



The Health Advocate

Your voice in healthcare

Close the Gap
10-year review

Why ACCHSs
are needed

The Yeddung Gauar
(Good Heart) Project

The Lower
Gulf Strategy

CLOSE THE GAP

**+MORE
INSIDE**

The official magazine of the
Australian Healthcare and Hospitals Association

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Vindhya Mendis,
HESTA member

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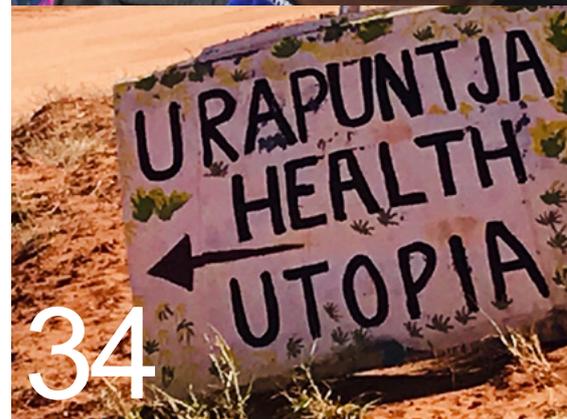
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DEBORAH COLE
Board Chair, Australian
Healthcare and Hospitals
Association (AHHA)

Increasing Aboriginal employment requires a tailored and compassionate approach

A 'one size fits all' strategy doesn't work. We need to invest in individuals and remove the barriers to success.

As healthcare professionals, we are passionate about improving the health of Aboriginal Australians by making our hospitals and clinics a welcoming space. A key part of this is the presence of Aboriginal staff. We know that increasing Aboriginal employment in the health sector is important because an Aboriginal workforce will deliver better outcomes for Aboriginal patients, greater workforce diversity brings improved organisational capability, Aboriginal staff can offer innovative solutions that help colleagues and be of benefit to all patients. Recruiting Aboriginal staff is not as simple as advertising a vacancy. It requires clear leadership, a strong emphasis on why Aboriginal staff are needed, understanding, tenacity, empathy, flexibility and a genuine, long term commitment.

We also know that Aboriginal people have much lower employment rates compared to other Australians. This is due to a variety of complex factors including different levels of access to education, training and employment opportunities, as well as interpersonal and institutional racism. Attracting Aboriginal people to work in healthcare

settings requires a multi-faceted and nimble approach. We need to partner with community representatives, support the education of Aboriginal Australians, create new employment opportunities, and remove barriers to success by focusing on individual circumstances and addressing interpersonal and institutional racism.

As CEO of Dental Health Services Victoria (DHSV), I am incredibly proud of the work we have done to increase Aboriginal employment in the oral health sector. Through our Aboriginal Employment Plan and traineeships, we have empowered people with an interest in healthcare to pursue a fulfilling career. We have exceeded our Aboriginal employment target with 13 staff enrolled in traineeships. Two of these trainees commenced a Bachelor of Dentistry, becoming the first Indigenous male and female students to be accepted in this degree at La Trobe University, one of whom graduated at the end of 2018. Our focus on Aboriginal employment is one of the major factors contributing to a 37% increase in Aboriginal people accessing public dental care between 2013-14 and 2017-18.

We haven't always gotten it right but here are the key lessons we've learned along the way.

“Through our Aboriginal Employment Plan and traineeships, we have empowered people with an interest in healthcare to pursue a fulfilling career.”

Increasing the Aboriginal workforce has to be an organisational priority

The DHSV Board and Executive Team made growth of our Aboriginal workforce a key strategic priority, incorporating it into our five-year Strategic Plan.

Our Aboriginal Employment Plan focuses on continuing to exceed the 1% employment target and ensuring that all staff are invested in the outcomes.

Aboriginal people must be involved in designing the recruitment strategy

When it comes to Aboriginal employment, we need genuine engagement and a genuine sharing of power with a strong focus on doing things with Aboriginal Australians rather than to them. Community representatives need to be involved from day dot helping to craft a culturally appropriate recruitment strategy. The strategy also needs a long-term approach as some initiatives will require a 10-year commitment.

Ongoing, tailored support makes a difference

Students can come from very different backgrounds and have very different journeys. For example, some parents instil the importance of education from a young age, some not so much—which can make a difference to motivation and ability to ‘stick it out’ when courses get difficult.

Some have a comfortable and stable family background, while others experience extreme disadvantage and financial stress, coupled with the need to care for other family members, to the point where coursework and study seem overwhelming.

When we see such signs of difficulty, our approach

is to step in and ask ‘How can we help?’ Sometimes students are reluctant to share what is going on in their lives, but equally we are determined to offer any needed help—whether financial, emotional or academic—to keep them on track to achieving their educational and employment goals. We are invested in our students’ success and will always provide ongoing support tailored to their individual needs and circumstances.

You need to proactively remove the barriers to success

Aboriginal job seekers face many barriers in securing employment—our job is to find out what they are for each individual and take action. For example, a lack of funds can act as a major deterrent for first year dentistry students, with a dental kit and glasses costing upwards of \$5,000. We have been able to provide targeted support for Aboriginal dental students by providing a dental kit, an iPad and academic support with a tutor when needed. Whenever we can, we take swift action to smash the boulders blocking the path to graduation and employment.

DHSV is by no means a perfect organisation when it comes to Aboriginal education and employment, but it is something we are genuinely passionate about and determined to get right. I hope all of us across the health sector continue to expand our Aboriginal employment initiatives so Aboriginal people interested in a career in health get the opportunity to care for their communities. This will build our skilled workforce, help us better care for our Indigenous patients and develop the next generation of healthcare leaders. ■



ALISON VERHOEVEN
Chief Executive
AHHA

2019—a time to ‘refresh’

REFRESH NO. 1 COAG Closing the Gap Strategy

It is over 10 years since the Council of Australian Governments (COAG) Closing the Gap Strategy was developed following the signing of the Closing the Gap Statement of Intent in March 2008.

Last year the Australian Human Rights Commission opined that it was time to ‘critically reflect on why Australian governments have not yet succeeded in closing the health gap to date, and why they will not succeed by 2030 if the current course continues’. A 10-year review was conducted, and we have featured its major findings and recommendations in this issue of *The Health Advocate*.

At the heart of the Review’s assessment of what went wrong was a lack of focus on the social determinants of health inequality (income, education, racism) which they felt needed to be ‘addressed at a fundamental level’. At the beginning these were central, the Commission says, to both the Closing the Gap approach and the original statement of intent.

Earlier, in December 2016, COAG agreed to refresh the Closing the Gap agenda ahead of the 10th anniversary. In June 2017 they further agreed to a ‘strengths-based approach’ and ensuring that Aboriginal and Torres Strait Islander peoples were ‘at the heart of the development and

implementation of the next phase of Closing the Gap’.

Next followed many roundtables, workshops and similar consultation sessions around the country. After these were concluded in 2018 there was some nervousness among 13 Aboriginal and Torres Strait Islander peak bodies, notably NACCHO (National Aboriginal Community Controlled Health Organisation), that proposals and targets were going to be put to COAG at its 12 December 2018 meeting with Aboriginal and Torres Strait Islander groups not knowing if their views were reflected in the proposals or if they were to be true partners in subsequent target-setting and implementation.

On 20 November 2018 we publicly supported NACCHO in urging the Commonwealth to confirm that Aboriginal and Torres Strait Islander peoples needed to be involved as partners at the heart of the Closing the Gap strategy.

On 12 December COAG issued a ‘draft framework for Closing the Gap as a basis for further discussion with Aboriginal and Torres Strait Islanders communities’. COAG also issued the following statements in its meeting communique:

‘COAG is listening to Aboriginal and Torres Strait Islander peoples, communities and their peak and governing bodies. Leaders are committed to ensuring that the finalisation of targets and implementation of the Closing the Gap framework

“On 12 December COAG issued a ‘draft framework for Closing the Gap as a basis for further discussion with Aboriginal and Torres Strait Islanders communities’.”

occurs through a genuine, formal partnership between the Commonwealth, state and territory governments and Indigenous Australians through their representatives.

‘This formal partnership must be based on mutual respect between parties and an acceptance that direct engagement and negotiation is the preferred pathway to productive and effective outcomes. Aboriginal and Torres Strait Islander peoples must play an integral part in the making of the decisions that affect their lives—this is critical to closing the gap.

REFRESH NO. 2

The Health Advocate

Welcome to the first—refreshed—issue of *The Health Advocate* for 2019. You will see that our long-running bi-monthly magazine has undergone some changes to optimise it for our digital publishing platform.

The changes will enable more interactivity, embedding of video and sound clips, and a better online reading experience—via the AHHA website, or on your tablet or phone using the issuu app.

A useful feature of the app is that you can ‘clip’ your favourite pages from the magazine and on-forward those pages to your colleagues.

AHHA POSITION STATEMENT AND RAP

Position Statement Aboriginal and Torres Strait Islander Health sets out our commitment to sustained comprehensive action to reduce inequities in outcomes.

We acknowledge that risk factors and the social determinants of health account for over half of the difference in health outcomes, and hold that racism and intergenerational trauma also have a significant impact on disease levels and care outcomes.

Culturally safe health services are essential, and we concur with the National Aboriginal Community Controlled Health Organisation (NACCHO) (see article elsewhere in this publication) that Aboriginal Community Controlled Health Organisations (ACCHOs) have an integral role, together with culturally safe mainstream services.

The *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* needs to be funded and implemented, along with increasing the size of the Aboriginal and Torres Strait Islander health workforce.

Closer to home, our Reconciliation Action Plan sets out the positive actions that we are undertaking to support Aboriginal and Torres Strait Islander peoples through health public policy. 

AHHA in the news

13 JANUARY 2019

We need a national primary healthcare data set

A new year should bring new efforts to properly establish a national primary healthcare dataset, according to the Australian Healthcare and Hospitals Association (AHHA).

‘The Commonwealth Government and individuals invest considerable sums of money every year in primary healthcare—typically GPs and Aboriginal Medical Services’, says AHHA Chief Executive Alison Verhoeven.

‘But, to date, no comprehensive ongoing national data set exists that can give insights into why people use and access primary healthcare services, what occurs in individual consultations, and the outcomes of those services.’

The AHHA has released an Issues Brief, *Call for the establishment of a primary health care national minimum data set*, by Maddy Thorpe and Sharon Sweeney (Brisbane South Primary Health Network). The work was undertaken as part of the Jeff Cheverton Memorial Scholarship hosted by the Deeble Institute for Health Policy Research at AHHA.

‘What is needed is what is called a National Minimum Dataset (NMDS)—that is, a set of data items, using the same definitions, that every General Practice in every state and territory commits to collecting as a minimum.’

‘We think the primary healthcare NMDS needs to include standardised data on:

- Provider demographics—to help workforce planning
- Patient demographics

- Patient health status and health-related behaviours
- Patient encounters—to understand why people are using GPs and other primary healthcare providers
- Health outcomes—to evaluate how efficient and effective services are.

‘Fortuitously a national mechanism has been recently set up to lead national primary healthcare data development—the National Primary Health Care Data Unit at the independent statutory agency, the Australian Institute of Health and Welfare (AIHW).

‘Accordingly, we call on the Australian Government to capitalise on this initiative and back the AIHW to the greatest extent possible to lead the development of a Primary Health Care National Minimum Data Set.

‘In so doing the Institute will need to be crystal clear on why the data are being collected and be mindful of the practicalities associated with collection of the data, the need for workforce development and training, the need to address consumer issues, and the need to assure privacy and security of the data.

‘There is also a strong need for alignment with other national data sets in health through a national data governance framework’, Ms Verhoeven said.

The *Call for the establishment of a primary health care national minimum data set* Issues Brief is available on the AHHA website at www.ahha.asn.au. 

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

5 DECEMBER 2018

Medical training, 4-hour rule in emergency, endometriosis, aggression in nursing homes covered in recent AHHA-published research

Medical training, emergency department transit times, endometriosis and aggression in nursing homes are among the topics investigated in the December 2018 edition of the Australian Healthcare and Hospitals Association's peer-reviewed academic journal *Australian Health Review (AHR)*.

Monitoring medical graduates

A University of Sydney research team led by Dr Christine Jorm suggests that:

- In view of the recent suicides of three junior doctors and reports of workplace bullying, the time is ripe to ask medical graduates how they feel, and for the profession to take an objective look at work-life balance
- In view of the cost of medical training to taxpayers and students, medical schools should monitor how their graduates are performing in the workplace.
- In view of reported wide variations in clinical practice, unnecessary tests and procedures, and financial exploitation of some patients, action should be taken to research variations in practice, and measure and improve patient outcomes.

The authors suggest such improvements become 'preventative measures' that help future medical practitioners to have better wellbeing, attract fewer patient complaints, and consistently practise a high standard of evidence-based care.



The 4-hour rule in emergency

A research team from Princess Alexandra Hospital in Brisbane closely examined the '4-h rule' in the UK and the National Emergency Access Target (NEAT) in Australia. These policies aim at most patients (95% in the UK, 80-85% in Australia) exiting emergency departments (EDs) within 4 hours of presentation.

Timeliness in ED care has improved in both countries. Evidence of improved patient outcomes is strong in terms of reduced mortality for selected serious illnesses—but is limited in terms of improvements for other conditions.

The authors argue that continually reducing times to the exclusion of other factors does not necessarily bring better outcomes—doctors need to guard against premature exiting of patients from ED who are at risk of subsequent deterioration. One study showed that as ED transit times decreased, the rate of unplanned return presentations increased.

AHHA in the news

30 NOVEMBER 2018

Endometriosis—is it a chronic disease?

A Monash-University-led team examined whether endometriosis met accepted definitions of ‘chronic disease’. In Australia, such long term and complex conditions are managed within a chronic diseases framework that includes chronic disease management plans and team care arrangements.

The authors found that endometriosis should be classified as a chronic disease. It met 5 out of 6 characteristics of chronic disease. The sixth—a long period of onset—could not be proved. Some women present with symptoms in their teens while others experience them much later. Some show no symptoms but are diagnosed through laparoscopy.

Resident-to-resident aggression in nursing homes

A Melbourne research team led by Dr Briony Jain (Monash University) established that resident-to-resident aggression is common in nursing homes, affecting up to 1 in 5 residents, with potentially fatal consequences and serious implications for nursing home staff and administration. The problem is under-recognised and under-researched in Australia.

The authors conclude that the key to preventing and managing such aggression may lie in interpreting behaviour from the resident’s viewpoint. This could involve obtaining detailed life histories from residents to better understand and develop person-centred care plans for them.

The December 2018 issue of *Australian Health Review* is available at www.publish.csiro.au/ah#CurrentIssue. Some articles are freely available through open access, while others need a subscription or can be purchased individually. 



GraphicStock

‘Bottom-up’ approach led to Victorian assisted dying laws; other States will follow, say researchers

Two research papers released last November show how a citizen-driven ‘bottom-up’ approach led to the passing of Victoria’s new voluntary assisted dying laws, Australian Healthcare and Hospitals Association (AHHA) Chief Executive Alison Verhoeven said.

Victoria’s Voluntary Assisted Dying Act was passed by the state parliament in December 2017 and will come into effect in June 2019 after an 18-month period of implementation work.

‘On the basis of what occurred in Victoria, plus international trends, scientific evidence and changes to the local political environment, it is likely that similar reforms will become law in the other Australian states and territories’, Ms Verhoeven said.

The two papers, published in the AHHA’s *Australian Health Review* journal, are *Documenting the process of developing the Victorian assisted dying legislation* (author team led by Professor Margaret O’Connor, Monash University), and *The Future of assisted dying reform in Australia* (by Professors Ben White and Lindy Willmott, Queensland University of Technology).

Despite sustained law reform efforts in parliaments across the country over many years, Victoria is the first Australian jurisdiction to successfully legislate for voluntary assisted dying.

The lack of lasting legislative reform in other jurisdictions is surprising when public support for change has been very strong—estimated at 75% in an ABC survey in 2016.

‘The authors say that the rise of individualism and personal autonomy in society has been a key factor in changing social attitudes to issues such as assisted dying’, Ms Verhoeven said.

‘They argue that “restlessness” in democratic societies can be attributed to individuals seeking to maximise their places in society through expressing their individuality and autonomy in various ways.

‘This includes the rise of the consumer voice in healthcare, resulting in an increasing focus on consumer or patient decision-making, and a cultural shift away from traditional “top

down” communication patterns to a more equal relationship between consumers, the professions and governments.

‘The key to the legislative outcome in Victoria was that an inclusive public health approach was adopted, combining evidence, science and social action.

‘The process began with a government request to the Parliamentary Legal and Social Issues Committee (Victoria) to inquire into the need for Victorians to make informed decisions regarding the end of their lives. Significantly, the Committee always comprises membership from all political parties and cross benches—and Parliaments across Australia are increasingly taking this kind of approach to complex social issues.

‘The Committee sought input from all sectors of the community and received over 1,000 submissions before recommending legislating for voluntary assisted dying (VAD), using a cautious approach that was most likely to be passed in the Parliament—where VAD would only apply to people in the end stages of terminal illness, and with numerous safeguards and respect for conscientious objections.

‘The government then formed an innovative seven-person Multidisciplinary Advisory Panel to progress the work, supported by Department of Health and Human Services staff. The legislation was never in question, only the shape of it with regard to eligibility, the request and assessment process, and oversight and governance. Again, consultation and listening to concerns were key, as well as catering for every detail. ■



PAT TURNER
 CEO, National Aboriginal
 Community Controlled
 Health Organisation
 (NACCHO)

Why Aboriginal Community- Controlled Health Services are needed

More than just another health service—
 they put Aboriginal health in Aboriginal hands.

We are around for the long haul — commitment and continuity are required to close the gap

Our first members have been around since the very early 1970s. Our roots are deep. We have endured as a high quality, clinically accredited community-controlled service for over 40 years. As the health system becomes more complex, the role of our services becomes even more critical. The Indigenous population is also increasing rapidly, yet funding levels have not kept pace with demand.

We punch above our weight:

Aboriginal controlled health services provide about three million episodes of care each year for about 350,000 people. In very remote areas, our services provided about one million episodes of care in 2015-16.

Our customers trust us with their health

Our services build ongoing relationships to give continuity of care so that chronic conditions are managed and preventative health care can be effectively targeted. Studies have shown that



Aboriginal controlled health services are 23% better at attracting and retaining Aboriginal clients than mainstream providers. Through local engagement and a proven service delivery model, our clients 'stick'. The cultural safety in which we provide our services is a key factor of our success.

More people are using Aboriginal controlled health services. It is reported that in the 24 months to June 2015, our services increased their primary health care services, with the total number of clients rising by 8% (from 316,269 to 340,299).

We are proven to be clinically effective

As recently reported in the *Australian Health Review* (March 2017), we are more effective than other health services at improving Indigenous health. Our services specialise in providing comprehensive primary care consistent with our clients' needs. This includes: home and site visits; provision of medical, public health and health promotion services; allied health, nursing services; assistance with making appointments and transport; help accessing child care or dealing with the justice system; drug and alcohol services; and providing help with income support. This is funded by both State and Australian Governments.

We provide value for money

Aboriginal controlled health services are cost-effective. Our activities result in greater health benefits per dollar spent; measured at a value of \$1.19 to \$1.00. The lifetime health impact of interventions delivered by our services is 50% greater than if these same interventions were delivered by mainstream health services, primarily due to improved Indigenous access.

All revenue is re-invested into our health services. There is no profit-taking. We reinvest in our Indigenous workforce and in locally-designed strategies to trial new approaches. We are part of Indigenous communities and understand how critical respectful community engagement is to improving health outcomes.

We have a high level of community oversight and accountability. Our boards are made up of local Indigenous people and we serve our communities. We are responsive to their needs and they are not shy to tell us to lift our game, if we disappoint. We have innovative, robust and flexible service models grounded in the culture of our people and contemporary primary health care practices.

Governments and communities have invested in the sector and have grown it over time — it is a valuable health asset

Our community-controlled health services are an integral part of the Australian health system just as hospitals are. An exemption under section 19(2) of the *Health Insurance Act 1973* allows Aboriginal controlled health services access to Commonwealth funding, even if they are funded by state governments. This flexibility allows all parties to work closely together to provide the full-service offer and get the best outcomes according to local need and circumstances.

There are many examples of important partnerships between our services and mainstream providers working collaboratively to maximise impact. For example, in Western NSW, the roll-out of a new partnership saw the number of Aboriginal people using integrated care services for chronic conditions more than double in the space of just four months.

The health system is increasingly complex in nature and the dire state of Indigenous health has meant that Aboriginal people need to have control over their own health response and be part of the solution. We work closely with mainstream services to extend the reach of services and share our expertise to improve cultural safety. While governments struggle to deliver service models that rarely reach or effectively service the needs of the most vulnerable Aboriginal people, we excel.

That's because we are Aboriginal people who understand what is required to change the future health of our people and we deliver it.

Most of our staff are Indigenous, but we need more Indigenous clinical staff

Our network provides a critical and practical pathway into employment for many Indigenous people. Currently, 56% of our staff are Indigenous.

The greater representation is amongst non-clinical staff. Much more needs to be done to develop viable career pathways to get more Indigenous doctors, nurses and allied health professionals. Across Australia, there are only about 170 Indigenous medical practitioners, 730 allied health professionals, and 2,190 nurses.

We are the largest employer of Indigenous people

Our 145 Aboriginal controlled health services employ about 6,000 staff (most of whom are Indigenous). This means that one out of every 44 Indigenous jobs in Australia is with one of our services (3,300 of 141,400 FTE: 2.33%). This puts us well ahead of all mining employers. This is in a context where the health and social care sector employs 15% of the Aboriginal and Torres Strait Islander workforce; almost four times as many as the mining industry (4%). Our large network of services is also critical to the economic health of many remote and local communities.

The need is compelling

Good progress has been made, but Indigenous health is still vulnerable to disturbing developments such as the recent outbreak of congenital syphilis across regions of Northern Australia. This is an entirely preventable disease not seen in Australia for generations and its occurrence raises concerns about the delivery of antenatal care and sexually transmitted infection and blood borne virus control programs for all high-risk groups. ^{na}

This article is based on a NACCHO Fact Sheet and its use is authorised by NACCHO CEO Ms Pat Turner. Access the original, including reference details at <https://www.naccho.org.au/wp-content/uploads/Key-facts-1-why-ACCHS-are-needed-FINAL.pdf>.

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Co-designing 'leaner' approaches to healthcare



AHHA and North Queensland PHN co-design Lean healthcare training with North Queensland Aboriginal Medical Services and Aboriginal Community Controlled Health Organisations.

By Greg Kilbey, Business Development Manager, LEI Group Australia, and Dr Chris Bourke, Strategic Programs Director, AHHA

Lean training and North Queensland PHN

AHHA, North Queensland Primary Health Network and Aboriginal Community Controlled Health Services (ACCHOs) in North Queensland worked together in 2018 to co-design 'leaner' approaches to healthcare.

The rationale was to work with ACCHOs and Aboriginal Medical Services (AMSs) to build, support and improve business practices that would enhance their ability to deliver healthcare services.

A co-design process was used to focus on issues that matter for Aboriginal and Torres Strait Islander

peoples. The two-day co-design workshop was held in Cairns with Aboriginal and Torres Strait Islander representatives from AMSs and ACCHOs.

The workshop considered two levels of Lean Healthcare training—White Belt and Yellow Belt—and discussed presenter introduction, training delivery methodology, terminology, relevance to ACHHOs and AMSs, relevant case examples, post-training sustainability, relevant imagery within presentations, Aboriginal and Torres Strait Islander co-presenters, demonstrable benefit, board and CEO communication, and developing ongoing community of practice support.



Lean training group in Cairns.
Authors Greg Kilbey and
Dr Chris Bourke are third and
second from left, respectively

'Lean' is a tried and trusted methodology that has been used worldwide for over 60 years to provide greater efficiency for organisations as well as providing a better service for customers. It is about improving processes by the continuous elimination of activities that do not add value. This focus enables customers and patients to be served more efficiently and provided with a greater value of service.

Today, standard healthcare is fragmented with systems and manual interventions that do not work cohesively or in a seamless fashion. In fact, most health care processes are organised around functional departments requiring patients to travel from one site to another, causing frustration and time-wasting for the patient.

“Today, standard healthcare is fragmented with systems and manual interventions that do not work cohesively or in a seamless fashion.”

The main findings included:

- Lean Healthcare training has significant potential to benefit AMSs and ACCHOs.
- Non-Indigenous presenters can build trust faster by using Indigenous introduction methods.
- Formulaic terminology that appears marketing-driven, e.g. White Belt, Yellow Belt, is a major barrier to connecting with workshop participants.
- Images of Aboriginal and Torres Strait Islander people should be used in presentations.
- Case scenarios drawn from AMS and ACCHO experience should be used in workshops.
- The material to be covered in a single-day workshop should be White Belt and some of Yellow Belt.
- Workshops need to be conducted at a venue away from the workplace.
- Delivering two consecutive single-day training workshops will enable large and busy AMSs and ACCHOs to get more staff through training and will support sustainability despite staff turnover.
- A review of the single-day training afterwards will provide useful learnings for further advanced workshops.
- Post-training follow-up will be required.

The result of these findings is a 1-day Lean Healthcare Foundations course, built on the experiences of Aboriginal and Torres Strait Islander health staff, that equips attendees with tools to improve service delivery and improve practice activity flows. These processes are central to the patient’s journey and to the health organisation as a whole. Improvements can be about patient services or address non-clinical business practices to free up valuable resources within the organisation. This practical hands-on course is about learning by experience and can be immediately adopted within the AMS/ACCHO workplace.

Workshops have been delivered in Mackay and Cairns with strong positive feedback from participants.

Co-design workshop participants said:

- *‘My CEO told me I had to go to this—and I’m so glad she did.’*
- *‘If you need change, Lean Training is a way forward.’*
- *‘Let’s clear the waste to produce better growth.’*
- *‘Lean Healthcare Training could help recognise what we actually do in our organisations, and the impact we make. It identifies processes that may be enhanced or improved, to be more streamlined in an increasingly competitive funding environment.’*

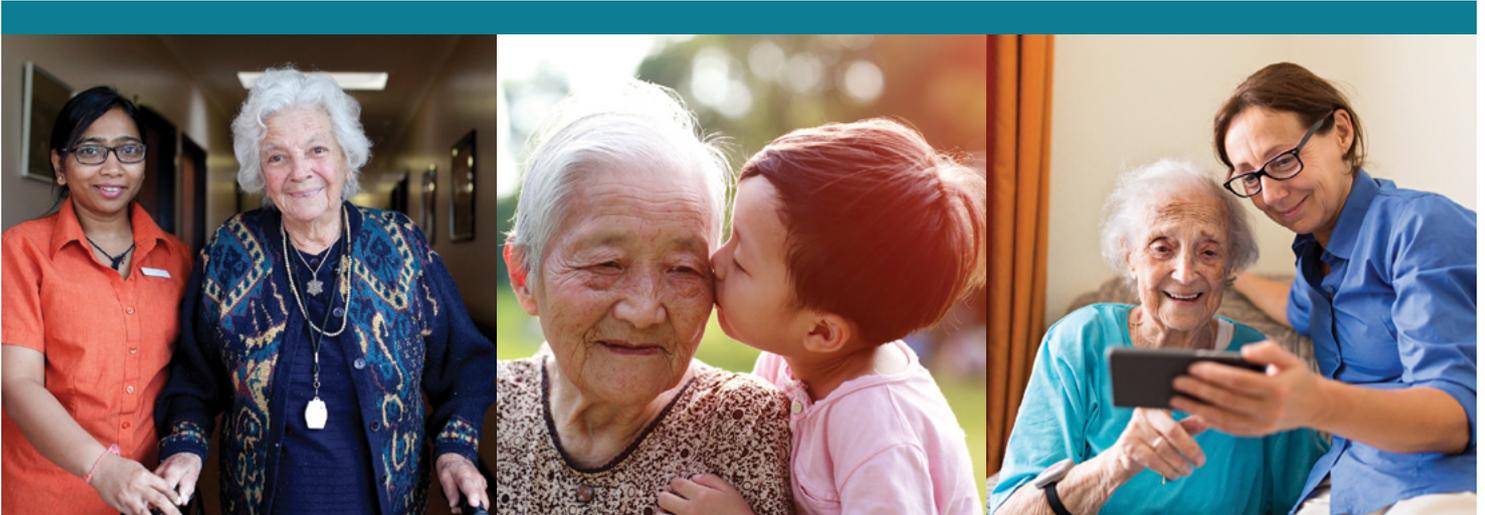
Testimonials from Cairns and Mackay workshop participants included:

- *‘Very easy to understand and appropriate for our work environment to implement.’*
- *‘Lean training is very beneficial for the roles and practices as a nurse. The Lean tools are practical and easy to understand.’*
- *‘Information that could see changes in AMSs.’*
- *‘Great training and using it would mean a better service.’*
- *‘Information can be used within your organisation improving changes for the better.’*
- *‘Activities and discussion were great.’*
- *‘Have managers and staff attend.’* 

For more information on how you can access the 1-day Lean Healthcare Foundations course for AMSs and ACCHOs please contact Lisa Robey, AHHA Engagement and Business Director, at lrobey@ahha.asn.au.



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Improving oral health for Aboriginal and Torres Strait Islander people in Victoria

Our reconciliation journey.
Dental Health Services Victoria

“As the lead public oral health agency in Victoria, Dental Health Services Victoria (DHSV) is committed to the journey of reconciliation.”

Background

Oral disease is largely preventable and yet Aboriginal and Torres Strait Islander Australians are more likely than non-Indigenous Australians to have lost all their natural teeth, have gum disease and to have received less dental care.

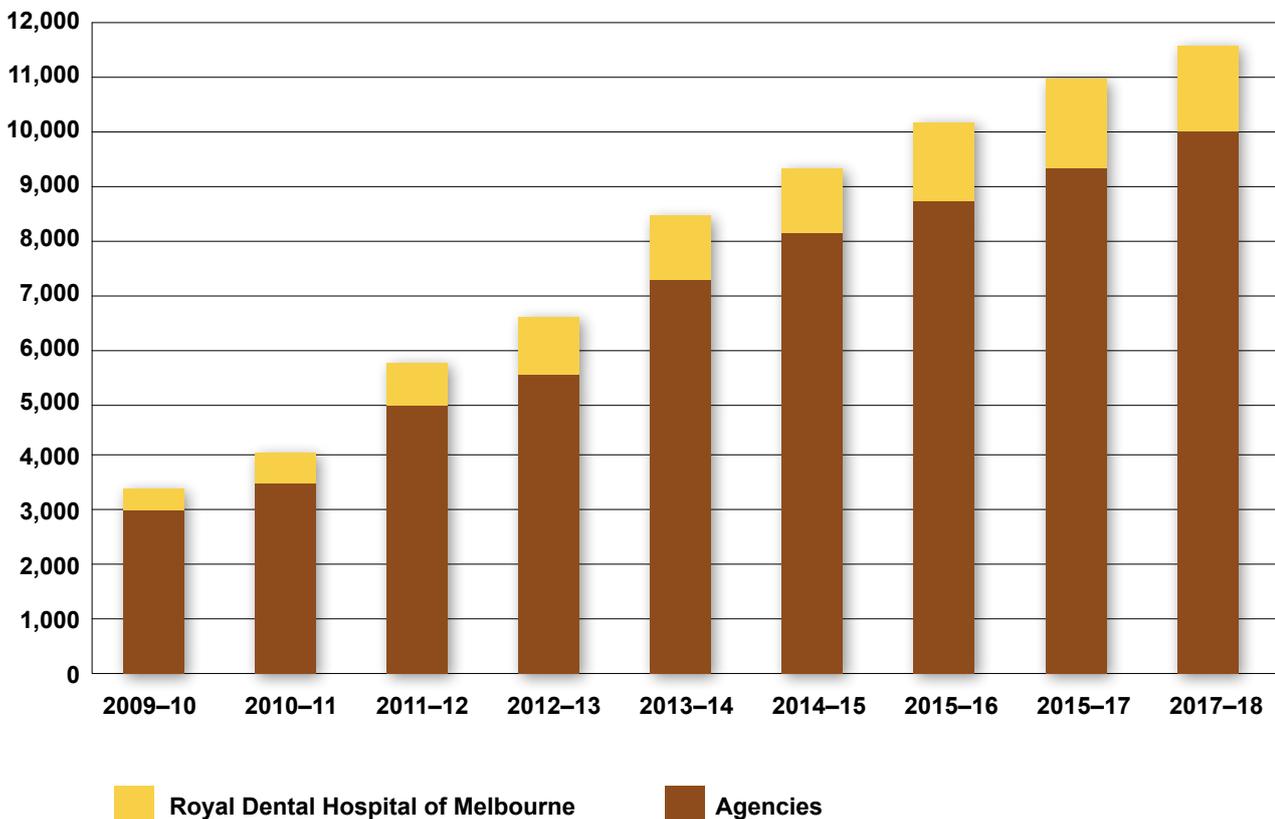
As the lead public oral health agency in Victoria, Dental Health Services Victoria (DHSV) is committed to the journey of reconciliation. Over the years we have implemented a number of strategies to work towards Closing the Gap and improving oral health for Aboriginal and Torres Strait Islander people.

Accessing public dental services

From 1 July 2016 to 30 June 2018, 31% of the Victorian Aboriginal and Torres Strait Islander population accessed public dental services, attending both Aboriginal-specific (20%) and mainstream dental clinics (80%).

We have seen a steady increase in the number of Aboriginal and Torres Strait Islander people accessing public dental services over the last nine years from 3,373 individuals in 2009-10 to 11,561 individuals in 2017-18.

Figure 1: Number of Aboriginal and Torres Strait Islanders accessing public dental services in Victoria.



Our journey to date

Table 1: Timeline of major activities at DHSV to improve the oral health of Aboriginal and Torres Strait Islander people in Victoria.

2007	Appointed our first Aboriginal Community Development Worker.
2008	Engaged with the Victorian Aboriginal Committee on Koori Health (VACKH) and the oral health subcommittee.
2009	Conducted ceremony to acknowledge traditional owners at the Royal Dental Hospital of Melbourne (RDHM).
2010	Signed the Close the Gap Statement of Intent. Established the Aboriginal Oral Health Reference Group and implemented a dedicated Aboriginal Oral Health Plan, to support culturally appropriate oral health services and improve access to services for Aboriginal and Torres Strait Islander people. Appointed our first Aboriginal Hospital Liaison Officer at RDHM.
2013	Launched the DHSV Aboriginal Employment Program.
2014	Three Closing the Gap Dental vans were commissioned—one in the east, west and north of Victoria. They operate in remote and regional Aboriginal and Torres Strait Islander communities to extend the reach.
2015	DHSV signed a Memorandum of Understanding (MOU) for a two-year period with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), as a commitment to working together to achieve and sustain better oral health outcomes for Victorian Aboriginal and Torres Strait Islander people.
2016	The Aboriginal Community Development Officer was appointed as a joint role between DHSV and VACCHO. The joint role enables close partnerships to be maintained between Aboriginal and mainstream services in oral health.
2017	DHSV and VACCHO renewed the MOU.

Growing and supporting the workforce

DHSV has a strong commitment to the attraction, engagement and development of an Aboriginal and Torres Strait Islander oral health workforce, and we currently have nine Indigenous employees. We exceed the 1% employment target outlined by Karreeta Yirramboi (The Victorian Government's Aboriginal Employment Strategy).

We launched an Aboriginal Dental Assistant

Traineeship Program in 2012 to encourage new young talent into the organisation and the public dental sector as a whole. We expanded our traineeship opportunity to non-clinical roles in 2015 and partnered with VACCHO to deliver a Patient Liaison Traineeship Program at RDHM.

Many of our Aboriginal and Torres Strait Islander staff have excelled in their studies and have been encouraged to further their careers. We support

“We launched an Aboriginal Dental Assistant Traineeship Program in 2012 to encourage new young talent into the organisation and the public dental sector as a whole.”

two staff who were the first Aboriginal and Torres Strait Islander students to be accepted into the Bachelor of Dentistry degree at La Trobe University, one whom recently graduated as a dentist.

Another two dental assistants completed the RMIT Certificate IV in Oral Health Promotion this year and are working as Oral Health Educators at RDHM. Another staff member has applied to undertake a Bachelor of Oral Health Science degree at La Trobe University in 2019.

Our 2016-2021 Aboriginal Employment Plan focuses on creating further opportunities for our Aboriginal and Torres Strait Islander workforce.

Health promotion to Aboriginal communities

DHSV partners with Aboriginal and Torres Strait Islander services to deliver Health Promotion programs.

HEALTHY FAMILIES HEALTHY SMILES

This program builds the capacity of health and early childhood professionals to incorporate oral health promotion in their everyday practice.

Some of the key initiatives through this program include:

- In 2012, Koori Maternity Services were targeted for recruitment in the pilot of a comprehensive online oral health training program for Victorian midwives working in antenatal care. Subsequent expansion of the program has seen 7 rounds of training conducted between 2013 and 2017, reaching 22 midwives working in 18 Koori Maternity Services.
- Bigger Better Smiles is an oral health education program developed in partnership with Mallee District Aboriginal Service in 2014, and builds the capacity of ACCHO workers to provide oral

health advice, screening and support referrals. Since 2014, the program has been delivered to a further 11 services, reaching 151 staff working with Aboriginal families.

- The Little Koori Smiles package was developed specifically for Aboriginal Supported Playgroups to include oral health promotion in their programs. The package consists of a flipchart, an informal one-hour training session and a resource pack to support this.

SMILES 4 MILES

This program aims to improve the oral health of children and their families in high-risk areas across Victoria, and assists early childhood services to encourage and promote good oral health habits and healthy eating among children in their care.

Since 2013, the program has focused on engaging Aboriginal and Torres Strait Islander services in Smiles 4 Miles by introducing a flexible approach to the program. In 2018, 7 Aboriginal early childhood services were enrolled. The program also reaches Aboriginal and Torres Strait Islander children in mainstream services with 52% of Smiles 4 Miles services indicating Aboriginal and Torres Strait Islander children are enrolled in the program.

The Smiles 4 Miles team is currently working with the VACCHO nutrition team to provide additional support around healthy eating and oral health policy review, and menu assessments for Aboriginal early childhood services.

Continuing our journey

Last year (2018) DHSV began development of its first Reconciliation Action Plan. This will uphold and continue our commitment to improving oral health outcomes for Aboriginal and Torres Strait Islander people. 



ALLANA JACKSON
Project Officer,
Lighthouse Hospital
Project Phase 3, Cairns
and Hinterland Hospital
and Health Service

A good news story from the Lighthouse Hospital Project

Collaboration brings a better outcome.

'The Good News stories need to be told because all the Health Workers are doing great work with their patients against lots of obstacles, and the Lighthouse Project can make significant changes to how we do our business in this Hospital considering the significant numbers of Aboriginal and Torres Strait Islander patients that we care for and who receive many procedures. We need to ensure we are ahead of our game and that the service we provide is culturally appropriate, safe and supporting of these patients, so they don't discharge against medical advice, receive the required treatment in time and are fully advised of their procedures.'

Norma Solomon, Aboriginal and Torres Strait Islander Health Worker Cluster Coordinator,
Division of Medicine, Cairns and Hinterland Hospital and Health Service.



(L-R) Norma Solomon, Aboriginal and Torres Strait Islander Health Worker Cluster Coordinator, and Veronica Reabel, Aboriginal Health Worker, Cairns Hospital.

Several weeks ago, John*, an Aboriginal man, was admitted to the cardiac ward and it was determined that this man needed a stent procedure.

Some of you may understand what is involved with this procedure, including the work-up that is necessary to have this—for example, the fasting.

Due to a heavy workload the procedure was moved back several times within the three days of John’s admission.

While clinicians had made a decent effort to provide this information to the patient and it had been delivered to John by various clinicians, it was during a bedside meeting with the Aboriginal

Health Worker for the cardiac ward (Veronica at the time) that he appeared to be agitated and voiced his frustrations saying something to the effect of ‘What will it take for me to be seen around here? Do I have to die to be seen around here?’.

This is what Aboriginal and Torres Strait Islander patients’ stories tell us patients would like:

- full disclosure of treatment, straight-up talk with evidence-based care delivered in a way that is understandable.
- an Aboriginal or Torres Strait Islander person’s face present throughout treatment.

“Norma and Veronica both made their way to where John was (the cardiac ward). Norma sat with him and heard his story, giving him the time he needed to tell it.”

Here is where the separation and disconnection may have taken place:

- the patient felt hungry and felt frustrated, believing he had been forgotten about
- the patient was told that the doctor was seeing him next, the operation was important and to wait—again, with no further explanation
- the patient became upset when he saw the doctor going for coffee and consequently considered himself ‘not important’
- this had occurred before when John was admitted for the same procedure and for various reasons it did not happen, so John had discharged himself and gone home.

Veronica explained why it was so important to stay on the ward and that the treating team would see him, and he would have the procedure. John nevertheless decided he was going to ‘go downstairs’.

Veronica then made a phone call to the Aboriginal and Torres Strait Islander Cluster Coordinator, Norma, as Veronica was concerned that John would discharge himself against medical advice.

Norma and Veronica both made their way to where John was (the cardiac ward). Norma sat with him and heard his story, giving him

the time he needed to tell it. She then reiterated information accompanying his admission that indicated the dangers of his discharging at this time.

John said he would give Norma until 1.00pm, then he was going to discharge. Norma asked him to wait and she would talk to the senior staff. Norma then talked to the Nursing Director, explaining the situation. They went through the various options to contact the cardiologist to come and talk to John to reassure him about when he was going to get his procedure.

Norma then returned to the cardiac ward and spoke to the Clinical Nurse Consultant who then paged the cardiologist and spoke with him, indicating the importance and urgency of visiting the patient as soon as possible.

Both Norma and Veronica were instrumental in using available staff and procedures to persuade John to stay to receive treatment, and a successful procedure was carried out. ^{ha}

**Not his real name*

The Lighthouse Hospital Project is a joint initiative between the Heart Foundation and the Australian Healthcare and Hospitals Association (AHHA). It is aimed at improving the treatment of coronary heart disease among Indigenous Australians.

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The Close the Gap 10-year review 2018

A short summary.

Australian Human Rights Commission

The Review

The Review assesses the most significant national effort to date to improve Aboriginal and Torres Strait Islander health: the 2008 Council of Australian Governments' (COAG) Closing the Gap Strategy with its target to achieve life expectancy (health) equality by 2030.

The COAG Closing the Gap Strategy was developed by Australian governments following their signing of the Close the Gap Statement of Intent from March 2008 onwards. The Close the Gap Statement of Intent is, first, a compact between Australian governments and Aboriginal and Torres Strait Islander peoples. Second, it embodies a 'human right to health'-based blueprint for achieving health equality—referred to as the 'close the gap approach'.

The close the gap approach and the Close the Gap Statement of Intent are founded on an understanding that population health outcomes are fundamentally the result of underlying structural factors, such as social determinants, institutional racism, the quality of housing, and access to appropriate primary health care.

This does not mean that funding should be pulled from Closing the Gap Strategy elements such as addressing preventable, chronic and communicable diseases and child and maternal health. Indeed,

there is an obligation to address these, including risk behaviours (such as smoking) within a rights-based approach. However, policy-makers should not take their eyes off the 'main game': sustainable long-term improvement to the health of Aboriginal and Torres Strait Islander peoples by addressing the underlying structural factors—treating the causes rather than focusing on symptoms.

Major findings

1. The Close the Gap Statement of Intent and close the gap approach have to date only been partially and incoherently implemented via the Closing the Gap Strategy:
 - An effective health equality plan was not in place until the release of the *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan* in 2015—which has never been funded. The complementary *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* needs an implementation plan and funding as appropriate. There is still yet to be a national plan to address housing and health infrastructure, and social determinants were not connected to health planning until recently and still lack sufficient resources.



A ten-year review:
the Closing the
Gap Strategy and
Recommendations
for Reset

- The [current] Closing the Gap Strategy’s focus on child and maternal health and addressing chronic disease and risk factors is welcomed and should be sustained. However, there has been no complementary systematic focus on building primary health service capacity according to need, particularly through the Aboriginal Community Controlled Health Services, and truly shifting Aboriginal and Torres Strait Islander health to a preventive footing rather than responding ‘after the event’ to health crises.

2. The Closing the Gap Strategy—a 25-year program—was effectively abandoned after 5 years and so cannot be said to have been anything but partially implemented. This is because the ‘architecture’ to support the Closing the Gap Strategy (national approach, national leadership, funding agreements) had unravelled by 2014-2015.
3. A refreshed Closing the Gap Strategy requires a reset which re-builds the requisite ‘architecture’ (national approach, national leadership, outcome-orientated funding agreements).
4. A refreshed Closing the Gap Strategy must be founded on implementing the existing Close the Gap Statement of Intent commitments. In the past 10 years, Australian governments have behaved as if the Close the Gap Statement of Intent was

of little relevance to the Closing the Gap Strategy when in fact it should have fundamentally informed it... A refreshed Closing the Gap Strategy must focus on delivering equality of opportunity in relation to health goods and services, especially primary health care, according to need and in relation to health infrastructure (an adequate and capable health workforce, housing, food, water). This should be in addition to the focus on maternal and infant health, chronic disease and other health needs. The social determinants of health inequality (income, education, racism) also must be addressed at a fundamental level.

5. There is a ‘funding myth’ about Aboriginal and Torres Strait Islander health...that is, the idea of dedicated health expenditure being a waste of taxpayer funds.

“A refreshed Closing the Gap Strategy must focus on delivering equality of opportunity in relation to health goods and services, especially primary health care, according to need and in relation to health infrastructure...”

Higher spending on Aboriginal and Torres Strait Islander health should hardly be a surprise...the Aboriginal and Torres Strait Islander population has, on average, 2.3 times the disease burden of non-Indigenous people. Yet on a per-person basis, Australian government health expenditure was \$1.38 per Aboriginal and Torres Strait Islander person for every \$1.00 spent per non-Indigenous person in 2013-14.

Recommendations

Recommendation 1: The ‘refreshed’ Closing the Gap Strategy is co-designed with Aboriginal and Torres Strait Islander health leaders and includes community consultations.

Recommendation 2: To underpin the Closing the Gap Strategy refresh, Australian governments reinvigorate the ‘architecture’ required for a national approach to addressing Aboriginal and Torres Strait Islander health equality. This architecture includes: a national agreement, Federal leadership, and national funding agreements that require the development of jurisdictional implementation plans and clear accountability for implementation.

Recommendation 3: The Closing the Gap Strategy elements such as maternal and infant health programs and the focus on chronic disease (including the Tackling Indigenous Smoking

program) are maintained and expanded in a refreshed Closing the Gap Strategy... The social determinants of health inequality (income, education, racism) must also be addressed at a far more fundamental level than before.

Recommendation 4: The current Closing the Gap Strategy health targets are maintained, but complemented by targets or reporting on the inputs to those health targets.

Recommendation 5: *The National Aboriginal and Torres Strait Islander Health Plan Implementation Plan* is costed and fully funded by the Federal government, and future iterations are more directly linked to the commitments of the Close the Gap Statement of Intent; and, an implementation plan for the complementary *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017-2023* is developed, costed and implemented by the end of 2018 in partnership with Aboriginal and Torres Strait Islander health leaders and communities.

Recommendation 6: An overarching health infrastructure and housing plan to secure Aboriginal and Torres Strait Islander Peoples equality in these areas, to support the attainment of life expectancy and health equality by 2030, is developed, costed and implemented by the end of 2018. ^{ha}

This article has been adapted (shortened with minor corrections) under Creative Commons licensing arrangements from *A ten-year review: the Closing the Gap Strategy and Recommendations for Reset*, published by the Australian Human Rights Commission in 2018. The original report may be found at <https://www.humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-social-justice/publications/close-gap-10-year-review>.

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Remote primary healthcare

Strengthening the transition for urban-based health professionals

What is RAHC (Remote Area Health Corps)?

The Remote Area Health Corps (RAHC) was established in 2008 and is funded by the Australian Government Department of Health under the *Indigenous Australians' Health Programme: Stronger Futures Northern Territory* to 'address persistent challenges to accessing primary healthcare services for Aboriginal and Torres Strait people in the Northern Territory'.

RAHC focuses on recruiting, culturally orientating and deploying urban-based health professionals to deliver primary health care services in remote Indigenous Northern Territory communities.

Strengthening the transition—nursing, driving, trachoma, trichiasis

Remote Area Health Corps (RAHC) has launched four new eLearning modules to assist, educate and strengthen the transition of urban-based health professionals into remote primary healthcare. The new modules will be hosted on a new and improved eLearning platform.

The *Remote nursing scope of practice* and *An introduction to remote driving* modules were developed in conjunction with the Central Australian Rural Practitioners Association (CARPA).

Modules focusing on *Trachoma grading* and *Trichiasis grading* were developed with Indigenous Eye Health at Melbourne University. Currently, Australia is the only developed country with endemic trachoma, affecting only the Indigenous population, and notably prevalent within communities in the Northern Territory.

The modules, particularly those on trachoma and trichiasis grading, are important educational tools that will assist health professionals in eliminating trachoma by 2020. Through further education for both patients and health professionals, there has been a reduction in the rate of blindness amongst Indigenous people from six times the national rate in past years to three times the national rate now.

Trachoma and trichiasis

Trachoma starts as an infection of the membrane that covers the outside of the eyeball and lines the inner surface of the eyelids (conjunctiva). Repeated infections can over years eventually lead to scarring that causes the margin of the eyelid to turn inwards. The eyelashes become inverted and rub on the clear cornea, painfully scratching it and causing damage. This eventually results in opaque, scarred corneas and distressingly uncomfortable eyes.

In a desperate attempt to alleviate the pain caused by this trichiasis—or inverted eyelashes—many people resort to pulling out their eyelashes with crude, makeshift tweezers. Both eyes are usually affected and the scarring leads to irreversible blindness—usually when a person is between 30 and 40 years old.

The information above is from the Fred Hollows Foundation: www.hollows.org/au/eye-health/trachoma

Remote Area Health Corps releases four new eLearning modules.

The new eLearning platform

RAHC's eLearning platform has been central to preparing health professionals to work in remote Indigenous settings. This portal has helped orientate and better prepare health professionals to understand their scope of practice, legal and legislative requirements, cultural awareness and how better to use tools such as the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual for clients in remote areas.

Aaron Richardson, Northern Territory Manager—RAHC, says 'The four new eLearning modules have been designed to further support health professionals who are interested in working in Indigenous healthcare. Over the past 12 months (2018) there have been more than 5,500 module completions. We have already seen a rise in

participation numbers since the launch of the new platform in October and there has been keen interest in the *Trachoma grading* and *Introduction to remote driving* modules, both of which explore specific challenges faced by health professionals when working in remote Indigenous healthcare.

'With this move to the new portal, we are now in a position to develop eLearning modules more efficiently. We will be looking to develop more modules and partner with more organisations to create relevant educational eLearning content. This will offer support to all health professionals to make a smooth transition to working within a remote Indigenous community.'

The new eLearning portal is accessible through the rahc.com.au website.

The RAHC program is funded by the Australian Government Department of Health. 

NATIONAL CLOSE THE GAP DAY 21 MARCH 2019

National Close the Gap Day is a time for all Australians to come together and commit to achieving health equality for Aboriginal and Torres Strait Islander people.

The Close the Gap Campaign will partner with Tharawal Aboriginal Corporation - Aboriginal Medical Service, South Western Sydney, to host an exciting community event and launch our Annual Report.

Go to the ANTaR website for more information, to register your support and get some ideas on how to host your own event.

www.antar.org.au/closethegap



CLOSE THE GAP



Working as a nurse in remote Aboriginal communities

Anna Heaton's story.
Rural Australia Health Corps

A long way from Yorkshire

Living and working in some of Australia's most remote Aboriginal communities has become part of the life journey for Yorkshire-born nurse Anna Heaton. Speaking from Ampilatwatja during her fourth week at the local health clinic, Anna was already planning her next posting with the Remote Area Health Corps (RAHC). She has previously worked at locations such as Alice Springs and

Urapuntja, located 360 km south of Tennant Creek, Northern Territory.

RAHC offers short-term paid placements to urban-based health professionals to support the hard-working permanent health workforce in remote Indigenous communities all over the Northern Territory.

Ampilatwatja is 320 km from Alice Springs along mostly unsealed roads toward the Queensland



Anna Heaton

border. The district language is predominantly Alyawarr and there are up to 650 residents.

Anna has been nursing in Australia for over eight years after completing her nursing diploma at Manchester where she stayed to work for two and a half years.

‘I started in Melbourne but didn’t like it, so I went to Alice Springs on a three-month contract and absolutely loved it’, she said.

‘I liked working with a different culture, meeting nurses who had seen so much of the world, travelling and having new experiences.’

Anna’s keenness to experience the outback took her to Leonora in the Western Australian Goldfields and then to various communities in WA, New South Wales and Queensland.

The trip home was via Ghana, where she worked in a HIV clinic, after which Anna didn’t enjoy being back with the National Health Service in England.

‘My family said I should go back to Australia because I was too miserable’, she said.

The benefits

What does Anna like about remote nursing?

‘I love the autonomy of rural and remote nursing compared with being in a big hospital’, Anna said.

‘In city hospitals, the more you move up the career ladder the more removed you become from patient care.

‘I just love being a nurse and for me it’s all about caring for the patient.’

Anna said there are situations every day where she gets the satisfaction of making a difference.

In one recent example, a young man presented after having a seizure. He was otherwise fit and healthy and the cause was unclear. Transferring him to Alice Springs was a difficult logistical exercise.

Upon arrival at Alice he was found to have a brain tumour and sent to Royal Darwin Hospital for life-saving surgery.

Every working day is different: ‘Some days, we load the car with medications, immunisations,

diagnostic equipment, treatments, dressings and laptops and head out to one of the outstations in the area', she said.

'In a tiny room we call a clinic, we get to work. Usually there are just two nurses, occasionally a doctor, and up to three patients in this small space.

'In this environment that is so totally unique, we discuss, assess, diagnose and treat what we can.'

Despite being 'in the middle of nowhere, like slap bang in the middle', Anna said the living conditions were generally first class.

'The brilliant thing about working in remote communities in the NT with RAHC is that you get provided with accommodation', she said.

"I recommend that anyone thinking about this should go to a rural hospital first, get used to the isolation and get exposure to Aboriginal culture."

'It's also a great learning experience. Every day is a school day.'

At Ampilatwatja, Anna shares a comfortable three-bedroom house with another nurse. It has air-conditioning and wi-fi.

The home is a refuge surrounded by complex social issues and disadvantage.

Anna said she was well supported by her employer.

'Ampilatwatja is a neighbouring community to Ali Curung where, just recently, a man was killed and dozens of people rioted after four people died when their car broke down on an isolated road.

'The young boy who died was from our community', Anna said.

'RAHC were on the phone straight away, asking

how I felt. They really have my wellbeing at the forefront.'

The challenges

The cultural differences pose a significant challenge.

'Communication can be difficult, especially with older people who don't speak much English. It helps to have Aboriginal health workers who act as interpreters.

'Without that it can be hard to gain informed consent and provide the best treatment.'

Anna said she typically sees patients with diabetes, cardiovascular conditions, ear and eye infections, and rheumatic heart disease. Mental health issues are also profound.

All of this stretches the skills of health professionals.

'Obviously you get pushed and challenged', Anna said.

'You don't have the support networks you have in urban areas; you have to think for yourself.

'While we always follow policies and procedures, in terms of practical skills you get to learn so much.

'Every day teaches me how much I still don't know.'

Just do it?

Despite the challenges, Anna is happy to recommend the experience and lifestyle to others who might be contemplating a desert change.

There's the satisfaction of knowing her work makes a difference to the lives of disadvantaged people.

Her advice is to take regular holidays and connect with friends often.

'It's not easy to get out of a remote community', she said.

'I recommend that anyone thinking about this should go to a rural hospital first, get used to the isolation and get exposure to Aboriginal culture.

'The Transition to Remote Area Nursing Program



“In a tiny room we call a clinic, we get to work. Usually there are just two nurses, occasionally a doctor, and up to three patients in this small space.”

Four legs sometimes better than four wheels

through the Centre for Remote Health is also very worthwhile.

‘I also think people should try a 5-6 week placement for their first experience and see how it goes.’

Anna said RAHC have been ‘absolutely fantastic’.

‘I chose them because of their specialty expertise with remote communities’, she said.

‘They send you out with an educator for the first week. I’m not sure I would have survived without that!’

‘RAHC provides ongoing support and they’re in regular contact with me.’

For her next placement, Anna is thinking about Arnhem Land or the Torres Strait.

‘Living among Aboriginal people is a tremendous honour and it’s interesting to travel to different areas’, she said.

‘My advice to anyone who wants challenge and adventure in their life is just do it.’ ^{ha}



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The Yeddung Gauar (Good Heart) Project

An Aboriginal and Torres Strait Islander women's cardiac rehabilitation program.

The Yeddung Gauar Project

What is it? It is a women-only Aboriginal and Torres Strait Islander cardiac rehabilitation program in a non-Indigenous health service setting. It assesses the implementation of evidence-based enablers for Aboriginal and Torres Strait Islander women to attend cardiac rehabilitation while providing culturally safe care. Women 18 years or older are eligible, and participants can self-refer or be referred by health professionals. We welcome all women and family members to come along!

What is its purpose? The Yeddung Gauar Project's main purpose is to decrease risk factors for CVD, enhance quality of life and prevent initial

and recurrent cardiac events within the Aboriginal and Torres Strait Islander population of Canberra.

It is our ongoing aim to make a tangible difference to local Aboriginal and Torres Strait Islander communities and to also improve health professionals' cultural safety within Canberra.

When? A rolling program started in June 2018, with weekly sessions on Wednesdays from 12pm to 2pm. The program consists of a 1-hour exercise session and 30-minute education session delivered by a member of our multidisciplinary team. The six rotating topics include: 'Yarning about exercise', 'Yarning about food', 'Yarning about hearts', 'How do medicines heal my heart?', 'Protecting my heart', and 'How do you feel?'.



A new cardiac rehabilitation program at the University of Canberra has been established to provide Aboriginal and Torres Strait Islander women with better access to treatment.

The facts

- Cardiovascular disease (CVD) is diagnosed in almost one-half of Aboriginal and Torres Strait Islander people aged 55 or more and is the largest cause of premature death in this population.¹
- CVD is also the primary influencing factor in the life expectancy gap between Indigenous and non-Indigenous populations.¹
- Ischaemic heart disease alone is reported to account for 24% of the avoidable and preventable gap, with Aboriginal and Torres Strait Islander people being 3 times as likely to have a major cardiac event as non-Indigenous Australians.^{1,2}
- Aboriginal and Torres Strait Islander people are more than 2 times as likely to die in hospital from heart disease and are more likely to have numerous cardiac risk factors.²

Where? It is held at the University of Canberra's Faculty of Health Clinics. The Aboriginal Community Transport Bus of Canberra is available to collect participants and take them to and from the project at no cost.

How? A physiotherapist and an exercise physiologist run the exercise sessions. In addition, education sessions can be delivered by other multidisciplinary team members, including an Aboriginal liaison officer, dietitian, pharmacist and psychologist. All staff completed face-to-face Cultural Awareness Training before the start of the project.

The project is led by Aboriginal and Torres Strait Islander voices within the local community.

It is funded by the University of Canberra's Collaborative Indigenous Research Initiative and supported by the Faculty of Health Clinics. Key stakeholder supporters include the University of Canberra's Elder in Residence, the ACT Aboriginal and Torres Strait Islander Elected Body, Winnunga Nimmityjah Aboriginal Health Service, Yurauna Centre at Canberra's Institute of Technology, Heart Foundation ACT, the Australian Healthcare and Hospitals Association and surrounding private and public hospitals. Grand Pacific Health (community health service provider) and Capital Health Network (the ACT's Primary Health Network) have also given ongoing support.

How we are helping

Cardiac rehabilitation decreases mortality, improves risk profiles, decreases hospital admissions, increases medication adherence and improves quality of life in people diagnosed with CVD.³

Secondary prevention strategies such as cardiac rehabilitation programs have been implemented in Australian Indigenous populations to improve cardiovascular health—however, there are barriers to participation.⁴

To overcome the barriers, various strategies have been shown to be successful.⁵ They include programs having gender specificity, being multifactorial in nature, having a culturally safe program structure, using Indigenous Health Workers, and providing transport assistance as well as general education about medications.⁵

The Yeddung Gauar project attempts to incorporate some of these components.

Feedback

The program has great community support and feedback has been very positive:

‘I can now walk 500m from my car to the shops without having to stop for a rest’

—64-year-old participant.

‘I feel more in control of my body and aware of my heart since starting this program’

—19-year-old participant.

‘There is such a need for this project to continue—the patient whom I referred has improved in a lot of her outcome measures’

—Hospital-based cardiac rehabilitation coordinator.

The future

The Yeddung Gauar Project aligns with contemporary knowledge about cultural safety in healthcare settings for Aboriginal and Torres Strait Islander people, where the best combination of strategies is still unknown—because there is always something more to learn!

If the project continues to be a success, further funding will be sought to support its ongoing operation and possible trialling in rural settings, community sporting clubs and Aboriginal Medical Services. 

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Applying my learning from cultural safety training with CATSINaM

An interview with nurse practitioner Matthew Ball.

Matthew Ball is a Nurse Practitioner with a specialist focus on mental health who works in Adelaide. He undertook the March 2017 Cultural Safety Training workshop hosted by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), delivered by Sharon Gollan and Kathleen Stacey. [READ STORY NEXT PAGE >](#)

Tell us a little about yourself

I grew up in England and learned a little about Aboriginal heritage and culture at school. When I came here 20 years ago I was surprised by the dreadful level of racism.

While here I had a psychotic episode and became homeless. The only people who looked after me were Aboriginal people in a park in Northbridge, Perth...When I became homeless they were the people I turned to and asked for help. They got me home to England by taking me to the immigration centre—the irony of this is not lost on me.

I came back 15 years later in 2011, naively thinking things may have moved on. In my first few months at the Noarlunga Health Service, there was a person who came in frequently who mostly wanted to have a yarn and feel a sense of connection. I heard a nurse say, 'We don't work with them', referring to Aboriginal people. I would sit down with him and talk. I saw him every couple of months. We would have a sandwich and a cup of tea. I realised how little I knew about what was happening in Australia and how offensive it was that people wouldn't think to do this; just sit down and talk.

Tell us about the CATSINaM cultural safety training

I didn't know what to expect, the change in language was a distinct difference to any other

training available in the health service, which was called cultural awareness and cultural competence.

Of course, it's not possible for me to be competent in someone else's culture. I learned about dominant culture, white privilege and different dimensions of racism. I learned that I didn't need to walk in shame about white privilege but use it to work for change...I also realised that instead of asking Aboriginal people to talk about their culture, I can do some research and reading and find out more myself rather than Aboriginal people being asked to explain themselves and always have spotlight put on them.

How have you taken your learnings back into your work context?

I work in mental health and am also involved in the Hearing Voices Network in SA. The training gave me permission to work there and get my whiteness out of the way a bit.

One client sobbed his way through and I cried throughout the session. He said, 'You were the first whitefella to listen to that without trying to stop me'. I realised I may have got something right here. I got out of the way, so he could hold the space. We don't always do this as mental health professionals, as it is uncomfortable.

A practical thing I did was print the map of Indigenous Australia and use it for people in the

“The workshop changed my life. It’s not so easy for me to shut my eyes, look the other way and pretend anymore.”

clinic to identify themselves. I have met people from 44 different nations! I often tell colleagues I came to the cultural safety training, and one thing I didn’t know was who the people were walking around me in my area (I live and shop near my work). That is a powerful story for people, as they don’t realise that.

I also regularly do Acknowledgement of Country when I start a meeting with 5-6 people and share why we need to do this. It is a way of paying respect but reminding myself, holding myself to account. What comes with privilege is the easiness of life, so it is easy to not do it.

Another thing I got from the workshop was the obviousness of negotiation and collaboration, but how little of that we actually do, little meaningful negotiation with Aboriginal clients. It helped me watch my language as well, just in terms of not saying something, specific words I now won’t use.

Has it affected your life in other ways?

The workshop changed my life. It’s not so easy for me to shut my eyes, look the other way and pretend anymore. It took me way back to when I was growing up. My friend was black—he was adopted by his white parents. We cut our fingers to be blood brothers at seven years old, and I never forget being surprised that his blood was the same colour as mine!

The workshop gave me some permission to go

back there and re-understand this. We were split up when we were nine, didn’t see each other for 20 years, but we stayed friends.

It has changed how we talk about Aboriginal people, culture and safety in our home. We talk about cultural safety and use that language. We talk about how white our house is, that it represents more than just a group of white people living in a house. My kids were 5 and 7 when I did the workshop. When I was doing a presentation in Sydney they came and joined me. I told them about the Welcome from the Gadigal people. We went to Circular Quay and saw an Aboriginal education enterprise there. My kids wanted to go and talk to the people involved. I feel like this is an important journey we are doing. 

In 2017, Matt Ball was recognised as Nurse of the Year by the Australian College of Mental Health Nurses for his work with people experiencing psychosis.

This story is a shortened version of an article originally published by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives in its CATSINaM Newsletter, October 2018. Reproduced with permission. The original article is available at: www.catsinam.org.au.

More information on CATSINaM training is available at <https://www.catsinam.org.au/catsinam-programs12>.

A community-inspired agenda in Cape York

Catholic Health Australia

Opportunity in partnerships

The Apunipima Cape York Health Council has a mantra—to build the capacity of local Indigenous people, to employ Indigenous people, to build health and wellbeing of their people.

After more than 40 years of imposed top-down approaches that failed to shift the dial on Indigenous disadvantage and health outcomes, in 1994, traditional owners from 17 communities across Cape York gathered near Injinoo (the tip of Cape York) to discuss poor health. That summit resolved to establish the Cape York Health Council, mandated to inform the then Aboriginal and Torres Strait Islander Commission (ATSIC). Apunipima now has 150 staff across 11 communities and is growing.

Apunipima and other Cape York organisations and leaders attest to Aboriginal entities being the best trainers, recruiters and employers of Aboriginal people. They understand the cultural requirements and circumstances of their employees better than any other. This is backed by research that shows that these businesses are 100 times more likely to employ Indigenous Australians than other businesses. The factors that support Indigenous economic development are the same as the factors that contribute to any economic development initiatives—including human capital.

That's where Catholic Health Australia and its members Cabrini, Mercy, and St Vincent's Health Care groups come in. A partnership established in 2017 has been built on the premise of empowerment to support training, organisational

practices, mentorship, skills exchange, and locally led research, for the growth of locally run health services.

During a recent trip to Kowanyama by Catholic Health Australia (CHA), HESTA, St Vincent's Health Australia (SVHA), Mercy Health, Cabrini Outreach and the Royal Australasian College of Physicians (RACP), members of the local Council reiterated the need to grow their own workforce from local community members, to replace the flow of fly-in fly-out (FIFO) services.

Self determination

For Cape York people, 'Indigenous health' is much more than the clinical. It is Indigenous participation in health development, taking responsibility for their own health, social, and cultural wellbeing, and leading independent and productive working lives.

Roughly 1,000 people live in Kowanyama and surrounding homelands. It is remote and can be cut off by road for weeks during the wet season. Families remain deeply rooted in tribal traditions, ancestral languages and culture, and local leadership is flourishing.

Walking beside the community

The CHA-Apunipima Group met with local leaders, government agencies, and community action groups including the Women's Shelter and discussed the challenges around building local health workforce capacity, women's health and wellbeing, and barriers to service delivery.



Catholic Health Australia (CHA), HESTA, St Vincent's Health Australia (SVHA), Mercy Health, Cabrini Outreach, the Royal Australasian College of Physicians (RACP) with Apunipima in Kowanyama.

This was the second Cape trip following a visit to Aurukun in 2016 to establish how Catholic health providers could support a community agency. The gathering reaffirmed the group's commitment to eliminating health inequality and setting tangible outcomes based on community goals.

'This workshop has given us the opportunity to reflect on what we've achieved since this partnership commenced in 2015, and to look strategically at how we can continue building on the strengths of these relationships and the community', says Paul Stephenson, Apunipima's Chief Executive Officer.

'The visit connected delegates with local people and frontline health workers who shared the challenges that remote health service delivery presents. We look forward to continuing to work together to deliver community-driven services in the Cape.'

Suzanne Greenwood, CHA's Chief Executive Officer, said: 'As Catholic providers it is our mission to ensure that every Australian receives equitable access to quality healthcare, especially the most marginalised and vulnerable'.

'CHA's vision for our partnership is to use our position with our members to support Apunipima's service delivery; and to continue to advocate for better access to healthcare, housing, prevention,

and other measures that will go towards addressing these intolerable gaps in health and social-emotional wellbeing outcomes for the communities of Cape York.'

HESTA Executive Partnership Engagement, Neil Saxton says the visit provided valuable insight into the challenges experienced by HESTA members working at Apunipima and in rural and remote areas.

'HESTA is very proud to be a part of this initiative. It has provided the opportunity to learn first-hand about the gaps in women's health and the unacceptable health gaps experienced by Aboriginal and Torres Strait Islander peoples.

'We share in Apunipima's goal to close these gaps and look forward using these learnings to inform how we can continue to partner with organisations like CHA to have a meaningful impact in addressing these challenges.

Ms Greenwood said 'These are exciting times, with unlimited prospects. By working together, we can achieve reconciliation and empowerment by having "skin in the game", and ensuring the growth of strong local capacity'. ¹⁸

Reprinted with permission from Catholic Health Australia, *Health Matters* magazine, Spring 2018—Issue 87.



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The Lower Gulf Strategy

High burden of chronic disease in Doomadgee, Mornington Island and Normanton

Discreet Aboriginal communities in the Lower Gulf communities of the North-West Hospital and Health Service (HHS) area have for years borne a heavy burden of disease—for example, cardiovascular disease, diabetes, mental disorders, chronic respiratory disease and cancer—many of which are lifestyle diseases and therefore preventable.

Fragmented and ineffective primary healthcare services were not meeting these needs. Hospitals in the three communities targeted by the HHS—Doomadgee, Mornington Island and Normanton—reported potentially preventable hospitalisations (PPHs) of over 20%.

A more appropriate model of care

Clearly what was needed, and what the communities themselves called for, was a more appropriate model of care for each community, with the emphasis on primary and preventive healthcare, under Aboriginal community control.

Through the Western Queensland Primary Health Network (WQPHN), the North-West Hospital and Health Service (HHS) and Gidgee Healing (a regional Aboriginal Community Controlled Health

Organisation [ACCHO]), a tri-partite framework was adopted to Close the Gap in Doomadgee, Mornington Island and Normanton.

An MoU was executed by all parties in June 2017, providing a blueprint for design and implementation of the most appropriate model of care for each community.

The HHS Executive, Integrated Health Services team and HHS teams on the ground in Doomadgee, Mornington Island and Normanton began implementing an integrated model of care in May 2017. This model of care uses the nationally recognised ACCHO model, tailored to the nuances of the community with integration of both acute and primary care services. Primary care services have been consolidated with Gidgee Healing, with an 85% Indigenous workforce. Overall, 10% of the HHS workforce is Indigenous (state target 3%).

A feature of this shared service model—and central to the initiative—is strong community engagement and building cultural capability in the HHS teams. In addition to improved health outcomes, the project has seen an increase in the Indigenous health workforce, recruited directly from the communities. Transition to Aboriginal community control continues, with the project expected to be completed by June 2019.

Indigenous leadership

The building of cultural capability is led by the Director of Cultural Capability and Engagement, who is Aboriginal. The Doomadgee Health Council and Mornington Island Health Council (both with 95% Indigenous membership), and the Normanton Community Action Group (33% Indigenous representation) have provided essential support to the Lower Gulf Strategy through contributing to Model of Care design and the development of Health Action Plans. The HHS prides itself on extensive Indigenous cultural training for all staff and locums prior to commencement.

The HHS team's cultural capabilities have been strengthened by working with Gidgee Healing on the transition of services journey. Both organisations have learnt from each other's cultural awareness understanding and approaches. This has led to increased community engagement, resulting in interwoven services that meet cultural needs. For example, targeted promotion of My Health Record by both parties has raised awareness and uptake, resulting in better access to patient records for both acute and primary care teams.

Key achievements and outcomes

The outcomes expected from the Lower Gulf Strategy project are:

- a governance partnership, supported by a formal MoU, providing a strategic blueprint for future service and systems development in the Lower Gulf
- joint commissioning that directs State and Commonwealth resources to new culturally informed, integrated models of care targeting better management and prevention of chronic conditions
- effective clinical engagement and leadership from the region's primary care and specialist services

- development of a joint health intelligence capability to support an evidence-based approach
- consolidation of current integrated care initiatives
- quality monitoring and evaluation, and shared learning activities, at local, State and national levels.

The Lower Gulf Strategy has had a significant impact on primary healthcare in the targeted communities. For example:

- Since the introduction of community-controlled services, there has been a reduction in Emergency Department (ED) Category 4 and 5 presentations in the respective emergency departments (EDs) of the three hospitals with:
 - 1 in 5 Category 4 & 5 presentations diverted from Normanton ED to Gidgee Healing
 - a 31% decrease at Doomadgee
 - an 18% decrease at Mornington Island.
- There has been a 1,300% increase in Aboriginal Health Checks.
- 58% of the Mornington Island population have now seen a GP.

An evaluation framework provides the means for all parties to measure progress and informs the quality improvement process. Learnings were shared at a State level at a 2018 'Partners in Prevention' forum.

The Lower Gulf Strategy shows that an integrated model of care, driven by an ACCHO, does help to Close the Gap through increased and more efficient use of available healthcare resources. This can be seen in the reduction of Category 4 and 5 presentations to EDs and the marked increase in Aboriginal health checks performed. 



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Navigating the healthcare maze

A new model of care for epilepsy.

Waiting up to 17 years before being offered life-changing surgery is the reality for people with uncontrolled epilepsy. A new way of caring for people with this most severe form of epilepsy promises to speed up access to treatment, clearing a path through the often-daunting maze of health services.

Epilepsy affects around 1 in 26 Australians at some time in their life. Refractory epilepsy is at the severe end of this chronic condition, where people fail to respond to medication, leaving them unable to control their seizures.

Possible treatments are often buried in a maze of decision-making that has proven difficult for patients and healthcare professionals to navigate. For people with refractory epilepsy, life becomes a confusing and frightening journey through the health system.

Developing the new care model

I was fortunate enough to lead a team from Macquarie University, Cardiff University (UK) and

Sydney hospitals, Royal Prince Alfred Hospital, Royal North Shore Hospital and Westmead Hospital, to develop a new model of care to support and guide people with chronic neurological conditions, their families and care teams.

During the course of the study, researchers interviewed one woman who had refractory epilepsy for 27 years but had only recently been fully diagnosed. She had been prescribed many different medications and had numerous misdiagnoses and all the while experienced debilitating seizures that did not respond well to anti-epileptic drugs, disrupting her work and family life.

Researchers also spoke to a man who, after living with refractory epilepsy for many years, had finally undergone surgery but this had proven unsuccessful. He was left confused and disappointed and described the enormous emotional effort now required to remain hopeful of future success in the face of more surgery.

“Possible treatments are often buried in a maze of decision-making that has proven difficult for patients and healthcare professionals to navigate. For people with refractory epilepsy, life becomes a confusing and frightening journey through the health system.”



These cases are not unusual. It is currently taking a very long time for patients to move from first diagnosis, through a range of complex assessments, to an eventual full diagnosis of refractory epilepsy with more clear routes of treatment such as a surgical procedure—up to 17 years in Australia and up to 22 years in the United States. The journey is not a smooth or straightforward one, with many periods of delay, uncertainty, treatment gaps, disrupted home and work life, and concerns about the health system.

For the first time in neurological and brain research fields, this new model, called the PRIME Model, hopes to address this complexity and time lag. PRIME stands for Patient Reported, ImpleMentation sciEnce (PRIME). It will help to identify new pathways through the health system, avoiding system gaps and fractured journeys through care, and providing tools to overcome breakdowns in communication between patients, their families and healthcare professionals.

A new starting point—ask the patient

We believe that care should start from the point of asking patients what they believe to be important for their own health and wellbeing along with what they understand about their treatment and options. This then leads to determining pathways through the different clinical services and medications available for their unique set of circumstances.

The model also identifies where gaps lie in treatment and where there are breakdowns in communication, for example between the patient and their specialist doctor. The model places a strong emphasis on the patient's individual situation—including whether they are alone or well-supported; their comorbidities; and their expectations for care and wellness.

For example, Indigenous Australians living in remote communities will need care plans that

consider not only their individual profile but also cultural issues and geographic isolation.

An 'implementation science' approach

To develop this model, researchers took a unique approach. They recognised the need to give patients a voice; to give weight to the emotional toll of a chronic condition on people and their families; and to apply an 'implementation science' approach.

Implementation science is exactly what it sounds like—it is the skill of putting theories or ideas that have proven, through evidence, to be worthwhile into real world practice. It is about ensuring that well-evidenced advances in medicine and health services actually make it to the people who need them most, at the right time, and in the right place. Implementation science also looks at what barriers there might be to the widespread uptake or dissemination of new ideas, techniques or treatments and how these might be overcome.

For instance, surgery for people with refractory epilepsy has been available for decades, and yet it takes so long for Australians with the condition to come to a surgical intervention. Researchers asked why?

They also acknowledged that people with a whole host of brain and neurological disorders would benefit from being educated about their condition and treatments and being involved by clinicians in decision-making. This builds confidence and trust, without which people can suffer anxiety, which in turn leads to poorer health outcomes.

There is a known relationship between physical and psychosocial domains in epilepsy—and the PRIME model has the capacity to incorporate these factors into a care plan.

Professor Rapport says that 'next steps' will be to refine the model and test it through a pilot randomised control trial. ^{ha}

Walking together towards a better future



At HESTA, making sure every member can look forward to their future is what we're all about. And we don't stop there: we want to see all Australians enjoying a brighter tomorrow.

Aboriginal and Torres Strait Islander Australians in remote communities face unique challenges with super. Language barriers, limited phone coverage and missing or mismatched identification can make it tricky for people even to find their super accounts, let alone start growing them.

That's why our current Reconciliation Action Plan aims to help Aboriginal and Torres Strait Islander Australians' make the most of their super. To do that, we need to walk beside people to find a path to a better financial future.

In May 2018, HESTA employees Dee Eldridge and Husna Jamal travelled to the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands in the South Australia with the Australian Securities and Investments Commission's Indigenous Outreach Program. Joining peers from other super funds, they set out to learn from the APY communities and offer practical help to get their super on track.

"Dee and I sat down with members of the community to help them understand what super actually is and how to find and access it," says

Husna. "We were lucky enough to touch base with some HESTA members, including Darlene, which was great. We helped Darlene ensure her legacy could be passed on to her daughter through super. We also listened to our other members talk about respect for the land; passion to grow and give back to their community; about ensuring the next generation is educated to do this, and how super could help them on this path."

"It was hard sometimes to believe that we had made a difference due to the complexity of the Anangu's situations" says Dee. "But we did make a difference, by directly assisting almost half of the working aged population of the Lands. This is a fantastic outcome."

The experience was deeply moving, but more than that: the group is now working hard on how HESTA and the super industry can better support members whenever, and wherever, they need us.

YOU DESERVE A GREAT FUTURE TOO

And we'd love to help you take your next steps towards it. hesta.com.au/join



Become an AHHA member

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

The Australian Healthcare and Hospitals Association (AHHA) is the ‘voice of public healthcare’. We have been Australia’s independent peak body for public and not-for-profit hospitals and healthcare for over 70 years.

Our vision is a healthy Australia, supported by the best possible healthcare system. AHHA works by bringing perspectives from across the healthcare system together to advocate for effective, accessible, equitable and sustainable healthcare focused on quality outcomes to benefit the whole community.

We build networks, we share ideas, we advocate and we consult. Our advocacy and thought leadership is backed by high quality research, events and courses, consultancy services and our publications.

AHHA is committed to working with all stakeholders

from across the health sector and membership is open to any individual or organisation whose aims or activities are connected with one or more of the following:

- the provision of publicly-funded hospital or healthcare services
- the improvement of healthcare
- healthcare education or research
- the supply of goods and services to publicly-funded hospitals or healthcare services.

Membership benefits include:

- capacity to influence health policy
- a voice on national advisory and reference groups
- an avenue to key stakeholders including governments, bureaucracies, media, like-minded organisations and other thought leaders in the health sector

- access to and participation in research through the Deeble Institute for Health Policy Research
- access to networking opportunities, including quality events
- access to education and training services
- access to affordable and credible consultancy services through JustHealth Consultants
- access to publications and sector updates, including:
 - Australian Health Review
 - The Health Advocate
 - Healthcare in Brief
 - Evidence Briefs and Issues Briefs.

To learn about how we can support your organisation to be a more effective, innovative and sustainable part of the Australian health system, talk to us or visit ahha.asn.au/membership.



‘Our vision is a healthy Australia, supported by the best possible healthcare system.’

Our goals

In partnership with our members, we aim:

- **to enhance the health and wellbeing of Australians through improved standards in primary, acute, community and aged care**
- **to improve health service provision and health outcomes by developing, providing, disseminating and promoting research and education**
- **to support the delivery of high quality healthcare by promoting evidence-informed practice and advocating for funding models that support primary, acute, community and aged care services**
- **to support the health sector through the provision of business, education, advisory and consultancy services by connecting the diverse contributions of health practitioners, researchers, policy makers, and consumers**
- **to promote and support universally accessible healthcare in Australia for the benefit of the whole community**
- **to focus on innovation that enhances integration of care, including development of new models of care, and funding models that support health reform that responds to emerging issues.**

More about the AHHA

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

AHHA Board

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

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Dr Michael Brydon

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Dr Paul Dugdale

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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

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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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NATIONAL CLOSE THE GAP DAY

21 MARCH 2019

National Close the Gap Day is a time for all Australians to come together and commit to achieving health equality for Aboriginal and Torres Strait Islander people.

The Close the Gap Campaign will partner with Tharawal Aboriginal Corporation - Aboriginal Medical Service, South Western Sydney, to host an exciting community event and launch our Annual Report.

Go to the ANTaR website for more information, to register your support and get some ideas on how to host your own event.

www.antar.org.au/closethegap



CLOSETHEGAP

