

**SA Health Equity and Access in Health Care Policy
Directive Version No 1**

Consultation draft issued August 2018

Comment from Health Performance Council SA

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Comment from Health Performance Council on SA Health “Equity and Access in Health Care” Policy Directive Version No 1

Introduction

Health Performance Council (HPC) is the South Australian Government’s statutory Ministerial advisory body established under section 9 of the Health Care Act 2008 to provide advice to the Minister for Health on the performance of the health system, health outcomes for South Australians and specific population groups, and the effectiveness of community and individual engagement. HPC is not a body that advocates or advises on behalf of any particular group.

HPC has a working framework for reviewing health system performance that we apply as a set of key principles to consider in our data analysis and commentary. The council looks for situations when it appears system or policy changes may be causing unwarranted widening of health outcomes gaps between specific population groups. Most especially the council is concerned about specific population groups in our community that can be excluded and therefore vulnerable such as, and not exhaustively, Aboriginal peoples, people who live in rural and remote South Australia and culturally and linguistically diverse populations.

Acknowledgment

HPC acknowledges the Aboriginal peoples of South Australia and their ongoing contributions to and participation in the life of South Australia. The council acknowledges and respect their spiritual relationship with their respective countries.

The council also acknowledges the diversity of Aboriginal people in South Australia. South Australia is estimated to be the area of 50 different language groups at the time of European colonisation and 36 continuing language groups (Reconciliation SA 2012). Aboriginal peoples in their diversity have demonstrated resilience and have made significant contributions to South Australia despite the ongoing effects of colonisation and dispossession.

Council comment on the consultation draft policy directive

HPC agrees there is a good set of evidence of what works to improve equity and access in the health system – public and private - and commends SA Health on acknowledging the challenges by preparing this draft policy directive called “Equity and access in health care” for the public health services.

However, in commenting on this draft policy directive, **HPC has assumed from the drafting that SA Health has deliberately focused on identifying select actions and resources to support equity of public health service access for specific population groups**, rather than evidence-based policy to achieve equity and access by tackling wider determinants of health and action on preventable burden of disease. The council suggests, if the assumption is correct, the policy directive title might need tightening up to avoid future confusion and manage expectations.

This also means the council is not commenting on policy topics such as equity as it relates to the Public Health Act or the spectrum of public health action in the Chief Public Health Officers Report. The council encourages SA Health to produce the definitive policy directive on equity of access to public health services, and also encourages SA Health to continue the discussion within government and with stakeholders to develop an all-of-SA strategic direction on the broader aspects of equity and access in health care – public and private - and develop monitoring of social determinants of health care inequality as well as measuring access, service use and health outcomes.

HPC review work has enabled the council to consider whether there are common characteristics of successful policies in tackling equity and access, and how they could enhance the finalisation of this policy directive. From past HPC reviews looking at characteristics of health services correlated with differential outcomes between specification population groups, the council has this advice in broad actionable areas to contribute to the finalisation of this policy directive:

1. The policy directive should be clearer and more explicit about expectations for change from the top of SA Health with accountability in organisational performance assessments and complete transparency of outcomes, including the ways in which the chief executive and LHN Governing Boards will model behaviour and commission and track metrics to monitor the effectiveness of this policy.
2. There should be robust methods by which SA Health seeks to understand the equity of access challenges by (1) listening to consumers and service providers including the measurement of institutional harassment and discrimination including racism in the public health service and (2) using the data to identify how things are going and to see trends and patterns.

Although the draft intends SA Health to provide access to information in an open,

clear and timely manner about services, treatment, options and costs, the text is currently silent on key issues such as:

- equity of access to rural public health services at no cost to the consumer; and
 - equity of access to training and development opportunities for rural service providers.
3. The rationale for each proposed policy intervention should be clearer in the policy directive to encourage evidence-informed policy and focus on the line-of-sight between interventions and measurable outcomes. This is best identified via referencing evaluations and past research.

It might be helpful to draft an outcomes framework, or some other way of stating the theory of change, that shows a set of indicators of inequality in healthcare access and health outcomes. It's likely this indicator set will have indicators at different stages of a consumer pathway. There may be proxy measures that need to suffice for the launch of the policy directive such as, and not exhaustively, women accessing antenatal visits, immunisation of children, potentially preventable hospital admissions and health workforce density across and between local health network areas. In time, the outcomes framework could be developed into a form of equity of access 'dashboard' for communicating findings to decision-makers such as policy makers, service planners, service providers and consumers in a relevant, clear and concise format. It may suit adoption into the QIP Hub system.

4. Echoing SA Government diversity policy, the directive should state the value of actively measuring and improving diversity in the workforce in all groups from policy makers, service planners and service providers as it improves access and outcomes in the public health system.

The policy directive should nuance the extent to which it expects HR policies, procedures and training to be key drivers of change in ways of working.

The evidence tells us that for Aboriginal people, institutional racism in hospitals and health services fundamentally underpins racial inequalities in health and is a barrier to accessing healthcare. The policy directive should address racism by calling it out and requiring policy makers, service planners and service providers to take additional actions to overcome existing bias and realise health equality.

The HPC review paper, currently in the final stages of preparation, 'Post-implementation Review of Country Health Aboriginal Community and Consumer Engagement Strategy' references a matrix developed for identifying, measuring and monitoring institutional racism that appears simple and cost-effective to administer and evidence-informed showing value as both an internal and external assessment tool (Marrie H & Marrie A 2014 A matrix for identifying, measuring and monitoring

institutional racism within public hospitals and health services - .pdf copy attached)

As Stephen Duckett, Director, Health Program, Grattan Institute, wrote in response to the draft Code of Conduct for Medical Practitioners (Medical Board of Australia) that service providers should be: *“Recognising that non-Indigenous Australians may exercise unconscious bias in their treatment of Indigenous Australians, who also experience other forms of discrimination in healthcare; and taking steps to overcome bias and address the impacts of discrimination in your treatment decisions.”* (July 2018) <https://grattan.edu.au/news/good-medical-practice-needs-to-be-founded-on-patients-rights/>

There are recent independent clinical resources on improving ways of working. For instance, a recent consensus guideline process by RANZCOG with a group of medical colleges, professional bodies and peak organisations has produced an Overview of Cultural Competence in Professional Education, Training and Standard Setting for Clinicians (August 2017) <http://culturaldiversityhealth.org.au/wp-content/uploads/2017/09/Overview-of-Cultural-Competence-in-Professional-Education-Training-and-Standard-Setting-for-Clinicians-August-2017.pdf>

5. In communications and awareness-raising about the policy directive and its desired changes, it would help to have a narrative about equity and access that neatly summarises and makes imperative why all new efforts and accountability will deliver improvements to the experience and outcomes of consumers and service providers and how inequities affect individuals. There is much to leverage in current strengths on positive community attitudes about community diversity while the communications need to be brave enough to acknowledge racism and discrimination where it exists.

Conclusion

In general, these comments repeat the discussion items shared with Skye Jacobi and Kathy Ahwan from Policy and Governance Division, SA Health, at the council meeting session on 22 February 2018 before the consultation draft paper was provided.

The council encourages SA Health to produce the definitive policy directive on equity of access to public health services, and also encourages SA Health to continue the discussion within government and with stakeholders to develop an all-of-SA strategic direction on the broader aspects of equity and access in health care, and develop monitoring of social determinants of health care inequality as well as measuring access, service use and health outcomes.

Attachment

Marrie, H & Marrie, A 2014, A matrix for identifying, measuring and monitoring

institutional racism within public hospitals and health services

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A Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services

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Disclaimer:

This document has been produced as the basis of a pilot project to assess the effectiveness of the matrix in identifying, measuring and monitoring institutional racism in hospitals and health services (HHS) in each of the states and territories, and for soliciting local Aboriginal and Torres Strait Islander community and community controlled health service feed-back in order to improve the matrix before its final release for the purposes intended.

Best endeavours have been made by the authors of the document to ensure the accuracy of the information used, and referred to in developing the matrix. The responsibility for the interpretation and application of government policies in the development of the matrix is the authors' alone. The concept of the matrix as applied for the identification, measurement and monitoring of institutional racism within public hospitals and health services is and remains the intellectual property of the authors.

The authors acknowledge that they are not qualified health professionals and that they do not work in the health sector either in a private or public capacity, and that, therefore, any advice relating to specific health matters should be sought from an appropriately qualified health professional. The document has been produced in a private capacity concerning a matter of public interest. While the authors accept responsibility for the content of this document, they will not accept any liability, including for any loss or damage, resulting from the reliance by others on the content, or arising from its unauthorised use.

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Although the task of confronting institutionalized racism may seem overwhelming, it is not. The first step is to name racism in a society where many are in denial about its continued existence and impacts... The second step is to identify the mechanisms by which institutionalized racism operates..... The final step is to mobilize the political will for action.

Camara Phyllis Jones, M.D., M.P.H., Ph.D.¹
Confronting Institutionalized Racism (2003)

1. INTRODUCTION

In 2011 the Australian Institute of Health and Welfare (AIHW) reported that Indigenous Australians are more likely to end up in hospital than other Australians, particularly when the admission is potentially preventable. The rate of potentially preventable hospitalisations for Indigenous Australians was almost 5 times the rate for other Australians in 2008-09. For overall hospital admissions, the hospitalisation rate for Aboriginal and Torres Strait Islander people was almost 2.5 times the rate for other Australians.²

Racism is an ever present factor in the lives of most Indigenous Australians. For example, a recent survey of Aboriginal experiences of racism in Victoria, in which 755 Aboriginal people participated, found that nearly all participants (97%) reported at least one racist incident in the preceding 12 months, with 25% reporting between one and seven experiences, 38% reporting between eight and 11 experiences and 34% reporting 12 or more experiences. However, nearly a third of people in the survey reported racism in health settings in the 12 month period.³

Launched in July 2013 by the Australian Government, the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (the Health Plan) identifies:

Racism [as] a key social determinant of health for Aboriginal and Torres Strait Islander people, and can deter people from achieving their full capabilities, by debilitating confidence and self-worth which in turn leads to poorer health outcomes. Evidence suggests that racism experienced in the delivery of health services contributes to low level of access to health services by Aboriginal and Torres Strait Islander peoples.⁴

The vision guiding the Health Plan is one in which:

¹ Emerging Investigations and Analytic Methods Branch, Division of Adult and Community Health, National Centre for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, USA.

² AIHW (2011, p. 2).

³ Kelahe *et al* (2014, pp. 2 and 3).

⁴ Australian Government (2013, pp. 14-15), citing Awefoso (2011). Of the new health plan, Pat Anderson, chair of the Lowitja Institute, commented that “there is one area in which this plan breaks new ground, and that is its identification of racism as a key driver of [Aboriginal and Torres Strait Islander] ill-health.” And that “there is a growing body of evidence that the health system itself does not provide the same level of care to indigenous people as to other Australians. This systemic racism is not necessarily the result of individual ill-will by health practitioners, but a reflection of inappropriate assumptions made about the health behaviour of people belonging to a particular group.” <http://nacchocommunique.com/2014/02/28/naccho-aboriginal-health-and-racism-what-are-the-impacts-of-racism-on-aboriginal-health/> Accessed 19/03/2014.

The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address inequalities and determinants of health, this provides the necessary platform to realise health equality by 2031.⁵

The first of the key strategies identified in the Health Plan to achieve a “culturally respectful and non-discriminatory health system” is to: “Implement the *National Anti-Racism Strategy 2010-2020*”.⁶ In order to achieve a culturally respectful and non-discriminatory health system the Health Plan also promotes the need to: “Identify, promote and build on good practice initiatives to prevent and reduce systemic racism.”⁷ In describing racism, the Australian Human Rights Commission (AHRC) points out that:

It can also occur at a systemic or institutional level through policies, conditions or practices that disadvantage certain groups... On a structural level, racism serves to perpetuate inequalities in access to power, resources and opportunities across racial and ethnic groups.⁸

The Close the Gap Campaign Steering Committee argues for a:

Genuine partnership, with shared decision-making power, in planning processes at the national, jurisdictional and community level is an extension of that clear articulation of where responsibility lies. It also further empowers: enabling communities to be heard in policy, service and program design and delivery.⁹

However, as Howse has pointed out, the pace of the legal and policy reforms necessary for the recognition of Aboriginal and Torres Strait Islander peoples’ rights to be included in the stewardship, governance, administration and delivery of health services in which they are significant stakeholders has been “glacial”.¹⁰ However, there appears to be no dearth of good health policies to improve the health and life expectancy of Indigenous Australians, many of which have been around for a decade

⁵ *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*, statement of vision guiding the Strategic Framework (Australian Government, 2013, p. 8)

⁶ AHRC (2012)

⁷ Op. cit., Note 5, p. 15. In its submission to the AHRC National Anti-Racism Strategy consultation, the Royal Australian College of General Practitioners National Faculty of Aboriginal and Torres Strait Islander Health recommended, *inter alia*, “inquiring into institutionalised racism towards Aboriginal and Torres Strait Islander peoples in the health system” (AHRC 2012b, p. 15).

⁸ AHRC (2012, p. 3). Unfortunately no working definitions are given to enable observers to identify and distinguish between systemic, institutional and structural forms of racism in the *National Anti-Racism Strategy*. In the context of the Matrix, structural racism is located at the legislative level as hospital and health service (HHS) laws effectively provide the legislative architecture or infrastructure which structures governance, management, performance, employment, reporting and accountability arrangements. If the needs of the Indigenous population are not visible in the relevant laws, this has a flow-on effect within public hospitals and health services. Systemic racism is treated more as a senior and middle management phenomenon, particularly within the domain of human resources departments/units charged with the management of workplace relations. In identifying institutional racism, this is seen as a phenomenon that has many manifestations that can occur across all facets of an organisation’s activities and as reflected in the culture of an organisation as a whole - therefore, from a point of view of analysis and measurement institutions/organisations are treated holistically as discrete entities. In terms of their relationship, structural racism (in this case referring to HHS laws) is the fundamental driver of institutional culture, institutional racism encompasses the various direct and indirect manifestations of racism within an institution as a whole, and systemic racism is a particular manifestation of racism primarily occurring within workplace management, and which can also be a primary site where interpersonal racism can occur.

⁹ Holland (2014, p. 9).

¹⁰ Howse (2011:11).

or more¹¹ – the problem appears to be more a case of the slow up-take and implementation of those policies particularly by public hospitals and health services (HHSs) at the local level, and a lack of accountability mechanisms, reinforced by legislation and regulation, to make them do so.

One of the key messages in a recent report to the National Aboriginal Community Controlled Health Organisation (NACCHO)¹² is that: “The failure of mainstream [health] programs to deliver adequately lies at the heart of the continuing disadvantage of Aboriginal and Torres Strait Islander people.”¹³ It is also noted in the report that:

Cultural competency issues pervade the mainstream health system with little evidence of improvement. This is acknowledged in Australian Health Ministers Advisory Council reports (AHMAC). “*Indigenous people’s reticence to use government services*” is also noted by the Council of Australian Governments (COAG 2012:B53). Recognition of the problem has not resulted in its resolution. **A pervasive assumption that mainstream health services are an acceptable substitute [for Aboriginal Community Controlled Health Services] in urban Australia is not supported by evidence.**¹⁴

Also noting that, in regard to health system performance, “*equity, effectiveness and efficiency* are the three overarching performance indicators in annual *Reports on Government Services* (ROGS) measuring progress in health and other key sectors”, the report’s author also concludes that: “Judged against these measures and their component parts including access, appropriateness and cost effectiveness, the health system’s performance regarding Aboriginal Australians is poor.”¹⁵

However, within the overall framework for Closing the Gap on Indigenous Health Outcomes, there appear to be no indicators or assessment tools to measure public health sector engagement and inclusion of Aboriginal and Torres Strait Islander people directly in, for example, decision-making processes at board and executive levels, policy formulation and implementation, and service and program design and delivery of the health services provided to Aboriginal and Torres Strait Islander communities - particularly at the local level of health service delivery. It is also critically important that Aboriginal and Torres Strait Islander people are engaged in community consultative mechanisms to help guide the above processes. Such engagement is necessary if local hospital and health services (HHSs)/local health districts (LHDs)¹⁶ are to provide culturally secure,¹⁷ responsive,¹⁸

¹¹ Many of these federal and state/territory Indigenous healthcare policies relate to, for example, increasing Indigenous participation in the health workforce, cultural capability/competency, and inclusion in senior decision-making levels, date back a decade or more. These include: AHMAC’s *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework* (2002) and *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009* (2004); the Department of Health and Ageing *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013* (2003); and at state level, the 2002 *Agreement on Queensland Aboriginal and Torres Strait Islander Health* (between Queensland Health, the Commonwealth Department of Health and Ageing, the Aboriginal and Torres Strait Islander Commission and the Queensland Aboriginal and Islander Health Forum).

¹² National Aboriginal Community Controlled Health Organisation – the peak body representing the 150 Aboriginal community controlled health organisations around Australia.

¹³ Alford (2014, p. 9).

¹⁴ Alford (2014, p. 24). Emphases in the original.

¹⁵ Alford (2014, p. 26).

¹⁶ In Queensland, for example, the term Hospital and Health Services is used in referring to the entities which provide such services in 16 different regions in the state; in NSW, the term Local Health District is used.

¹⁷ Cultural security is defined as:

...the final stage in a continuum of development from cultural awareness, safety, and competency to security. Key principles for implementation of a cultural security policy include: changing service providers’ behaviour; improving understanding of service providers’ own cultural influences; actions at the structural, systemic and individual levels; ongoing organisational cultural competency evaluations that involve industry partners and Indigenous clients. Critically, this definition operates

respectful,¹⁹ appropriate and clinically safe health care²⁰ to Aboriginal and Torres Strait Islander people and their communities – particularly those living in remote locations.

The Matrix has therefore been developed as a tool for external assessment purposes to provide an objective, straight-forward and easy way to identify, measure and monitor racism in an institutional setting and to provide a measure for public health sector engagement with Aboriginal and Torres Strait Islander people in the decision-making, planning, implementation and accountability processes regarding Aboriginal and Torres Strait Islander community healthcare needs and service delivery. As such, it is also intended to complement those assessment tools that have been developed for internal assessment purposes – to broaden the range of tools available. In using the Matrix, most of the information needed both in framing the criteria and sub-criteria and measuring responses can be found in publicly available documents, most notably, annual reports, federal and state/territory health sector reports, service agreements, HHS websites, and federal and state/territory policies.²¹ Once the state/territory policy settings have been initially determined as a prelude to the assessment of the HHSs within their jurisdiction, and the sub-criteria for each HHS have been established and calibrated to reflect local HHS district characteristics and expectations of local Aboriginal and Torres Strait Islander communities and their community controlled health services, then assessments should be able to be undertaken via desktop analysis. It is also important for legal reasons that the information be publicly available or in the public domain.

Based on research to date, the Matrix appears to be unique in that:

- 1) It relies on publicly available sources of information to score each of the criteria and sub-criteria. In this respect, HHS annual reports, for example, as documents of public accountability are assessed as much on what they contain, as on what they don't.
- 2) It is intended as an external as well as internal assessment tool. Tools reviewed to date have all been intended for internal assessment purposes. Internal assessments usually remain "in-house", will probably remain that way so that the public is none the wiser, and do not and

within the human rights agenda. It encompasses an active conceptualisation of cultural security, emphasising 'behaviour' over 'attitude' and 'action' over 'understandings'. ... cultural security is inclusive of the other cultural states on the cultural continuum: awareness, safety and competency. (Dunbar, 2011, p. 4, citing Coffin, 2007. See also Dunbar *et al*, 2009)

¹⁸ *Koolin Balit: Victorian Government strategic directions for Aboriginal Health 2012-2022* defines 'cultural responsiveness' as referring to "healthcare services being respectful of, and relevant to, the health beliefs, health practices and cultural needs of Aboriginal communities" (Victorian Government 2012, p. 60).

¹⁹ The first of the nine principles underpinning the 2002 *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework* is cultural respect – 'ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander Peoples are respected in the delivery of culturally appropriate health services' (AHMAC 2002, p. 2). Cultural Respect, as defined in the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009*, is the: "recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples." Furthermore:

Cultural Respect is about shared respect. Cultural Respect is achieved when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples and where cultural differences are respected. It is a commitment to the principle that the construct and provision of services offered by the Australian health care system will not unwittingly compromise the legitimate cultural rights, practices, values and expectations of Aboriginal and Torres Strait Islander peoples. The goal of Cultural Respect is to uphold the rights of Aboriginal and Torres Strait Islander peoples to maintain, protect and develop their culture and achieve equitable health outcomes. (AHMAC, 2004, p. 7).

²⁰ The terms cultural awareness/competence/respect/responsiveness and safety are each briefly defined in the Victorian Government Department of Human Services *Aboriginal Cultural Competence Framework* (2008, p. 56).

²¹ Policies also include agreements, plans, strategies, frameworks, etc.

are not intended to create comparative data. In this respect, the Matrix would enable, for example, health research institutes, peak Indigenous health bodies, industry bodies like the Australian Healthcare and Hospitals Association and the Social Determinants of Health Alliance, or relevant government agencies to undertake HHS assessments within any state or territory and compare results.

- 3) Through its reliance on publicly available information, it establishes an assessment process which is open, transparent, verifiable and publicly available and which reflects the current health policy environment.
- 4) It is simple and cost effective to administer. Once the policy settings have been established for each state/territory jurisdiction as a prelude to assessing the HHSs within that jurisdiction, and the sub-criteria have been developed for each HHS to take into account local HHS characteristics and Aboriginal and Torres Strait Islander community expectations, assessments can essentially be undertaken by a single individual via desktop search of the relevant published sources.
- 5) In keeping with its simplicity and cost effectiveness, it is designed to be able to regularly monitor a HHS's progress in reducing and ultimately eliminating institutional racism over time.
- 6) It can be adapted/reconfigured for used by members of a single racial, ethnic, religious or cultural community or other group which experiences discrimination to enable them to undertake their own assessments of agencies/organisations/service providers that they interact with. Current internal assessment tools tend not to focus on specific groups, but address workplace diversity in all its manifestations.
- 7) Scores obtained by using the Matrix have the potential to be correlated with other Health System Performance data, including clinical data, to provide measures of the cost-effectiveness of the elimination of institutional racism from HHSs.

1.1 INSTITUTIONAL RACISM

Racism can be broadly defined as the behaviours, practices, beliefs and prejudices that underlie avoidable and unfair inequalities across groups in society based on race, ethnicity, culture or religion.²² Racism can be expressed through stereotypes (racist beliefs), prejudice (racist emotions) or discrimination (racist behaviours and practices).²³ Racism can occur at three conceptual levels - internalised, interpersonal and institutional - that are interrelated and frequently overlap in practice.²⁴

Regarding the reference to institutional racism, in the discussion paper arising from the *Racism and Indigenous Health* symposium held in November 2007 at Melbourne University (the Melbourne symposium), systemic racism is also referred to as institutional racism.²⁵ However, a distinction is made here between institutional racism and systemic racism - for the purposes of the Matrix they are not seen as being synonymous. Institutional racism is contextualised in reference to organisations or institutions as discreet entities, and the institutional culture which exists within them which is largely created and driven by the decision-makers at board and executive levels. Boards and executive groups can exercise a degree of autonomy and flexibility within the limits of the laws and policies under which the institution they govern must operate. Systemic racism refers more to the actual set policies, rules, health industry awards and procedures that exist (in this case

²² Kelaher *et al* (2014, p. 1). Paradies *et al* (2009, p. 7) also note that systemic discrimination can also refer to institutional, organisational, societal and cultural discrimination.

²³ Paradies (2006).

²⁴ Paradies *et al* (2008, p. 4). In this assertion, the term "institutional" has been substituted for "systemic" in the original.

²⁵ Ibid.

across a state or territory's public health service/system), and their observance and management in the day-to-day operation of an organisation,²⁶ and the decisions that flow from them that may unfairly impact people (both employees and clients) of a particular racial, ethnic, religious or cultural group. Systemic racism is sometimes referred to by Aboriginal and Torres Strait Islander people as "red-tape racism" and largely emanates from their experiences with Human Resource departments and can be closely associated with interpersonal racism.

Accordingly, for the purpose of developing the Matrix, institutional racism means:

The formal policies, practices, processes and conditions that serve to increase power differentials between racial, ethnic, cultural or religious groups.²⁷

And systemic racism, in the context of the Matrix, refers to:

The observance and administration of policies, rules and procedures that purport to treat everybody equally, but are unfairly or inequitably administered or applied in dealings with people belonging to a particular racial, ethnic, religious or cultural group.

In noting the relationship between internalised,²⁸ interpersonal,²⁹ systemic and institutional racism, it is institutional racism that fundamentally underpins racial/ethnic inequalities in health. Institutional racism is the most pervasive form of racism across a range of life domains and influences other social determinants of Indigenous health such as housing, education, employment, and justice administration.³⁰

The Melbourne symposium discussion paper also points out that "systemic [institutional] racism can persist in institutional structures and policies in the absence of prejudice at the individual level and that it is a fundamental cause of both internalised and interpersonal racism."³¹

²⁶ In Queensland's public health system, these responsibilities fall under the people and culture division of HHSs and have responsibility for, *inter alia*, workforce planning, employee relations, organisational development, human resource and occupational health and safety functions, Indigenous training and development, and cultural competency/awareness programs (see, for example, CQHHS 2013, p. 83; MHHS 2013, p. 6-37). People and culture divisions are also responsible for ensuring compliance with a suite of human resources policies such as Queensland's public service Code of Conduct, anti-discrimination policy, workplace harassment, complaints resolution and grievance resolution.

²⁷ Ferdinand *et al* (2012, p. 2).

²⁸ Paradies *et al* (2008, p. 4) define internalised racism as the:

Acceptance of attitudes, beliefs or ideologies by members of stigmatised ethnic/racial groups about the inferiority of one's own ethnic/racial group (e.g. an Indigenous person believing that Indigenous people are naturally less intelligent [or capable] than non-Indigenous people).

²⁹ *Ibid.* Interpersonal racism refers to:

Interactions between people that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups (e.g. experiencing racial abuse).

³⁰ This paragraph is largely derived from the following quote from the Melbourne symposium discussion paper:

Symposium participants readily acknowledged the importance of each of these levels of racism [ie, internalised, interpersonal and systemic racism], but noted that systemic racism is the level of racism that fundamentally underpins racial/ethnic inequalities in health. Systemic racism is the most pervasive form of racism across a range of life domains such as education, employment, and housing. These life domains have, in turn, been found to strongly influence health and wellbeing (Marmot & Wilkinson 1999).

³¹ *Ibid.*

Both institutional and systemic racism also generally fall into the category of “indirect racism”. Indirect racism frequently arises out of policies that purport to treat everyone equally but which, nevertheless, impact groups differently and therefore results in an unequal distribution of power, access to resources and services, and opportunities across different racial, ethnic, cultural and religious groups.³² Aboriginal and Torres Strait Islander people often refer to this situation whereby everyone is to be treated equally, as “mainstreaming”, especially when services once delivered through community controlled organisations, are instead delivered to their communities via mainstream organisations such as some of the large charities, and training and employment providers. This raises the issue of the cultural competency of such organisations to deliver services to Aboriginal and Torres Strait Islander people, and the spectre of the increased incidence of institutional racism as Aboriginal and Torres Strait Islander people are further removed from being included in decision-making structures regarding the design, planning, implementation and delivery of the services to be provided to them.

Aboriginal and Torres Strait Islander people as employees working in HHSs/LHDs that exhibit a very high degree of institutional racism, also suffer consequences – disempowerment, marginalisation and de-moralisation.³³ High levels of institutional racism can foster an institutional culture in which interpersonal and systemic racism can thrive.³⁴ Furthermore, such a culture can discourage Aboriginal and Torres Strait Islander people from seeking employment in hospitals and health services³⁵ - a serious consequence when Aboriginal and Torres Strait Islander participation in the health workforce is desperately needed to raise the overall cultural competency of HHSs. Systemic racism can fester in middle level management, for example, in decisions regarding the need for and number of identified positions for Aboriginal and Torres Strait people in the health workforce and at what level, fulfilling federal and state/territory Indigenous health workforce participation targets by only employing Aboriginal and Torres Strait Islander people in junior or non-clinical positions, denial of career advancement and training opportunities to Aboriginal and Torres Strait Islander health workers,³⁶ workplace deployment, unnecessary demarcation/award disputes (such as over the respective duties and responsibilities of Indigenous Health Workers and nurses), and criteria for patient assisted travel.³⁷

³² See Ferdinand *et al* (2012, p. 3). In the Queensland Government’s *Anti-Discrimination Human Resources Policy*, for example, indirect discrimination is defined as:

Any outcomes of rules, practices and decisions which purport to treat people equally and therefore appear to be neutral, but which are unreasonable and reduce an individual’s chances of obtaining a benefit or opportunity eg height weight requirements for candidates for a role which are irrelevant (Queensland Government 2009, p. 7).

³³ As the Coalition for Aboriginal Health Equity Victoria reports:

Racism has flow on effects for individuals’ social cohesion and for their levels of workforce productivity and educational achievement. The effects of racism for employees and employers include high rates of absenteeism, low overall workplace morale and productivity, high staff turnover, and increased health care and social service costs (Coalition for Aboriginal Health Equality Victoria 2013, p. 3).

³⁴ For example, Moreton-Robertson (2007:91), while serving as an expert witness for a case involving allegations of racially discriminatory behaviours by white nurses against an Aboriginal nurse in the Townsville Hospital in 2002, noted that the nurses could make statements consistent with racial stereotypes that position Aboriginal and Torres Strait Islander people as inferior, less than human and unworthy of the same treatment as non-indigenous people because they “felt safe in the institutional context to air such views. Their sense of safety signals that such comments are considered normal within the white space of the hospital.”

³⁵ See, for example, Felton-Busch *et al* (2009, p. 4).

³⁶ *Ibid.*

³⁷ For example, in the Northern Territory, Aboriginal patients needing medical treatment from a Health Centre may apply for patient travel assistance under the Patient Assisted Travel Scheme (PATS), however, it is not accessible for those patients who live within the 200km zone of the Health Centre. As Dunbar reports: “the objectives of a policy [in this case the PATS] to assist patients gain safe access to service can have quite the

1.2 EXISTING ASSESSMENT TOOLS FOR ADDRESSING INSTITUTIONAL RACISM

While institutional racism has been defined in many ways,³⁸ given legal recognition as a form of racism by the Stephen Lawrence Inquiry in England in 1999,³⁹ and examples of its existence in Aboriginal and Torres Strait Islander healthcare delivery described,⁴⁰ none has provided an objective and systematic way of identifying, measuring and monitoring the phenomenon, and in a way that enables external comparisons between HHSs/LHDs and over time to be made.

This dilemma was broadly noted at the Melbourne symposium:

The study of racism and Indigenous health is particularly challenging because of the difficulties in measuring racism itself. ... each level of racism has its own particular measurement challenges. ... Systemic [institutional] racism can be explicit or implicit. Most explicit systemic [institutional] racism is historical and includes a raft of legislation that has existed in Australia and Aotearoa for the purpose of controlling the lives of Indigenous peoples (see Chesterman & Galligan 1998). ... contemporary forms of systemic [institutional] racism are almost exclusively implicit in form. Systemic [institutional] racism is measured using audit-based tools that seek to compare indicators (process or outcome-based) across ethnic/racial groups using indirect methods. Such audit approaches establish avoidable and unfair outcomes that result from institutional or organisational requirements, conditions, practices, policies or processes. ... To enable the identification of systemic [institutional] racism, it is vital to have complete, accurate and timely data on health and social outcomes for Indigenous peoples. The symposium noted that further work is required to improve the quality of such data in both Australia and Aotearoa.⁴¹

While a number of assessment tools have been developed overseas to deal with race-based and other forms of discrimination in its various forms⁴², only one, the *Workplace Diversity and Anti-*

opposite effect if it is developed without knowledge about the social, demographic, environmental and cultural contexts for Aboriginal patients" (Dunbar 2011, pp. 10 and 16)

³⁸ Henry *et al.* (2004:517, citing McConnachie, *et al.*, 1988), for example, describe institutional racism as referring to "the ways in which racist beliefs or values have been built into the operations of social institutions in such a way as to discriminate against, control and oppress various minority groups", and that in Australia, "institutional racism has been an almost constant feature of our history,...". Elsewhere, in a Fact Sheet published by the NSW Government Department of Education and Communities (2013), institutional racism or systemic racism "describes forms of racism which are structured into political and social institutions. It occurs when organisations, institutions or governments discriminate, either deliberately or indirectly, against certain groups of people to limit their rights." In the literature some authors make a distinction between structural, systemic and institutional racism, while others use the terms often interchangeably.

³⁹ The Inquiry examined the conduct of the police investigation into the murder of Stephen Lawrence, a black teenager, in London in 1993. In its indictment of the police for mishandling of the murder investigation and the subsequent internal inquiry, it defined institutional racism for the purposes of the official inquiry as "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin" (*The Stephen Lawrence Inquiry*, 1999. See also *The Lancet* 1999; and Henry *et al.* 2004, p. 517).

⁴⁰ Henry, *et al.* (2004) and Mooney (2003) provide a number of earlier examples of institutional racism citing, for example, funding inequity, differential performance criteria for black and white with regard to (over) expenditure of healthcare funds; cultural barriers to Aboriginal use of healthcare services; and inequitable Medicare Primary Health Care (Medicare Benefits Schedule plus Pharmaceutical Benefits Scheme) – Katjungka (a remote Aboriginal community) = \$80/head/year, compared to Double Bay (an affluent Sydney suburb) = \$900/head/year.

⁴¹ Paradies *et al.* (2008, pp. 11-12).

⁴² For a review of some of these, see Trenerry and Paradies (2012a); and Trenerry *et al.* (2010).

*Discrimination Assessment Tool*⁴³ has been developed for the Australian context, and which can function as a standalone self-assessment process. As its authors point out:

The Workplace Diversity and Anti-Discrimination Assessment Tool has been developed following a comprehensive review of global literature on how to best assess workplace policy and practice in relation to diversity and anti-discrimination. A key finding of the review was that a tool to assess diversity and anti-discrimination workplace practices within an Australian context was not currently available, which led to the development of this tool.⁴⁴

The tool is structured according to five domains representing key organisational functions: (i) organisational profile; (ii) diversity planning and resources; (iii) communications; (iv) human resources; and (v) data collection and monitoring.⁴⁵ However, as the authors also point out, “[t]he tool has been developed in the context of internal workplace and employee issues and does not focus on organisational function relating to service delivery or external community engagement.”⁴⁶ Service delivery and external community engagement are important subject areas dealt with in the Matrix. Also the tool focusses on what might be described as the interpersonal and systemic manifestations of race-based discrimination in the workplace and as it affects people of diverse racial, ethnic, cultural, religious and linguistic backgrounds, rather than the more structural and institutional aspects of discrimination as they impact on a particular population group as a whole, in this case the Aboriginal and Torres Strait Islander community. Thus, from the perspective of Aboriginal and Torres Strait Islander healthcare service delivery, and in particular, in relation to Closing the Gap on Indigenous Health Outcomes and the plethora of complementary federal and state/territory policies, plans, strategies and frameworks, the *Workplace Diversity and Anti-Discrimination Assessment Tool* has limited application.

The Melbourne symposium participants also pointed out that:

...it is clear that much more applied research is required to determine how best to combat both interpersonal and systemic [institutional] racism against Indigenous people in Australia and Aotearoa. In particular, it will be important to establish the forms of systemic [institutional] racism that will be easiest and most beneficial to address, and to develop proven interventions to foster sustainable anti-racist cultures and environments.⁴⁷

The Matrix identifies a number of manifestations or characteristics of institutional racism that can be both easily and beneficially addressed, namely governance (in relation to inclusion of some form of Indigenous representation on HHS boards and at executive management level); establishment of appropriate Indigenous community consultative mechanisms; development of Indigenous health service plans and Reconciliation Action Plans; and open accountability in reporting HHS achievements and initiatives in annual reports (including Closing the Gap financial statements). All these, with the necessary level of commitment, could be achieved within a 12-18 month time-frame and lift a HHS score from, say, below 20 to somewhere between 60 to 80 points on the Matrix scale, that is from an extreme level of institutional racism to a moderate to low level. However, increasing the participation of Aboriginal and Torres Strait Islander people in the health workforce to levels that reflect their proportion of the local HHS district population could, with respect to some HHS districts with comparatively high populations of Aboriginal and Torres Strait Islander people, as in north Queensland, take much longer. Or ensuring that all non-indigenous health workforce employees in a HHS are culturally competent.

⁴³ Trenerry and Paradies (2012b).

⁴⁴ Trenerry and Paradies (2012b, p. 4).

⁴⁵ Ibid, pp. 5-6.

⁴⁶ Ibid, p. 3.

⁴⁷ Ibid, p. 14.

The Matrix is also capable of addressing other issues raised by the Melbourne symposium. For example the discussion paper raised the issue of health system performance as a way of dealing with institutional/systemic racism:

Symposium participants strongly supported improvements in health system performance as one approach to addressing systemic [institutional] racism in the health sector. Enhancing and tightening health system practices, policies and processes leaves less leeway for systemic [institutional] or interpersonal bias to influence clinical decision-making. Research in Australia (Devitt *et al.* In press) and Aotearoa (Penney, Moewaka Barnes & McCreanor 2006) has demonstrated better treatment and outcomes for Indigenous patients via improvements in service provider practices. Moreover, recent research from the United States describes a range of effective approaches to reducing racial bias among health care providers that should be explored in Australia and Aotearoa (Burgess *et al.*, 2007).⁴⁸

Using KPIs from AHMAC's *Aboriginal and Torres Strait Islander Health Performance Framework* the Matrix includes criteria in relation to Tier 3 Health System Performance particularly in relation to improving the cultural competency of a HHS both in relation to its non-indigenous health workforce staff, and by increasing the participation of Aboriginal and Torres Strait Islander people in its health workforce (see section 2.2 below).

2. INTERNATIONAL INDIGENOUS HEALTH POLICY CONSIDERATIONS

2.1 UN Declaration on the Rights of Indigenous Peoples: Realising the health rights of Aboriginal and Torres Strait Islander peoples

The *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) was adopted by the United Nations General Assembly in September 2007. On 3 April 2009 the Hon. Jenny Macklin MP, as Minister for Indigenous Affairs, announced in the federal parliament that Australia supported the declaration. The health rights of Indigenous peoples⁴⁹ are recognised in the following Articles:

Article 23. Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24. 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Furthermore, Article 18 states that:

Indigenous peoples have the right to participate in decision-making in matters which would affect their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions.

⁴⁸ Ibid, p. 14.

⁴⁹ See also Howse (2011, pp 14-15) with regard to other international instruments that have relevance to the health rights of Aboriginal and Torres Strait Islander people.

In addition, Article 19 complements Article 18, stating that:

States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain free, prior informed consent before adopting and implementing legislative or administrative measures that may affect them.

The Matrix is intended to reflect the requirements of these Articles. For example, with regard to the first key indicator concerning Aboriginal and Torres Strait Islander participation in organisation governance and leadership, the three criteria concerning legal visibility, representation at HHS board level, and representation at executive management level directly reflect the requirements of Articles 18 and 19 of the Declaration. Similarly, with regard to the second key indicator regarding policy implementation, the desirability of each HHS/LHD establishing a health services plan in collaboration with the local Aboriginal and Torres Strait Islander community embodies the right of Indigenous peoples “to be actively involved in developing and determining health ... programmes affecting them, and, as far as possible, to administer such programmes through their own institutions.” (Article 23). This speaks to the need for active collaboration between Aboriginal and Torres Strait Islander community controlled health services and the public health system at the local level in order to provide coordinated and integrated health care services to local Aboriginal and Torres Strait Islander communities via locally engineered health services plans.

2.2 Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health (WHO CSDH, 2008)

The Final Report of the WHO Commission on Social Determinants of Health does not identify racism (in any of its forms) as a social determinant of health. However, it does make some minor references to Indigenous peoples. The Report makes the following comment:

The differential status some groups enjoy and the differential opportunities for participation by specific populations is clearly manifested in the treatment of indigenous cultures – their world views, values, and aspirations – on the part of governments and those who deliver direct services.⁵⁰ The persistent inequity in the health conditions of Indigenous populations goes to the heart of the relationship between health and power, social participation, and empowerment.⁵¹ Regaining personal and cultural continuity has massive implications for the health and well-being of these communities,⁵²

The Report further notes that:

Indigenous Peoples’ lives continue to be governed by specific and particular laws, regulations, and conditions that apply to no other members of civil states. Indigenous People continue to live on bounded or segregated lands and are often at the heart of jurisdictional divides between levels of governments, particularly in areas concerning access to financial allocations, programmes, and services. As such, Indigenous Peoples have distinct status and specific needs relative to others.⁵³

The Commission therefore recommended that:

⁵⁰ Citing Indigenous Health Group, 2007.

⁵¹ Ibid.

⁵² WHO CSDH, 2008, p. 157.

⁵³ Ibid, p. 159.

- 14.2 National government acknowledges, legitimizes, and supports marginalized groups, in particular Indigenous Peoples, in policy, legislation, and programmes that empower people to represent their need, claims and rights.

The Commission then essentially recognises the rights relevant to health articulated above in the UN *Declaration on the Rights of Indigenous Peoples*.⁵⁴

Given that racism is not identified as a social determinant of health, and that only passing – albeit important, references are made to Indigenous Peoples and health in the CSDH report, the Matrix provides a unique opportunity to address those gaps.

3. NATIONAL INDIGENOUS HEALTH POLICY CONSIDERATIONS

The principal elements of the national policy environment which reflect the COAG 2008 National Partnership Agreement on Closing the Gap on Indigenous Health Outcomes and which are used to establish the criteria for the Matrix template (see Part 4) are provided by the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), the *Aboriginal and Torres Strait Islander Health Performance Framework*, Continuous Quality Improvement as a tool to facilitate Closing the Gap efforts and strategies, and relevant elements from the report of the National Commission of Audit. However, many other policy documents spanning the last decade or more are also referred to in the discussion of the indicators and criteria for the Matrix and its presentations. At the state and territory level, the template for the Matrix is to be set to reflect the relevant Closing the Gap health policy settings of each State and Territory. In Part 5, as a working example, Queensland's relevant hospital and health services legislation and policies are used to set the Matrix for undertaking assessments of the state's HHSs. At the local level, in Part 6, also as a working example, the Matrix (as set for Queensland) is then further calibrated and an assessment provided for the Cairns and Hinterland Hospital and Health Service (CHHS).

2.1 ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PERFORMANCE FRAMEWORK: Health System Performance⁵⁵

The Aboriginal and Torres Strait Islander Health Performance Framework (HPF) was designed to measure the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) and was an important tool in the development of the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*.⁵⁶ The HPF monitors progress in Aboriginal and Torres Strait Islander health outcomes, health system performance and the broader determinants of health.⁵⁷ The HPF covers the entire health system, including Indigenous-specific services and programs, and mainstream programs. As is pointed out in the HPF:

Monitoring the performance of health services and governments in their stewardship role is critical.

⁵⁴ At the time of publication of the CSDH's report, the United Nations General Assembly had not yet adopted the UN *Declaration on the Rights of Indigenous Peoples*.

⁵⁵ AHMAC (2012).

⁵⁶ Australian Government (2013).

⁵⁷ AHMAC (2012, p. 1).

In doing this, attention should be given to assessing not only the level of access to appropriate care but the personal experiences of Aboriginal and Torres Strait Islander peoples as active partners in managing their health.⁵⁸

The matrix is concerned to measure health system performance particularly from the perspective of Aboriginal and Torres Strait Islander community engagement, HHS accountability and service delivery. Accordingly a number of Tier 3 Health System Performance measures (HSPMs) were selected from the HPF as criteria for incorporation into the matrix.⁵⁹ These measures are:

- 1) Under the matrix key indicator for service delivery:
HSPM Effective/Appropriate/Efficient:
 - 3.07 Selected potentially preventable hospital admissions (PPHs);⁶⁰ and
 - 3.08 Cultural competency.
 HSPM Responsive:
 - 3.09 Discharge against medical advice (DsAMA); and
 - 3.12 Aboriginal and Torres Strait Islander people in the health workforce
 HSPM Sustainable:
 - 3.22 Recruitment and retention of [Aboriginal and Torres Strait Islander]staff
- 2) Under the matrix key indicator for participation in organisation leadership/governance:
HSPM Responsive:
 - 3.13 Competent governance.
- 3) Under the matrix key indicator for recruitment and employment:
HSPM Capable:
 - 3.20 Aboriginal and Torres Strait Islander people training for health related disciplines

2.2 CONTINUOUS QUALITY IMPROVEMENT (CQI)

Continuous Quality Improvement (CQI) can be described as:

The principles, methods and techniques that have been developed so that the application of the learnings that come from experience are captured. CQI is both a management approach that allows it to occur and the methods and techniques that are used in its application. Quality improvement occurs when opportunities for obvious change to practice for the better present themselves. It also occurs as the result of test projects where opportunities for improvement are analysed and the change strategy is planned, implemented and evaluated.⁶¹

In the *Aboriginal and Torres Strait Islander Patient Quality Improvement Toolkit for Hospital Staff*, following a number of case studies undertaken through the Improving the Culture of Hospitals Project (ICHP), it was noted that hospitals that were considered to be successfully addressing the issues of their Aboriginal patients shared the following:

- Strong partnerships with Aboriginal communities
- Leadership by hospital Boards, CEOs and clinical staff
- Strategic policies within the hospitals
- Structural and resource supports

⁵⁸ Ibid. p. 10.

⁵⁹ AHMAC (2012, Figure 1: Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures).

⁶⁰ PPH = potentially preventable hospitalisations – the acronym generally used for this KPI in HHS annual reports.

⁶¹ Willis *et al* 2010b, p. 17.

- A well supported Aboriginal workforce
- Enabling state and federal policy environments.⁶²

The matrix addresses and measures these characteristics to the extent that a HHS/LHD:

- 1) Fosters strong partnerships with the Aboriginal and Torres Strait Islander community, for example, through collaboration with their community controlled health services to establish health services plans;
- 2) Includes Aboriginal and Torres Strait Islander representation within its governance structure (for example, as board members), and input in decision-making (through community consultative bodies) regarding the design, implementation and delivery of health care services to their communities;
- 3) Formulates strategic policies that focus on, for example, the cultural competence of the non-indigenous health workforce (including those in executive, administrative and managerial roles), and participation of Aboriginal and Torres Strait Islander people in the health workforce, and as reflected, for example, in health service agreements;
- 4) Maintains structural and resource supports such as an Aboriginal and Torres Strait Islander workforce development unit, and a cultural competency training unit;
- 5) Maintains a well-supported Aboriginal and Torres Strait Islander workforce through, for example, the development of career pathways, opportunities for professional development, scholarships and access to mentoring and training across all health professions – clinical and non-clinical;
- 6) Implements state and federal policies – the matrix takes into account the relevant federal policies/frameworks/strategies for Closing the Gap on Indigenous Health Outcomes, and their state/territory counterparts, to establish the measurable content of the matrix at the local level. The intent of the matrix is to provide an overall assessment of the extent to which these policies translate into practice.

Within the policy context of Closing the Gap on Indigenous Health Outcomes, it was also noted in the Toolkit that:

Hospital Boards and CEOs are now required to respond to this challenge [regarding the continuous quality improvement process for improving the culture of hospitals for Aboriginal and Torres Strait Islander people], especially as many current federal and state/territory health funding agreements include requirements to improve the health of Aboriginal and Torres Strait Islander people.⁶³

In its first national audit of national Key Performance Indicators (nKPI) for Aboriginal and Torres Strait Islander primary health care, the Australian Institute of Health and Welfare (AIHW) reports that:

The analysis shows that **well-established CQI programs make a positive difference** and supports the view that the nKPI system itself can contribute to local CQI endeavours. ... The report also highlights the need for further development of a CQI system that supports organisations in improving the delivery of primary health-care services for Aboriginal and Torres Strait Islander people.⁶⁴

The audit concerns data collected primarily from Aboriginal community controlled health services, as well as those with other governance arrangements, that receive funding from the Australian Government Department of Health to provide services primarily to Aboriginal and Torres Strait Islander people. However, in the report the AIHW notes that:

⁶² Willis *et al* 2010a, p. 10.

⁶³ Ibid.

⁶⁴ AIHW (2014, p. ix). Original emphasis.

There is sound evidence to support the contribution that performance indicator systems can play in the delivery of effective primary health care when they are integrated with sound continuous quality improvement (CQI) strategies.⁶⁵ The nKPIs build on a body of work in Australia that integrates primary care performance data with quality improvement methods. ...CQI is one component of a broader health system response that is required to improve primary health-care delivery. ... The process of making sense of the [nKPI] data and adopting CQI practices requires organisational commitment, capability and capacity. ... A commitment to quality improvement is something that needs to be shared across all parts of a national approach to the provision of primary health care for Aboriginal and Torres Strait Islander people.⁶⁶

This last comment applies equally to both the Aboriginal and Torres Strait Islander community controlled health services sector as well as to public HHSs.

The Matrix supports the CQI approach to the extent that it identifies “opportunities for obvious change to practice for the better.” As noted above, HHSs/LHDs that exhibit very high or extreme levels of institutional racism can improve their rating within one or two years simply by addressing the criteria where they are found wanting, for example by including Aboriginal and Torres Strait Islander representation in the governance structure, ensuring that appropriate consultative mechanisms are in place, adequate reporting of their service to the Aboriginal and Torres Strait Islander community in their annual reports, and by working in partnership with Aboriginal and Torres Strait Islander community controlled health/medical services to establish health services plans for the community. Other opportunities for positive change may take longer, such as amending state/territory health services legislation to provide the necessary legal infrastructure for implementing the COAG National Partnership Agreement on Closing the Gap on Indigenous Health Outcomes, and increasing the participation of Aboriginal and Torres Strait Islander people in the local HHS/LHD workforce to a level which represents their proportion of the local population.

2.3 THE REPORT OF THE NATIONAL COMMISSION OF AUDIT⁶⁷

The *Report of the National Commission of Audit* contains a number of statements, observations and recommendations of relevance to the Matrix. These include:

- Consistent with the Commission’s core Principles of Good Government, the ‘government should: (i) protect the truly disadvantaged and target public assistance to those most in need; and (ii) be transparent and honest, as “[t]ransparency and honesty are fundamental to accountability.”⁶⁸
- Addressing the severe disadvantage faced by Indigenous Australians has been identified as a national priority by successive Commonwealth Governments.⁶⁹
- With regard to Closing the Gap targets and status, that the target to Close the life-expectancy gap within a generation (by 2031) is “Not on track – progress needs to accelerate”, while the target to halve the gap in mortality rate for Indigenous children under five within a decade (by 2018) is “On track (if current trends continue).”⁷⁰
- Over 75 per cent of Indigenous Australians are resident in urban and regional locations, achievement of the Closing the Gap targets depends on the effectiveness of mainstream

⁶⁵ Citing Bailie *et al*, 2007.

⁶⁶ Ibid, p. 1.

⁶⁷ Australian Government (2014).

⁶⁸ Ibid, Phase One Report, p. iii.

⁶⁹ Ibid, Vol. 1 Appendix, p. 41.

⁷⁰ Ibid, Vol. 1 Appendix, p. 40.

services. In some critical areas, such as primary health, Indigenous Australians are underutilising services relative to need.⁷¹

- While noting significant progress at Commonwealth level, with regard to empowerment and place-based delivery of programs and services, the Commission notes that there is “still a case for better engagement of Indigenous representatives and organisations in decision-making.”⁷²
- In regard to mainstream services, in singling out access to primary health care as an example, the report states that:

Stronger mechanisms need to be introduced to ensure mainstream programmes are working effectively for Indigenous people and are properly coordinated with Indigenous-specific programmes. Consideration needs to be given in the design of these services as to how they will work for Indigenous people. Options include requiring that mainstream services: publicly report on Indigenous access and outcomes; use Indigenous providers in areas with high Indigenous populations; and ensure mainstream services are designed and delivered in collaboration with Indigenous communities where practical.⁷³

The Matrix addresses these issues with criteria regarding, for example, engagement in decision making (under participation in governance), the need for HHSs/LHDs to engage with local Aboriginal and Torres Strait Islander community controlled health/medical services to establish Aboriginal and Torres Strait Islander health services plans, and reporting and accountability requirements regarding Closing the Gap on Indigenous Health Outcomes with regard to selected KPIs (cultural competency training, discharges against medical advice and potentially preventable hospitalisations), and financial accountability and reporting.

4. THE MATRIX

The Matrix has been developed to speed up the process of addressing the institutional factors that exclude or impede Aboriginal and Torres Strait Islander people from fully participating in the design and delivery of public health services for their communities, and accessing those service, based on the premise that no public hospital or health service would want to be “outed” or branded as “racist”. Public shaming can provide a powerful incentive for action.⁷⁴ The Matrix can therefore provide a useful tool⁷⁵ for Aboriginal and Torres Strait Islander communities through their peak representative health bodies, such as NACCHO, the NSW AH&MRC,⁷⁶ QAIHC,⁷⁷ VACCHO⁷⁸ and

⁷¹ Ibid, Vol. 1 Appendix, p. 44. Citing the Australian Institute of Health and Welfare (2011).

⁷² Ibid, Vol. 1 Appendix, p. 45.

⁷³ Ibid, Vol. 1 Appendix, p. 51.

⁷⁴ From this perspective it is no different from the National Health Performance Authority releasing data on, for example, rates of golden staph infections in hospitals around the country. “The release of such data which names and shames poor performing hospitals allows them to compare themselves to better performing hospitals and to see how they improved over time.” (Dunley 2014, quoting NHPA chief Dr Watson). According to Professor John Tunbridge who leads the program for national surveillance of antimicrobial resistance and antibiotic usage, “the public reporting of infection rates has driven hospitals to improve infection control” (Dunley 2014). Another example is Queensland Government’s *Queensland Health Emergency Department Patient Experience Survey 2013: Queensland May and June 2013*, whereby comparative data for 35 Queensland hospitals is provided in regard to responses to a wide range of questions regarding patient Emergency Department experiences (Queensland Government 2013). Such comparative data can be used as the basis for a health performance incentive scheme in which those HHSs that meet performance benchmarks are financially rewarded (see for example, Hume 2014; Queensland Health 2014).

⁷⁵ Its use, however, is subject to the written permission of the directors of Bukal Consultancy Services P/L.

⁷⁶ Aboriginal Health and Medical Research Council.

⁷⁷ Queensland Aboriginal and Islander Health Council.

AMSANT,⁷⁹ to rate and make accountable to the them the public hospitals and health services that provide healthcare services to their communities.⁸⁰

3.1 THE FIVE KEY INDICATORS OF INSTITUTIONAL RACISM

The Matrix has been designed around five key indicators of institutional racism and a set of 13 criteria. The five key indicators focus on areas in which institutional racism is commonly noted or experienced by Aboriginal and Torres Strait Islander people: (i) governance; (ii) policy implementation; (iii) service delivery; (iv) employment; and (v) financial accountability.⁸¹

3.1.1 Governance

For Aboriginal and Torres Strait Islander people, as key stakeholders in public HHSs, exclusion from the governance structure is a primary signifier of institutional racism. Their direct involvement in the decision-making processes regarding the design, planning and delivery of health care services to their communities is a priority issue, and is a federal policy directive. It is essential to achieving the best outcomes in primary and acute care, and preventative, clinical and allied health services. Failure to directly engage Aboriginal and Torres Strait Islander people in decision-making will negatively impact on their access to and delivery of these services,⁸² compromise the cultural and clinical safety of healthcare provision, and therefore diminish the effectiveness of initiatives, services and programs designed to close the gap on Indigenous health outcomes. The principal source of empowerment, recognition and accountability for Aboriginal and Torres Strait Islander healthcare stewardship and responsibility must be the enabling health service laws and regulations. For this reason the criterion addressing “legal visibility” is given an additional 10-point weighting over all the other criteria.

3.1.2 Policy implementation

The policy environment for this key indicator is provided by the 2008 COAG *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: National Healthcare Agreement* and *The Indigenous Early Childhood Development National Partnership Agreement* and the suite of policies that the COAG Agreement has generated at state/territory levels. However, in order to achieve effective healthcare delivery there must be an integrated and coordinated approach between the public health and Indigenous community controlled health service sectors as embodied in the mutual development of local level health service plans. Community engagement is also fundamental for the successful implementation of Closing the Gap health policy. However, there has to be readily available sources of information to Aboriginal and Torres Strait Islander people if

⁷⁸ Victorian Aboriginal Community Controlled Health Organisation.

⁷⁹ Aboriginal Medical Services Alliance Northern Territory.

⁸⁰ While the Matrix has been designed specifically for hospital and health services, it can be adapted for other kinds of services and agencies in which Aboriginal and Torres Strait Islander people have a direct interest. Such agencies include employment and training organisations, environmental agencies, educational institutions, the justice system and correctional services, child welfare agencies, cultural bodies, and a range of statutory authorities.

⁸¹ A recent study in New Zealand where there is a 7.3 year disparity in life expectancy between Maori and non-Maori lists five sites of institutional racism in public health policy making: (i) decision making practices; (ii) (mis)use of evidence; (iii) deficiencies in cultural (and political) competency; (iv) flawed consultation practices; and (v) impact of crown filters [“crown” essentially refers to ministerial and departmental authority and responsibility](Came 2014). Came (p. 214) also notes that “the Ministry of Health has recognized institutional racism as a determinant of health in policy documents since the 1990s...”.

⁸² See, for example, NHFA and AHHA (2010, pp. 10, 12, 14-19).

community engagement is to be effective. Such information, in the first instance, should be made available in the HHS annual reports.

3.1.3 Service delivery

Effective and culturally safe and appropriate health service delivery to Aboriginal and Torres Strait Islander people hinges on having both a culturally competent non-indigenous health workforce⁸³ and strong participation by appropriately trained Aboriginal and Torres Strait Islander people in that workforce.

3.1.4 Recruitment and employment

This indicator is focused on the actual status of the Aboriginal and Torres Strait Islander health workforce within a HHS/LHD according to employment trends, measurement against national and the relevant state/territory targets, commitment to employment equity principles at the local level, and whether or not there are strategies in place to improve Aboriginal and Torres Strait Islander employment in the health workforce.

3.1.5 Financial accountability

This indicator is based on the premise that both the Aboriginal and Torres Strait Islander communities and the Australian community at large have a right to know how the considerable amounts of funding allocated by both the Commonwealth and the states/territories to Closing the Gap in Indigenous Health Outcomes is actually being spent. This indicator is included to promote transparency and accountability in funding arrangements at the local level.

3.2 THE 13 CRITERIA FOR IDENTIFYING, MEASURING AND MONITORING INSTITUTIONAL RACISM

The criteria reflect aspects of the key indicators, with a number of criteria assigned to each indicator. Each criterion can then be broken down with a sub-set of criteria (or sub-criteria) that suit or reflect the particular circumstances of the hospital and/or health service being measured and monitored. The Matrix can thus be adapted to local circumstances, and the scoring also weighted to suit. Sub-criteria can be developed according to the jurisdiction, applicable laws, particular characteristics of the region (urban, rural or remote), demographics regarding Aboriginal and Torres Strait Islander people and the general population, relevant state/territory policy settings, the particular hospital or health service, and so on. If “the Devil is in the detail”, then the detail can be measured by inserting sub-criteria under each of the principal criteria to more accurately reflect local circumstances. What might be included as sub-criteria could result from consultations with local Aboriginal and Torres Strait Islander communities and their community controlled health services to determine the matters of importance to them and what they want to be included for measuring. In this way, they have a say in the finer details of the measurable content of the Matrix. The Matrix is therefore flexible enough for application to health services operating in very different contexts, such as the Northern Sydney Local Health District with a local Aboriginal population of some 2,500 comprising 0.3% of the district’s population, and the Cairns and Hinterland Hospital and Health Service where

⁸³ As the Closing The Gap Campaign Steering Committee has pointed out:

Health services and professionals need to foster culturally supportive and culturally safe environments to ensure Aboriginal and Torres Strait Islander patients feel comfortable identifying. This needs to be complemented by approaches to address systemic racism within the health service (Holland 2014, p. 18).

the Cairns Hospital, as the major regional hospital for Far North Queensland, serves an Aboriginal and Torres Strait Islander population of nearly 40,000 comprising 15% of the region's population – a population that is greater than the total Aboriginal and Torres Strait Islander population of Victoria.⁸⁴

3.3 PURPOSES OF THE MATRIX

The Matrix is designed to:

- In a broader sense, enable HHSs to “see what institutional racism looks like”, that is, its identification purpose.
- Measure HHS/LHD compliance with federal and state/territory policies for Closing the Gap in Indigenous Health Outcomes both in relation to Aboriginal and Torres Strait Islander community engagement and the accountability of the HHS/LHD to the Aboriginal and Torres Strait Islander community for the health services it provides to Aboriginal and Torres Strait Islander people.
- In consultation with local Aboriginal and Torres Strait Islander communities, reflect both the local circumstances and the manner of engagement with their local HHS/LHD in defining the sub-criteria that a local community wants to have measured.
- Incorporate examples of best practice – or at least better practice within the public HHS sector. Thus it can also be seen/used as an aspirational tool by including things that should be happening to make HHSs/LHDs more effective and accountable in providing health care to Aboriginal and Torres Strait Islander people and, thus by extension, speed up the process in Closing the Gap on Indigenous Health Outcomes.⁸⁵
- Enable HHSs/LHDs within a state/territory, or nationally, to be rated and compared while taking into account different state/territory and local HHS/LHD circumstances and characteristics.
- Be used by a HHS/LHD as an internal monitoring tool – as a check list or annual report card.
- Enable public health administrators to confront institutionalized racism by “examining structures, policies, practices, and norms to identify the mechanisms of institutionalized racism” as it is only through intervening at the institutional level that profound and permanent change can occur.⁸⁶

The Matrix is not designed to:

- Address or measure the incidence of interpersonal racism and discrimination occurring within a HHS/LHD. Other assessments tools, such as the *Workplace Diversity and Anti-Discrimination Assessment Tool* developed by Trenerry and Paradies,⁸⁷ are better suited for this purpose.
- Measure clinical performance as such, although some aspects of clinical performance may be referred to in terms of KPIs disclosed in annual reports (for example, with regard to numbers of non-indigenous staff who have received cultural competency training, and discharges against medical advice).

⁸⁴ ABS Census 2011.

⁸⁵ For example, following the lead of the North Sydney Local Health District, it is appropriate that all HHSs/LHDs develop their own Aboriginal and Torres Strait Islander health plans in conjunction with their local Aboriginal and Torres Strait Islander communities as publicly available documents. Similarly, few, if any, HHSs/LHDs currently disclose their Aboriginal and Torres Strait Islander annual health budgets and how they were acquitted in the financial statements accompanying their annual reports. The Aboriginal and Torres Strait Islander community and the general public alike have a right to know this information.

⁸⁶ Jones (2003, p. 11).

⁸⁷ Trenerry and Paradies (2012b).

For those hospitals and health services that manifest extreme levels of institutional racism, that is, a score of 20 or less out of 140 points, a case could be made to have such institutions subjected to some official investigation or inquiry by, for example, the relevant state/territory authority, the Aboriginal and Torres Strait Islander Social Justice Commissioner, or the Australian Health Ministers' Advisory Council, because invariably, policy directives have been ignored.

3.4 LINKING THE MATRIX TO HOSPITAL AND HEALTH SERVICE (HSS) PERFORMANCE

The Melbourne symposium discussion paper identified a number of key questions that focus on systemic/institutional racism, stressing the importance of further research on the prevalence of racism, its impact on Indigenous health and approaches to eliminating it from society.⁸⁸ These key research questions concern:

- What is the best way to measure systemic [institutional] racism against Indigenous peoples?⁸⁹
- What are the best approaches to addressing systemic [institutional] racism against Indigenous peoples?
- What racist elements of institutions/systems are most amenable to change and how should the fostering of anti-racist cultures and environments be measured?
- How can we improve health system performance as a way of combating systemic [institutional] racism against Indigenous peoples in health care?
- What are the costs of racism and the savings from anti-racism policy and practice?^{90 91}

The Matrix attempts to address each of these questions.

In regard to the best way to measure systemic/institutional racism against Indigenous people, the Matrix offers a direct quantifiable and comparative approach using a number of indicators and criteria which can be used for either external or internal assessment. It relies on publicly available information to inform the assessment so that scoring can be readily verified and the results published.

As an approach to addressing systemic/institutional racism, as noted above, the results for a number of HHSs can be published and compared, and the assessment periodically repeated so that progress towards the elimination of institutional racism within a HHS can be monitored over time. HSSs can be compared against each other, providing an additional spur to improve their efforts to eliminate institutional racism.

With regard to racist elements which are most amenable to change, the Matrix is based on a set of thirteen criteria, all of which can be, in principle, readily addressed – although some, such as building the cultural competency of a HHS's non-indigenous workforce may take time, as will increasing the participation of Aboriginal and Torres Strait Islander people in that workforce to a level that reflects

⁸⁸ Ibid, p. 16.

⁸⁹ Paradies *et al* (2008, p. 12)

⁹⁰ Ibid, p. 15.

⁹¹ In relation to this question the Melbourne symposium discussion paper noted that:

Although it is now relatively common to measure the cost to society of phenomena such as arthritis, obesity (Access Economics 2005, 2006) or ageing (Productivity Commission 2005), there are no studies in Australia or Aotearoa that have systematically estimated the costs of racism to society. The symposium supports calls to systematically estimate the cost of racism to society in Australia and Aotearoa and, concomitantly, the potential benefits of anti-racism policy and practice (Paradies 2005; VicHealth 2007). (Paradies *et al*, 2008, p. 14)

the proportion of the Indigenous population within the total population, particularly in HHS districts where this is high, as for example in the Cairns and Hinterland, Townsville and North West HHSs in Queensland.

The criteria in the Matrix reflect certain federal and state/territory policy directives – and for which in some instances KPIs have been assigned - which are designed to improve a HHS's performance as a way of combating systemic/institutional racism. For example, as is noted in the Australian Government's *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*: "The employment of Aboriginal and Torres Strait Islander health professionals also contributes to the development and maintenance of culturally safe workplaces and assists in addressing institutional racism."⁹² Coupled with a culturally competent non-indigenous health workforce, this should lead to improved health outcomes for Aboriginal and Torres Strait Islander clients as seen, for example, in decreasing numbers of clients who discharge themselves against medical advice and in the numbers of potentially preventable hospitalisations.

While the Matrix is not intended to measure clinical performance of a HHS with regard to such health conditions as respiratory disease, high blood pressure, diabetes, etc. as detailed in the *Aboriginal and Torres Strait Islander Health Performance Framework*, it would seem feasible, however, to ally the annual scoring of a HHS with regard to institutional racism with its annual reporting of KPIs regarding treatment for a number of health conditions that are identified in the Framework. It is also presumed here that the average costs of treating a particular health condition are known, and therefore, as the anti-racism culture of a HHS improves through the elimination of institutional racism, so might the health outcomes for Aboriginal and Torres Strait Islander clients also improve (for example, (i) as HHSs become culturally "friendlier" places clients will present earlier and will be more likely to complete treatment – that is, be less likely to discharge themselves against medical advice; (ii) the patient journey across the healthcare service spectrum will be improved because there is a health services plan in place to better integrate and coordinate healthcare delivery between the public and community-controlled health sectors, etc).

In addressing all these questions it should be possible to provide an evidence base to test whether the elimination of institutional racism (as identified, measured and monitored via the Matrix) leads to better health outcomes for Aboriginal and Torres Strait Islander people and whether there is any correlation, and also, by extension, provide a cost-benefit analysis of these outcomes. This should also be able to provide evidence of the effectiveness of the Matrix both as an assessment tool and as an agent for the elimination of institutional racism.

3.5 SCORING

The scoring system is deliberately weighted around certain priorities (with each criterion being scored out of 10) as reflected in the overall federal and state/territory health policy environments and settings, otherwise a simple "yes/no" [yes=1; no=0] system would suffice. For example, particular priority is given to Aboriginal and Torres Strait Islander representation in the governance structure of HHSs/LHDs, as input at this level will be a major determinant in how well a HHS engages with and delivers culturally safe and competent healthcare services to the local Aboriginal and Torres Strait Islander community, and holds itself accountable to that community. In addition to issues of legal visibility in the relevant health services legislation, participation on boards and at executive management level (either through direct membership, or via a board or executive management committee) is a case of "either it exists, or it doesn't", in which case there is either a score of 10 or 0.

⁹² Australian Government (2013, p. 23-4).

This principle generally applies throughout scoring against the various criteria and sub-criteria employed in the matrix. For example, with regard to the criterion concerning community engagement, in terms of the policy settings for assessing Queensland's public hospital and health services used to illustrate how policy settings can be used to determine the measurable content of the Matrix at state/territory level, this has been broken in to two sub-criteria regarding whether or not there is both an Aboriginal and Torres Strait Islander community consultative body, and a Reconciliation Action Plan within each of Queensland's HHSs . While the criterion for community engagement is weighted at 10 points, the sub-criteria are weighted respectively at 6 points for a community consultative body, and 4 points for a RAP. Depending on whether such a consultative body or a RAP exists or not, the possible score out of 10 will be either 10/10, 6/10, 4/10 or 0/10.

3.6 PRESENTATION OF THE MATRIX

In this paper, the Matrix is presented:

- 1) As a template;
- 2) Adapted for Queensland's public hospital and hospital services (HHSs) to indicate legislative and policy settings for each of the criteria. This information can then be applied for local level assessment of the sixteen HHSs in Queensland;⁹³ and
- 3) Applied to the Cairns and Hinterland Hospital and Health Service (CHHHS) as an example of its local level application.

Each presentation of the Matrix is accompanied by a number of notes to explain various facets of the matrix, the rationale behind the five key indicators and the criteria and sub-criteria. The notes are indicated (). Footnotes are also included to further amplify, clarify, etc various points made in the notes.

⁹³ A matrix would have to be drawn up in consultation with the local Aboriginal and Torres Strait Islander community (including their community controlled health/medical services) for each of the HHSs to incorporate their expectations of their local HHS to be reflected in the sub-criteria. Material for the matrix would also be drawn from annual reports, health service agreements, websites, etc. for each HHS/LHD.

5. TEMPLATE

13 Point Matrix for identifying, measuring and monitoring Institutional Racism within Public Hospitals and Health Services (1)

Key Indicators (2) and Criteria (3)		Scoring	Score			
1. Participation in organization leadership/governance (4)						
• Legal visibility (5)		20	?			
• Aboriginal and Torres Strait Islander representation at Board level (6)		10	?			
• Representation at Executive Management level (7)		10	?			
Total		40	?			
2. Policy implementation (8)						
• Closing the Gap in Aboriginal and Torres Strait Islander health outcomes (9)		10	?			
• Local Aboriginal and Torres Strait Islander Health Services Plan (10)		10	?			
• Community engagement (11)		10	?			
• Public Reporting and Accountability (12)		10	?			
Total		40	?			
3. Service delivery (13)						
• Cultural competence (14)		10	?			
• Aboriginal and Torres Strait Islander participation in health workforce (15)		10	?			
Total		20	?			
4. Recruitment and employment (16)						
• Employment profile (17)		10	?			
• Aboriginal and Torres Strait Islander health workforce development (18)		10	?			
Total		20	?			
5. Financial Accountability and Reporting (19)						
• Closing the Gap Funding (20)		10	?			
• Other identified Indigenous public health service funding		10	?			
Total		20	?			
Score		140	?			
Institutional Rating scored against criteria						
Score:	>110	80-109	60-79	40-59	20-39	<20
Evidence of Inst. Racism:	Very Low	Low	Moderate	High	Very High	Extreme

Notes:

1. Racism is identified as a key social determinant of poor health among Aboriginal and Torres Strait Islander people.⁹⁴ Racism in its various forms (individual, systemic, structural and institutional) has been described as a “constant ‘background noise’ in the lives of Aboriginal and Torres Strait Islander people” (AHRC, 2012:5, quoting from a submission by the Victorian Aboriginal Child Care Agency) and is a serious impediment in the delivery of healthcare and services to Aboriginal and Torres Strait Islander people and their communities (see also Awefoso 2011, citing various sources; Belleair 2010; Henry *et al*, 2004; and Ferdinand *et al* 2013). The ability to monitor progress towards elimination of institutional racism is a core reason for the creation of this matrix. It is designed with Closing the Gap in Indigenous Health Outcomes in mind to enable progress to be monitored within the timeframe set for Closing the Gap, namely by 2033. Therefore those wanting to use this matrix may want to consider the time frame that they wish to monitor – indeed if that is their intention. Some manifestations can be easily fixed within short time frames (12 – 18 months), for example, ensuring Indigenous representation on boards and at executive level management, developing local level health service plans, providing relevant detailed and comprehensive information in annual reports, and ensuring Indigenous participation in community consultative bodies, thereby rapidly improving their score and rating on the Matrix. Other initiatives will take time, for example, convincing governments to amend relevant laws to require Indigenous representation on Boards of agencies that provide services to them, increasing Indigenous employment levels to parity, particularly in the health professions where considerable training is involved, and demand is high, both within the public health system and the Aboriginal and Torres Strait Islander Community Controlled Health Services sector.
2. The five key indicators focus on common characteristics or identifiers of institutional racism and are designed to measure: (i) empowerment; (ii) policy implementation; (iii) service delivery; (iv) employment; and (v) transparency and accountability in funding arrangements.
3. Under each of the 5 key indicators, the criteria indicated can be further expanded/broken down in order to accommodate state/territory, regional or local policy environments and circumstances. The point allocations can then be divided and weighted accordingly. While there is an element of subjectivity involved in assigning points and measuring against them, the object is to create an assessment structure for future monitoring such that, over time, the performance of the institution in eliminating institutional racism can be tracked.
4. In its *Aboriginal and Torres Strait Islander Health Performance Framework* 2012 Report, the AHMAC offers this view on governance:

Governance enables the representation of the welfare, rights and interests of constituents, the creation and enforcement of policies and laws, the administration and delivery of programs and services, the management of natural, social and cultural resources, and negotiation with governments and other groups. The manner in which such governance functions are performed has a direct impact on the wellbeing of individuals and communities.⁹⁵

The Report then goes on to state that:

Competent governance in the context of Indigenous health must also address the cultural responsiveness of mainstream service delivery for Indigenous clients and effective participation of Indigenous people on decision-making boards, management committees and other bodies as relevant.⁹⁶

The NHFA and AHHA also point out that:

The current lack of opportunities for Aboriginal and Torres Strait Islander people to contribute to hospital governance is ... problematic. Aboriginal and Torres Strait Islander people are often powerless in the mainstream healthcare system, and this is a major factor

⁹⁴ Australian Government (2013, pp. 14-15).

⁹⁵ AHMAC (2012, p. 147). Citing de Alcantra 1998; Hawkes 2001; Westbury 2002; Dodson *et al* 2003.

⁹⁶ Ibid. The AHMAC’s statement of aims and principles in the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2011-2015)* with regard to localised decision making includes the following:

Ensuring decision making about health needs and priorities is driven by local Aboriginal and Torres Strait Islander communities so that health needs are met in a culturally-appropriate way and promote collaboration between Aboriginal and Torres Strait Islander and mainstream health services (AHMAC 2011, p. 5).

driving disparities in care. Including Aboriginal and Torres Strait Islander representatives on hospital boards is one way to address this imbalance.

The NHFA and AHHA therefore duly recommended that: “Aboriginal and Torres Strait Islander people should be systematically included in hospital governance.”⁹⁷

This key indicator essentially measures Indigenous empowerment/disempowerment – the extent to which Aboriginal and Torres Strait Islander people have been included in, or excluded from the key decision-making processes in the governance structure. Failure to include Aboriginal and Torres Strait Islander people directly in the key-decision-making processes throws into question the cultural competency of a HHS as a whole, particularly if, for example, the board members and members of the executive management team/group themselves have not undergone cultural competency training (see also Note 14 below).

5. The legal visibility criterion measures the extent to which Aboriginal and Torres Strait Islander people are recognised and empowered in the relevant state/territory health law(s). Hospital and health service legislation should also provide the necessary legal infrastructure and compliance framework for Closing the Gap in Indigenous Health Outcomes to set standards, *inter alia*, for reporting and accountability. The current body of federal, state and territory laws governing health administration renders Aboriginal and Torres Strait Islander peoples “legally invisible” with respect to their inclusion in governance and administrative arrangements in the public health sector for the delivery of healthcare and services to their people.⁹⁸ If Aboriginal and Torres Strait Islander peoples are to be empowered within a hospital or health service, it is fundamental that the relevant law(s) enables this to happen, for example, by requiring representation on the board/governing body⁹⁹ (or at least requiring the Minister to give due consideration for such representation on a board), representation on consultative bodies, enabling the Minister to establish special bodies/committees that may include such bodies comprising only Aboriginal and/or Torres Strait Islander membership, cultural competency in health care delivery, embedding the Continuous Quality Improvement (CQI) approach to improving health care delivery to Aboriginal and Torres Strait Islander people, etc. At the moment, it appears that no state/territory health law has such requirements. Legislation is a primary signifier of structural racism and is a key driver of institutional culture – change the law to recognise and accommodate the health needs of the Indigenous community, and current HHS culture will also change. Howse suggests this could be done by the inclusion in the objectives of the law and principles used for its interpretation and implementation the following
 - Participation of Aboriginal and Torres Strait Islander people in all aspects of governance
 - Recognition that Aboriginal and Torres Strait Islander people have a holistic approach to health, and that their holistic approach includes traditional medical approaches to healing, and this should be reflected in health policy making and programming
 - Delivery of health programs and services in a culturally appropriate and sensitive way

⁹⁷ NHFA and AHHA (2010, pp. 14 and 16).

⁹⁸ As Howse (2011:1-2) concluded:

A comprehensive review of existing health legislation in Australia found very little specific recognition of the needs of Aboriginal and Torres Strait Islander people in any of Australia’s nine jurisdictions. Where it was found, it generally failed to provide for a mechanism of input to decision making or implementation. This almost total lack of recognition in national and sub-national laws for the health needs of Aboriginal and Torres Strait Islander people leaves a weak or non-existent legislative structure on which to found stewardship and governance for Aboriginal and Torres Strait Islander health.

⁹⁹ In a New Zealand study of institutional racism in the public health sector District Health Boards (DHBs) were identified as sites of institutional racism in the context that they are decision-making entities for drafting and overseeing local health policy in spite of a legal requirement that there be a minimum of two Maori board members. As Came (2014, p. 216) explains:

Democracy and more particularly majoritarian decision-making is often upheld as the epitome of fairness as this type of decision-making reflects the viewpoints of the majority of people.... This seems reasonable to many within the dominant population. However for an indigenous minority such a system can be a structural impediment to getting indigenous priorities on the agenda. ...when indigenous peoples become a minority in their own country the imposition of majoritarian democracy and decision making become a culturally specific manifestation of historic racism.

- Statement of intent that the Act is consistent with and seeks to positively implement treaty obligations, specifically: the International Covenant on Civil and Political Rights; the International Covenant on Economic Social and Cultural Rights; the United Nations Declaration on the Rights of Indigenous Peoples; and the Convention on the Elimination of All Forms of Racial Discrimination
- A requirement for data collection to support health planning for Aboriginal and Torres Strait Islander people.¹⁰⁰

Having the necessary legal infrastructure in place that imposes requirements on decision-makers (HHS boards and their executive management teams) regarding the implementation of various measures for closing the gap on Indigenous health outcomes helps to ensure that Indigenous health priorities are not ignored particularly in cases where Aboriginal and Torres Strait Islander people are not represented in the governance structure.

6. Given the national priority and commitment to improving Aboriginal and Torres Strait Islander health it is highly desirable that there be Aboriginal and Torres Strait Islander representation on HHS boards. As the NHFA and AHHA recommend:

Aboriginal and Torres Strait Islander people need to be placed in positions of influence in the hospital system, including around the board table. Hospital boards also need to engage with local Aboriginal and Torres Strait Islander communities and seek community advice on how to deliver appropriate services.¹⁰¹

However, it is also recognised, particularly in cases where there are small numbers of Aboriginal and Torres Strait Islander people within a local health service district that this may not be feasible. In such situations, it nevertheless seems appropriate that a board committee be established to enable the local Aboriginal and Torres Strait Islander community to have direct input into board (decision-making) processes. In Queensland, in relevant circumstances, it would be appropriate that both the Aboriginal and Torres Strait Islander communities be represented on some of the local HHS boards.

7. Local Aboriginal and Torres Strait Islander communities may want to determine how they should be represented at executive management level, eg, a separate division or department for Aboriginal and Torres Strait Islander health under Indigenous directorship, via an advisory committee, reference group, etc. It is important that membership of such a body should include representation from the local Aboriginal and Torres Strait Islander community-controlled health/medical service(s). Executive Management usually operates an advisory committee structure. One or more of the committees may provide advice on matters of direct interest to Aboriginal and Torres Strait Islander communities, and therefore they should be represented. The criteria can therefore be adjusted accordingly and with an appropriate points' allocation.
8. This key indicator measures the extent to which health policies directed towards Aboriginal and Torres Strait Islander people are being designed, recognised, implemented and accounted for within a particular hospital/health service. The 2008 COAG *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* provides the fundamental point of reference, together with the federal and state/territory policies/strategies/frameworks/plans generated.
9. There is a suite of federal policies, with their state/territory counterparts, directed at different aspects of the National Partnership Agreement. In addition to the COAG Agreements, at the federal level these include:
 - Australian Government: *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*.
 - Australian Health Ministers' Advisory Council: *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011 – 2015*.
 - Australian Health Ministers' Advisory Council: *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009*.¹⁰²

¹⁰⁰ Howse (2011, pp. 29-30). See also pp. 33-34.

¹⁰¹ NHFA and AHHA (2010, p. 16).

¹⁰² In summarising the Framework, Willis *et al* (2010b, p. 69) point out that:

The goal and vision of the Framework is to uphold the rights of Aboriginal people to maintain, protect and develop their culture and achieve equitable health outcomes. It aims to influence corporate health governance, organisational management and delivery of the Australian health care system to adjust policies and practices to be culturally respectful and thereby contribute to improved health outcomes for Aboriginal people. The Framework emphasises that health and cultural wellbeing of

- Australian Government: *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Australian Government Implementation Plan 2007-2013*.¹⁰³
 - National Aboriginal and Torres Strait Islander Health Council (2008): *A blueprint for action: Pathways into the health workforce for Aboriginal and Torres Strait Islander people*.¹⁰⁴
10. According to the Australian Government Primary Health Care 2009 report:
The complex, fragmented and often uncoordinated delivery systems that operate across primary health care have implications for the services individuals receive, how they pay for them, and how care providers interact and provide care...the primary health care sector...is less successful at dealing with the needs of people with more complex conditions or in enabling access to specific population groups that are hard to reach.¹⁰⁵
- Most HHSs/LHDs will also have at least one Aboriginal and Torres Strait Islander community controlled health/medical service within their area. There may also be separate independent community controlled facilities for aged care, drug and alcohol rehabilitation, mental health and harm prevention, and child-care/youth services. Alford, in her report to NACCHO, also points out that that:
The lack of a coherent Indigenous primary health care policy or strategy and associated funding commitments results in inadequate and poorly distributed government expenditure on Aboriginal health, and in particular on Indigenous-specific, community based and controlled health care services. The predictable result is that **too much money is being spent on hospitals. High levels of avoidable admissions and avoidable deaths primarily reflect inadequacies in the provision of primary health care**.¹⁰⁶
- While the policy issues emanate from higher up at the government level, one way of addressing these issues, including government expenditure on Aboriginal and Torres Strait Islander health, is at the local level. It is important that the public health and Aboriginal and Torres Strait Islander health services sectors, and their respective funding allocations, are properly integrated and coordinated in their responsibilities for delivering healthcare to the Aboriginal and Torres Strait Islander population living in their area.¹⁰⁷ This can only be effectively achieved through a mutually developed and costed health service plan.
11. Different hospitals and health services have different mechanisms for community engagement. For example, via community consultative committees with membership drawn from the HHS district, a community reference group with membership based on expressions of interest, or an Aboriginal and/or Torres Strait Islander consultative body. Reconciliation Action Plans might also be another mechanism to promote community engagement. Thus a number of (sub-)criteria could be established under community engagement, and the points allocated accordingly.
12. In relation to its aims and principles regarding accountability for health outcomes, the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011-2015* states:
Recognising that accountability is reciprocal and includes accountability for health outcomes and the effective use of funds by Aboriginal and Torres Strait Islander community-controlled and mainstream services to government and communities. Governments are accountable for

Aboriginal people within mainstream health settings requires special attention. It identifies many factors that contribute to poor standards of Aboriginal health and wellbeing, including the low levels of confidence Aboriginal people have in being able to access acceptable mainstream health services.

¹⁰³ DoHA (2007).

¹⁰⁴ NATSIHC (2008).

¹⁰⁵ Australian Government PHC (2009, p. 19). Quoted by Alford (2014, p. 25).

¹⁰⁶ Alford (2014, p. 21). Original emphasis.

¹⁰⁷ In the Australian Government's Implementation Plan 2007-2013 for the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*, in relation to the health system delivery framework, one of the objectives is the:

Enhanced provision of comprehensive primary health care through increased coordination and the establishment of partnerships and collaborative linkages between Aboriginal community controlled health services and general (mainstream) services (DoHA 2007, p. 12).

Coordination, partnerships and linkages are best achieved through a local Aboriginal and Torres Strait Islander health services plan.

effective resource application through funding support, meaningful policy, planning and service development in genuine partnership with Aboriginal and Torres Strait Islander communities.¹⁰⁸

Annual reports are the primary documents for institutional public accountability. Information could also be conveyed through regular HHS bulletins, etc., distributed through Aboriginal and Torres Strait Islander community-controlled health/medical services. The primary purpose of this criterion is the degree to which annual reports demonstrate recognition, respect and inclusivity towards the Aboriginal and Torres Strait Islander community within each HHS – that the HHS is also “their” health service, also operating on their behalf, and how it is delivering healthcare and health services to meet their needs. Traditional Owner acknowledgement, progress on Closing the Gap (e.g., by reporting on national Key Performance Indicators), Aboriginal and Torres Strait Islander health workforce employment data, special achievement – these could all serve as indicators of how the HHS is respecting and serving the Aboriginal and Torres Strait Islander community. Comprehensive and quality information is also essential to enable Aboriginal and Torres Strait Islander communities to give informed advice and guidance to their representatives involved in HHS governance.

13. Service delivery, as a key indicator, generally refers to the cultural competence/capability of a hospital or health service to deliver culturally safe and appropriate healthcare, and, because Aboriginal and Torres Strait Islander health workers are a key part of this, the extent to which they are participating in the organisation’s health workforce. However, as the NHFA and AHHA point out:

Aboriginal and Torres Strait Islander health staff can’t carry the full responsibility for making hospitals welcoming and culturally safe for Aboriginal and Torres Strait Islander people. All staff should build trust with Aboriginal and Torres Strait Islander patients and deliver effective care in a culturally safe way. Cultural safety training for all staff is critical. Many non-Indigenous people, including hospital staff (particularly the many overseas-trained staff) have limited knowledge of Aboriginal and Torres Strait Islander issues. This may make it difficult for them to know how to communicate and treat patients appropriately. Large investment in cultural competence training in the hospital workforce is needed to improve communication, trust and care. Such training needs to be properly resourced and sustainable, and evaluated for its effectiveness.

The NHFA and AHHA have therefore recommended that: “All clinicians and hospital staff should be given effective cultural competence training.” It is also recommended that:

Cultural competency training should be included in undergraduate curricula for all health professionals. It is critical that on-the-job training in cultural competency is available and mandatory not only to clinicians, but also for all hospital staff who come into contact with patients and families, and for hospital executives and bureaucrats whose policy and funding decisions affect Aboriginal and Torres Strait Islander patients. This training should use evaluated, proven models.¹⁰⁹

14. A distinction is made between cultural capability and cultural competency. Cultural capability refers to the “skills, knowledge and behaviours that are required to plan, support, improve and deliver services in a culturally respectful and appropriate manner.”¹¹⁰ Cultural competency is defined as:
 - The awareness, knowledge, skills, practices and processes needed by individuals, professions, organizations and systems to function effectively and appropriately in situations characterized by cultural diversity in general and, in particular, in interactions with people from different cultures.
 - A set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. Cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services.¹¹¹

The cultural capability of a HHS/LHD largely rests on it having culturally competent staff. Based on the second of the above two descriptions of cultural competency, the cultural capability of a HHS would seem to depend on it having a “coherent set of policies and planning instruments backed by congruent behaviours and attitudes among professional/clinical and managerial staff alike, that enables it to integrate culturally secure, responsive, respectful, appropriate and clinically safe

¹⁰⁸ AHMAC (2011, p. 6).

¹⁰⁹ NHFA and AHHA (2010, pp. 14 and 16).

¹¹⁰ Queensland Health (2010c, p. 9).

¹¹¹ Queensland Health (2009b, p. 3)

practices in delivering health care to Aboriginal and Torres Strait Islander people.” Culturally inappropriate health service provision contributes to persistent health inequalities for Aboriginal and Torres Strait Islander people. For HHSs the concept and development of cultural competency is still an emerging discipline.¹¹² According to Dudgeon *et al*:

Cultural competency requires that organisations have a defined set of values and principles, and demonstrate behaviour, attitudes, policies and structures that enable them to work effectively cross-culturally.¹¹³

The NT Department of Health, in collaboration with the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) and the National Aboriginal and Torres Strait Islander Health Officials Network (NATSIHON), is developing a cultural competence framework based around three elements:

- (1) Organisational cultural competency;
- (2) Systemic cultural competency; and
- (3) Clinical/professional/individual cultural competence.¹¹⁴

Cultural competency training (CCT) for non-indigenous employees within a HHS is a core part of the strategy for Closing the Gap, and for which there is a KPI. Four elements could make up this criterion, namely:

- The institutional capacity to deliver CCT;¹¹⁵
- The number of non-indigenous health workers who have participated in or received CCT;
- The level of Discharges Against Medical Advice (DsAMA) as a reflection of the effectiveness of CCT;¹¹⁶ and
- The level of separations for potentially preventable hospitalisations (PPH).¹¹⁷

¹¹² While the concept of cultural safety as a requirement in the delivery of healthcare has been around for at least twenty years (see for example, Papps and Ramsden 1996), its acceptance in the HHS workplace has been problematic (see for example, Johnstone and Kanitsaki 2008) and in many instances ineffective (Downing *et al* 2011).

¹¹³ Dudgeon *et al* 2010. Quoted in AHMAC (2012, p. 135).

¹¹⁴ AHMAC (2012, p. 135).

¹¹⁵ Cultural competency training is emerging as a discipline in its own right with the necessity to tailor training programs not only for different clinical, non-clinical and allied health services, but also for board, executive, administrative and management roles. For example, the Queensland Health Organisational Cultural Competency Framework element concerning leadership and partnership requires the “Inclusion of accountabilities for cultural capability in service level agreements and performance plans for executive and senior managers” (Queensland Health 2010c, p. 15). Training also needs to be ongoing with refresher courses offered regularly. This means that each HHS/LHD needs to establish a position or unit (depending on the size of the HHS/LHD), supported by adequate resources and a budget, to delivery CCT.

¹¹⁶ DsAMA as a Health System Performance measure/KPI reflects the extent to which Aboriginal and Torres Strait Islander people ‘vote with their feet’ (i.e., in discharging themselves from hospital against medical advice). The measure provides indirect evidence of the extent to which hospital services are responsive to Indigenous Australian patients’ needs. Between 2008 and 2010, Indigenous Australians discharged from hospitals against medical advice at 5 times the rate of non-indigenous Australians. Such DsAMA were most common for the 15-44 age group, and more common for Indigenous people living in remote and very remote areas (AHMAC 2012, p. 139)..

¹¹⁷ PPHs as a measure/KPI reflects the level of Health System Performance for admissions to hospitals that could have potentially been prevented through provision of and access to appropriate primary and community health services. Potentially preventable conditions are usually grouped into three categories: (i) vaccine-preventable conditions; (ii) potentially preventable acute conditions; (iii) potentially preventable chronic conditions. Such admissions reflect the timeliness, quality and cultural responsiveness of referrals, treatment and discharge planning. (See AHMAC 2012, pp. 133-134). As the AHMAC reports:

Compared with non-indigenous Australians, hospitalisation rates for selected potentially preventable conditions were around 10 times as high for Aboriginal and Torres Strait Islander people living in remote areas, 4 times as high in major cities and regional areas, and 3 times as high in very remote areas. Potentially preventable hospitalisations for Indigenous Australians living in remote areas represented a higher proportion of all hospitalisations (39%) than nationally (26%). (p. 133)

15. This criterion is intended to reflect recognition that Aboriginal and Torres Strait Islander health workforce staff are a key and integral part of not only providing culturally secure, appropriate and safe health care and health service delivery to Aboriginal and Torres Strait Islander clients, and as recognised in Closing the Gap strategies at federal and state levels, but also in identifying and addressing cultural barriers to public health care for Aboriginal and Torres Strait Islander people.¹¹⁸ As the NHFA and AHHA point out:

Aboriginal and Torres Strait Islander staff positions are critical to supporting the patient through hospital and improving the journey across the whole of the healthcare system. Practical benefits include reducing the incidence of discharge against medical advice, improving the interface with other parts of the healthcare system, and improving compliance with post-discharge treatment regimes.¹¹⁹

Relevant policies include: Australian Health Ministers' Advisory Council: *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011 – 2015*; and Australian Health Ministers' Advisory Council: *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009*. This criterion could be extended, for example, to include the full range of HHS jobs from medical professionals through to support services. Policy referents include the National Aboriginal and Torres Strait Islander Health Council (2008): *A blueprint for action: Pathways into the health workforce for Aboriginal and Torres Strait Islander people*. Currently, there are very few Aboriginal and Torres Strait Islander people qualified in the full range of health professions, however, over time this will improve to the extent that separate sub-criterion for each general professional category is warranted.

16. The recruitment and employment indicator measures the existence and effectiveness of employment strategies for recruiting and retaining Aboriginal and Torres Strait Islander people into an organisation's health workforce against declared national and state/territory targets, and the application of equity principles to Aboriginal and Torres Strait Islander employment. The primary document, the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011 – 2015*, is informed by health workforce elements within National Partnership Agreements for Closing the Gap In Indigenous Health Outcomes, Indigenous Early Childhood Development and Indigenous Economic Participation.¹²⁰
17. Very considerable policy emphasis is placed on increasing the Aboriginal and Torres Strait Islander health workforce to meet federal and state/territory targets. The national target is that 2.6% of the public health sector should comprise Aboriginal and Torres Strait Islander employees. Within any particular health service it would be important to note whether the trend is up, down or static, and points allocated accordingly. It may also be relevant to record progress against national and/or state/territory targets. While national and state/territory targets for Aboriginal and Torres Strait Islander participation in the health workforce have been set and provide a base-line for the measurement of employment in the health workforce, it is also important that equity principles apply at the local level, such that workforce participation reflects the percentage of Aboriginal and Torres Strait Islander people within the local population. As is pointed out in the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*: "The employment of Aboriginal and Torres Strait Islander health professionals also contributes to the development and maintenance of culturally safe workplaces and assists in addressing institutionalised racism."¹²¹
18. Some services may have established a responsible body within their organisation to oversee recruitment, employment, training and development – an Aboriginal Health Workforce Development and Liaison Unit, for example, with its own strategy. For those HHSs/LHDs that have a large Aboriginal and Torres Strait Islander population, this seems highly desirable.

¹¹⁸ With regard to cultural barriers, see for example, McBain-Rigg and Veitch 2011. As the authors point out, "for Aboriginal patients the focus on interpersonal relationships between themselves and health practitioners is paramount" (p. 70). In a HHS setting, Aboriginal and Torres Strait Islander health workforce staff share with each other, their communities, and their patients, in the words of Gungulu man Dr Shane Houston, a "communitarian solidarity" (Henry BR *et al* 2004, p. 518).

¹¹⁹ NHFA and AHHA (2010, p. 14) citing various authors.

¹²⁰ AHMAC (2011, Foreword).

¹²¹ Australian Government (2013, pp. 23-4)

19. In *The Report of the National Commission of Audit*, it is pointed out that transparency and accountability “are the hallmarks of responsible government.”¹²² In a general summation of the problems regarding Commonwealth public sector accountability and performance, the National Commission of Audit notes that:

The availability of good information on the performance of government programmes and activities is crucial to ensuring taxpayers funds are well spent and government is held to account. ... Current arrangements make it difficult for the community to determine whether money is well spent, whether spending programmes meet their objectives and how efficiently and effectively the public sector is performing.¹²³

In the Australian Government’s Implementation Plan 2007-2013 for the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*, in relation to accountability, one of the objectives is the:

Increased reciprocity of information between governments, providers and consumers of Aboriginal and Torres Strait Islander health services.

As an immediate priority action, one of the specific strategies is to: “Improve accountability requirements of funded organisations...” Further, with regard to appropriateness of mainstream health services and programs, another action to improve accountability is by: “Including in funding agreements for mainstream services (where applicable) an accountability requirement for improving outcomes for Indigenous Australians through mainstream and specific programs.” (DoHA 2007, p. 43). However, Alford notes that there is still a lack of balance in government funding on Indigenous primary health care expenditure:

Too much money is being spent on hospitals [compared to Aboriginal Community Controlled Health services as more effective providers of primary health care]. Government funding issues include rationing Aboriginal health expenditure, under-utilisation of mainstream services, mainstreaming Indigenous expenditure, false economies resulting in avoidable and expensive hospital usage, sustainability and reporting issues, and failure to distribute funding equitably by a coherent, transparent, formal process. **Up to two-thirds of Aboriginal people rely on Indigenous-specific primary health care services. Yet three-quarters of all government Indigenous health expenditure is on mainstream services and nearly half (48.4%) of all expenditure is on hospitals** (ROGS E 2012 Table 5.2). Maldistribution of funding adversely impacts on services and clients, in New South Wales, Tasmania and Queensland severely, and Victoria considerably.¹²⁴

Financial accountability and reporting with regard to money allocated/granted for Aboriginal and Torres Strait Islander health is extremely important whether under the Closing the Gap strategy, or in relation to other federal and state/territory allocations. Aboriginal and Torres Strait Islander people, as well as the community at large, want, and have a right to know how the money is spent on programs targeted to address Aboriginal and Torres Strait Islander health needs. Open and transparent financial accountability is therefore essential. Financial Statements included as annual reporting requirements, should routinely include, as part of their income-expenditure statements, separate statements regarding funding which has been specifically allocated to Aboriginal and Torres Strait Islander healthcare and service delivery (either through federal or state allocations) or through special grants programs – for example, for clinical trials, NHMRC grants, allied health services (ATODS, Mental Health, Dialysis), employment and training, or delivery of cultural competency training under Closing the Gap funding. Sub-criteria could be added to reflect local/regional funding circumstances.

20. The 2008 COAG National Partnership Agreement sets out indicative commonwealth and state/territory budgets to meet the costs of implementing the COAG health reforms in five priority areas: (a) preventative health; (b) primary health care; (c) hospital and hospital-related care; (d) patient experiences; and (e) sustainability. In order to produce desired outcomes in these priority areas, the Agreement is centred on the following five initiatives: (i) tackling smoking; (ii) providing a healthy transition to adulthood; (iii) making Indigenous health everyone’s business; (iv) delivering effective primary health care services; and (v) better coordinating the patient journey through the health system (COAG Agreement, p. 4). The total cost to all governments of the measures proposed under the National Partnership Agreement is \$1.58 billion over the four year period covering 2009-10,

¹²² Australian Government (2014, Phase Two Report, p. ix).

¹²³ Ibid, pp. ix-x.

¹²⁴ Alford (2014, p. 14). Original emphasis.

2010-11, 2011-12 and 2012-13. Of this, some \$805.5 million is proposed as measures funded through Commonwealth Own Purpose Expenses, and \$771.5 million from the States/Territories Own Purposes Expenses (p. 13). Each state/territory has indicated their health budget for implementing the health reforms (see Attachment A1, p. 16), and for tackling each of the priority initiatives as parties to the COAG Agreement (Attachment A2, pp. 17 -19). Hospitals and health services therefore should also show their budget allocations from both the commonwealth and the state/territory governments against these priority initiatives, as well as other areas as part of their annual financial statements and demonstrate how they have acquitted these allocations in their annual reports.

6. TEMPLATE ADAPTED FOR QUEENSLAND'S HOSPITAL AND HEALTH SERVICES – LEGISLATIVE AND POLICY SETTINGS

13 Point Matrix for identifying, measuring and monitoring Institutional Racism within Queensland's Public Hospital and Health Services (HHSs) (1)

Key Indicators and Criteria (2)	Scoring
1. Participation in organization leadership/governance	20
<ul style="list-style-type: none"> Legal visibility: the <i>Hospital and Health Boards Act 2011</i> (Qld) and <i>Hospital and Health Boards Regulation 2012</i> (Qld)(3) <ul style="list-style-type: none"> Recognition of Aboriginal and Torres Strait Islander peoples as the First Queenslanders as per the Preamble to the Queensland Constitution. 1 Recognition of Queensland's commitment to the COAG - Closing the Gap in Aboriginal and Torres Strait Islander Health Outcomes National Partnership Agreement 2¹²⁵ Inclusion in s.5 Object of Act, a clause recognising the need for a responsive, capable and competent health service for the delivery of culturally appropriate and clinically safe health care to Aboriginal and Torres Strait Islander people 2 Recognition that experience in Aboriginal and Torres Strait Islander healthcare and healthcare service delivery and knowledge of issues affecting Aboriginal and Torres Strait Islander health and healthcare be amongst the areas of expertise required for appointments to a HHS Board under s.23(2). 2 Ministerial discretionary power to appoint Aboriginal and Torres Strait Islander people to HHS Boards in relevant circumstances, or to establish an Aboriginal and Torres Strait Islander Advisory Committee as a HHS Board Committee in relevant circumstances; 3 A requirement in that community consultative bodies established by HHS Boards include Aboriginal and Torres Strait Islander people, or that, in relevant circumstances, a HHS Board establish a community consultative body with membership comprised only of Aboriginal and Torres Strait Islander people.¹²⁶ 2 A requirement that each HHS, in conjunction with local Aboriginal and Torres Strait Islander communities and their community controlled health services, develop triennial health service plans for the coordinated and integrated delivery of health care to Aboriginal and Torres Strait Islander people within the HHS district¹²⁷ 3 A commitment to the Continuous Quality Improvement (CQI) process in the 	

¹²⁵ A single point is awarded in recognition of the sole reference to Aboriginal and Torres Strait Islander people in Queensland contained in **s.4 Principles and objectives of national health system** sub-paragraph (c)(vi) "social inclusion and Indigenous health – Australia's health system promotes social inclusion and reduces disadvantage, especially for Indigenous Australians" in the *Hospital and Health Boards Act 2011*.

¹²⁶ Reference to this could be made by amending **s.40 Engagement strategies** of the HHB Act in relation to a HHS's consumer and community engagement strategy.

¹²⁷ Under **s.42 Protocol with primary healthcare organisations**, in accordance with **sub-section (1)**

A Service must use its best endeavours to agree on a protocol with local primary healthcare organisations to promote cooperation between the Service and the organisations in the planning and delivery of health services.

This could probably be best achieved through the creation of local triennial Aboriginal and Torres Strait Islander health services plans negotiated between a HHS and any Aboriginal and Torres Strait Islander community controlled health/medical services including allied health services (for example, diversionary centres, aged and palliative care facilities, and mental health and harm prevention facilities) which embed protocols and CQI commitments.

provision of health services to Aboriginal and Torres Strait Islander people ¹²⁸	2
- A requirement that all funding allocated to Aboriginal and Torres Strait Islander healthcare be disclosed in the Financial Statement accompanying the Annual Report of each HHS	3
• Aboriginal and Torres Strait Islander representation at Board level (4)	10
• Representation at Executive Management level	10
Total	40

2. Policy implementation

• Closing the Gap	
- Explicitly identified as a strategic priority in Strategic Plan	5
- Closing the Gap KPIs explicitly referred to in Health Service Agreement (5)	5
• Aboriginal and Torres Strait Islander Health Services Plan (6)	10
• Community engagement (7)	
- Aboriginal and Torres Strait Islander community consultative body	6
- Reconciliation Action Plan (8)	4
• Public Reporting and Accountability (via annual report, local health news bulletin)(9)	
- Traditional Owner acknowledgement (10)	1
- Closing the Gap	
(i) Separate section in report devoted to Closing the Gap	1
(ii) Reporting on KPIs	1
- Policy references (11)	
(i) Cultural Capability Framework	1
(ii) Making Tracks	1
(iii) Aboriginal and Torres Strait Islander environmental health plan	1
- Organisational structure (ATSI unit placement within)	1
- Aboriginal and Torres Strait Islander Employment	
(i) Data on ATSI employment	1
(ii) Reference to workforce planning, recruitment, etc. (12)	1
- Other recognition (e.g., awards, scholarships, etc.)	1
Total	40

3. Service delivery

• Cultural competence (13)	
- Capacity to deliver CCT	4
- Proportion of non-indigenous staff trained	2
- Discharges against medical advice (DsAMA)	2

¹²⁸ This could be achieved, for example, under **s.82 Establishment of quality assurance committees** whereby the Chief Executive under clause **(1)(b)** could establish an Aboriginal and Torres Strait Islander Quality Improvement/Assurance Committee to oversee the quality improvement process. See Willis *et al* (2010a). Willis *et al* (2010b, p. 69) also point out that:

The key component of [the CQI] approach requires an ongoing feedback process from the Aboriginal community directly to the hospital to facilitate and strengthen that relationship. One option to encourage hospitals to gather community feedback would be to ensure this component is embedded with the ACHS EQuIP accreditation process. This would facilitate hospitals gaining first-hand experience of community feedback and therefore receive the benefit that direct community consultation provides and will enhance their potential to bring about the organisational cultural reform required.

- Potentially preventable hospitalisations (PPH)	2
• Aboriginal and Torres Strait Islander participation in the health workforce (14)	
- Medical and other health professionals	2
- Nurses (15)	2
- IHWs (16)	2
- ILOs	2
- Operational and Support Services (17)	2
Total	20

4. Recruitment and employment (18)

• Employment profile	
- Aboriginal and Torres Strait Islander employment trend (19)	3
- Aboriginal and Torres Strait Islander employment against State and Federal targets (20)	4
- Application of employment equity principles	3
• Aboriginal and Torres Strait Islander health workforce development body	10
Total	20

5. Financial Accountability and Reporting (21)

• Closing the Gap Funding (22)	
- Commonwealth contribution (23)	5
- Queensland contribution (24)	5
• Other identified Indigenous service funding	10
Total	20

Score	140
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Institutional Rating scored against criteria

Score:	>110	80-109	60-79	40-59	20-39	<20
Evidence of Inst. Racism:	Very Low	Low	Moderate	High	Very High	Extreme

Notes:

1. HHSs are responsible for providing health services and programs that better meet the needs of the local community thereby ensuring a greater say in how future services will be designed and delivered.¹²⁹ In accordance with *Health Systems Priorities for Queensland 2013-14*:
 - All health service activities should be informed by, and align with, strategic plans that are linked to relevant Commonwealth and Queensland Government policy.¹³⁰
 - Closing the gap in health outcomes for Aboriginal and Torres Strait Islander Queenslanders is identified as one of the four health service directions listed as a health system priority.¹³¹
 - In relation to Closing the Gap, the desired outcomes sought by the Queensland Department of Health include:

¹²⁹ Queensland Health (2013b, p. 4)

¹³⁰ Ibid, p. 5.

¹³¹ Ibid, p. 7.

- * Access to culturally capable health services is increased for Aboriginal and Torres Strait Islander peoples
 - * Access to effective partnership is increased for Aboriginal and Torres Strait Islander peoples
 - * Cross health continuum efforts are enhanced to promote good health, prevent illness where possible and improve management of existing illness.¹³²
2. To avoid duplication of the notes provided for the Template, the notes provided here are for aspects that are specifically relevant to Queensland's public hospitals and health services.
 3. The *Hospital and Health Boards Act 2011* (Qld) and *Hospital and Health Boards Regulation 2012* (Qld). But for a single reference in **s.4 Principles and objectives of national health system sub-paragraph (c)(vi)** "social inclusion and Indigenous health – Australia's health system promotes social inclusion and reduces disadvantage, especially for Indigenous Australians", the *Hospital and Health Boards Act 2011* and the *Hospital and Health Boards Regulation 2012* (Qld) render Aboriginal and Torres Strait Islander people "legally invisible" and does not honour fundamental legislative principles as laid out in **s.4(3)(j)** of the *Legislative Standards Act 1992* (Qld) by having "sufficient regard to Aboriginal tradition and Island custom".¹³³ The Act and Regulation do not provide the necessary legal and compliance and accountability infrastructure to make HHS Boards abide by the COAG National Partnership Agreement on Closing the Gap on Indigenous Health Outcomes. For example, **Schedule 3 Agreements Part 1 Agreements with Commonwealth, State or entity** of the *Hospital and Health Boards Regulation 2012* (Qld) does not include among the list of agreements the COAG National Partnership Agreement on Closing the Gap on Indigenous Health Outcomes. The single reference in **s.4(c)(vi)** earns a score of 1 out of 19. Effectively this means that all public hospitals and health services in Queensland that fall under the *Hospital and Health Boards Act 2011* cop a nineteen point penalty when scored against the criterion of legal visibility in the Matrix. The score for this criterion will remain at 1 until the Queensland Government amends the *Hospital and Health Boards Act 2011* (Qld) to incorporate these (and other) suggestions within the Act to provide the necessary "legal visibility", or legal infrastructure,¹³⁴ that recognises and empowers Aboriginal and

¹³² Ibid, pp. 12-13.

¹³³ A good example of legal visibility for Aboriginal people and Torres Strait Islanders is the *Nature Conservation Act 1992* (Qld). For example, **s.4 Object of Act** states that:

The object of this Act is the conservation of nature while allowing for the following –

- (a) The involvement of indigenous people in the management of protected areas in which they have an interest under Aboriginal tradition or Island custom[.]

With regard to how the object of the Act is to be achieved, **s.5** states:

The object of this Act is to be achieved by an integrated and comprehensive conservation strategy for the whole of the State that involves, among other things, the following –

- (f) Recognition of interests of Aboriginal and Torres Strait Islanders in nature and their cooperative involvement in its conservation
 - * the recognition of the interests of Aborigines and Torres Strait Islanders in protected areas and native wildlife;
 - * the cooperative involvement of Aborigines and Torres Strait Islanders in the conservation of nature[.]

With regard to community participation in administration of the Act, **s. 6** states that:

This Act is to be administered, as far as practicable, in consultation with, and having regard to the views and interests of, landholders and interested groups and persons, including Aborigines and Torres Strait Islanders.

The *Nature Conservation Act 1992* then proceeds to lay out a regime for the involvement of Aboriginal and Torres Strait Islander people in the management of national parks, joint management arrangements for protected areas and participation in relevant committees. For example, with regard to **s.132A Committees for protected areas in Cape York Peninsula Region** whereby the Minister may establish advisory committees, under **s. 132A(3)**:

Each committee established under subsection (1) must consist of representatives of indigenous people the Minister is satisfied have an interest in the protected areas for which the committee is established.

¹³⁴ Howse (2011, p. 11).

Torres Strait Islander people within the public health sector in the provision of health care services to their communities.

4. In Queensland, under **s.23(1)** of the *Hospital and Health Boards Act 2011* the Minister has the responsibility for recommending to the Governor in Council appointments to the HHS Boards. How Aboriginal and Torres Strait Islander communities within each of the HHS districts wish to be represented at board level may depend on: (i) the population mix of Aboriginal and Torres Strait Islander people; and (ii) the overall percentage of Aboriginal and Torres Strait Islander people within a HHS district as whole. In the Cairns and Hinterland Hospital and Health Service (CHHS) and Townsville Hospital and Health Service (THHS), and in accordance with the wishes of the respective communities, it is appropriate that both peoples/communities are represented.¹³⁵ In other HHS districts, for example, in south-west Queensland or the Darling Downs, it may be appropriate to have only Aboriginal representation on the HHSB. The desired number of representatives can also be factored in. For example, the Aboriginal and Torres Strait Islander communities within a particular HHS district may consider it appropriate that there be more than one Aboriginal or Torres Strait Islander member on the board, and may want both male and female representation as a culturally appropriate requirement. It might also be taken into account that having only one Aboriginal or Torres Strait Islander representative on the board can be a particularly daunting experience for that person.¹³⁶ If there is more than one member, at least they are able to support each other and jointly recall and discuss the board's proceedings (even though these are generally required to be minuted). With regard to (ii), under **s.43A(1)** of the *Hospital and Health Boards Act 2011* (Qld), the Minister has the power to appoint an ancillary board to advise a public sector hospital, health facility, health service, or part of the State. This means that the Aboriginal and Torres Strait Islander communities within a HHS district, particularly where their numbers are small, might request the Minister to establish an Aboriginal and Torres Strait Islander ancillary body to advise the local HHSB, as an alternative to having direct representation on the Board.
5. The five Closing the Gap KPIs suggested for inclusion here include:
 - Estimated level of completion of Indigenous status – specifically the reporting of 'not stated' on admission
 - Percentage of inscope separations of Aboriginal and Torres Strait Islander consumers from the HHS' acute mental health inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated (in person or via videoconference), was recorded in one to seven days immediately following the separation

¹³⁵ It is also noted that an agreement between Queensland Health, the Commonwealth Department of Health and Ageing, the Aboriginal and Torres Strait Islander Commission and the Queensland Aboriginal and Islander Health Forum regarding Queensland Aboriginal and Torres Strait Islander Health, and signed on the 16th June 2002, contains the following clause:

- 3.10 The Commonwealth of Australia and the State of Queensland agree to enhance mainstream service delivery for Aboriginal and Torres Strait Islander peoples by responding to initiatives identified through the joint planning processes, which will:
 - (e) ensure Aboriginal and Torres Strait Islander peoples' representatives on the Queensland Department of Health's District Health Councils, Regional Health Forums and Health Advisory Groups at a district, regional and local level in recognition of the high level of need for mainstream hospital and other health services.

The intent of this clause has not been subsequently recognised in the *Hospital and Health Boards Act 2011* (Qld).

¹³⁶ Aboriginal and Torres Strait Islander people who have sat on boards of public institutions would empathise with the experience of a Maori member of a District Health Board in New Zealand:

I walk into the room and there is me and [my Maori colleague] and then the doctors come in and they are all Pakeha and then you have the CEO [who] is Pakeha and the population strategist is Pakeha and the cancer control people who are Pakeha, community groups who are Pakeha. And you know how the hell are we going to make a difference if all the people sitting around the table making decisions about Maori health are Pakeha and so [my Maori colleague] and I would battle for a Maori voice to be heard yet that would still be side-lined by the chair who was facilitating the discussion. (Quoted by Came 2014 p. 216).

- The percentage of Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice (quarterly data provided)
 - Percentage of potentially preventable hospitalisations
 - Percentage of non-indigenous workforce staff (in all categories) who have received Cultural Competency Training.
6. While this criterion emphasises the need for each HHS to establish an Aboriginal and Torres Strait Islander health service plan, other alternatives include the establishment of protocols, strategies, agreements, frameworks and partnerships.¹³⁷ A protocol with local Aboriginal and Torres Strait Islander community controlled health organisations could be established under **s.42 Protocol with primary healthcare organisations** of the *Hospital and Health Boards Act 2011* (Qld). **S.14** of the *Hospital and Health Boards Regulation 2012* (Qld) lists the prescribed requirements for a protocol with local primary healthcare organisations.¹³⁸ A plan is considered the most appropriate vehicle to address major health issues such as disparities in Indigenous access to healthcare, improving the patient journey through better coordination of healthcare across the service continuum, reducing the number of potentially preventable hospitalisations through improved integration of services, workforce capacity building, and the use of improved data and evidence to inform clinical practice and service planning.¹³⁹ It is important that each HHS, in consultation and partnership with local Aboriginal and Torres Strait Islander communities and their community controlled health services, develop its own Aboriginal and Torres Strait Islander health service plan. In addition to a shared vision and set of objectives, a plan could establish a protocol for promoting cooperation between a HHS and local Aboriginal and Torres Strait Islander community controlled health/medical services as primary healthcare providers and relevant allied services (and as referred to in **s. 42** of the HHB Act 2011), and set KPIs and other monitoring processes to ensure a commitment to CQI goals and processes. An example of a local plan is the *Aboriginal Health Services Plan 2013-2016* developed by the Northern Sydney Local Health District. This has been developed in response to the strategic direction to ensure integrated planning and service delivery within each local health district in NSW in accordance with NSW Health's *NSW Aboriginal Health Plan 2013-2023*.¹⁴⁰
7. Community engagement underpins much of the local level implementation/application of the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033*, in particular with respect to service planning, partnerships, capacity building, policy development and quality improvement.¹⁴¹
8. In the Foreword to the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033*, Queensland Health declares its intention to "act in the spirit of reconciliation".¹⁴² Reconciliation Action Plans (RAPs) provide an excellent opportunity to mutually articulate reconciliation statements and commitments incorporating organisational visions, values, goals and strategies. The Queensland Government released its Reconciliation Action Plan in 2009 committing all government agencies to developing their own RAPs. With regard to COAG's National Aboriginal and Torres Strait Islander reforms with regard to, *inter alia*, early childhood and health, all agencies were supposed to have strategies in place by December 2009 to put Queensland on track to

¹³⁷ In relation to partnerships, Queensland Health (2013b, p. 11) points out that: "The development of partnerships with a variety of stakeholders to promote health and enhance service delivery is essential to the provision of effective healthcare."

¹³⁸ An example of such a protocol is the CQHSEngagementProtocol (sic) between the Central Queensland Hospital and Health Service (CQHHS) and Central Queensland Medicare Local (CQML). With regard to deliverables, the list of outcomes includes the following:

1. Ensure alignment of planning for new services and programs, after-hours emergency medical services, Indigenous health services and overall strategic directions.
9. Ensure that CQHHS General Practice and Primary Care staff are encouraged and supported to focus on a collaborative approach to the development and implementation of services for Aboriginal and Torres Strait Islander people. (CQHHS 2013, pp. 109-110).

¹³⁹ See also Queensland Health (2013b, p. 12).

¹⁴⁰ See NSW Health (2012:12-13).

¹⁴¹ Queensland Health (2010c, p. 17).

¹⁴² Queensland Health (2010c).

meet the COAG targets.¹⁴³ Queensland Health co-signed with Reconciliation Australia¹⁴⁴ a *Statement of Intent for Reconciliation*, on 2nd June 2000, an *Affirmation of Commitment to Reconciliation* on 13th January 2005, and a *Statement of Commitment to Reconciliation 2010*. According to a Queensland Health statement (01 May 2012):

Every employee of Queensland Health is expected to acknowledge, understand and respond to the following statements in their everyday work practices:

- improving Aboriginal and Torres Strait Islander people's health is everyone's business;
- all Queensland Health staff are bound by the Queensland Government's commitment to close the gap in health inequities between Aboriginal and Torres Strait Islander and other Queenslanders;
- service must be culturally sensitive and responsive to the needs of Aboriginal and Torres Strait Islander people;
- we acknowledge and respect the diversity in Aboriginal and Torres Strait Islander people and culture and their right to equitable, accessible and quality health care; and
- cultural capability, just like clinical capability, is an ongoing journey of continuous individual learning and organisational improvement, in order to ensure best practice in health service delivery.¹⁴⁵

9. Annual reports are an important avenue for community accountability. The criteria developed here reflect the kinds/categories of information given in the Townsville Hospital and Health Service 2012-2013 *Annual Report*, and points allocated accordingly. In effect, for the purpose of developing these sub-criteria, the THHS annual report serves as the model.
10. Traditional Owner acknowledgement is underpinned by the recognition of Aboriginal and Torres Strait Islander peoples in the Queensland Constitution. In February 2010, the Queensland Government passed into law a preamble to the Queensland Constitution. This Preamble recognises for the first time Aboriginal and Torres Strait Islander peoples as the First Queenslanders:

The people of Queensland, free and equal citizens of Australia ... honour the Aboriginal peoples and Torres Strait Islander peoples, the First Australians, whose lands, winds and waters we all now share; and pay tribute to their unique values, and their ancient and enduring cultures, which deepen and enrich the life of our community...¹⁴⁶

11. The policy references here refer to Queensland Health's three principal policies for Closing the Gap: *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Policy and Accountability Framework* (2010), the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033*, and the *Aboriginal and Torres Strait Islander environmental health plan 2008-2013*¹⁴⁷ which was formulated before the COAG Closing the Gap Partnership Agreement came into effect. Other states/territories will have their own policies generated in response to the 2008 COAG National Partnership Agreement.
12. This inclusion is intended more as a reference to achievements in the area of recruitment, training and retention of Aboriginal and Torres Strait Islander health workforce staff, for example, the number currently enrolled in a relevant university or TAFE course, mentorships, other training programs, new initiatives, etc.
13. See Template Note 14. In the document *Health System Priorities for Queensland 2013-14* it is pointed out that:

To reduce cultural barriers to accessing mainstream health services there is a need to ensure services are culturally capable of communicating with, diagnosing and treating Aboriginal and Torres Strait Islander Queenslanders. Specifically there is a need to improve the cultural competence of health professionals and to increase the number of Aboriginal and Torres Strait Islander people in health professions.¹⁴⁸

Cultural competency training (CCT): the relevant policy document here is Queensland Health's *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033*. A

¹⁴³ Queensland Government (nd, p. 19).

¹⁴⁴ Then, the Council for Aboriginal Reconciliation.

¹⁴⁵ Queensland Health. <http://www.health.qld.gov.au/atsihealth/reconciliation.asp> Accessed 22/0/2014.

¹⁴⁶ Queensland Health (2010c, frontis page).

¹⁴⁷ Queensland Health (2008).

¹⁴⁸ Queensland Health (2013b, p. 12).

revised and expanded Aboriginal and Torres Strait Islander Cultural Capability Learning Program was planned for development to assist in the development of cultural capability. The intended program was structured for:

- All employees (mandatory)
- Employees working in clinical and other consumer service areas
- Employees (and contractors) working directly with Aboriginal and Torres Strait Islander communities
- Aboriginal and Torres Strait Islander employees
- Non-clinical employees involved in education and training, safety and quality, policy, improvement, planning, funding, and infrastructure that has the potential to impact on Aboriginal and Torres Strait Islander peoples and their health outcomes
- All line managers
- Senior and executive managers.¹⁴⁹

14. This criterion is intended to reflect that Aboriginal and Torres Strait Islander health workforce staff are a key and integral part of providing culturally appropriate and safe health care and health service delivery to Aboriginal and Torres Strait Islander clients, and as recognised in Closing the Gap strategies at federal and state levels. As is pointed out in the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033*:

Recruitment and retention of Aboriginal and Torres Strait Islander staff is a key factor in providing services that are culturally responsive, safe and capable for Aboriginal and Torres Strait Islander people. ... The engagement of Aboriginal and Torres Strait Islander peoples at all levels and occupational streams in the health system will assist to shape policy, reorient health services and engage with consumers to improve delivery of high quality healthcare. Achieving this requires long-term investments in the attraction, recruitment and retention of Aboriginal and Torres Strait Islander peoples to a level that reflects the population and service needs.¹⁵⁰

This criterion could be extended, for example, to include Aboriginal and Torres Strait Islander doctors, dentists, psychologists, etc. Currently, there are very few Aboriginal and Torres Strait Islander people qualified in these professions, however, over time this will improve to the extent that a separate sub-criterion is warranted. But then again, maybe this sub-criterion should be included if monitoring is considered for the long term - e.g. to the end of the Closing the Gap timeframe in 2033.

15. In recognising the value of Indigenous nurses in helping to Close the Gap in Indigenous health, West *et al* (2010) point out that “Their contribution has the potential to enhance future outcomes for Indigenous people by improving access to health services, ensure services are culturally appropriate and respectful, and assist non-Indigenous nurses to deliver culturally appropriate care.”
16. With regard to Aboriginal and Torres Strait Islander Health Workers, the relevant policy is Queensland Health’s, *Aboriginal and Torres Strait Islander Health Worker Career Structure* (revised 2009). Citing a number of references, the AHMAC noted that:

Aboriginal and Torres Strait Islander Health Workers (ATSIHWs) have been recognised as playing an important role in contributing to improved cultural competency... [and that a] small study in the cardiology unit of a WA hospital found that these health workers improved the cultural security of the care provided, reduced the number of discharges against medical advice and increased participation in cardiac rehabilitation (AHMAC 2012, p. 135).

17. Operational and Support Services, in a hospital setting, include: food services (catering), security, cleaners, bed washers, linen, wardspersons (“wardies”),¹⁵¹ couriers, mailroom, waste disposal, etc.

¹⁴⁹ Queensland Health (2010c, p. 16).

¹⁵⁰ Queensland Health (2010c, p. 17).

¹⁵¹ In the context of a major hospital, Aboriginal and Torres Strait Islander “wardies” are an integral part of the Aboriginal and Torres Strait Islander health workforce. While they perform non-clinical duties (as cleaners, intra-hospital patient transporters, etc), they are often the only Indigenous staff on duty at nights, and on weekends and public holidays. In addition to providing visibility in the Aboriginal and Torres Strait Islander health workforce, and in Emergency Departments in particular, they are often on hand to provide reassurance, a calming word, deal with language difficulties, help fill out forms, or direct accompanying family members where to get a cup of tea late at night. Their presence is particularly helpful in instances where patients have been flown in by the Royal Flying Doctor Service, are apprehensive and traumatised, and experiencing their

18. The primary policy reference here is *Queensland Health Aboriginal and Torres Strait Islander Workforce Strategy 2009-2012*.¹⁵²
19. This should be assessed against Aboriginal and Torres Strait Islander health workforce employment data covering the last five years.
20. See Template Note 17. The Queensland target, set in 2010, is 3.7%.¹⁵³
21. Introducing Queensland Health's *Blueprint for better healthcare in Queensland* (February 2013), the Premier's message opens with the following statement:

A statewide healthcare system with new capacity, co-operation, transparent reporting systems, financial accountability and with patients the focus of attention – this is a vision all Queenslanders want to see.

These sentiments should apply to Aboriginal and Torres Strait Islander people and their communities of Queensland too. They also want to see, *inter alia*, transparent reporting and financial accountability regarding funds allocated to their health needs not only in Queensland Health's annual reports and performance website,¹⁵⁴ but also in the annual reports of each of the HHSs in the state. As per the *Blueprint for better healthcare in Queensland*, all Hospital and Health Boards are required to publicly report on six statewide targets on a quarterly basis from 1 July 2013.¹⁵⁵ The targets relate to:

- Shorter stays in emergency departments
- Shorter waits for elective surgery
- Shorter waits for specialist outpatient clinics
- Increased support for families under the new Mums and Bubs policy
- Fewer hospital acquired infections
- Better value for money

The performance data for all Queensland HHSs are published together in local newspapers so that performance comparisons between HHSs can be made.¹⁵⁶ Why not also quarterly public reports on a set of targets relating to Closing the Gap on Indigenous Health Outcomes relating to, for example:

- Estimated level of completion of Indigenous status – specifically the reporting of 'not stated' on admission
- Percentage of in-scope separations of Aboriginal and Torres Strait Islander patients from acute mental health inpatient units
- The proportion of Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice
- The proportion of potentially preventable hospitalisations for Aboriginal and Torres Strait Islander people
- The percentage of non-Indigenous health workforce staff across all categories who have received cultural competency training in Aboriginal and Torres Strait Islander cultural practice.

Given the national priority accorded to Closing the Gap on Indigenous Health Outcomes, and state commitments made under the COAG National Partnership Agreement, it seems discriminatory not to do so. Each HHS should also be required to include in its annual Financial Statement a section dedicated to identifying the Closing the Gap and other Indigenous health allocations, programs/initiatives, the source of funding (ie, Commonwealth, Queensland, other), and its acquittal.

22. The 2008 COAG National Partnership Agreement funding agreed to by Queensland across the five reform initiatives [(i) primary care service that delivers; (ii) fixing the gaps and improving the patient journey; (iii) making Indigenous health everyone's business; (iv) tackle smoking; and (v) healthy transition to adulthood], in \$millions, was 2009-10 - \$12.34; 2010-2011 - \$44.84; 2011-12 - \$50.7; and

first visit to a major hospital. Needless to say, in "helping a countryman"/"uncle"/"aunty" they are "stepping over the line" in the interests of duty of care – a fact often not appreciated by clinical staff, and for which they can be (heavily) penalised or admonished. Wardies provide an excellent example of "communitarian solidarity" at work.

¹⁵² Queensland Health (2009).

¹⁵³ Queensland Health (2010c, p. 17).

¹⁵⁴ www.health queensland.gov.au/performance

¹⁵⁵ Queensland Health (2013, p. 44).

¹⁵⁶ For an example of this see Queensland Health's full-page advertisement regarding "Health waiting list performance – quarterly check-up" involving all the state's HHSs in *The Cairns Post*, May 19, 2014, p. 10.

2012-2013 - \$54.30, for a total budget of \$162.22 million.¹⁵⁷ The Close the Gap Campaign Steering Committee, in its *Progress and priorities report 2014*, noted that in its 2013 Shadow Report that Queensland had made deep cuts to its general population health expenditure with detrimental impacts on the national effort to close the gap in the past year (Close the Gap Campaign Steering Committee 2014, p. 23). Queensland's allocation to each of its HHSs needs to be identified in the Annual Report of each HHS. How the money is spent should also then be identified in the financial statement of each HHS annual report.

23. For example, with regard to the COAG – Indigenous Early Childhood Development National Partnership Agreement (Queensland Initiatives), the Australian Government funding commitment over four years to the following initiatives is:

Element 1: Integration of Early Childhood Services	\$75.18 million
Element 2: Antenatal Care, pre-pregnancy and teenage sexual and reproductive health	\$29.95 million
Element 3: Increase access to, and use of, maternal and child health services by Indigenous families	\$25.5 million

(The Queensland Government's commitment to Element 3 is \$21.25 million over five years across a range of programs including, for example, the expansion of the Deadly Ears Program, and the continued implementation of the Cape York Maternal and Child Care Health Package, including the Baby Basket Initiative).¹⁵⁸

24. Queensland's contribution of \$162.2 million to the COAG – Indigenous Health Outcomes National Partnership Agreement priority initiatives is:

Tackling Smoking	\$8.97 million
Primary Health Care (PHC) Services that can Deliver	\$90.79 million
Fixing the Gaps and Improving the Patient Journey	\$47.4 million
Healthy Transition to Adulthood	\$11.86 million
Making Indigenous Health Everyone's Business	\$3.2 million

Under each of the above COAG priority initiatives, Queensland has established a number of its own initiatives. For example, under Fixing the Gaps and Improving the Patient Journey, its initiatives are:

- QG 5.1: New or expanded patient accommodation
- QG 5.2: New or expanded patient transport
- QG 6.1: Indigenous hospital liaison project
- QG 6.2: New Cultural Capability Framework¹⁵⁹
- QG 7: New Care Connect pilot initiative.

Allocations/income and expenditure regarding these and other initiatives should be duly reported by each HHS in their annual report. For more detailed description of the implementation of these initiatives see the *Making Tracks...: Implementation Plan 2009-10 to 2011-12*.¹⁶⁰

¹⁵⁷ See also Queensland Health (2010a, p. 54).

¹⁵⁸ All information and amounts – Queensland Health (2010a, p. 53).

¹⁵⁹ All information and amounts – Queensland Health (2010a, p. 54).

¹⁶⁰ An implementation plan for the second triennium (2012-13 to 2014-15) does not appear to be available at present.

7. THE MATRIX APPLIED TO THE CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE (CHHHS)

Matrix for identifying, measuring and monitoring Institutional Racism at the CHHHS (1)

Key Indicators and Criteria	Scoring	Score
1. Participation in governance		
• Legal visibility: the <i>Hospital and Health Boards Act 2011</i> (Qld) and <i>Hospital and Health Boards Regulation 2012</i> (Qld)(2)	20	1
• CHHHS (3)		
- Aboriginal representative	5	0
- Torres Strait Islander representative	5	0
• Executive Management Team (4)	10	0
Total	40	1
2. Policy implementation		
• Closing the Gap in Aboriginal and Torres Strait Islander health outcomes		
- Explicitly identified as a strategic priority in Strategic Plan (5)	5	2
- Closing the Gap KPIs explicitly referred to in Health Service Agreement (6)	5	2
• Aboriginal and Torres Strait Islander health service plan (7)	10	0
• Community engagement		
- Aboriginal and Torres Strait Islander consultative body (8)	6	0
- Reconciliation Action Plan (9)	4	0
• Public Reporting and Accountability (via Annual Report) (10)		
- Traditional Owner acknowledgement (11)	1	0
- Closing the Gap		
(i) Separate section in report devoted to Closing the Gap (12)	1	0
(ii) Reporting on KPIs(13)	1	0
- Policy references (14)		
(i) Cultural Capability Framework (15)	1.5	0
(ii) Making Tracks (16)	1.5	0
- Organisational structure (ATSI unit placement within) (17)	1	0.5
- Aboriginal and Torres Strait Islander Employment		
(i) Data on ATSI employment (18)	1	0
(ii) Reference to workforce planning, recruitment, etc.(19)	1	0.5
- Other recognition (e.g., awards, scholarships, etc.)(20)	1	1
Total	40	6
3. Service delivery		
• Cultural competence (21)		
- Capacity to deliver Cultural Competency Training (CCT) (22)	4	1
- Proportion of non-indigenous staff trained (23)	2	0.5
- Discharges against medical advice (DsAMA) (24)	2	0
- Potentially preventable hospitalisations (PPHs) (25)	2	0
• Aboriginal and Torres Strait Islander participation in health workforce (26)		
- Medical and other health professionals	2	0.5

- Nurses	2	0.5
- Indigenous Health Workers	2	0.5
- Indigenous Liaison Officers	2	0.5
- Support Services	2	0.5
Total	20	4

4. Recruitment and employment

• Employment profile		
- Aboriginal and Torres Strait Islander employment trend (27)	3	0
- Aboriginal and Torres Strait Islander employment against Qld and Federal targets (28)	4	2
- Application of employment equity principles (29)	3	1
• Aboriginal and Torres Strait Islander health workforce strategy (30)	10	0
Total	20	3

5. Financial Accountability and Reporting

• Closing the Gap Funding (31)		
- Commonwealth contribution	5	0
- Queensland contribution	5	0
• Other identified Indigenous service funding (32)	10	0
Total	20	0

Score	140	14
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Institutional Rating scored against criteria

Score:	>110	80-109	60-79	40-59	20-39	<20
Evidence of Inst. Racism:	Very Low	Low	Moderate	High	Very High	Extreme

Notes:

1. The Cairns and Hinterland Hospital and Health Service (CHHHS) has responsibility for providing public hospital and health services within its primary region to approximately 250,000 people residing within a geographical area covering 142,900 square kilometres. The Cairns Hospital (CH) in particular also provides services to the secondary region covering Cape York, the Northern Peninsula Area and the Torres Strait. The total Aboriginal and Torres Strait Islander population across the three health service districts is about 39,000¹⁶¹ - more than the total Aboriginal and Torres Strait Islander population of Victoria, and over 7

¹⁶¹ CHHHS = 23,000 (Queensland Government 2012, p. 14):

In 2009, 25 per cent of all Queensland Aboriginal and Torres Strait Islander people resided within the [CHHHS]Service's total catchment area, with most (23,12 or 14 per cent) residing within the primary catchment of Cairns and Hinterland Health service District. Nine per cent of the Service's resident population was estimated to be of Aboriginal and Torres Strait Islander origin in 2009-2010, compared with 3.5 per cent for Queensland as a whole.

Cape York Hospital and Health Service = 6,800 (CYHHS, 2012-2013 Annual Report, p. 11); Torres Strait-Northern Peninsula Hospital and Health Service = 9,300 (TS-NPHHS, 2012-2013 Annual Report. Approximately

percent of the total Aboriginal and Torres Strait Islander population of Australia.¹⁶² Aboriginal and Torres Strait Islander people: (i) constitute about 15 per cent of the total Far North Queensland region;¹⁶³ (ii) contribute substantially to the linguistic diversity of the region; (iii) are among the most disadvantaged in the region with the Aboriginal community of Yarrabah, and the Northern Peninsula and Torres Strait regions ranked as having the highest level of disadvantage; and (iv) have a recognised excess burden of disease with a rate of hospitalisation more than four times the Queensland average.¹⁶⁴ The Emergency Departments (ED) of the hospitals in the CHHS district, in 2012-13 attended to 142,297 presentations, over one third of which (approximately 50,000) were by Aboriginal and Torres Strait Islander clients. In 2012-13 the CH ED attended to over 30,000 visits by Aboriginal and Torres Strait Islander people. The CH, together with the Royal Darwin Hospital, has the highest numbers of Aboriginal and Torres Strait Islander clients of any other public hospital in Australia. The services provided by the CHHS to the Aboriginal and Torres Strait Islander populations in Far North Queensland should therefore contribute significantly to national efforts to Close the Gap in Indigenous Health Outcomes.

2. See QH HHS Note 3. The single reference in **s.4(c)(vi)** earns 1 point out of 20.
3. The CHHHS comprises 6 members (compared with Townsville Hospital and Health Board [THHB] – 10, and the North West Hospital and Health Board [NWHHB] – 9).¹⁶⁵ Both the Aboriginal and Torres Strait Islander communities want representation on the CHHHS.¹⁶⁶ Currently the Board has neither. The neighbouring HHSs of Townsville and North West Queensland both have Indigenous representation on their boards.¹⁶⁷ None of the 8 CHHHS board members profiled in the CHHHS 2012-2013 *Annual Report* (pp. 48-52) lists among their current professional positions any specific connection to an Aboriginal and Torres Strait Islander health organisation, or a body that deals specifically with Aboriginal and Torres Strait Islander health.
4. The Executive Management Team comprises 9 members. Until 30 June 2013, the CHHHS maintained Aboriginal and Torres Strait Islander Health (ATSIH) as a separate Division with an Indigenous Executive Director.¹⁶⁸ As a result of the restructure which took effect in February 2013, ATSIH was incorporated into a super division to create the Division for Strategy, Policy, Planning and Aboriginal and Torres Strait

85 per cent of the Torres Strait – Northern Peninsula Area population of 11,000 people identifies as Aboriginal and/or Torres Strait Islander. pp. 1 and 3). Figures for CYHHS and TS-NPHHS based on 2011 Census.

¹⁶² According to ABS 2011 census data, the Aboriginal and Torres Strait Islander population of Victoria in 2011 was 37,991 or 0.7 percent of the total population of Victoria. The national total of Aboriginal and Torres Strait Islander people was 550,000.

¹⁶³ CHHHS 2012-2013 *Annual Report*, p. 9.

¹⁶⁴ Queensland Government (2012, pp. 14-15). 72 per cent of the Torres Strait and Northern Peninsula Area (NPA) residents speak a language other than English at home, as do 25 per cent of Cape York residents. With regard to levels of disadvantage, and based on 2006 census data, Yarrabah, Torres Strait and NPA were rated at 100 per cent, and Cape York 67 per cent. The 2011 Census also indicated that Yarrabah is the most disadvantaged local government area in Queensland (as noted in the CHHHS 2012-2013 *Annual Report*, p. 9).

¹⁶⁵ Of the six members listed for the 2012-13 reporting year, two were replaced on 17/05/2013 (CHHHS, 2012-2013 *Annual Report*, pp. 48-52).

¹⁶⁶ Among the 14 Key Recommendations put forward by the Cairns Aboriginal and Torres Strait Islander community controlled health organisation, Wuchopperen Health Service Ltd, is: "That representatives of Aboriginal communities and as selected by the Aboriginal communities, be co-opted to hospital boards and other health authorities." <http://www.wuchopperen.org.au/14-ke-recommendations/> Accessed 10/06/2014.

¹⁶⁷ Townsville Hospital and Health Services (THHS) 2012-2013 *Annual Report*, Aboriginal and Torres Strait Islander people constitute about 7 per cent of the THHS resident population (p. 24), and the service has one Indigenous representative on a board of 10 members (pp. 12-16); North West Hospital and Health Service (NWHHS) 2012-2013 *Annual Report*, Aboriginal and Torres Strait Islander people constitute 25.7 per cent, or about 8,000 of the total NWHHS resident population of 31,411 (p. 11), and the service has one Indigenous representative on a board of 9 members (pp. 50-53).

¹⁶⁸ The Executive Director ATSIH is responsible to the Chief Executive for the delivery and development of Indigenous Health services, including the monitoring, allocation and management of funding and expenditure. The Executive Director also provides direction and leadership to improve the health of Aboriginal and Torres Strait Islander Peoples through the promotion of effective health planning and service delivery (CHHHS 2012-2013 *Annual Report*, p. 93).

Islander Health (SPPATSIH) under a non-indigenous Executive Director.¹⁶⁹ Thus the Aboriginal and Torres Strait health workforce and clients no longer have Indigenous representation within the CHHHS Executive Management Team. HHS executive management teams usually maintain a committee structure. For example, the Central Queensland Hospital and Health Service maintains sixteen management committees and/or groups and forums (CQHHS 2013, p. 15). The CHHHS Executive Management Team does not have an Aboriginal and Torres Strait Islander body to provide advice, input or feedback.

5. CHHHS *Strategic Plan 2013-2017*. With regard to “1. Health Services focused on patient and people – Objective: Integration: We will provide integrated and coordinated health care services that are patient focused and culturally appropriate”, among the strategies listed are: (i) completion of the transition to community control of the Yarrabah health service, Gurriny Yealamucka; and (ii) implementation of Whole of Government plans and priorities (Closing the Gap, Mental Health and Alcohol and Other Drugs, Chronic Disease Strategy). However, other than to say that: “Work commenced on strategic and operational plans to advance the key Whole of Government priorities of *Closing the Gap*, Mental health,...” (p. 19) the CHHHS 2012-2013 *Annual Report* is silent. A score of 2 points out of 5 has therefore been awarded.
6. Of the five Closing the Gap KPIs listed in Note 5 of the Template adapted for QH’s policy settings, the CHHHS *Service Agreement 2013/14 – 2015/16* (November 2013 Revision) for this triennium identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (p. 41); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice [Aboriginal and Torres Strait Islander patients who discharge themselves against medical advice (DsAMA)] (p. 42). On this basis, two points out of five are awarded.
7. The CHHHS has a hospital and health service plan for the period 2012-2026¹⁷⁰ to cover all residents and visitors of both the CHHHS, and the broader service regions of Cape York and Torres Strait. The planning process received input from the Aboriginal and Torres Strait Islander community and its community controlled medical services.¹⁷¹ However, given the size and diversity of the Aboriginal and Torres Strait Islander communities, the number of community controlled health services and other health facilities (aged care, diversionary centres, drug and alcohol rehabilitation centres), the urgent need to build the Aboriginal and Torres Strait Islander health workforce capacity (see Note 30 below), and the need to strategically plan and coordinate service delivery between the CHHHS and the community services to improve cultural safety and support the patient journey, a coherent plan could be considered an absolute requirement. None exists.¹⁷²
8. Under the current CHHHS community engagement and consultative structure within the Division for People and Culture Aboriginal and Torres Strait Islander communities have the opportunity for input into the CHHHS via the three Community Consultation Committees (CCC) for the Trinity, Cassowary and Hinterland Hubs (each with six members) and the CHHHS Community Reference Group (CRG). There is also potential for Aboriginal and Torres Strait Islander representation on the Community Advisory Group (CAG) should an Aboriginal or Torres Strait Islander person happen to be elected chair of a CCC.

¹⁶⁹ Based on information available in the CHHHS 2012-2013 *Annual Report* (pp. 36-40) and their personal LinkedIn sites, of the 9-member Executive Management Team, only the Executive Director Medical Services appears to have had significant experience working at the front-line of Indigenous health, having spent 5 years working with the local Cairns Indigenous community controlled Wuchopperen Medical Service. The Executive Director SPPATSIH, according to his LinkedIn site does not list any direct involvement or experience with Aboriginal and Torres Strait Islander health. Effectively this means that between the 6 board members and the 9 members of the Executive Management Team, only one person lists having significant expertise or experience in Indigenous health. Thus the health needs of 39,000 Aboriginal and Torres Strait Islander people in the Far North Queensland region served by the CHHHS appear to be “spoken for” by the most senior group of decision-makers only one of whom lists any direct and sustained involvement with Aboriginal and Torres Strait Islander health care at the community level. However, it should also be acknowledged that, just because such information concerning experience in Indigenous health was not indicated in the CHHHS 2012-2013 *Annual Report* and their respective LinkedIn sites, individual members of the Board and the Executive Management Team do not have such experience – it just appears that such experience doesn’t seem significant enough to warrant disclosing. LinkedIn sites visited 2/06/2014.

¹⁷⁰ Queensland Government (2012).

¹⁷¹ Ibid, pp. 65-70.

¹⁷² In Note 6 of Part 5 QH HHSs, alternatives to a plan included protocols, agreements, frameworks, etc. The Report from the Board of the CHHHS of 4 June 2013 recorded that: The Board approved the CHHHS and Far North Queensland Medicare Local Protocol...”.

Membership on the three CCCs is via expression of interest and a three-member selection panel. The selection panel comprises the Consumer and Community Engagement Coordinator, the Director – Office of the Chief Executive, and the Director of Nursing for each of the three hubs. The CCCs also have the capacity to establish their own Working Groups. It would seem essential that each should have a Working Group to assist with the prioritisation of the three strategic priorities as laid out in the CHHHS *Community Consultation Committee Member Handbook 2013-2015*, one of which concerns “prioritisation of strategies as outlined in *Making Tracks*” (p.4). Currently there is no Aboriginal or Torres Strait Islander representation on: (i) the panel; (ii) the CCCs (and therefore no representation in the CAG); (iii) no Aboriginal or Torres Strait Islander people registered with the CRG; and (iv) none of the CCCs has established a *Making Tracks* Working Group. It is argued that the Aboriginal and Torres Strait Islander communities should have their own CCC with the chair(s) also as member(s) of the CAG. The points weighting here reflects the need for an Aboriginal and Torres Strait Islander CCC. This would essentially negate the need for Aboriginal and Torres Strait Islander representation on the existing consultative structures.

9. The Queensland Government released its Reconciliation Action Plan in 2009 committing all government agencies to developing their own RAPs. With regard to COAG’s National Aboriginal and Torres Strait Islander reforms with regard to, *inter alia*, early childhood and health, all agencies were supposed to have strategies in place by December 2009 to put Queensland on track to meet the COAG targets.¹⁷³ Queensland Health co-signed with Reconciliation Australia¹⁷⁴ a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. Both documents hang side-by-side in the ground floor foyer of the street entrance to A-Block at the Cairns Hospital. While QH has its own RAP, the CHHHS does not currently have one.
10. The criteria for public reporting and accountability were largely developed from references to the different kinds of information/data available in the Townsville Hospital and Health Service (THHS) *2012-2013 Annual Report*.
11. The THHS *2012-2013 Annual Report* includes such acknowledgement. None exists in the CHHHS *2012-2013 Annual Report*.
12. The THHS *2012-2013 Annual Report* contains a section on Closing the Gap (p. 31), as well as other references (pp. 42 and 54). The Mackay Hospital and Health Service (MHHS) also contains a section “Our performance: Indigenous Health” (MHHS 2013, pp. 47-48). The CHHHS *2012-2013 Annual Report* does not contain a section devoted to reporting on progress, initiatives, etc with regard to Closing the Gap.
13. The THHS *2012-2013 Annual Report* reports on the following Closing the Gap KPIs (p. 54):
 - Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission
 - Percentage of in-scope separations of Aboriginal and Torres Strait Islander consumers from the HHS’ acute mental health inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated (in person or via videoconference), was recorded in one to seven days immediately following the separation
 - The proportion of Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice (quarterly data provided)
 - Percentage of Aboriginal and Torres Strait Islander Cultural Practice Program participants.

The MHHS also reported on these KPIs (MHHS 2013, p. 55), while the NWHHS (2013, p. 36) reported on each of the above except the percentage of in-scope separations from acute mental health inpatient units. The CHHHS *2012-2013 Annual Report* did not disclose information regarding any of the Closing the Gap KPIs.
14. For the CHHHS, the primary Closing the Gap policy documents are the Australian Health Ministers’ Advisory Council (2011) *Aboriginal and Torres Strait Islander Health Performance Framework*, Queensland Health (2010) *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Policy and Accountability Framework* and the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033*. *Making Tracks* articulates the Queensland Government’s long-term strategy to close the health gap by 2033 and achieve sustainable gains for Aboriginal and Torres Strait Islander people in Queensland.

¹⁷³ Queensland Government (nd, p. 19).

¹⁷⁴ Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal identity, Dr Evelyn Scott as the Chairperson and co-signatory.

15. While there are a number of references made to, for example, “our communities’ culturally diverse needs” and the need for healthcare services that are “patient focused and culturally appropriate” (pp. 7 and 12) in the CHHHS 2012-2013 Annual Report, there is no explicit reference made to the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033*, and more particularly the need to build a culturally competent non-indigenous workforce in order to build the capacity of the CHHHS to deliver culturally safe and appropriate healthcare to Aboriginal and Torres Strait Islander people, therefore zero points are awarded.
16. The NWHHS 2012-2013 Annual Report (2013, pp. 46-47), for example, reported on initiatives taken for the implementation of two priority strategies in *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders*: (i) Improve access to culturally appropriate services for the Aboriginal and Torres Strait Islander population; and (ii) Engage Aboriginal and Torres Strait Islander health service providers and communities in the development and delivery of all health services. The CHHHS 2012-2013 Annual Report does not contain any information with regard to Making Tracks progress or initiatives.
17. The THHS 2012-2013 Annual Report provides a 2 page layout of its organisational structure (pp. 18-19) in which a number of services specific to Aboriginal and Torres Strait Islander people are located. The 1 page layout of the CHHHS organisational chart does not provide this level of detail (CHHHS 2012-2013 Annual Report, p. 16). Accordingly, half a point has been awarded.
18. The THHS 2012-2013 Annual Report, under the section on Workforce diversity, indicated that 3.17 per cent of the THHS workforce were of Aboriginal and/or Torres Strait Islander origin (p. 37). Similarly, the Central Queensland Hospital and Health Service (CQHHS, 2013, p. 28) reports that 3% of its workforce is made up of people who identify as Aboriginal and Torres Strait Islanders. The CHHHS 2012-2013 Annual Report provides no data on Aboriginal and Torres Strait Islander health workforce participation.
19. Reference is made in the CHHHS 2012-2013 Annual Report, p. 22, that “Establishing a strategy to increase our Aboriginal and Torres Strait Islander workforce will be a key emphasis in 2013-2014.” However, the CHHHS Strategic Workforce Plan makes no mention of this in the Plan’s 10 point strategy (p. 43). Accordingly, half a point has been awarded.
20. An Aboriginal alcohol and drugs support worker at Mossman Multi-Purpose Health Facility received the Encouragement Award at the inaugural National Indigenous Drug and Alcohol Awards in June 2012. CHHHS 2012-2013 Annual Report, p. 46.
21. Cultural competency is key to effective health system performance in delivering healthcare to Aboriginal and Torres Strait Islander clients.¹⁷⁵ Training in the Cultural Practice Program is listed among other programs (such as ChemAlert, Orientation to Occupational Violence, Fire Safety, etc) in the CHHHS 2012-2013 Annual report (p. 42) as a mandatory requirement.¹⁷⁶ The cultural competency of a HHS can be measured by: (i) the percentage of non-indigenous staff who have undergone cultural competency/capability training (CCT); and (ii) the percentage of Aboriginal and Torres Strait Islander people who discharge themselves against medical advice – that is “vote with their feet”.¹⁷⁷ Both are Closing the Gap KPIs.
22. Ideally all CHHHS staff should undertake cultural competency training at least once every two years. Since there are over 3,700 employees in the CHHHS,¹⁷⁸ this roughly translates into CCT for over 1,800 staff per year. Currently the Coordinator of the Aboriginal and Torres Strait Islander Health Unit is responsible for organizing and delivering CCT within the CHHHS, and has very limited capacity to meet this target. Accordingly, only one point is awarded.
23. Noting that THHS has developed a *Cultural Capability Companion* (THHS, 2012-2013 Annual Report, p. 37), and that NWHHS is still developing its capacity to deliver CCT (NWHHS, 2012-2013 Annual Report, p. 36), the respective staff percentages of those who had received CCT were THHS 27% and NWHHS 9% by June 2013. Given the very low capacity of the Aboriginal and Torres Strait Islander Health Unit in the CHHHS to deliver CCT, then the staff percentage that has received such training is more likely to be akin to that of

¹⁷⁵ A new framework is currently under development based around three elements: (i) organisational cultural competency; (ii) systemic cultural competency; and (iii) clinical/professional/individual cultural competence (AHMAC 2012: 135).

¹⁷⁶ However, the wording regarding mandatory training is somewhat contradictory – “Encouragement to participate in mandatory training:...” (p. 42).

¹⁷⁷ This measure provides indirect evidence of the extent to which hospital services are responsive to Indigenous Australian patients’ needs (AHMAC 2012: 139).

¹⁷⁸ CHHHS 2012-2013 Annual Report, (p. 42).

the NWHHS. Also on the basis that data concerning this KPI is not provided in the CHHHS 2012-2013 *Annual Report*, half a point is awarded.

24. No data on DsAMA were published in the CHHHS 2012-2013 *Annual Report*.¹⁷⁹
25. No data on PPHs were published in the CHHHS 2012-2013 *Annual Report*.¹⁸⁰
26. There has been a decline in the Aboriginal and Torres Strait Islander health workforce – the percentage of Aboriginal and Torres Strait Islander employees in the CHHHS has declined from 4.25% in June 2010 to 2.97% in December 2013, and in fact now sits below the state target set by QH of 3.7 percent.¹⁸¹ This potentially compromises the delivery of culturally safe and appropriate healthcare and health service delivery to Aboriginal and Torres Strait Islander clients.¹⁸² Half a point has been awarded to each of the sub-categories of Aboriginal and Torres Strait Islander health workforce employment, recognising that the numbers employed in each category are well below parity (see Note 27).
27. As noted above, the employment trend is negative, therefore no points are awarded.
28. While Aboriginal and Torres Strait Islander participation in the health workforce at the CHHHS is below the Queensland target, it remains above the national target of 2.6%, hence a score of 2 out of 4 points.
29. Employment equity: put simply, if the Aboriginal and Torres Strait Islander population in the region served by the CHHHS is 15% of the total population, then they should constitute 15% of the CHHHS workforce. Based on current CHHHS employment figures of 3,700, that means there should be over 500 Aboriginal and Torres Strait Islander employees in the CHHHS. In order to achieve parity with regard to closing the employment gap by 2033, this would mean adding some 20 Aboriginal and Torres Strait Islander staff per year for approximately the next 20 years. The CHHHS currently employs around 100 Aboriginal and Torres Strait people in various capacities.¹⁸³ Based on the employment equity principle for the region as a whole, this number is well below what it should be, hence a score of 1 out of 3 is awarded.
30. Both the THHS and NWHHS have established Aboriginal and Torres Strait Islander bodies to oversee their services' recruitment, employment and training needs. The Aboriginal Workforce Development Unit within the NWHHS:
 - Assists with the realignment of Aboriginal Health Workers to clinical areas in order to meet the needs of client, families and the community as a whole; and
 - Assists AHWs to progress through their formal qualifications, gain exposure to a variety of clinical specialty areas, and allows staff to gain competency in necessary clinical skills.¹⁸⁴

The Aboriginal and Torres Strait Islander Employment Committee (ATSIEC) within the THHS was originally established as a Working Party to assist in developing workforce cultural capability. During 2012-13 the working party transitioned to a structured committee supported and led by senior identified positions. The ATSIEC has assisted with:

 - Development of the 2012-2014 *Close the Gap* Plan, outlining proactive activities and initiatives working towards improving health outcomes;
 - Implementation of the *Cultural Capability Companion*, a practical approach for THHS to implement the *Aboriginal and Torres Strait Islander Cultural Capability Framework* and delivering services that close the gap; and

¹⁷⁹ Recorded in THHS 2012-2013 *Annual Report*, p. 54; NWHHS 2012-2013 *Annual Report*, p. 36; and identified in the CHHHS 2012-2013 *Annual Report* as a KPI "still requiring improvement" (p. 20).

¹⁸⁰ Recorded in the CHHHS 2012-2013 *Annual Report* (p. 20), but not in the annual reports of the THHS and NWHHS.

¹⁸¹ Monthly Workforce Profiles Cairns and Hinterland HSD/HHS, Client Support & Reporting, Finance Solutions, Finance Branch Corporate Services Division, Queensland Health. Website:

<http://qheps.health.qld.gov.au/hrinformatics>

¹⁸² In the *Cairns and Hinterland Hospital and Health Service Plan 2012-2026*, it was noted that:

During community consultations for the formulation of the CHHHS Plan 2012-2026, cultural appropriateness of acute hospital services was identified as an issue for Aboriginal and Torres Strait Islander people. They highlighted the need to expand the role of Indigenous Health Workers within the primary health care sector and within hospitals (Queensland Government, 2012, p. 17).

The plan was approved by the CHHHS Board 16 August 2012 (Version: 3.0).

¹⁸³ Precise reporting on Aboriginal and Torres Strait Islander employment data is difficult as many positions are non-identified positions for Aboriginal and Torres Strait Islander people. Also some Aboriginal and Torres Strait Islander employees in non-identified positions have not disclosed their identity in their employment records.

¹⁸⁴ NWHHS 2012-2013 *Annual Report*, p.25.

- Promotion and implementation of the newly developed Cultural Practice Program.¹⁸⁵

The CQHHS workforce retention strategy includes the Aboriginal and Torres Strait Islander Mentoring (*You Pla, Me Pla*) Program [the name "*You Pla, Me Pla*" is Torres Strait Creole and means "you fellas, us fellas"] (CQHHS, 2013, p. 3). Currently the CHHHS does not have a comprehensive Aboriginal and Torres Strait Islander workforce strategy, although it has flagged this as a priority in the CHHHS 2012-2013 *Annual Report* (p.22). See also Note 19 above. The CHHHS has yet to develop its Aboriginal and Torres Strait Islander Employment Strategy and a body/unit to oversee and implement it.

31. The CHHHS Financial Statements, as disclosed in its 2012-2013 *Annual Report* for the year ended 30 June 2013, contain no reference to Closing the Gap funding allocations and how they were spent. To support the delivery of the Making Tracks priorities and in accordance with CHHHS *Service Agreement 2013/14-2015/16*,¹⁸⁶ the CHHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

- Dental services
- Chronic disease management services
- Smoking and alcohol prevention activities
- Sexual and reproductive health services
- Indigenous cardiac and respiratory outreach services
- Indigenous hospital liaison services
- Cultural capability services

Details of the CHHHS Closing the Gap budget for the next financial year are contained in the memo entitled 'Closing the Gap funding allocations to Cairns and Hinterland Hospital and Health Service for 2013/2014', file reference PP003447 (10 May 2013).¹⁸⁷ Both federal and Queensland Closing the Gap funding allocations should be disclosed within CHHHS annual reports in the interests of public accountability and transparency. Score: 0 out of 10.

32. No data has been provided in the CHHHS 2012-2013 *Annual Report* regarding other sources of funding that has been allocated and used to deliver medical treatment and services to Aboriginal and Torres Strait Islander people.

¹⁸⁵ THHS 2012-2013 *Annual Report*, p.37.

¹⁸⁶ Queensland Health, 2013. *Cairns and Hinterland Hospital and Health Service Service Agreement 2013/14-2015/16* (November 2013 Revision), p. 27.

¹⁸⁷ CHHHS *Service Agreement 2013/14-2015/16* (November 2013 Revision), p. 27.

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Bukal Consultancy Services P/L: Introducing the Directors:

Henrietta Marrie (Dip. T; Grad. Dip. of Arts [Indigenous Studies]; Masters in Environmental and Local Government Law) is an Elder of the Gimuy Walubara clan of the Yidinji people and Traditional Owner of the land on which the City of Cairns and southern suburbs are now located. Henrietta has wide experience in Indigenous cultural and natural resource management and impact assessment, intellectual and cultural property law, heritage legislation and philanthropy. As an academic she has had published over 40 papers in books and journals. She served for 6 years with the UN Secretariat of the Convention on Biological Diversity in Montreal, before becoming the Program Officer for North Australia with The Christensen Fund, a position in which she served for nearly nine years. Henrietta recently joined Central Queensland University as Associate Professor (Indigenous Engagement) working from the Cairns campus. Currently she is also an Adjunct Senior Fellow with the United Nations University – Institute of Advanced Studies (based in Yokohama, Japan and which serves as a research institution and “think tank” for various UN agencies) working on the Institute’s Traditional Knowledge Initiative. She is an Adjunct Professor of the Cairns Institute, James Cook University and Adjunct Associate Professor at the Centre for Sustainable Resource Management with the Sustainable Mining Institute Queensland University. She is a Co-Patron of the Cairns Indigenous Art Fair, a position she shares with the Governor of Queensland. Henrietta is listed among the Westpac and *Australian Financial Review* 100 Women of Influence for 2014 for her work in public policy.

Adrian Marrie (BA with 1st Class Honours – Adelaide University; BA with 1st Class Honours – Flinders University; Grad. Dip. of Arts – University of South Australia) also serves as Bukal company secretary. Adrian has worked privately as a consultant with organisations such as the Foundation for Aboriginal and Islander Research Action (FAIRA), Bama Wabu Rainforest Aboriginal Corporation, and the Yarrabah Community Council, essentially advising on cultural heritage policy and issues, community development plans and the development of reference manuals and guides. As a director of Bukal, he has been involved in a number of consultancy projects which include cultural impact assessments regarding major local and regional development projects, Indigenous tourism development, and repatriation of cultural property and ancestral remains. Consultancies have also included working with the Great Barrier Reef Marine Park Authority and the CSIRO.