with ready access to resources. Aboriginal people should feel safe, free from racism, empowered as individuals and have health services to meet their needs and overcome health inequality.’

The government strategy to Close the Gap on key health indicators, including life expectancy and health status, is paramount to achieving lasting positive outcomes within a generation. ‘Of course housing, education and employment opportunities also matter and need to be redressed’, Pat says.

With the imprimatur of the Council of Australian Governments (COAG), the Close the Gap strategy is seen by Pat as the best opportunity to meet the strategy’s objectives by working in true partnership with Aboriginal and Torres Strait Islander people and communities at all levels, but especially at the local community level where the people live.

‘Top-down imposed programs generally fail because local people have no ownership

of them. Solutions are only fully effective and practical when they come from the locals themselves’, she concludes.

As the Co-Chair of the Close the Gap Campaign Steering Committee, and with extensive experience in the public sector, academia and corporate practice, Pat is committed to making a difference and advocating for Aboriginal people to all levels of government.

*Pat Turner is CEO of the National Aboriginal Community Controlled Health Organisation (NACCHO) in Canberra, where she lives with her extended family. Pat is of Arrernte and Gurdanji descent. She had a long and distinguished career in the Australian Public Service including as Deputy Secretary of the Department of Prime Minister and Cabinet, and Centrelink, and was the longest serving CEO of the former Aboriginal and Torres Strait Islander Commission (ATSIC). She was also the inaugural CEO of National Indigenous Television (NITV).* **ha**





**PROFESSOR IAN RING**  
Research and Innovation Division,  
University of Wollongong

IN DEPTH

# Are the Gaps Closing?

A mixed and somewhat flawed picture.

**T**he latest *Overcoming Indigenous Disadvantage* (OID) report provides a mixed and somewhat flawed picture of progress for Aboriginal people. Life expectancy gets a tick (progress), a somewhat heroic and contentious reading of the available data. Young child mortality also gets a tick, definitely true for infant mortality, though the gap in mortality of children aged under 5 years, while improving significantly, would perhaps take up to 50 years to be eliminated at the present rate of progress.

There are also real gains in key aspects of education. The proportion of Aboriginal and Torres Strait Islander 20-24 year olds completing Year 12 or equivalent, or above, increased from 45% in 2008 to 62% in 2014-15, while for non-Indigenous Australians, the proportion remained at 88% in 2014-15. Further, the proportion of Aboriginal and Torres Strait Islander 20-64 year olds with a Certificate level III or above, or studying, increased from 26% in 2002 to 47% in 2014-15, though the gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians remained steady at around 23-25

percentage points over the period.

Median real gross weekly household income for Aboriginal and Torres Strait Islander Australians increased from \$402 in 2002 to \$542 in 2014-15, representing a narrowing of the gap from \$349 in 2002 to \$316 in 2014-15.

But outcomes have **worsened** in some areas. The proportion of adults reporting high levels of psychological distress increased from 27% in 2004-05 to 33% in 2014-15, and hospitalisations for self-harm increased by 56% over this period. Substance misuse appears to be increasing.

Worst of all, the justice system in general, and the juvenile justice system in particular, are complete debacles and represent massive social and political failures. The adult imprisonment rate increased 77% between 2000 and 2015,

and while the juvenile detention rate has decreased, it is still 24 times the rate for non-Indigenous youth.


But the OID report itself, while an improvement on earlier iterations, still focuses largely on the D (disadvantage) and not enough on the O, what needs to

be done to **overcome** disadvantage. The report lists some examples of 'Things that work', and rightly highlights the paucity of rigorous evaluations. But the lack of focus on services is really the nub of the problem. What is needed is not just examples of successful programs, but a clear concept

**“Prime Minister Malcolm Turnbull’s words about doing things with Aboriginal and Torres Strait Islander people rather than to them need to be taken to heart.”**

of the actual services and other changes required to overcome disadvantage. Instead of hoping that the next year’s figures will look better, there needs to be a much clearer idea of precisely what services and changes are required for that purpose, what services are missing, and to





have and report on progress in filling the service gaps.

And there needs to be a much clearer idea of the lag times between initial funding and measured outcomes. As an example, key health outcomes as a result of Closing the Gap initiatives are not expected to be measurable until 2018 at the earliest. That point is not well understood by senior officials and politicians, who are concerned at an apparent lack of progress that could not reasonably be expected at this stage.

For health, the future largely rests on the National Aboriginal and Torres Strait Islander Implementation Plan. The outline released so far covers key points, but the hard part has yet to be spelt out—the core services required and associated workforce and funding mechanisms, and identifying the areas with high levels of avoidable illness and deaths and inadequate services. It is abundantly clear that culture, racism, wellness, genuine partnership and empowerment are fundamental, but how are they to be approached in practice?

That said, things are happening. Though funding is still not at a level commensurate

with the size of the population and the level of need, and even if it is often inequitable in distribution and driven by history rather than goal driven service planning, it has increased significantly, and the general thrust of current policy represents much-needed major improvements on the past.

But there is a long, long way to go. In some ways, implementation is harder than policy. Prime Minister Malcolm Turnbull's words about doing things *with* Aboriginal and Torres Strait Islander people rather than to them need to be taken to heart. And is it not time to move beyond good intentions and gifted amateurism? If dealing with Indigenous disadvantage was straightforward, much more progress might have been expected. But it is not straightforward—far from it. Much greater returns on investment in Overcoming Indigenous Disadvantage might be expected if people were more adequately trained for the complex tasks involved, as part of a National Training Plan for administrators, service providers and public servants. **ha**



# Overcoming Indigenous Disadvantage

## Productivity Commission

**T**he 2016 Overcoming Indigenous Disadvantage (OID) report measures the wellbeing of Aboriginal and Torres Strait Islander Australians, and was produced in consultation with governments and Aboriginal and Torres Strait Islander Australians.

This comprehensive report, now in its seventh edition, shows where things have improved (or not) against the 52 indicators that make up the OID framework (see page 3 of the OID 2016 Overview for more details). The framework is based on best available evidence about the root causes of disadvantage, in order to ensure that policy attention is directed at prevention, as well as responding to existing disadvantage. Areas covered in the framework include governance, leadership and culture, early child development, health, education, economic participation, home environment and safe and supportive communities.

The report shows outcomes have improved in a number of areas. However, there has been little or no change for some indicators, and outcomes have worsened in some areas. A snapshot of results for health

and related indicators is provided below.

Young child mortality is a long established indicator of child health and the physical and social environment. Mortality rates declined between 1998 and 2014 for Aboriginal and Torres Strait Islander children aged 0-4 years, with the greatest improvement seen in those aged less than one year (from 14 to 6 deaths per 1,000 live births). Indicators of early child development showed improvements with:

- the increased use of antenatal care, with the proportion of Aboriginal and Torres Strait Islander women who gave birth attending at least one antenatal visit in the first trimester, up from 50% in 2011 to 52% in 2013
- a reduction in the proportion of Aboriginal and

Torres Strait Islander women who smoked while pregnant, down from 55% in 2005 to 48% in 2013

- a reduction in the proportion of

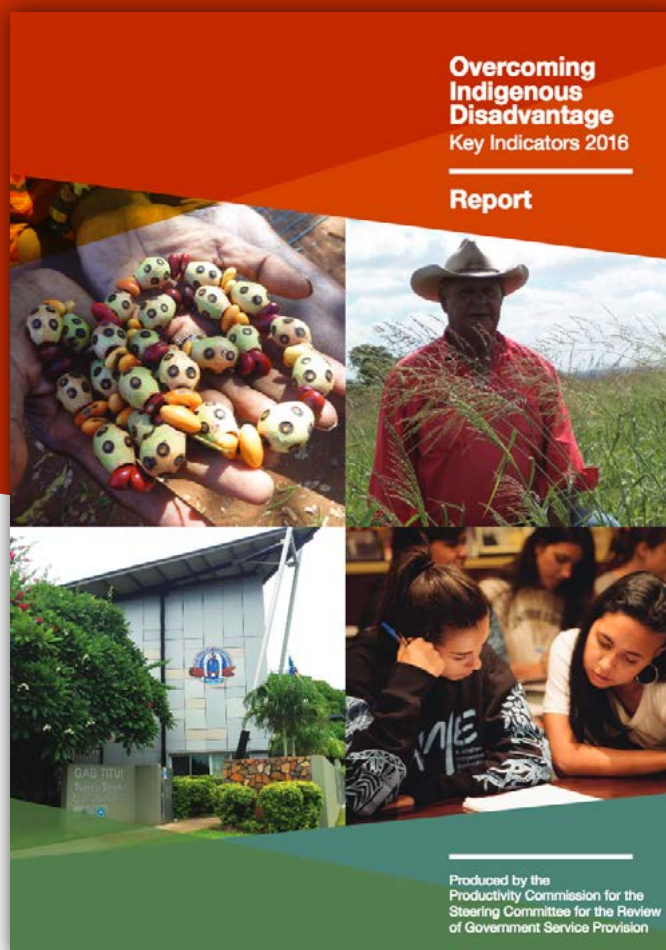
Aboriginal and Torres Strait Islander mothers who had low birthweight babies, down from 12% in 2000 to 11% in 2013.

Life expectancy is a broad indicator of a population's long term health and wellbeing. From 2005-2007 to 2010-2012, life expectancy at birth for Aboriginal and Torres Strait Islander Australians increased for both males (up about 1.5

years) and females (up over 0.5 years). More recent data available for related indicators show reduced rates of potentially avoidable deaths from 1998 to 2014 (down by around one-third), though the rate for

**“Data alone cannot tell the complete story about the wellbeing of Aboriginal and Torres Strait Islander Australians, nor can data fully tell us why outcomes improve (or not) in different areas.”**





Aboriginal and Torres Strait Islander Australians is still three times the rate for non-Indigenous Australians. The most common cause of potentially avoidable deaths for Aboriginal and Torres Strait Islander Australians is ischaemic heart disease/heart attacks, which accounted for around one in five potentially avoidable deaths.

Health outcomes are influenced by a range of factors, with health risk factors including smoking and excessive alcohol consumption. While there has been progress in reducing rates of smoking (for Aboriginal and Torres Strait Islander adults the rate declined from 51% in 2001 to 41% in 2014-15), there has been no change over the longer term in levels of risky alcohol consumption (the proportion of Aboriginal and Torres Strait Islander Australians aged 15 years and over drinking at levels exceeding the lifetime alcohol risk guidelines in

2014-15 was 15%—similar to 2002, though lower than 2008).

Mental health, essential to the overall health and wellbeing of individuals, and including both mental illness and overall mental wellbeing, has shown regress. The proportion of Aboriginal and Torres Strait Islander adults who reported high or very high levels of psychological distress increased from 27% in 2004-05 to 33% in 2014-15. Suicide and self-harm also increased, with hospitalisation rates for intentional self-harm for Aboriginal and Torres Strait Islander Australians increasing by 56% in the last 10 years, while the rate for other Australians remained relatively stable. The suicide rate for Aboriginal and Torres Strait Islander Australians was twice the rate for non-Indigenous Australians during 2010-2014.

Data alone cannot tell the complete story about the wellbeing of Aboriginal and Torres Strait Islander Australians, nor can data fully tell us why outcomes improve (or not) in different areas. To support the indicator reporting, the OID report includes case studies of ‘things that work’ to improve outcomes for Aboriginal and Torres Strait Islander Australians. However, the relatively small number of case studies included in the 2016 report reflects a lack of rigorously evaluated programs in the Indigenous policy area. <sup>1a</sup>

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The main report, overview, data tables and a short video can be found at: [www.pc.gov.au/oid2016](http://www.pc.gov.au/oid2016).

# Researching policy implementation of

## ‘CLOSING THE GAP’

Centre for Research Excellence for Social Determinants and Health Equity. **Tamara Mackean, Matt Fisher, Emma George, Fran Baum and Sharon Friel**

**T**he Centre for Research Excellence in the Social Determinants of Health Equity (CRE Health Equity) is a 5 year project (2015-2020) and joint collaboration between Flinders University, Australian National University, University of Sydney, and the University of Ottawa.

The purpose of the CRE is to improve understanding of how public policy can address the social determinants of health to more effectively improve health, and a fairer distribution of health. The CRE Health Equity is researching a range of policy areas, through different stages of the policy process: agenda setting, policy formulation, implementation, and evaluation. Our research on ‘Closing the Gap’ (CTG) will examine the implementation of the CTG strategy from 2008 to the present. Aims of the CRE Health Equity and the CTG case study are shown in Table 1.

Our research fills a gap in the policy implementation literature by focusing on the role of community-controlled organisations in policy implementation, especially in relation to the national implementation of the CTG strategy and through an examination of the CTG policy on early childhood. Previous research has investigated the role of public bureaucracies in policy and community

control in relation to service delivery<sup>1,2,3</sup>, so this research breaks new ground.

The 2016 CTG ‘Shadow Report’ by the Australian Human Rights Commission<sup>4</sup> argues that Aboriginal Community Controlled Health Organisations (ACCHOs) should be the preferred model for implementation of the CTG strategy. They support their case by arguing that communities exercising greater levels of control have an increased ability to manage disease, adopt healthier lifestyles and use health services more effectively. However, the potential benefits of community control go well beyond delivery of healthcare, and extend into the potential for more direct control over policy implementation processes and allocation of resources<sup>5,6,7</sup>.

Evaluation of CTG policy implementation shows that ACCHOs in different states have had very different roles<sup>8</sup>. In one state, the relationship between state government and ACCHOs may be collaborative, and include community controlled decision making, whereas in another state, the role of ACCHOs may be more restricted by mainstream service directives and limited funding. Comparing policy implementation in different jurisdictions, and the role of these community controlled organisations, is important because CTG implementation processes and actions can differ

considerably, despite all falling under one CTG strategy<sup>9</sup>.

An important theoretical framework and ethical consideration in this research is the embedding of Indigenous knowledges. There is an important place for these dynamic, collective, and holistic knowledges in current research. Research at the interface of western scientific research and Indigenous knowledges requires a commitment to principles of mutual respect, reciprocity, dignity and discovery<sup>10</sup>.

Therefore working with the Lowitja Institute and Indigenous researchers and advisers is an important priority for the CRE Health Equity. Our research will provide evidence of ways in which Indigenous knowledges can contribute to improved health and equity, and more effective and equitable policy, for all Australians. **ha**

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## Table 1: CRE Health Equity Aims

### Aims:

1. Understand how government policies can work more effectively to address the social determinants of health, including the social determinants of Indigenous Australians' wellbeing, so as to improve health and reduce health inequities.
2. Increase understanding of the use of evidence in policy under conditions of multiple policy agendas and differences in power among groups.
3. Build research capacity and undertake knowledge exchange.

### CRE-HE RESEARCH PROGRAM

THEMATIC ISSUES	<i>Problem Identification and Agenda Setting</i>	<i>Policy Solutions/ Formulations</i>	<i>Implementation</i>	<i>Evaluation of impact on health equity</i>
	WORK PACKAGE 1	WORK PACKAGE 2	WORK PACKAGE 3	WORK PACKAGE 4
	<i>Making health equity a policy concern</i>	<i>Formulating policy: how policies interact across sectors</i>	<i>Effective policy implementation for health equity</i>	<i>Health equity impacts of public policy</i>
CASE STUDIES	<ul style="list-style-type: none"> <li>• Medicare</li> <li>• Paid Parental leave</li> <li>• Trans Pacific Partnership</li> <li>• NT Intervention</li> </ul>	Policy responses to, and health effects of, SA's transitioning economy and closure of Holden	<ul style="list-style-type: none"> <li>• NBN</li> <li>• Land use policy</li> <li>• Primary Health Care</li> <li>• <b>Closing the Gap</b></li> </ul>	<ul style="list-style-type: none"> <li>• NBN</li> <li>• Land use policy</li> <li>• Primary Health Care</li> <li>• Closing the Gap</li> </ul>

### 'CLOSING THE GAP' POLICY IMPLEMENTATION AND HEALTH EQUITY

#### Aim 1:

To examine how rights, self-determination and health equity can be advanced through community leadership, governance and organisations at a regional level, with effective support from government and public sector agencies.

#### Aim 2:

To conduct a comparative case study on implementation of 'Closing the Gap' policies, with a particular focus on policies on early childhood.





**FADWA AL-YAMAN**  
Australian Institute of Health  
and Welfare



**TRACY DIXON,**  
Australian Institute of Health  
and Welfare

# The Australian Burden of Disease Study

Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011.

**T**he *Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011* report examines the burden of disease of Indigenous Australians in 2011.

‘Burden of disease’ analysis is a way of measuring the combined effects of living with ill health (non-fatal burden or YLD) or dying prematurely (fatal burden or YLL) relative to a life lived to its natural limits and without disease. The analysis uses a wide range of data sources and other evidence to come up with a burden of disease estimate that allows us to rank all diseases from highest to lowest in terms of their disease burden. The contribution of behavioural risk factors like smoking, excessive alcohol consumption, physical inactivity and high blood pressure to the disease burden is also assessed in this study.

The burden of disease analysis of Australia’s Indigenous population found that a total of 190,227 healthy years of life were lost in 2011. This is equivalent to a loss of 284 years for every 1,000 Indigenous persons due to living with ill health or an early death. The

fatal burden was higher than the non-fatal burden (53% compared with 47%) and was higher in males than females (54% compared with 46%).

About two-thirds of the disease burden (64%) was caused by chronic conditions, with mental and substance use disorders (19%), injuries (15%), cardiovascular disease (12%), cancer (9%) and respiratory diseases (8%) being the leading causes. The disease burden for mental and substance use disorders was mostly non-fatal, while the burden from cancer, cardiovascular diseases, and injuries was mostly fatal.

In 2011, a total of 89,564 years of healthy years of life, or 134 YLD per 1000 people, were lost because of living with illness. This non-fatal burden was mostly caused by mental health and substance use disorders (39%) followed by musculoskeletal diseases (14%) and respiratory diseases (12%).

The fatal burden was higher than the non-fatal burden, as stated earlier. A total of 100,663 years or 150 years per 1,000 people were lost because of premature death. Injuries, including traffic road accidents and

suicides (24%), cardiovascular disease (21%) and cancer (17%) were the leading causes of the fatal burden.

A significant part of the burden of disease experienced by Indigenous Australians is preventable. The study examined 29 different behavioural factors and these factors combined were responsible for an estimated 37% of the disease burden. They provide opportunities for intervention to reduce the overall disease burden among Indigenous Australians.

For example, tobacco smoking contributes to ill health and deaths from cardiovascular and respiratory diseases, as well as from cancer and diabetes. Of the risk factors examined in the study, tobacco was responsible for 12% of the disease burden, alcohol (8%), high body mass index (8%), physical inactivity (6%), and high blood pressure and high blood sugar (5% each). The combined effect of a range of dietary factors, including a diet high in processed meat, low in fruit and vegetables, low in fibre, and high in sweetened beverages were responsible for 9.7% of the burden. These

risk factors are responsible for one-half of the gap in disease between Indigenous and non-Indigenous Australians.


The total burden of disease of Indigenous Australians was 2.3 times the rate for non-Indigenous Australians. The contribution to the total burden of premature death was 2.7 times that for non-Indigenous Australians and for non-fatal disease, twice the burden of the non-Indigenous population. Chronic disease was the cause of 70% of this gap in the burden of disease.

The burden of disease of Indigenous Australians was not evenly distributed geographically across Australia. Indigenous Australians living in the Northern Territory or Western Australia were found to have higher disease burden than those in New South Wales or Queensland. The burden was highest in remote and very

**“Indigenous Australians living in the most socioeconomically disadvantaged areas had a disease burden more than twice those living in areas with the least socioeconomic disadvantage.”**

remote areas. Indigenous Australians living in the most socioeconomically disadvantaged areas had a disease burden more than twice those living in areas with the least socioeconomic disadvantage.

The pattern of causes of the burden was also different geographically, with mental and substance use disorders being the leading cause of burden in major cities, while the burden from injuries was highest in remote and very remote areas.

There was some small overall reduction in the burden of disease of Indigenous Australians between 2003 and 2011 (5%). During that period, there was a 4% increase in the non-fatal burden and an 11% decrease in the fatal burden. Most of the improvement came from reductions in premature deaths from cardiovascular diseases. 



# Added sugar consumption among Indigenous Australians

Alana Cameron and Paul Atyeo, Australian Bureau of Statistics.



Alana Cameron and Paul Atyeo

**E**xcess consumption of added sugar is a significant dietary risk factor for all Australians and particularly so among Aboriginal and Torres Strait Islander people. A recent burden of disease study estimated that high body mass and high blood sugar accounted for 14% and 9% respectively of the overall health gap between Indigenous and non-Indigenous Australians<sup>1</sup>. To help address the global disease burden associated with sugar, the World Health Organization (WHO) recommends adults and children limit their consumption of free sugars to less than

10% of dietary energy<sup>2</sup> (with free sugars being defined as the added sugars in manufactured foods as well as the sugar spooned into the foods and beverages prepared by consumers, plus honey and the sugar naturally present in fruit juice).

Analysis of the 2011-13 Australian Health Survey (AHS)<sup>3</sup> shows that on average, Aboriginal and Torres Strait Islander people derived around 14% of their total dietary energy from free sugars. The report found that the Indigenous population consumed an average of 75 grams of free sugars per day,

equivalent to 18 teaspoons of white sugar, or the amount from almost two cans of a sugary soft drink.

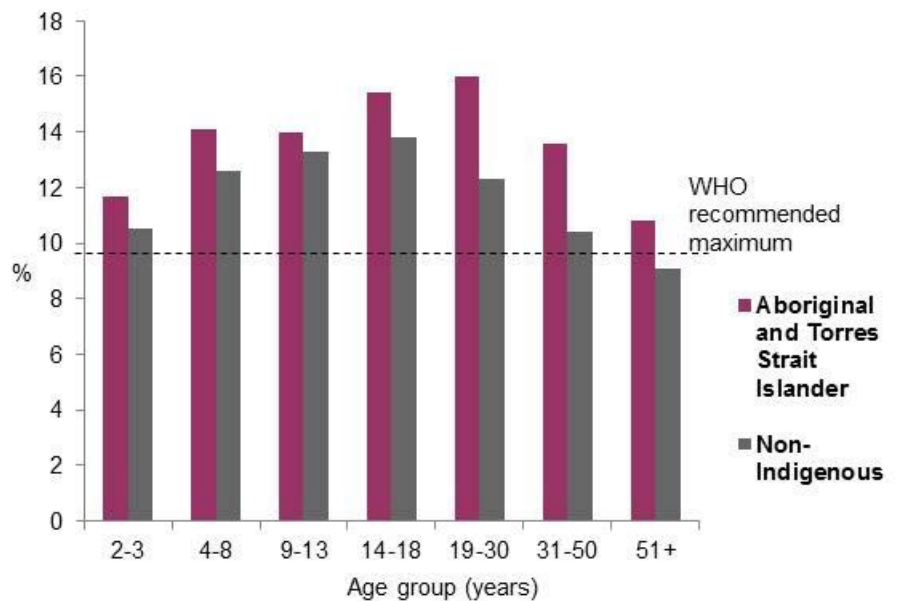
Free sugar consumption was highest among older children and young adults. For example, teenage boys (aged 14-18 years) derived 18% their dietary energy from free sugars as they consumed the equivalent of 25 teaspoons (106 grams) of free sugars per day (roughly the amount of sugar in just over two-and-a-half cans of soft drink). Women aged 19-30 years consumed 21 teaspoons (87 grams) of free sugars, which contributed 17% of their dietary energy.

## Beverages are the main source of free sugars

The majority (87%) of free sugars were consumed from energy dense, nutrient-poor 'discretionary' foods and beverages. Beverages were the source of two-thirds of free sugars consumed by the Aboriginal and Torres Strait Islander population, with soft drinks, sports and energy drinks providing 28%, followed by fruit and vegetable juices with 12%, cordials (9.5%), sugars added to beverages such as tea and coffee (9.4%), alcoholic beverages (4.9%) and milk drinks (3.4%).



## Proportion of dietary energy from free sugars by Indigenous status



Source: 2011-13 Australian Health Survey

### Higher consumption in non-remote areas...

Intakes of free sugars were higher for Aboriginal and Torres Strait Islander people living in non-remote areas, where the average daily consumption was 78 grams (18.5 teaspoons), around three teaspoons more than Indigenous people living in remote areas of Australia (65 grams or 15.5 teaspoons). Although Indigenous people in remote areas actually consumed less sugar from cold sweetened beverages (particularly soft drinks, fruit drinks/juices, alcoholic drinks or flavoured milk) than the non-remote population, they consumed a greater proportion of their free sugars from beverages overall than the non-remote population (71% compared with 66%). This was in part because more sugar was

consumed in tea and coffee in remote areas (14%) compared with non-remote areas (8%), but was also due to lower amounts of certain sugary foods (such as confectionery and ice cream) being consumed in remote areas.

### ...compared with non-Indigenous Australians

Despite Aboriginal and Torres Strait Islander people consuming 4% fewer kilojoules

**“Despite Aboriginal and Torres Strait Islander people consuming 4% fewer kilojoules on average than non-Indigenous Australians, Indigenous people consumed 15 grams (almost 4 teaspoons) more free sugars than non-Indigenous Australians.”**

on average than non-Indigenous Australians, Indigenous people consumed 15 grams (almost 4 teaspoons) more free sugars than non-Indigenous Australians. This resulted in the significantly greater proportion of dietary energy from free sugars among Indigenous people compared with non-Indigenous Australians (14% and 11% respectively).

Beverages were the most common source

of free sugars for both populations—however, Aboriginal and Torres Strait Islander people derived a higher proportion of free sugars from beverages than non-Indigenous people (67% compared with 51%). <sup>1a</sup>

For more information and to get the data used in this article, visit: [www.abs.gov.au](http://www.abs.gov.au) and search for ‘added sugars’.

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**DARRYL WRIGHT**  
CEO at Tharawal Aboriginal  
Corporation

# Innovative ear health program helps urban Aboriginal kids to thrive

**SEARCH** partnership study opens door to a new model of care in Indigenous communities.

**F**or a whole host of reasons, Indigenous children experience middle ear disease earlier, more often and with more complications than non-Indigenous children. Left untreated, diseases like otitis media can cause huge long term problems for kids' hearing, and their speech and language development.

When kids can't hear in school and can't properly participate in society, it's no surprise that this creates all kinds of problems. Their language skills don't develop as quickly, they don't sleep well, they have to take more time off, they can misbehave and their education can fall behind.

As the Chief Executive Officer of Tharawal Aboriginal Corporation at Campbelltown in Western Sydney, I have seen first-hand the long-term impact of ear health problems and the struggles that families face in accessing the services such as specialist appointments and surgery to address this issue in a timely manner.

Far too many kids missed out on crucial years of speech, language and educational development because their problems were not diagnosed or they didn't get access to the services they needed. Some kids couldn't hear; some couldn't even speak.

To properly address these and other Aboriginal child health issues we first needed to identify the scale of the problem and then tackle it, but in a way where Aboriginal

communities are partners and leaders in the entire process.

This is why the Study of Environment on Aboriginal Resilience and Child Health (SEARCH)—the largest ongoing study of urban Aboriginal children ever conducted—was established. SEARCH is an active partnership between four Aboriginal Community Controlled Health Services in NSW, the Aboriginal Health and Medical Research Council (AH&MRC) of NSW, the Sax Institute, and leading university researchers.

It aims to do two equally important things: better understand the causes of health and disease among urban Aboriginal children and their families; and use this information to drive real improvements in health and services outcomes for Aboriginal people.

SEARCH has shown that more than 40% of participating urban Aboriginal children aged under eight have significant speech and language impairments and/or ear health problems. The information gathered through SEARCH meant that we could identify these at-risk kids. This resulted in the establishment of the HEALS (Hearing Ear health and Language Services) program, so

that the kids identified can get access to the services they need.

Since 2013, the HEALS program has delivered more than more than 7,000 speech and language services and ear operations to almost 800 urban Aboriginal children at five Aboriginal Community Controlled Health Services and one Aboriginal clinic.

With funding from the Federal Government and the NSW Department of Health, we have almost eliminated the waiting lists for speech and language therapy, specialist appointments and

surgeries at the six participating centres.

For the kids, families and the wider communities involved, it has been life changing. I see it every day at Tharawal—kids who were struggling are now happy and smiling, and excelling in their community and in their schooling.

As suggested in a paper recently published in the *Australian and New Zealand Journal of Public Health*, this is a model that could be scaled up to benefit even more Aboriginal kids and families

HEALS is an example of what happens when researchers, Aboriginal communities, policy-makers and clinicians come together to

**“SEARCH puts the Aboriginal community at the heart of the decision-making process.”**



Latoya Terry and her daughter Saraya Thompkins, who is among 1,600 urban Aboriginal children involved in SEARCH.

tackle big-picture problems. Instead of just talking about or researching the problems, HEALS is helping to change the record for hundreds of kids and their families.

And while HEALS has been funded as a pilot, now we know the model works as a way to Close the Gap, it could be scaled up. We need more Aboriginal children right across the country to access the services they need to give them the best start.

This project also highlights the importance of long-term research projects like SEARCH,

which put the Aboriginal community at the heart of the decision-making process and allow us to direct resources into the areas where we know they are needed the most.

SEARCH is about much more than understanding the causes of ill-health and disease among urban Aboriginal children—it's designed in a way so that information is actually put to use to drive real improvements in services and health outcomes for Aboriginal people.

Both SEARCH and HEALS show that we

have a way forward. Now it's time to get on with it and help change the record for more Aboriginal kids. [ha](#)

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Darryl Wright was born in Murrundi and is the Chief Executive Officer at Tharawal Aboriginal Corporation in Campbelltown, one of four Aboriginal Community Controlled Health Services that are partners in SEARCH.



# Overcoming the barriers of detection

New health pilot for cervical cancer self-screening for Aboriginal women in Western NSW. **Marathon Health**



Laurinne Campbell, Marathon Health Primary Health Care Nurse; Rene Wykes, CEO MPREC and Anne Denis, Western NSW Local Aboriginal Land Council Councillor and Deputy Chair NSW Aboriginal Land Council, with the HPV self-sampling kits.

**A** boriginal women in eight Western NSW communities are being offered an alternative to the traditional Pap test to increase the detection of cervical cancer.

The ethics-approved pilot program will allow Aboriginal women who do not want to have a Pap test to undertake a self-sampling test for HPV (a significant cause of cervical cancer).

Marathon Health is coordinating the pilot program in partnership with the Murdi Paaki Regional Enterprise Corporation (MPREC), the NSW Aboriginal Land Council and the University of Western Sydney.

Shellie Burgess, Primary Health Service Manager at Marathon Health, said the program aims to increase the number of Aboriginal women living in rural and remote NSW being screened for HPV, and in turn increase the detection of cervical cancer.

'This program is the first of its kind in Western NSW and empowers Aboriginal women to take control of their own health and wellbeing through accessible and culturally appropriate health services', Ms Burgess said.

'Research showed us there were significant barriers to Pap testing for Aboriginal women living in remote and rural communities'.

'In addition, the incidence of cervical cancer among Aboriginal and Torres Strait Islander women is more than twice that of non-Aboriginal women, and mortality is four times the non-Indigenous rate.

**"...the incidence of cervical cancer among Aboriginal and Torres Strait Islander women is more than twice that of non-Aboriginal women, and mortality is four times the non-Indigenous rate."**

'This effective self-sampling test will remove these barriers and allow Aboriginal women to self-screen for cervical cancer with the support of a Marathon Health Primary Health Care Nurse and an Aboriginal female Community Engagement Worker employed by the Local Aboriginal Land Council within each of the communities.'

The pilot began in August 2016 and is focusing on Aboriginal women living in the communities of Baradine, Coonamble, Gilgandra, Gulargambone, Gwabegar, Nyngan, Trangie and Warren.

Coordinator of the program with Marathon Health, Laurinne Campbell, said five female Aboriginal Land Council Community Workers are being formally trained as part of the program, and screening is currently underway.

'Trained local female Aboriginal Land Council Community Workers have begun engaging with eligible women in their local communities

to encourage them to participate in the pilot', Ms Campbell said.

'The women receive an HPV self-sampling kit to screen for cervical cancer, and are supported through the process, including sending their test to pathology and helping those who return positive results to get the health care they need.

'We have started testing women in some communities and hope to have our target sample group screened by early 2017.

'The project shows the great potential of partnerships in Aboriginal health care, with

the enthusiasm and hands-on commitment of representatives of both the Murdi Paaki Regional Enterprise Corporation and the Local Aboriginal Land Council being keys to the pilot's early successes.'


Rene Wykes, Acting CEO of MPREC, said the trial has significant potential across the region and would be a positive step in detecting cervical cancer and for the Closing the Gap initiative.

'Western NSW has a lower rate of cervical screening than the state average and this will provide an accessible test for many women who may never have had a Pap test.'

The customised self-sampling kits have been funded from a grant from the Western NSW Primary Health Network.

The cervical cancer self-screening kits include:

- A canvas case with cultural artwork designed by Murdi Paaki and Central West Sista Circle.
- Instruction card and HPV brochure.
- Pathology information form.
- A cotton swab in a plastic tube.
- A plastic zip lock bag.

The University of Western Sydney will be evaluating the project and determining the effectiveness of the community engagement approach using local Aboriginal Land Council Community Workers. 

**For more information on the HPV self-screening program please call the Primary Health Care Nurse team on (02) 6826 5200.**

1. Australian Institute of Health and Welfare 2015. Aboriginal and Torres Strait Islander health performance framework 2014 report: detailed analyses. Accessed 24 November 2016, <<http://www.aihw.gov.au/publication-detail/?id=60129550871&tab=2>>.



# Providing aeromedical care to remote Indigenous communities

## Royal Flying Doctor Service of Australia

**T**he Royal Flying Doctor Service (RFDS) formalised its commitment to improving health outcomes and access to health services for Indigenous Australians through its first Reconciliation Action Plan (RAP), released in January 2016.

This was, and is, particularly important given that around one-third of face-to-face RFDS primary healthcare services, and more than one-quarter of RFDS aeromedical retrievals, are provided to Indigenous Australians.

A key commitment of the RFDS RAP was to seek to use RFDS data to inform research and policy to improve Indigenous health outcomes. Accordingly, in November 2016, the RFDS released the research paper *Providing aeromedical care to remote Indigenous communities*<sup>1</sup>, which details the demand and reason for aeromedical retrievals of Indigenous Australians by the RFDS from remote and very remote areas of Australia.

The paper analyses 62,528 aeromedical retrievals provided by the RFDS between July 2013 and December 2015, and for which Indigenous status of patients was recorded.

Of these 17,606 (28.2%) were for Indigenous Australians from remote and very remote areas of Australia. This equates to 19 patients every day who required RFDS aeromedical transport to a tertiary hospital to receive definitive care.

Ensuring that there is timely and appropriate access to healthcare for Indigenous Australians in remote and rural areas is critical given the relationship between declining health status and increasing remoteness, and Indigenous Australians being overrepresented in remote and rural populations. In the 2011 Census, 3% of the Australian population identified as Indigenous Australians, and 21% of Indigenous Australians lived in remote and very remote areas. The need for appropriate and comprehensive services for Indigenous Australians living in these remote and very remote areas is further demonstrated through the high proportion of Indigenous Australians from these locations requiring an emergency RFDS aeromedical retrieval (Figure 1). It is hoped that making this RFDS data available for the first time will assist all levels of government as well as service delivery organisations to make decisions on

where resources are best directed.

An analysis of the 62,528 RFDS aeromedical retrievals yielded the following key results (Figure 2):

- Indigenous females were 1.2 times as likely as Indigenous males to require an RFDS aeromedical retrieval.
- The average age at which an Indigenous Australian underwent an RFDS aeromedical retrieval was 30-34 years.
- Children aged 0-4 years were the group of Indigenous patients most likely to require an RFDS aeromedical retrieval.

Aeromedical retrieval data were classified into one of 22 disease categories according to the International Statistical Classification of Diseases and Related Health Problems, 10th Edition, Australian Modification (ICD-10-AM). Using this classification, the top three reasons an Indigenous Australian required an RFDS aeromedical retrieval resulted from:

- injury, poisoning and other consequences of external causes (17.9%);
- diseases of the circulatory system, such as heart attacks or stroke (14.3%); and
- diseases of the respiratory system, such as a respiratory infection, influenza, and pneumonia (12.8%).



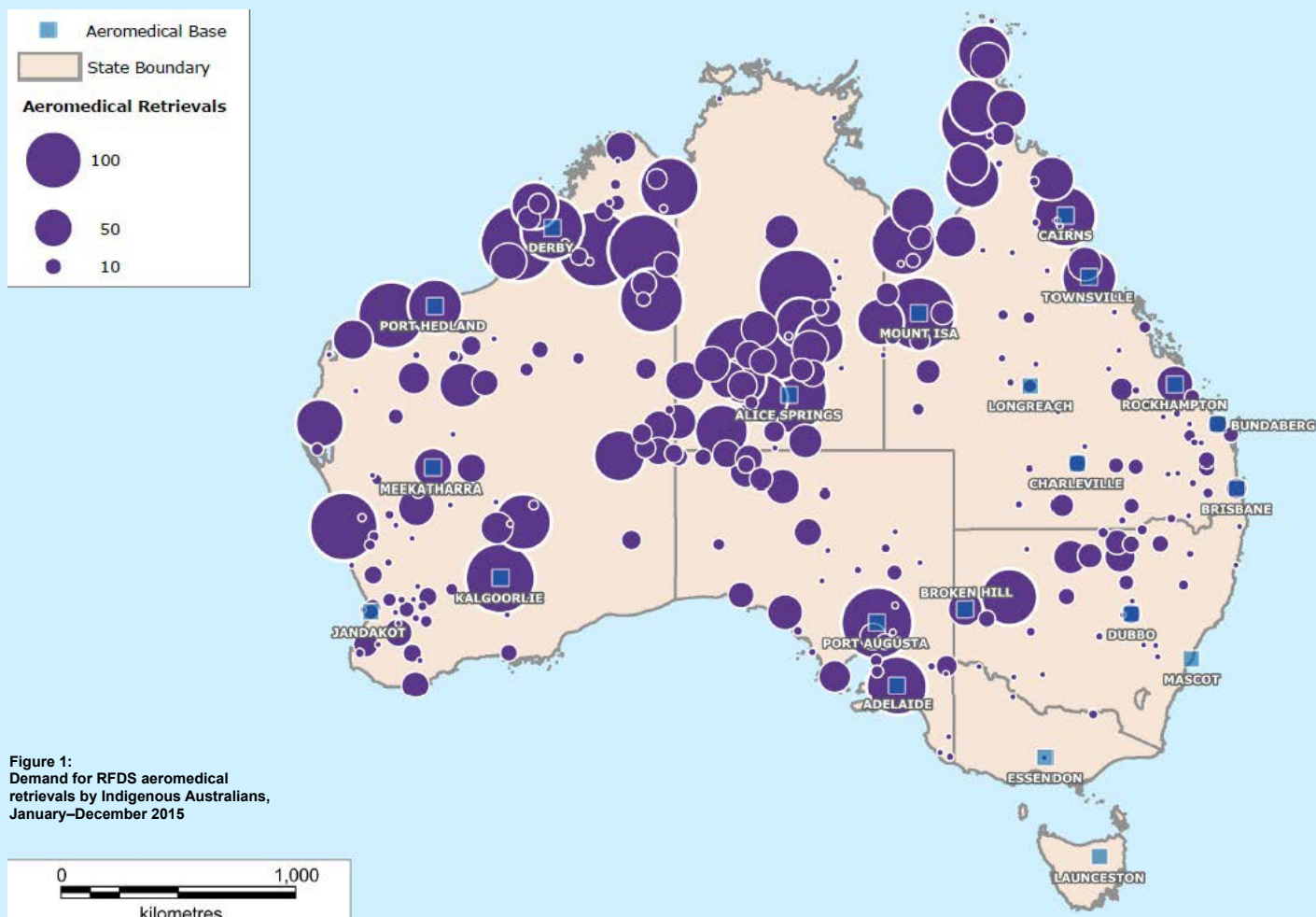


Figure 1:  
Demand for RFDS aeromedical  
retrievals by Indigenous Australians,  
January–December 2015

These top three reasons are each, to a large extent, preventable. In a previous publication, *Responding to Injuries in Remote and Rural Australia*<sup>2</sup>, released in February 2016, the RFDS called for a new National Injury Prevention Strategy that includes rural and remote Australians as well as Indigenous Australians as priority populations, with targeted strategies to reduce the incidence of injury. The high proportion of RFDS aeromedical retrievals for Indigenous Australia for circulatory diseases such as heart attacks, as well as the high proportion of retrievals for children under five for respiratory diseases such as pneumonia, bronchitis and asthma, indicates the ongoing need for investment in culturally appropriate primary healthcare and chronic disease management for Indigenous Australians in remote and rural Australia. <sup>ha</sup>

1. Bishop L, Lavery M & Gale L 2016. Providing aeromedical care to remote Indigenous communities. Canberra: Royal Flying Doctor Service of Australia.

2. Bishop L, Gale L & Lavery M 2016. Responding to injuries in remote and rural Australia. 2016, Canberra: Royal Flying Doctor Service of Australia.

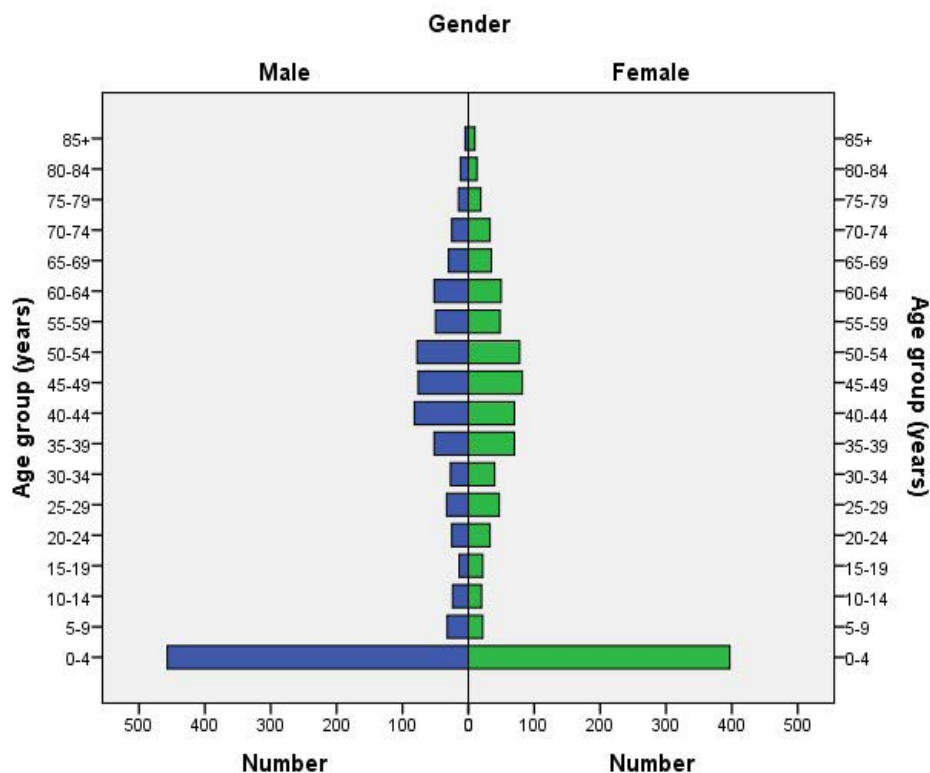


Figure 2:  
Gender of Indigenous patients by age who  
underwent an aeromedical retrieval for diseases of  
the respiratory system, July 2013–December 2015



**KRISTIN MICHAELS**  
CEO, Society of Hospital  
Pharmacists of Australia

# Pharmacy initiatives for Indigenous people

More exceptions than rules.

**A**ccess to pharmacy services remains a challenge for people living in regional and remote areas. Data from the Australian Institute of Health and Welfare (AIHW) illustrates that access to the pharmacy workforce is poor in very remote and outer regional areas, and proximity to a pharmacy is inversely related to a patient's remoteness<sup>1</sup>. For Indigenous people this situation

is exacerbated by higher rates of chronic conditions and multiple comorbidities, resulting in more complex medication needs compared to the general population. This means that clinical pharmacy skills in medicines management

including counselling and patient education, medication reviews and collaboration with the broader healthcare team, are potentially even more valuable.

Positively, initiatives and programs have long been established by the federal government to address the barriers to medicines and pharmacy services for Indigenous populations. The Closing the

**“Positively, initiatives and programs have long been established by the federal government to address the barriers to medicines and pharmacy services for Indigenous populations.”**

Gap (CTG)—Pharmaceutical Benefits Schedule (PBS) Co-payment Measure was established in 2010 to increase access and adherence to medicines for Indigenous patients living with chronic disease, acknowledging that the cost of medicines was a barrier. If eligible, general patients pay the concessional co-payment for PBS prescriptions instead of the general co-payment (\$6.20 vs \$38.30 in 2016),

while concessional patients have the co-payment waived.

This broad-stroke approach, which reduces a significant obstacle to care, is admirable. However, with the benefit of over five years' hindsight, our members tell us it's not what the CTG-PBS Co-

payment Measure does, but the gaps it leaves, that continue to hinder the achievement of its goal:


- Only patients with or at risk of chronic disease in regional, rural or urban areas (not remote) are eligible.
- Excludes medicines listed under the Highly Specialised Drugs Program and other Section 100 programs which

include chemotherapy and kidney disease treatments.

- Hospital pharmacies and hospital medical officers, including specialists, cannot prescribe or dispense CTG prescriptions.
- Only GPs who have selected to participate in the Practice Incentive Program's (PIP) Indigenous Health Incentive can prescribe CTG prescriptions.
- Patients have to 'prove' their CTG eligibility each time, as it is not documented officially with Medicare records.
- If a GP accidentally omits 'CTG' endorsement on a prescription, the pharmacist cannot amend the prescription and it must be returned to the prescriber.

For our members, there appears to be a contradiction between access and eligibility for pharmacy services based on chronic disease, with the exception of many medicines commonly used to treat chronic disease. Incidence of End Stage Kidney Disease is 30 times the non-Indigenous rate in many remote communities. Indigenous Australians aged 45-64 are 13 times as likely as non-Indigenous Australians to have End Stage Kidney Disease<sup>2</sup>. Yet erythropoiesis-stimulating agents such as darbepoetin alfa, routinely used to treat chronic





kidney disease-induced anaemia, is not eligible for the CTG-PBS Co-payment measure, as it is listed in the Section 100 Highly Specialised Drug Program.

Another challenge is the omission of hospital-based prescribers. It is a hindrance for specialists in outpatient clinics, who treat the sickest public patients for serious conditions, that they cannot prescribe medicines under the CTG-PBS Co-payment Measure for them. And it is most burdensome for hospital pharmacists, who are unable to supply medicines a patient needs at discharge under standard hospital operating and care models. These unintentional barriers to achieving better patient outcomes are highly frustrating and contrary to the ethos of the CTG-PBS Co-payment Measure.

The hospital pharmacist, in conjunction with the patient and the patient's carers, is often then responsible for requesting and enabling the discharge medications to be prescribed again by an obliging GP, but this time endorsed as CTG, and then dispensed by a community pharmacist. Organising dose administration aids such as Webster packs are similarly difficult, despite the proven benefit of improved medication adherence they provide. Clinicians are caring and creative individuals, who often go to considerable logistical effort to ensure that patients

receive appropriate care, but with the challenges presented, it is not surprising cracks emerge.

The exclusion of Indigenous patients living in remote areas from the CTG-PBS Co-payment Measure is also perplexing. Theoretically, the pharmacy needs of remote Indigenous patients are instead covered under the Section 100 Remote Area Aboriginal Health Service (RAAHS) program, where patients are able to obtain their medicines at no charge from their Aboriginal Health Service (AHS). However, this program also has exclusions that affect achievement of a quality-use-of-medicines outcome. Importantly, the two different funding models ignore the contemporary reality of many populations. People are mobile. They do not necessarily get sick where they live, so they need to be able to access medicines wherever they are. When they get sick, people living in remote areas are flown into major hospitals in metropolitan centres, often without their medicines or the funds they would need to obtain them.

Hospital pharmacists recognise that an acute episode of care in a major hospital for an Indigenous patient can often present an opportunity to implement a holistic medicines management approach—to identify problems, improve adherence and achieve better patient

outcomes and treatment goals. This opportunity can rarely be taken under the current model.

SHPA members are progressive advocates for clinical excellence, passionate about patient care and committed to evidence-based practice. In our consultations, concerns regarding the access of pharmacy services and medicines for Indigenous people continue to be identified as a priority. We have recommended in our recent submission to the Review of Pharmacy Remuneration and Regulation that the CTG-PBS Co-payment Measure, and the Section 100 RAAHS program, be reviewed so they can better achieve their admirable goals. We will continue to work with our members and any interested parties to improve access to medicines management expertise for those who would benefit from it. [ha](#)

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**ALEX LAKANI**  
Policy Advisor, Australian  
Physiotherapy Association

# Physiotherapy's Close-the-Gap journey

## Australian Physiotherapy Association

**A**t the Australian Physiotherapy Association (APA), we, like many other organisations, envisage a nation where all Australians fully understand and come to terms with the historical injustice inflicted on Aboriginal and Torres Strait Islander people that resulted in dispossession, interruption of culture and intergenerational trauma. We understand the significant and ongoing impact this has had on Indigenous health and wellbeing—it has led to a large ‘gap’ in health and life expectancy between Indigenous and non-Indigenous Australians.

As a peak body, the APA has a responsibility to contribute to discussions on Australia's health, and to lead the profession on social justice and equity issues. Accordingly, the APA is a committed member of the Close the Gap Campaign Steering Committee, and we stand behind the peak Aboriginal organisations that lead the efforts of the committee.

In this short article we outline some of our principles and initiatives that we trust will help to Close the Gap in Aboriginal health and life expectancy.

### Supporting principles

As health professionals we support the following general principles in seeking to

#### Close the Gap:

- Aboriginal community control and self-determination;
- establishing partnerships with peak Aboriginal and Torres Strait Islander organisations;
- being vigilant about the social and emotional wellbeing of Indigenous Australians; and
- carefully considering and taking account of the social determinants of health.

### Reconciliation Action Plan

The APA will launch its second Reconciliation Action Plan in 2017. Development of the

Plan was led by the APA's Aboriginal and Torres Strait Islander Health Committee, and sets out the organisation's strategies and policies for more meaningful engagement with Aboriginal and Torres Strait Islander communities, and with Indigenous health matters.

**“It is not credible to suggest that one of the wealthiest nations in the world cannot solve a health crisis affecting less than 3% of its citizens.” – Dr Tom Calma, AO, Close the Gap Campaign founder.**

### Education, training and networks

We often hear from graduate physiotherapists that they have left university without sufficient education and training on the issues facing Aboriginal and Torres Strait Islander patients. As a result, we are now working with the Deans of Australian and New Zealand physiotherapy schools to integrate

and embed Aboriginal issues education and associated curricula into university physiotherapy courses.

We are also in preliminary discussions with Aboriginal community-controlled health organisations to implement a program of clinical placements for physiotherapy students at various Aboriginal Medical Services (AMSs).

Students will gain valuable experience in working with Aboriginal people, increasing their knowledge of culturally safe practices, and contributing to the development of a culturally safe physiotherapy workforce.

Cultural safety knowledge and work habits are crucial and important to the APA—for





Tiana Pitman (University of Newcastle), and Jessie Thompson (University of Sydney), Australian Physiotherapy Association (APA) Bursary 2016 winners (Young Aboriginal Physiotherapists)

example we ask all APA employees to complete a cultural awareness program as a starting point on their knowledge journey.

We are also working towards a culturally safe workforce so that appropriate patient questions are asked, and data and record management systems are available to collect more accurate data. This has a knock-on effect of reducing service gaps, as well as serving to strengthen our advocacy efforts.

The APA has initiated a bursary program for Aboriginal physiotherapy students to attend our annual conferences—these students will be subsequently invited back


to mentor the next set of students. We want to cultivate long-term relationships with our bursary winners and maintain these relationships through their student and career trajectories.

#### Clinical practice—bronchiectasis

On a clinical level, physiotherapists have achieved very good outcomes with their work on bronchiectasis. There is a high incidence of this condition in Indigenous populations compared with the non-Indigenous population, and Indigenous Australians with bronchiectasis have a significantly shorter life

expectancy than non-Indigenous Australians.

Along with the appropriate prescription of medications, physiotherapy plays a very important role in the management of people with bronchiectasis, and maintaining their quality of life. A toolbox has been developed to share knowledge—particularly for those who work and live in rural and remote areas.

Patients can access the Bronchiectasis Toolbox ([www.bronchiectasis.com.au](http://www.bronchiectasis.com.au)), which among its many resources includes videos setting out how to use prescribed techniques for airways clearance at home. Physiotherapy students can use the Toolbox for revision. 



**KATHERINE THURBER**  
Postdoctoral Fellow  
Australian National University

IN DEPTH

# ‘They’ve got to do something about the supply’

Improving food security is critical to Closing the Gap.

**P**oor diet—including high intake of sugar-sweetened beverages and energy-dense foods, and low intake of fruit and vegetables—is a leading contributor to the burden of disease in Australia, particularly through its association with conditions such as cardiovascular disease and diabetes. Poor diet is also a leading contributor to the gap in health between Aboriginal and Torres Strait Islander (hereafter respectfully referred to as Indigenous) people and non-Indigenous Australians.

Although dietary behaviours are often perceived as individual choices, a broad range of factors can constrain food choice. For example, income and household composition can impact on Indigenous families’ food purchasing:

*... if you have got to feed a couple of kids ... and you have to buy all of this fruit and veg, whereas you can have a couple packages of chips, or takeaway—well, what are you going to do? ... Even though they may know it’s [fruit and veg] really good for them.<sup>1 p.10</sup>*

Food security exists when there are no physical, social, cultural, or environmental barriers to safe, nutritious, and culturally appropriate food. It is well-established that Indigenous Australians disproportionately experience food insecurity compared to non-

Indigenous Australians. This inequity stems from the impacts of colonisation, including displacement and dispossession, the loss of traditional knowledge and food systems, and persisting socioeconomic disadvantage.

Access to healthy foods, such as fruit and vegetables, is an important component of food security. Recent analysis of data from the national Longitudinal Study of Indigenous Children (LSIC) identified that almost one-half of the 1,230 caregivers in the study reported barriers to their children’s fruit and vegetable intake.<sup>1</sup> Overall, around 7% of caregivers reported problems accessing fruit and vegetables, including: that fresh produce was too expensive, not readily available, or of poor quality; transportation issues (e.g. shop too far away, no car); and problems with cooking infrastructure (e.g. no food preparation area or storage).

These accessibility-related barriers were more commonly reported by families living in

remote areas (24% of families) versus urban areas (3% of families). This reflects the high cost, limited availability, and poor quality of fresh food in remote areas. In remote settings, the food environment itself poses a substantial barrier to food security.

These issues were not only faced by families living in remote settings, however. Some families living in urban areas also faced barriers to accessing fruit and vegetables.

Urban families were at increased risk of facing these barriers if they were disadvantaged in terms of financial security, health, housing, and community wellbeing.

Where fruit and vegetables were accessible, available, and affordable, children’s dislike (particularly of vegetables) posed a

substantial barrier—overall, dislike was the most commonly reported barrier to children’s intake of fruit and vegetables (reported by 33% of caregivers). This dislike was understood to be related to the pervasiveness and

**“...in both remote areas and disadvantaged urban settings, the relative affordability and availability of unhealthy options compared to healthy options makes it difficult for many families to make healthy choices.”**





accessibility of unhealthy food options.

Improving underlying determinants of food security such as financial security and housing may improve the ability of Indigenous families to access fruit and vegetables. But regardless of individual or household characteristics such as these, the food environment itself can constrain the ability of caregivers to provide their children with a healthy diet. For example, in both remote areas and disadvantaged urban settings, the relative affordability and availability of unhealthy options compared to healthy options makes it difficult for many families to make healthy choices.

Therefore, it will be critical to improve the food environment in order to improve food security and nutrition—as an Indigenous key informant explained, ‘they’ve got to do something about the supply’.<sup>1 p.11</sup>


Our findings from LSIC are consistent with findings from the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands,<sup>2</sup> where community-led programs and policies contributed to increased availability and affordability of healthy foods—including fruit and vegetables—and some improvement in micronutrient intake. However, despite these improvements, overall diet quality had decreased in the area since 1986. This was

driven by the increased supply and intake of sugar-sweetened beverages and energy-dense foods such as takeaway and convenience meals. Taken together, these findings indicate that even when healthy options are available, affordable, and accessible, other barriers to healthy nutrition remain—particularly the competing availability of unhealthy options.

In summary, in order to improve food security and nutrition among Indigenous Australians, and to help Close the Gap, we will need an approach that combines the following:

1. improving the underlying determinants of food security and nutrition (such as financial and housing security) through culturally-relevant programs; and
2. improving the food environment by increasing the accessibility of healthy foods and decreasing the accessibility of unhealthy foods.

This is of particular priority in remote and disadvantaged urban settings, and will require sustained cross-sectoral action and leadership.<sup>3</sup>

Finally, and most importantly, programs and policies to promote food security and nutrition should be conducted in partnership with, and draw on the strengths of, Indigenous families, communities, and organisations. 

**Katherine Thurber is a Postdoctoral Fellow in the Aboriginal and Torres Strait Islander Health Unit at the National Centre for Epidemiology and Population Health, Australian National University. Her PhD research explored the social determinants of Aboriginal and Torres Strait Islander child health, focusing on nutrition and weight status.**

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**DEBORAH COLE**

Chair of the Australian Healthcare and Hospitals Association (AHHA);  
CEO Dental Health Services Victoria

## BRIEFING

# No data, no gains

**Dr Deborah Cole** explains why more evidence is needed on the oral health of Aboriginal children.

**E**arlier this year I had a heated debate with a radio show host about Aboriginal and Torres Strait Islander patients getting priority access to public dental care. He claimed it was unfair, that it was giving Aboriginal people a helping hand while other low-income Australians suffered. While he was seeking to create controversy, it was clear he just didn't get it. After I ended the interview I thought about all the things I should have said to demonstrate the importance of providing priority access to one of our most vulnerable population groups. While we know Aboriginal people suffer from poorer oral health, priority access is only one piece of the puzzle to targeting improvements within this community. More research is needed to allow us to explore all the issues involved and roll out appropriate interventions, particularly when looking at the oral health of Aboriginal children.

So what do we know? Despite being largely preventable, dental caries are more common and widespread in Aboriginal children compared to non-Aboriginal children in Australia. That means Aboriginal children experience higher rates and severity of dental caries, periodontal disease and tooth loss. These higher rates of dental disease are compounded by an increased level of untreated oral disease due to a reluctance to access oral health services. Aboriginal clients often wait until they are in pain before seeking dental care, and by then their dental

issues are too advanced to adopt a preventive approach.

The impact of poor oral health for Aboriginal children goes well beyond the state of their teeth. Poor oral health can negatively impact speech, development and learning, sleeping patterns, self-esteem as well as psychological and social wellbeing. Poor oral health in childhood also tracks into adulthood with lifelong implications.

Both at the national and state level, Aboriginal communities have been highlighted as a priority

population group for accessing public oral health services and targeting improvements in oral health and justly so. However limited information on the oral health status of Aboriginal children makes it difficult to guide appropriate policy development and improvements in oral health outcomes. That's why a key

action of the National Oral Health Plan is to improve the collection and quality of oral health information relating to the Aboriginal population through regular standardised collection and dissemination of data.

**“The impact of poor oral health for Aboriginal children goes well beyond the state of their teeth. Poor oral health can negatively impact speech, development and learning, sleeping patterns, self-esteem as well as psychological and social wellbeing.”**


The *Flying Blind: trying to find solutions to Indigenous oral health* review examined the published evidence in Australia relating to the oral health of Aboriginal children and determined trends in Aboriginal oral health over time. The review identified studies reporting data from the Northern Territory (14), Western Australia (7), South Australia (7), Queensland (7), New South Wales (1), Australian Capital Territory (1) and Tasmania (1). Of significant interest was the absence of any oral health data for Aboriginal children

living in Victoria. This is a significant gap, as 2011 Census data estimates indicate that more than 47,000 Aboriginal and Torres Strait Islander people are living in Victoria.

The review also found that there are limited data in general on the oral health of Aboriginal children throughout Australia. While risk factors for oral disease are well


known, most of the studies did not analyse the link between these factors and oral disease. There was also inconsistency between studies in relation to how caries was reported in terms of age and caries criteria.





Of the studies reviewed, 47% were in rural locations, 9% in urban and 44% in both rural and urban locations. It is known that approximately 670,000 Aboriginal people reside throughout Australia with many living in metropolitan locations. Despite this, most studies reported the oral health of Aboriginal children living in rural and remote locations. This means that the available data cannot be relied on to inform the development of policies and programs to address the oral health differences in Aboriginal populations living in metropolitan areas.

As recommended by the review, we need more data on Aboriginal children living in metropolitan and regional areas of Australia with consistency in the reporting of caries data with regard to age, study location and fluoridation status. We also need more studies examining oral health inequities that include risk factor analysis, along with studies that go further than simply describing oral disease and undertake a more sophisticated exploration of the issues involved and possible solutions.

If we want to make meaningful improvements to the oral health of Aboriginal children, we need more varied and robust evidence to inform future activities. As healthcare workers and advocates, it's up to us for search for better evidence and a greater understanding of the challenges and solutions faced by Aboriginal communities. Priority access is only one piece of the puzzle, albeit an essential one. 

# Learning from Intensive Eye Surgery Weeks

The Fred Hollows Foundation is working with partners to encourage the participation of Aboriginal and Torres Strait Islander Australians.

The Fred Hollows Foundation continues the work of health advocate and human rights campaigner, Professor Fred Hollows to end avoidable blindness and improve the health of Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander Australians are three times as likely to go blind as other Australians—however, 90% of vision loss is preventable or treatable.

The Foundation's key eye disease priorities are cataract, diabetic retinopathy, trachoma and refractive error.

Currently, cataract is the leading cause of blindness and is 12 times as common among Aboriginal and Torres Strait Islander adults. While it is treatable with simple surgery, Aboriginal and Torres Strait Islander people are more likely to wait longer for cataract surgery than other Australians, and almost 40% of those who need cataract surgery have not accessed services.

To reduce this disparity the Foundation has supported partners to deliver Intensive

Eye Surgery Weeks (IESWs) in the Katherine, Darwin, Central Australia and Barkly, Western New South Wales and Cape York regions. While the surgery weeks use different models, they each aim to reduce significant backlogs in both outpatient and surgery waitlists, providing improved access to much-needed ophthalmology services.

IESWs have been supported since 2007, with the Foundation's involvement helping to reduce waiting times for patients by removing some of the barriers to accessing eye care services for Aboriginal and Torres Strait Islander people. As part of the IESWs, Regional Eye Health Coordinators and Aboriginal and/or Torres Strait Islander Liaison Officers are engaged and provide vital coordination and liaison points within the

health system to support individual patients with travel and accommodation management, ongoing patient support, and problem-solving. These positions have improved coordination, cultural appropriateness and flexibility along various patient pathways, while also increasing patient numbers and reducing 'did not attend' rates.

Experience with IESWs has enabled the Foundation to reflect on the key components required for a comprehensive model of eye care that is seamless and works for patients.

It is this comprehensive model

of eye care that the Foundation continues to aspire towards, which encompasses a patient journey that is fully integrated and entirely patient-centred, while facilitating the right care at the right time by the right team and

**“Currently, cataract is the leading cause of blindness and is 12 times as common among Aboriginal and Torres Strait Islander adults.”**





in the right place. Taking this comprehensive approach also allows eye care services to be fully integrated across all levels of eye care—primary eye care, secondary or visiting eye care services, and tertiary levels (including surgery).

While the IESWs were originally conceived as a short-term measure to reduce unacceptable waiting periods for patients, they continue to have their place in reducing some of the barriers to accessing eye care for Aboriginal and Torres Strait Islander people. IESWs have also provided an evidence base for showing what works to improve eye care services for Aboriginal and Torres Strait Islander Australians—good coordination, culturally appropriate support, and flexibility.

With the Foundation's long-term approach to health systems strengthening in Australia, lessons learnt from IESWs should be adopted wherever possible into standard practice to ensure a more holistic approach to eye care that works for Aboriginal and Torres Strait Islander Australians. **ha**

## CASE STUDY

Alex Dennis, a musician and former Australian boxing champion, noticed his vision becoming cloudy and blurry. He was diagnosed with blinding cataracts through the Outback Eye Service, and was forced to give up work and hang up his boxing gloves

Within a short space of time he had gone from living a full and independent life to completely relying on his wife Daphne and children to get around.

'First one eye went cloudy and then the other—it got so bad my wife had to lead me around everywhere, I couldn't see.'

Alex had his sight restored with simple cataract surgery during an Intensive Eye Surgery Week in the rural town of Bourke in NSW. He said having his sight back has turned his life around, and described it as a 'pure miracle'.

'When I lost my bit of sight it affected my boxing training with my mates and my friends, and it affected my music. I couldn't focus or set up anything. I couldn't drive. I couldn't cook, which is terrible because I like cooking and well everything, general in life—it changed my life, very hard.'

'Now I can see my beautiful wife again. I can see the green grass.'

Alex was one of 30 patients to receive operations carried out by the Outback Eye Service, with the support of the Fred Hollows Foundation and the federal and New South Wales governments.



**KATE WALES**  
Northern Territory PHN

## BRIEFING

# A step in the right direction

Improving foot health in remote communities in the Northern Territory.

**A**roving podiatrist is improving foot health in Indigenous communities in Central Australia by delivering podiatry and foot-care education services.

For 26 weeks a year, podiatrist Sara Coombes, and her husband and podiatry assistant Tim, tour 14 Central Australian communities treating foot ailments associated with chronic disease. By providing foot care and education, Sara and Tim are reducing the risk of infection, complications and amputation among Indigenous patients in remote communities.

Since 2014, the number of remote Indigenous patients receiving treatment from Sara has grown by 167%<sup>1</sup>. Furthermore, since her first community visits in 2009, Sara estimates the number of people with diabetes that have achieved at least one foot check per year has increased from 10-15% in most communities she visited to between 70% and 90% in each of those communities.

Through frequent and targeted treatment for diabetic patients, Sara and Tim are taking a preventative approach to minimise the risk of infection and amputation from diabetic foot.

‘Prevention is the only way we are going to reduce the amputation rate, so preventative treatment needs to start early and be repetitive to prevent damage rather than treat it. We engage patients in their own foot care and use preventative methods to reduce

the risk of getting complications in their feet’, Sara said.

Sara and Tim educate their patients on simple foot care to support their efforts to reduce amputations. They conduct one-on-one demonstrations and discussions on scrubbing feet, removing cracked and dry skin, the importance of footwear and cutting nails.

‘Simple foot care is one of the major reasons that diabetic patients don’t end up with amputations. Even when they have really poor circulation, if you can keep the skin intact, you can keep the foot healthy’, said Sara.

But even simple foot care can be challenging in some remote areas where patients have limited access to quality footwear. A lack of high-quality shoes that can be fitted with orthotics has led Sara to develop what she calls ‘Thongthotics’. By hand-cutting and sticking layers of felt onto a patient’s thongs, Sara alleviates pressure to treat or prevent foot ulcers, sore heels, aching tendons and more.

Sara relies on her relationships within each community to engage patients and share knowledge with local health service

providers. While the arrival of Sara and Tim’s caravan acts as a visual cue for most patients to visit the podiatrist team, Tim actively seeks others out to encourage them to visit the clinic. This personalised and targeted approach has helped to build rapport with each patient and trust within the community.

‘In one community, I’ve seen two young girls who have gone from being very nervous to see me to now being the first ones in when the clinic opens. They’ve started managing

their own toenails, are doing really well with their feet and now bring older community members to receive treatment too’, Sara said.

The visible sharing of information and increased community engagement also stems from Sara’s passion for sharing knowledge with local

health professionals. During each community visit, she tries to teach local health service providers one key piece of information surrounding foot health. From trimming toenails, to learning which dressings are best suited to foot wounds, improving and maintaining foot health has become daily practice for health practitioners and patients alike. Local nurses provide an essential role

**“For 26 weeks a year, podiatrist Sara Coombes, and her husband and podiatry assistant Tim, tour 14 Central Australian communities treating foot ailments associated with chronic disease.”**



Sara spends 26 weeks a year providing podiatry services to 14 Central Australian communities.

Sara builds 'Thongthotics' by sticking layers of felt to a patient's thongs.

Track between Kantore and Nyirripi:  
Sara and Tom travel to 14 Central Australian communities to provide foot care to patients with chronic conditions.

Sara's caravan acts as a visual cue for patients to visit the clinic to receive foot care.



by maintaining a patient's feet in between Sara's visits to minimise complications, and provide dressings and debridement for wounds and ulcers.

Sara explained, 'I had a desire for a long time to do something in Indigenous health. I love it, I love the people and find it really rewarding. It's just so nice to see things changing—albeit only slowly. My clients all tell me about keeping skin healthy and intact now, as opposed to asking why we were washing their feet in the initial visits. And yes, that has taken nearly 7 years, but that's a great outcome'.

Sara is funded under Northern Territory Primary Health Network's Medical Outreach Indigenous Chronic Disease Program. Under the program, she and other allied health professionals—including an exercise physiologist, physiotherapist, dietitian, speech pathologist and occupational therapist—provide remote outreach services to over 80 Indigenous communities across the Northern Territory. Together, they're working to prevent, detect, treat and manage chronic conditions among Indigenous Australians. **ha**



For more information on the Medical Outreach Indigenous Chronic Disease Program, visit [ntphn.org.au/our-programs](http://ntphn.org.au/our-programs).

1. NT PHN Outreach Services Visit Activity Report.





The Aboriginal Health Unit team at St Vincent's Hospital, Melbourne: (L to R) Toni Mason, Sye Hodgman, Sonya Parsons, Kendra Keleher, Fay Halatanu.

**E**mployment parity for Aboriginal and Torres Strait Islander health professionals no longer feels like a pipe dream for Sye Hodgman.

When he first discussed employment parity with Susan O'Neill, CEO of St Vincent's Hospital Melbourne, Susan immediately suggested setting executive-level Key Performance Indicators (KPIs) at the hospital for employment of, and projects for, Aboriginal and Torres Strait Islander health professionals, and for completion of cultural safety training.

'At St Vincent's, the commitment to Closing the Gap is very real—this is just one aspect of it', Sye says.

'Setting KPIs means that the executive is now accountable for driving strategies to meet the KPIs. This has not been done, as far as I'm aware, at any health service in Victoria.'

A registered nurse and member of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Sye is the HR and Indigenous Program Specialist at St Vincent's.

The hospital initially set a 1% Indigenous

employment target, which has seen its employment of Indigenous staff increase from 17 to 29 in the past 18 months.

The hospital also established a new Aboriginal Health Unit. The unit oversees cultural safety training and a range of education, training and employment initiatives for Indigenous workers, while providing consultation and guidance, and contributing to strategic directions, partnerships, policy implementation and research.

St Vincent's is also leading the way in creating a range of Aboriginal-specific positions, such as the Aboriginal Health Unit Manager and the unique role of Aboriginal Health Care Coordinator.

Attracting and retaining more Indigenous

health professionals is pivotal to delivering better health outcomes for Indigenous peoples.

**"My advice for organisations is to become accountable for the change you would like to see. If you are genuinely committed to Aboriginal health and Aboriginal employment, report on it and make sure it's accountable at an executive level."**

As the peak body for Aboriginal and Torres Strait Islander nurses and midwives, CATSINaM and its members are working on a range of pioneering initiatives across the nation, championing an increase in the targeted recruitment and retention of Aboriginal and Torres Strait Islander people in the health workforce.

At the Department of Health in Western Australia, CATSINaM member Melanie Robinson is working with colleagues to increase the level of Aboriginal and Torres Strait Islander employment at the Department from 1.3% to 3.2% by 2024.



# Championing targeted recruitment

How **CATSINaM** and its members are Closing the Gap within health services.

As a Senior Development Officer in the Aboriginal Health Policy Directorate, Melanie works to manage and strategically increase the Indigenous workforce through initiatives such as traineeships, cadetships and graduate programs.

Melanie helped develop an Aboriginal Workforce Strategy, and a career pathways booklet for school students to shine the spotlight on the wide range of pathways and job opportunities available to Indigenous youth in the health sector.

A registered nurse who practised for 16 years, Melanie mentors jobseekers and health workers and is passionate about creating culturally safe recruitment and employment for Indigenous peoples.

Melanie says health services don't need a big budget to deliver change in their workforce.

'I think it's about getting your executive on board and don't give up', she says.

'You just need the will and a few champions and you can really make a difference to your system.'

With cultural safety pivotal to increasing the

recruitment and retention of Indigenous health professionals, CATSINaM is working with the Australian Nursing and Midwifery Accreditation Council (ANMAC), the Nursing and Midwifery Board of Australia (NMBA) and universities to embed cultural safety and culturally safe practices across nurse and midwife training, education, development, accreditation and practice standards.

Janine Mohamed, CEO of CATSINaM, says it is paramount that health services commit to lifelong cultural safety education for staff to develop culturally safe and respectful health systems.

'We're also calling on Australian governments to embed cultural safety training in health practitioner legislation, which New Zealand has already achieved', she says.

'It's crucial to the recruitment and retention of our membership. Plus we know that Aboriginal and Torres Strait Islander people do not access services commensurate with need—they don't access services because they have poor experiences with services.'

Ms Mohamed says a systems approach is vital.

'We need cultural safety and respect within legislation, within our hospitals' accreditation schemes, and we need the people assessing those hospitals to understand cultural safety.'

For Sye, his role as one of three HR and Indigenous Program Specialists across St Vincent's Health Australia (SVHA) is to support and coordinate employment of Indigenous Australians. He also assists with pre-employment training and mentoring for Indigenous job-seekers.

In its work to Close the Gap, SVHA has now unveiled a new target designed to achieve 3% Aboriginal and Torres Strait Islander employment by 2020.

'My advice for organisations is to become accountable for the change you would like to see. If you are genuinely committed to Aboriginal health and Aboriginal employment, report on it and make sure it's accountable at an executive level', Sye says.

'Parity has always been my end goal. Only once our staff population represents our patient population, can we ever have effective service delivery.' **ha**

# Privacy and the Australian healthcare sector

A general discussion.

**P**rivacy obligations vary between state and federal levels and produce complex situations. This article discusses the Commonwealth and state systems broadly, and does not apply to the collection and use of health data by medical researchers.

## Applicable laws

Federal and state legislation now governs Australia's privacy laws, in addition to common law and ethical principles<sup>1</sup>. The federal act is the *Privacy Act 1988*<sup>2</sup>. This legislation established the Office of the Information Commissioner and contains the Australian Privacy Principles<sup>3</sup>. Interested health sector members must also understand the state laws and frameworks, as these are unique in each state and can vary requirements.

## What information is protected and what organisations are bound?

Generally, health services and information includes any information regarding a person's health or disability, any information regarding diagnosis or treatment and any information regarding assessing, recording, maintaining or improving a person's health<sup>4</sup>.

Any organisations delivering these services

must comply, which extends the reach of the law beyond hospitals and medical practitioners to other health services such as gyms, dietitians and even weight loss clinics<sup>5</sup>.

## What situations can justify disclosure?

Generally, you can only use private information for the primary purpose that it was provided and collected for; however private healthcare information can be disclosed in limited situations including where<sup>6</sup>:

1. Consent has been provided.
2. Under Court Orders, law and through some government agencies.
3. Health or safety is being threatened and the person is incapacitated or unable to provide consent<sup>7</sup>.
4. Preventing serious threats or harm to the public<sup>8</sup>.
5. Disclosure to persons responsible for an individual in limited circumstances<sup>9</sup>.

Generally, privacy laws are only applicable when living, therefore they cease to apply

after death<sup>10</sup>. However, this varies between the states, and privacy laws can continue to apply to deceased individuals in limited circumstances<sup>11</sup>.

## Children and age of consent

The federal scheme does not dictate an

age where children can make decisions regarding procedures and private information.

The legislation focuses on the maturity, understanding and capacity of the child to understand the event, its nature and effect<sup>12</sup>.

Legislative guides suggest

that children should be allowed to make decisions if capable of doing so, while their views should be considered even if they are not deemed to have capacity<sup>13</sup>. It is important to assess each case on an individual basis.

## Access to medical records

Federal and state legislation governs access to medical records. Public sector healthcare providers must provide individuals access to their records, subject to specific exemptions under the *Freedom of Information Act 1982*,

**“Generally, privacy laws are only applicable when living, therefore they cease to apply after death.”**





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which includes and is not limited to public interest exemptions, personal information, government and defence documents, business information and trade secrets<sup>14</sup>.

Private sector health providers must provide access to patients who request information, subject to several specific exemptions including threats to the health or life of an individual<sup>15</sup>.

### Power of attorney and guardianship

Individuals can manage another's health information in instances where they are a parent, guardian or power of attorney<sup>16</sup>. Different types exist<sup>17</sup>. Generally, only an enduring or medical ensuring power of attorney will suffice to gain access to health and medical records, however this can vary between states<sup>18</sup>. When dealing with a guardian or power of attorney, take note of the type of document and ensure it is valid. **ha**

You can contact AMK Law for further information at [admin@amklaw.com.au](mailto:admin@amklaw.com.au) or visit [www.amklaw.com.au](http://www.amklaw.com.au)

The material contained in this publication

**is of a general nature only and it is not, nor is intended to be, legal advice. This publication is based on the law as it was prior to the date of your reading of it. If you wish to take any action based on the content of this publication, we recommend that you seek professional legal advice. Liability limited by a scheme approved under Professional Standards Legislation.**

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# Fairer super for all

HESTA

**With almost 30 years of experience and \$36 billion in assets, more people in health and community services choose HESTA for their super.**

**T**he vast majority of the 820,000 HESTA members are women working in health and community services, where the gender pay gap is 27.7%, according to figures from the Workplace Gender Equality Agency. We want to close this gap. And here are some of the things we've done, and are doing, to help do so.

In 2016, HESTA made a submission to the Senate inquiry addressing women's super inadequacies. It stressed that the wage gap between men and women remains the biggest factor in women retiring with less than men.

Three important recommendations underpinned our submission.

## **Remove the \$450 monthly super threshold**

The successful introduction of SuperStream,

which simplifies and removes the admin burden on businesses, means employers can now make contributions more easily. With the removal of that barrier, all employees should be eligible for guaranteed super contributions, including those who earn less than \$450 a month.

This is particularly vital for nurses or other people in care-giving professions, who may work shifts with multiple employers earning less than \$450 a month through each employer.

## **The low income super contribution**

Our campaign pressuring the government to abolish plans to discontinue the low income superannuation contribution (LISC) was effective. When it runs out in 2017, the LISC will be replaced by a new Low





Income Superannuation Tax Offset (LISTO). Continuing this equity measure is a welcome step.

The LISTO will provide a much-needed boost to the savings of about 3 million low paid workers, around 2 million of which are women. Without it, this group would have paid the same, or in some cases, a higher tax rate on their super contributions than they pay on their wages.

### Value unpaid caring roles

We think Australia can learn from the many overseas examples where unpaid caring roles are recognised and remunerated. Many European and South American countries have systems that ensure women receive a pension voucher or benefit for time taken off work to raise children or care for the elderly. HESTA's submission to the inquiry points to

the success of Chile and we believe a similar system could be adopted here in Australia.

These recommendations would help ensure all Australians can afford a dignified retirement.

But the gender gap is not the only one we're trying to close.

We're the first ever industry super fund to kick start a plan to make a tangible impact on reconciliation with Aboriginal and Torres Strait Islander peoples and organisations.

You can read more here: [hesta.com.au/RAP](https://hesta.com.au/RAP)

And through our Financial Inclusion Action Plan we're playing a critical role in Australia's future by improving financial resilience with education and support, for large numbers of people experiencing financial exclusion and hardship. Read more at [hesta.com.au/FIAP](https://hesta.com.au/FIAP) 

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**HESTA**



# Become an AHHA member

Help make a difference to health policy, share innovative ideas and get support on issues that matter to you – **join the AHHA.**

**T**he 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

policy makers, 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](http://www.ahha.asn.au)



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# 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 2015-2016 Board is:

**Dr Michael Brydon**

Sydney Children's Hospital Network

**Dr Paul Burgess**

NT Health

**Mr Jeff Cheverton**

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**Dr Deborah Cole**

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**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](http://ahha.asn.au/governance)

## Secretariat

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Chief Executive

**Mr Murray Mansell**

Chief Operating Officer

**Dr Linc Thurecht**

Research Director

**Mr Krister Partel**

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## 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:

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- HESTA Super Fund
- Good Health Care

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

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**Everyone deserves  
the right to  
A HEALTHY  
FUTURE**

Photo: Jason Malouin/ Oxfam AUS

# **CLOSE THE GAP**

A healthy future means the freedom for all Australians to take full advantage of life's opportunities — no matter where they are from. It means kids being healthy enough to go to school with their friends. It means being able to enjoy a fulfilling life. And it means being able to watch your grandkids grow up.

Many Australians are being denied these opportunities. On average, Aboriginal and Torres Strait Islander people live 10–17 years less than other Australians.

It doesn't need to be this way. Join us on for National Close the Gap Day to stand up for health equality for all Australians.

**16 March 2017**

**Register your event now at  
[oxfam.org.au/closethegapday](http://oxfam.org.au/closethegapday)**