REPORT ON
NATIONAL PARTNERSHIP FORUM
ON INDIGENOUS HEALTH

COUNCIL OF PRESIDENTS OF MEDICAL COLLEGES

11 AUGUST 2017, NEWCASTLE, AUSTRALIA

ACKNOWLEDGEMENTS

At the commencement of the forum the participants and staff of the HMRI Building were taken through a smoking ceremony before being Welcomed to Country by traditional custodians and brothers, Malcolm and Edward Smith of the Wirrigan Aboriginal nation in the Newcastle area.

On conclusion of the Welcome to Country, Edward and Malcolm gifted to the Forum and CPMC a clapstick that was used in the smoking ceremony.

The Clapstick (pictured here) was then used in the closing of the Forum as a "talking" stick, and participants agreed that it would be kept and used by CPMC to support the work of the partnership. It is a notable and important symbol, a reminder of the work that is being started through this Forum.

Professor Jacinta Elston, Associate Dean at James Cook University facilitated the proceedings.

All photography was taken by CPMC with the permission of the participants.

BACKGROUND

On 31 May 2017 the Australian Government, along with leaders from specialist Medical Colleges, the Australian Indigenous Doctor's Association and the National Aboriginal Community Controlled Health Organisation entered into a partnership agreement to work more closely together on *Closing the Gap* in health outcomes and life expectancy between Aboriginal and Torres Strait Islander Peoples.

To develop the partnership, CPMC convened a forum to discuss the issues identified in the Closing the Gap report from the perspective of the Health Performance Framework which was launched by the Australian Government in May 2017.

Held on 11 August 2017, the forum participants agreed that attention to Tier 3 of the framework was necessary to improve the outcomes in health for Aboriginal and Torres Strait Islander Peoples. Inherent in any focus on system improvement is the need to increase the number of Indigenous doctors and specialists in the health space, as well as nurses and health workers.

FORUM AIMS AND OBJECTIVES

The participants were brought together to firstly develop a partnership but also to identify a set of projects which could be undertaken in the short, medium or longer term and recommended to the Australian Government as ways to focus on improving outcomes as identified in Tier 3 of the Health Performance Framework. Each of the projects would need to be achievable and contain key deliverables with measurable outcomes, and each should estimate the level of resourcing required.

The agenda and list of attendees as pictured below are included in Appendices A and B.

FORUM DISCUSSION AND KEY THEMES

The forum was structured around three key themes:

1. Consensus building on the priorities for the partnership group,
2. Unpacking the challenges in the priorities and generating ideas for projects, and
3. Priority projects/actions to be recommended.

1. PRIORITIES FOR THE PARTNERSHIP GROUP

Agreed Priorities

The forum participants agreed on Tier 3 of the Health Performance Framework with a strong focus on priority one as *perinatal and infant wellbeing* as key to improving Indigenous health and wellbeing, as this involves communities, education and services.

1. Perinatal and Infant wellbeing
2. Avoidable Blindness
3. Avoidable Deafness
4. Reducing Foetal Alcohol Syndrome Disease
5. Reducing Rheumatic Heart Disease
6. Chronic disease focus including diabetes, cancer treatment and pain management
7. Indigenous health workforce, which includes Indigenous participation and the cultural, clinical and technical capability of the non- Indigenous health workforce.

In general discussion, the participants were invited to add further to why these were the priorities and what other information might be useful to consider in making recommendations to address them.

It was agreed that it was everyone's responsibility to address the social determinants of health and a prevention focus specifically in early childhood health and education was key to achieving change. Reference was made to the National Aboriginal and Torres Strait Islander Plan 2013-2023. It was also acknowledged that to 'close the gap' effort has to occur at the early health education interface, as it remains challenging for schools.

In the area of service delivery a series of issues were raised which with more effective leadership and management could result in greater efficiencies and lead to enhanced access to services. For example, health care CEOs are often equipped with limited knowledge of local issues because much of their attention is on finance; services can sometimes be poorly coordinated, and at times chaotic; cultural awareness is inconsistent across services. Given forty-five per cent of remote communities are Aboriginal and Torres Strait Islanders, a focus on what can be done is important because health outcomes decrease for populations the further remote they are from major cities.

Participants suggested that greater attention is required on building the Indigenous workforce and that there can be barriers to entry and bias. In order to build the Aboriginal and Torres Strait Islander workforce, more STP places could be quarantined for training in a particular specialty. A focus on mentoring and development of junior doctors who identify as Aboriginal and Torres Strait Islanders was also considered worthwhile. A suggestion to develop a culture of excellence was encouraged where hospitals and health services competed for Aboriginal and Torres Strait Islander talent identified either at school, university or in health services.

The paucity of performance framework data and inconsistencies between the jurisdictions requires attention by Government through COAG.

By collaborating in discussion at the forum it was agreed that moving forward, a lot more could be achieved between all of the partners in delivering services, resourcing the workforce and improving health status overall of Aboriginal and Torres Strait Islander peoples.

2. UNPACKING THE CHALLENGES IN THE HEALTH PRIORITIES AND GENERATING IDEAS INTO RECOMMENDATIONS

The TASK:
In four self-selected groups participants were asked to consider, discuss and gain consensus on each of the priorities in regard to the following:
- What has worked well in the past?
- What's currently happening? What should we be gearing up or down?
- What else could we be doing?
- What's in scope (with AIDA and NACCHO), to take forward?

Group 1 EAR AND EYE HEALTH

In general, the underlying issues and factors that contribute to ear and eye health conditions are common across many areas. Prevention of ear and eye health conditions was considered a serious public health issue. There was agreement about advocating for what does work well in particular communities, for example the eye vans. Greater resourcing of these is critical to reducing eye disease. Rolling out the Ideasvan nationally was agreed and more information can be found at http://www.ideasvan.org/

The group agreed that what else we could be doing is improving data and information management, because currently data are captured at different levels within jurisdictions that makes national reporting difficult. It was agreed that improving system reporting was a keymatter for the Australian Government and States/Territories.

It was agreed that improving the recognition of telehealth in the delivery of services should be considered because a lot more work could be done on 'store and capture' but it is not recognised by Medicare.

Similarly, it was agreed that enhancing awareness of the Medicare Item Number 715 across the field of general practice would result in greater opportunity for doctors to ask more questions by opening up conversation. This is because 715 is a Medicare Health Assessment for Aboriginal and Torres Strait Islanders aimed at ensuring primary health care is matched to their needs. It was agreed that if doctors used item 715 more this would help to diagnose, and intervene for common and treatable conditions that cause morbidity and mortality.

The forum agreed to work on developing a national ear health strategy which addresses ear health prevention and treatment.

Service fatigue is a major factor which many service groups do not acknowledge and there are coordination problems. It was agreed that better coordination of services is a priority to both ease the fatigue but also achieve efficiencies in delivery.

It will be important to improve the education of health workers to reduce the current high turnover and work to better train and retain staff.

Group 2 ANTENATAL HEALTH

What works well in antenatal health care for Aboriginal and Torres Strait Islander people is that ultimately antenatal health is a community driven program which is determined by what the community needs and works to foster the mother and child. Only by governments and service providers listening to the community can any improvements occur. What has worked well is the focus on reducing teenage pregnancy by early identification, and supporting plans for pregnancy with Aboriginal and Torres Strait Islander women to reduce FASD and other development issues related to substance misuse in pregnancy. It was agreed that addressing cultural risk is required because of a 'disconnect' currently between community and hospital. There needs to be a removal of barriers to multi-disciplinary teams working on the issues.

The group agreed that greater assistance is required for Aboriginal and Torres Strait Islander community members to navigate the complex health system. It was suggested that this could occur through the nurse and allied health training program - NACCHO. It was agreed that more support and structured education was required for health workers.

Service providers need to develop the capability to gain greater understanding of what may be behind a missed appointment, start a conversation about 'why', and determine is it cultural, financial or for another reason? The conversation leads to an opportunity to talk about health promotion.

Group 3 CHRONIC DISEASE

The management of chronic diseases in the Aboriginal and Torres Strait Islander community requires greater attention to cultural competency and training as well as access to health services in a coordinated way. The group agreed that health systems and services would benefit from coordination around a more holistic view of chronic disease. There is a lack of coordination across the jurisdictions in data collection and greater centralisation is necessary to improve analysis. There is a subjective institutionalised racism apparent in some health services which impacts on access and treatment.

NACCHO has the data on service delivery and where there are gaps, but it has an inability to compare the data between the jurisdictions. AIHW may have a role here. A greater focus is required on cultural safety, introducing e-health, improving telehealth, improving outreach clinics and the ability to track what happens from screening along the patient journey, if chronic disease management is to improve.

What can be done to improve the outcomes for Aboriginal and Torres Strait Islander people with chronic disease is for better distribution of health care workers ranging from doctors, pharmacists, nurses and allied health workers to rural areas with outreach to remote areas, so that access to primary care was improved, and through outreach access to specialist services where appropriate.

Group 4 MENTAL HEALTH

There was agreement that the Aboriginal and Torres Strait Islander Suicide Prevention Education Program (ATSISPEP) was a valuable and useful resource containing recommendations and a free toolkit. The training and retaining of more local practitioners to be culturally competent will increase the buy-in between doctors, nurses and health workers. Expanding on the Kimberly Mums Mood Scale tool was recommended. The interview concept of ‘here and now’ assessment was recommended. There was agreement that what works well is the sharing of resources on Aboriginal and Torres Strait Islander mental health care, and making the material available through CPD portals is the best approach to ensure consistency and quality.

3. PRIORITY PROJECTS/ACTIONS TO BE RECOMMENDED

3.1 HEALTH WORKFORCE

In discussion, it was agreed that all parties need to demonstrate a commitment to developing the Indigenous workforce and that achieving population parity leads to trust and equity. The concept of ‘additional opportunity’ is preferred to equal opportunity.

To recruit and retain the Aboriginal and Torres Strait Islander health workforce, it was agreed that all parties need to work to neutralise the risks of drop out and that robust support is required once through training.

Equally there was a need to make sure of cultural competency of non-Indigenous peoples to better meet the needs of peers and colleagues.

Project Proposals on health workforce

- **Short to Medium Term 'ready to go now'** 'Operationalised Doctors' A project to examine why Indigenous doctors do not make it through training, identifying possible cultural barriers that may exist, and exploring the causes of poor completions. This is a project which can occur in tandem with JCU/GMT at a cost of $100K but which must be completed before the end of 2017.
- **Medium Term Project 'where to now?'** A project examining after Medical School would examine what the graduate doctor may want to specialise in after medical school, and to contain data and mentoring options.

3.2 HEALTH SYSTEMS

The discussion centered on the importance of community controlled health systems where the local health worker is vital and hence, enabling the collection of appropriate data and ensuring proper coordination of services is required. Making the progression from health worker to practitioner is available from NATSIHWA. On the ground, there may appear to be a variety of personnel and services in communities but it was agreed the value was questionable considering the chaotic spread and poor local coordination. It was agreed that one step which would improve the capacity for the health system to be more culturally aware was to increase compulsory CPD for cultural awareness. The Australian Council on Healthcare Standards may consider including a tick of approval where hospitals and health services have been assessed to meet cultural safety standards.

- **Short-Medium term project:** conducted by NATSISHWA in tandem with NACCHO to define a set of skills to function effectively and to determine a career structure – what are the type of skills.
- **Medium - Long term project:** Undertake a scoping study – a gap analysis to determine what services are where and what/s missing. NACCHO to lead the undertaking of this and the development of a standard to be set regarding the type of services. Key outcome is improved data collection and data entry.

3.3 DEVELOPING CHARTER OF PRINCIPLES

Defining a set of principles to adopt to translate to action by the member colleges, the core principles may include:

1. Every College to have a Reconciliation Action Plan
2. Every College to have Aboriginal and Torres Strait Islander employment action plan
3. Aboriginal and Torres Strait Islander Fellows pathway to incorporate population parity, R&R and sharing information
4. Cultural intelligence coordination
5. Develop best practice relationship with community, e.g. LIME project
6. Aboriginal and Torres Strait Islander Health Action Plan at each College
7. CPMC advocates implementation of the NATSIHP

NEXT STEPS

The report from this Forum will be presented to the participants and after consultation to further define project proposals, ultimately to Minister for Indigenous health. A funding submission will be developed to access the resources necessary to facilitate the partnership ongoing, and any projects.

As equal partners in their commitment to improving the health and wellbeing of Aboriginal and Torres Strait Islanders, it is recommended that CPMC and AIDA will utilise the existing collaboration agreement to invite NACCHO to further develop the partnership. Currently AIDA undertakes the secretariat support for this process. This collaborative forum will add to its membership base by including

- Professor Ruth Stewart ACRRM
- Dr Catherine Yelland, RACP
- Dr Rod Mitchell, ANZCA
- Dr Simon Judkins, ACEM
- Professor Phil Truskett, CPMC

This report was produced following notes taken from the forum as facilitated by Professor Jacinta Elston, with research and policy development in the coordination and convening of the forum by CPMC Chief Executive with venue support from the University of Newcastle's HMRI Building. Special thanks to the staff of the HMRI.

APPENDIX A: FORUM AGENDA

11 AUGUST 2017 9-4PM CAVES THEATRE, HMRI BUILDING NEWCASTLE

8:45am	Arrival	
9:15am	Welcome to Country - Smoking Ceremony	(HMRI gumtrees)
9:45am	Opening remarks - Professor Talley	(Caves Theatre)
10am	Forum Remarks - Dr Kali Hayward	
10:15am	Forum Remarks - NACCHO	
10:30am	Introductions – Professor Jacinta Elston	
11am	Overview of Closing the Gap – Professor Ruth Stewart	
	Remarks from PM&C Director Timothy Saunders	
11:30am	MORNING TEA	(Haggarty Space)
12md	Group activity – 4 tables	
	Focus on existing challenges and generate ideas to set the agenda for the afternoon groups	
1pm	LUNCH	
1:45pm	Group activity to focus on priority areas and decide top 3 projects specific to them	
3pm	AFTERNOON TEA BREAK	
3:15pm	Plenary	
4pm	CLOSE	

APPENDIX B: LIST OF ATTENDEES

1. Professor Jacinta Elston – Facilitator
2. Professor Nicholas Talley – CPMC Chair
3. Professor Phillip Truskett – Chair of CPMC – elect
4. Ms Angela Magarry - Chief Executive, CPMC
5. Professor Kelvin Kong – RACS (Surgeons)
6. Dr Adam Castricum – President, ACSEP (Sports Physicians)
7. Dr Simon Judkins – Vice President, ACEM (Emergency)
8. Professor Ruth Stewart – President ACRRM
9. Dr Rodney Mitchell – Vice President, ANZCA (anaesthesiology)
10. Dr Greg Slater – President RANZCR (Radiology)
11. Dr David Andrews – CEO RANZCO (Opthalmology)
12. Dr Catherine Yelland – President RACP
13. Professor Steve Robson – President RANZCOG
14. Dr Ray Raper – CICM (Intensive Care)
15. Dr Siva Balaratsingham – RANZCP (Psychiatry)
16. Dr Kali Hayward – President AIDA
17. Mr Craig Dukes – CEO AIDA
18. Ms Pat Turner – CEO NACCHO
19. Dr Kristopher Rallah-Baker – Vice President AIDA
20. Dr Fadwa Al Yemen – Group Head, Social and Indigenous Group, Australian Institute of health & Welfare (AIHW)
21. The Hon Carmel Tebbutt – CEO Medical Deans
22. Dr Helen Cameron – Policy National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA)
23. Professor Jill Sewell – President Australian Medical Council
24. Mr Timothy Saunders – Director, PM&C, Australian Government
25. Dr Kiarna Brown – RANZCOG
26. Dr Marilyn Clarke – RANZCOG
27. Ms Michelle Quinlan – RANZCOG
28. Dr Tony Austin – RACMA
29. Odette Mazel, Leaders in Indigenous Medical Education (LIME)