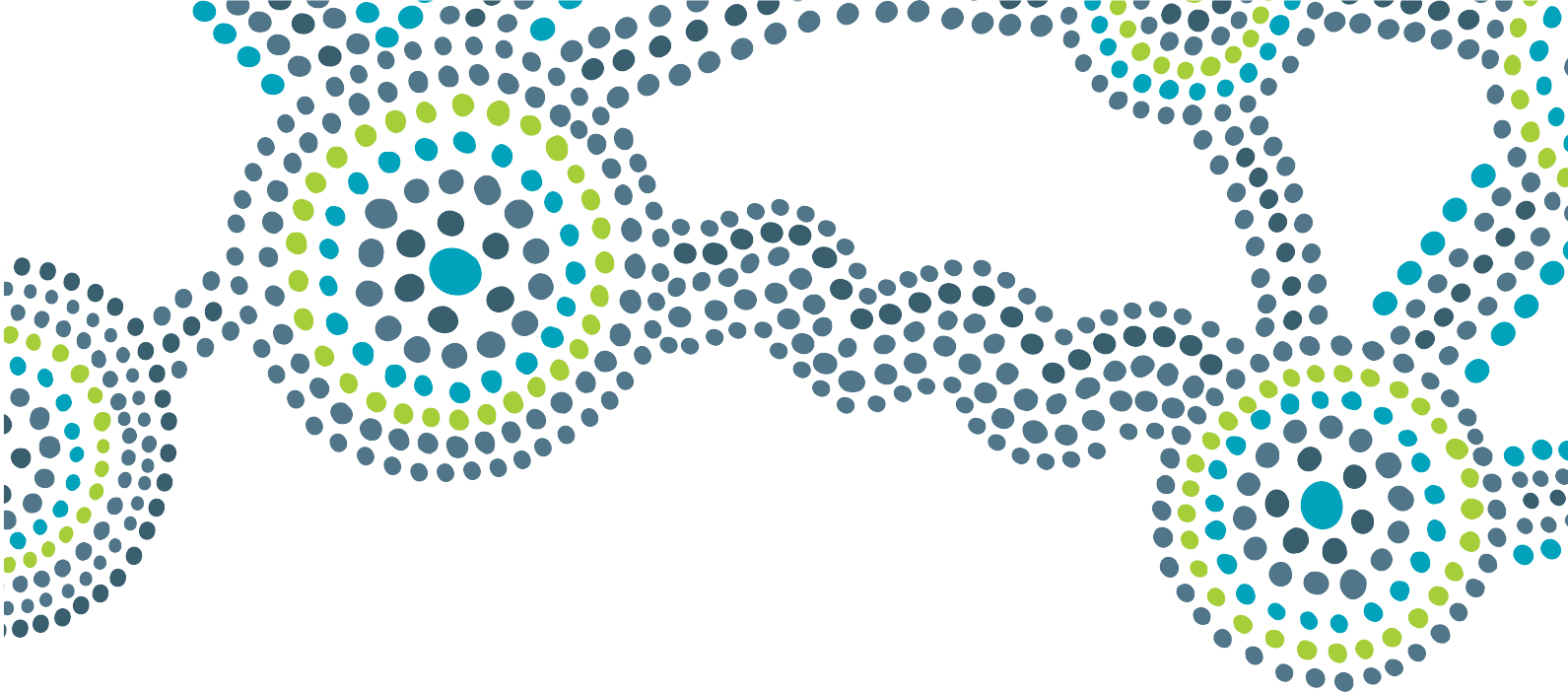






Addressing Institutional Barriers to

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Health Equity for Aboriginal and Torres Strait Islander People in Queensland’s Public Hospital and Health Services

REPORT TO:

Commissioner Kevin Cocks AM

*Anti-Discrimination Commission Queensland*

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MARCH 2017 Reformatted by ADCQ

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]](#footnote-1)

Confronting Institutionalized Racism (2003)

**Dedication**

This report is dedicated to my Gungalu brother Noel Brown and the Aboriginal and Torres Strait Islander employees of the Cairns and Hinterland Hospital and Health Service who give and endure so much in the service of their mob, and who are the inspiration and the beginning of this journey to stamp out institutional racism.

Adrian Marrie

March 2017

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I would like to acknowledge my wife, Henrietta for her contribution and partnership in the development of the original Matrix which provided the foundation for the assessment tool used in this report. Her insights, strength and feistiness have forever been my inspiration. The revised Matrix is renamed in her honour: the Bukal Institutional Racism Matrix.

All good ideas need champions to see them into fruition. The author wishes to acknowledge the tremendous support, interest and contributions of the following during various stages of the Matrix journey:

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* Professor Komla Tsey (Cairns Institute, James Cook University)

Adrian Marrie

March 2017

# Language policy

’Aboriginal and Torres Strait Islander’ and ‘Indigenous’ are respectfully used to refer to the First Peoples of Australia.

# Acronyms

1. **Queensland’s public hospital and health services (HHSs)**

CH Cairns and Hinterland Hospital and Health Service

CHQ Children’s Health Queensland Hospital and Health Service

CQ Central Queensland Hospital and Health Service

CW Central West Hospital and Health Service

DD Darling Downs Hospital and Health Service

GC Gold Coast Hospital and Health Service

M Mackay Hospital and Health Service

MN Metro North Hospital and Health Service

MS Metro South Hospital and Health Service

NW North West Hospital and Health Service

SW South West Hospital and Health Service

SC Sunshine Coast Hospital and Health Service

TC Torres and Cape Hospital and Health Service

T Townsville Hospital and Health Service

WM West Moreton Hospital and Health Service

WB Wide Bay Hospital and Health Service

1. **General**

AHHA Australian Healthcare and Hospitals Association

AHMAC Australian Health Ministers’ Advisory Council

AHPRA Australian Health Practitioner Regulation Agency

AHRC Australian Human Rights Commission

AIDA Australian Indigenous Doctors Association

AIHW Australian Institute of Health and Welfare

ATODS Alcohol, Tobacco and Other Drugs Service

ATSICCHS Aboriginal and Torres Strait Islander Community Controlled Health Service (aka: Aboriginal Medical Service – AMS; Indigenous Community Controlled Health Organisation/Service – ICCHO/S);

CALD Cultural and Linguistic Diversity

CGCSC Close the Gap Campaign Steering Committee

COAG Council of Australian Governments

DAMA Discharge Against Medical Advice

DoH Department of Health (Commonwealth)

DoHA Department of Health and Ageing (Commonwealth)

HHB Act *Hospital and Health Boards Act 2011* (Qld)

HHB Hospital and Health Board

HHS Hospital and Health Service

HSCE Health Service Chief Executive

IHW Indigenous Health Worker

ILO Indigenous Liaison Officer

IUIH Institute for Urban Indigenous Health

MIRM Marrie Institutional Racism Matrix (viz *Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services*)

MOHRI Minimum Obligatory Human Resource Information (presented as two sets of data for: (i) MOHRI Occupied FTE (Full Time Equivalent); and (ii) MOHRI Headcount, which includes all employment categories (Full Time permanent, Part Time permanent, FT temporary, PT temporary, and Casual)

MPHS Multi-Purpose Health Service

NACCHO National Aboriginal Community Controlled Health Organisation

NATSIHC National Aboriginal and Torres Strait Islander Health Council

NATSIHP *National Aboriginal and Torres Strait Islander Health Plan 2013-2023.*

NHFA National Heart Foundation of Australia

NHPA National Health Performance Authority

NHRA COAG National Health Reform Agreement

NIRA COAG National Indigenous Reform Agreement (Closing the Gap)

NPACGIHO COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

OID Report *Overcoming Indigenous Disadvantage* reports prepared by the Productivity Commission for the SCRGSP (see below).

PHN Primary Health Network

PPH Potentially Preventable Hospitalisation

QAIHC Queensland Aboriginal and Islander Health Council

QH Queensland Health (Queensland Department of Health)

QHMT Queensland Health Matrix Template

RDA *Racial Discrimination Act 1975* (Cth)

RoGS Report of Government Services – see SCRGSP below

SDOHA Social Determinants of Health Alliance

SCRGSP Steering Committee for the Review of Government Service Provision

VACCHO Victorian Aboriginal Community Controlled Health Organisation

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# Foreword

The Anti-Discrimination Commission (the ADCQ) has the function under the *Anti-Discrimination Act* (the AD Act) of consulting with various organisations to ascertain means of improving services and conditions affecting groups that are subjected to contraventions of the Act.

Institutional racism has been identified in the Australian Government’s *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* and subsequent *Implementation Plan* as a significant barrier in the delivery of health care to Aboriginal and Torres Strait Islander people.

In June 2014, inspired by the work of the Matrix authors, the FNQ Regional staff of this Commission undertook a community engagement project in partnership with them. The project aimed to improve health outcomes for the Aboriginal and Torres Strait Islander population serviced by the Cairns and Hinterland Hospital and Health Service (CHHHS). Together they recruited the support of senior leaders within CHHHS and the community controlled health sector to work on identifying and addressing the barriers faced by the target population. With an immediate positive response from senior executives within CHHHS itself and Wuchopperen, Apunipima Cape York and Gurriny Yealamucka Aboriginal Health Services, Queensland Aboriginal and Islander Health Council and James Cook University, the project team boasted an impressive list of talented, knowledgeable and motivated individuals who collectively had both the skill and the opportunity to promote positive change, and indeed they did so.

In subsequent years, the team grew and a CHHHS Board Member joined the team along with the CEO of Mulungu Health Service and an additional academic from the University. Over the past three years, the team have achieved several significant and positive changes such as the appointment of an Aboriginal person to the CHHHS board and the establishment of an Aboriginal and Torres Strait Islander health committee as a community advisory committee to contribute to the overall goal of the project. Quite early on however, it became apparent that many of the issues the project team were addressing were not specific to the CHHHS service region. Many had state-wide or national relevance. With this in mind, the state-wide audit of hospitals and health services was commissioned.

The primary driver for the commissioning of this report was to identify ways in which Aboriginal and Torres Strait Islander leaders in the health sector can strengthen cooperative and constructive relationships with public health providers and the Queensland government, to effectively improve the implementation of the Closing the Gap policies and frameworks in the health sector.

I commend this report to you, and look forward to working with you to promote, protect and fulfil the human rights of Aboriginal and Torres Strait people’s in Queensland.



**Kevin Cocks AM**

**Anti-discrimination Commissioner,**

**Queensland**

# EXECUTIVE SUMMARY

Institutional barriers to health equity for Aboriginal and Torres Strait Islander people in Queensland’s hospital and health services (HHS) can occur in a number of ways, for example, by failing to:

* include provisions in the *Hospital and Health Boards Act 2011* (Qld) that require Aboriginal and Torres Strait Islander people be included in the governance structures of HHSs, and in the design and delivery of health care services to their people;
* properly implement relevant federal and Queensland government closing the health gap policies;
* include Aboriginal and Torres Strait Islander people in HHS advisory and consultative mechanisms;
* publicly and consistently report on progress and initiatives undertaken to close the Indigenous health gap in HHS annual reports in a way that can invite public feedback into HHS processes;
* provide culturally safe and appropriate health care services in accordance with nationally agreed health system performance standards;
* employ Aboriginal and Torres Strait Islander people in clinical and front-line services; and
* publicly and transparently report on Aboriginal and Torres Strait Islander health care funding and expenditure so that both the Aboriginal and Torres Strait Islander community and the general public can be assured that they are getting value for money for the services specifically provided to Aboriginal and Torres Strait Islander people.

These examples can act singularly or in concert to prevent the optimal delivery of health services to Aboriginal and Torres Strait Islander people and stymy efforts to close the Indigenous health gap. These examples, in their different ways, constitute barriers to achieving health equity for Aboriginal and Torres Strait Islander people.

In order to identify and provide some objective and evidence-based assessment of these barriers, the *Matrix for Identifying Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services* (the Matrix) has been used to conduct an audit of each of Queensland’s sixteen HHSs. The Matrix is based on the NSW Government Department of Education and Communities’ description of institutional racism as a:

…form of racism which [is] 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.[[2]](#footnote-2)

Developed in 2014, the Matrix was first used to conduct an audit of the Cairns and Hinterland Hospital and Health Service (CHHHS) to provide a case study of its application. Early in 2016 a preliminary trial of the Matrix on the 16 HHSs was carried out resulting in some revision preparatory to this audit. While the Matrix is still under development, this audit will provide reviewers and stakeholders (including Queensland Health, peak Aboriginal and Torres Strait Islander health NGOs, human rights agencies, and national health authorities) with the opportunity to gauge its effectiveness, as part of a formal validation process, in eliminating institutional racism.

Noting that institutional racism has been identified in the Australian Government’s *National Aboriginal and Torres Strait Islander Health Plan 2013-2013* and subsequent *Implementation Plan* as a significant barrier in the delivery of health care to Aboriginal and Torres Strait Islander people, as an assessment tool, the Matrix offers a new approach in dealing with institutional racism not only in the public health system, but also in other service areas such as the justice system, child welfare services, public housing, education and employment. The Matrix also has the potential to be adapted to address other forms of institutional discrimination regarding gender, disability and age, for example. Ultimately, it is hoped that the Matrix will provide a credible tool that can be used by government agencies, NGOs and researchers to assess the performance of public institutions over time in the services that they provide, and as a medium to promote public discussion and debate on the resolution of any issues that a Matrix audit might expose. In this capacity, the Matrix can act as a change agent.

In its construction, the criteria used for assessment are directly derived from the relevant national Closing the Gap partnership agreements and federal and Queensland Closing the Gap health policies and implementation frameworks. The audit process uses only publicly available information provided, for example, in HHS annual reports, health service agreements, strategic and operational plans, summaries of HHS board meetings, and information provided on HHS web sites. By only using publicly available information in both the construction and assessment processes, this assures that the Matrix assessments are transparent, repeatable and verifiable. By using a simple scoring system in which each of the criteria used in the assessment process is assigned 10 points (except for the criterion addressing the *Hospital and Health Boards Act 2011* (Qld) which is scored out of 20) an overall score can be achieved. Thus each of the HHSs can be rated and compared, and the results of each audit can be used to focus discussions between HHSs and the Aboriginal and Torres Strait Islander community controlled health services (ATSICCHS) and communities within their region. The Matrix assessments can also be used to highlight examples of best practice which might be adopted by other HHSs as a part of their overall strategies to eliminate institutional racism.

As a change agent, elements of the Matrix, if not the Matrix itself, can be incorporated into public health sector quality improvement and accreditation processes, as well as in the reporting process of, for, example, the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures* endorsed by the Australian Health Ministers Advisory Council in 2011, with flow-on effects in the way government reporting agencies such as Reconciliation Australia, the Australian Institute of Health and Welfare (AIHW), the Australian Human Rights Commission, the Aboriginal and Torres Strait Islander Social Justice Commissioner, and the Productivity Commission can report on institutional racism. Ultimately, however, much of this will depend on institutional racism, as a form of racial discrimination, being recognised in the *Racial Discrimination Act 1975* (Cth) to provide the nation’s human rights agencies with the statutory authority to address this form of racism.

**Principal findings based on an analysis of the Matrix audit results:**

It is emphasised that the evidence used in the audits of the HHSs is gathered from publicly available information – primarily: HHS 2014 – 2015 annual reports, 2013/14 – 2015/16 service agreements, strategic plans, community and consumer engagement plans; board summaries for 2014 and 2015, and other information available on individual HHS websites.

1. **Indigenous participation in HHS governance**

**The *Hospital and Health Boards Act 2011* (Qld) (HHB Act) and *Hospital and Health Boards Regulation 2012* (Qld) (HHBR 2012)**:

* Insofar as the National Health Reform Agreement (NHRA) lays down the statutory blueprint for state/territory public health services legislation, it is the source of the structural conditions that enables institutional racism in HHSs to flourish.
* To the extent that laws establishing statutory bodies provide the legislative architecture which structures governance, management, performance, employment, reporting and accountability arrangements, the HHB Act and HHBR 2012 do not provide the necessary legal, and compliance and accountability mechanisms to compel HHS Boards to abide by the COAG National Partnership Agreement on Closing the Gap on Indigenous Health Outcomes (NPACGIHO) and the National Indigenous Reform Agreement (NIRA), neither of which are listed in **Part 1 Agreements with Commonwealth, State or entity** contained in **Schedule 3 Agreements** of the HHBR 2012.
* Except for a single reference to Indigenous health in **s.4 Principles and objectives of the national health system**  in sub-paragraph **s. 4(c)(vi)**, the *Hospital and Health Boards Act 2011* (Qld) renders Aboriginal and Torres Strait Islander peoples “legally invisible” and creates the structural conditions for institutional racism and health inequality to exist within Queensland Health’s sixteen public hospital and health services by, *inter alia,*  not including:

1. a statement of commitment to Closing the Gap in Aboriginal and Torres Strait Islander health in a Preamble to the Act, reflecting that “Aboriginal and Torres Strait Islander health is everyone’s business”;
2. a provision for the delivery of responsive, capable and culturally competent health care to Aboriginal and Torres Strait Islander people in Queensland as an object of the Act;
3. a requirement that HHS boards have among their members a person (or persons) with expertise and experience in Aboriginal and Torres Strait Islander health care or health service delivery among the skills, knowledge and experience required for a HHS to perform its functions effectively and efficiently under **s.23(2)**;
4. a provision that requires the establishment of Aboriginal and Torres Strait Islander consultative and advisory bodies to provide input into the administration and management of hospital and health services
5. a provision that requires HHSs to establish Aboriginal and Torres Strait Islander health plans;
6. a provision that requires HHSs to report on their progress on closing the Aboriginal and Torres Strait Islander health gap in their annual reports; and
7. a provision that requires HHSs to report the sources and expenditure of funds for Aboriginal and Torres Strait Islander health care and health service deliver in their annual financial statements.

* The *Hospital and Health Boards Act 2011* (Qld) does not comply with **s.4(3)(j)** of the *Legislative Standards Act 1992* (Qld) in so far as it does not show that it has “sufficient regard to Aboriginal tradition and Island custom” in relation to those traditions and customs that specifically relate to Aboriginal and Torres Strait Islander health and wellbeing.
* In this regard, the *Hospital and Health Boards Act 2011* (Qld) compares poorly with the *Nature Conservation Act 1992* (Qld) both in terms of compliance with **s.4(3)(j)** of the *Legislative Standards Act 1992* (Qld) and with regard to “legal visibility” in so far as the *Nature Conservation Act* contains provisions that acknowledge and protect the rights, interests and responsibilities of Aboriginal and Torres Strait Islander people in the conservation and management of Queensland’s natural resources and protected areas.

In summary, the HHB Act and HHBR 2012 fail to give the necessary legislative force to the COAG national partnership agreements and federal and Queensland policy imperatives to close the Aboriginal and Torres Strait Islander health gap, thus indicating to the Aboriginal and Torres Strait Islander communities that the State is not taking its responsibilities to Close the Indigenous Health Gap seriously.

**Aboriginal and Torres Strait Islander peoples’ participation in hospital and health service governance as at 30th June 2015**:

* Of the 131 board members appointed across all HHSs, only 5 were Aboriginal and/or Torres Strait Islander. Only three HHSs had Indigenous representation.
* Of the 156 executive positions identified among the 16 HHSs, none were occupied by an Aboriginal or Torres Strait Islander person – Aboriginal and Torres Strait Islander people were not members of any HHS executive management team or group.
* Within the 16 HHS governance structures, of the 131 board memberships and 156 executive management positions, Aboriginal and Torres Strait Islander people occupied only 5 of the 287 positions
* No HHSs included Aboriginal and Torres Strait Islander health at divisional level as a stand-alone dedicated division within their executive management structure, although two HHSs included Aboriginal and Torres Strait Islander health with other portfolio responsibilities at divisional level.
* As a possible consequence of the lack of Aboriginal and Torres Strait Islander representation at both board and executive management levels, Indigenous health matters only accounted for about one per cent of board agenda items as presented in board meeting summaries for 2014 and 2015. In these board meeting summaries:

1. While it is reasonable to expect that each HHS board should review its HHS’s performance in relation to closing the gap in Indigenous health outcomes at least once in every year, none of the agenda items explicitly included an annual report or review of a HHS’s performance or contribution to closing the Indigenous health gap; and
2. For 5 HHSs, Indigenous health was not listed as an agenda item for 2014 and 2015.

1. **Closing the Gap policy implementation**

**Closing the Gap**:

* Eight HHSs did not explicitly identify closing the Aboriginal and Torres Strait Islander health gap as a strategic priority in (their statutory) HHS strategic plans
* In accordance with Queensland Health’s health system priorities, only two of a possible twenty-two Tier 3 Health System Performance Measures from the *Aboriginal and Torres Strait Islander Health Performance Framework Performance Measures* endorsed by AHMAC were included in the 2013/14 – 2015/16 Health Service Agreements. These measures related to discharges against medical advice (DAMA) and potentially preventable hospitalisations (PPH).

**Community engagement**:

* Only five HHSs had established Aboriginal and Torres Strait Islander community consultative bodies to enable Aboriginal and Torres Strait Islander people within their HHS region to have direct input and receive feedback regarding the running of the HHS.
* Despite the Queensland Government in its own Reconciliation Action Plan 2009-2012 committing all Queensland Government agencies to establishing their own RAP, no HHS had a current RAP for the 2014- 2015 period.
* Only one HHS regularly publishes a dedicated Aboriginal and Torres Strait Islander health community newsletter, while another publishes a newsletter almost entirely devoted to Aboriginal and Torres Strait Islander health news.

**Public Reporting and Accountability (via HHS 2014-2015 Annual Reports)**:

* Only 6 of the 16 HHSs included a discrete section devoted to initiatives, progress, programs, etc., in relation to their efforts to Close the Gap in their 2014-2015 annual report.
* Overall, reporting on Closing the Gap health and other initiatives was very poor receiving an overall average audit score of 3/10. To address this, the *Annual report requirements for Queensland Government agencies* compliance check list for HHS reporting should be amended to include a requirement for a Closing the Gap statement which should include requirements to report on: Aboriginal and Torres Strait Islander employment; non-Indigenous Cultural Competency Training completion rates; performance against selected Closing the Gap KPIs; and a Closing the Gap financial statement.

1. **Service delivery**

**Aboriginal and Torres Strait Islander health plan**:

* Of the 16 HHSs only one had a comprehensive, published plan while nine of the HHSs provided no tangible evidence of such plan. Six HHSs had entered into agreements or established MoUs or protocols with local ATSICCHSs.

**Mandatory cultural competency training (CCT)**:

* In spite of the considerable federal and Queensland policy emphasis on having a culturally competent workforce, and all HHSs (except for one) being specifically funded in their 2013/14 – 2015/16 health service agreement to provide cultural capability services, seven of the 16 HHSs provided no evidence of having established a cultural competency policy, plan, strategy or program.
* Only six HHSs demonstrated a capacity to deliver Cultural Competency Training through a dedicated unit, team or specialist cultural advisor.
* In terms of the proportion of non-Indigenous staff trained:

1. 12 HHSs provided no data on either the number or percentage of their non-Indigenous staff to complete CCT in their 2014-2015 annual report.
2. In those HHSs that provided comparative completion rates of mandatory training modules, completion rates for CCT were as little as a third of those for other training modules.

**Reporting on selected *National Aboriginal and Torres Strait Islander Health Performance Framework* Tier 3 Health Service Performance Measures (HSPM)**:

* Despite being included in the 2013/14 – 2015/16 HHS service agreements, only two of the 16 HHSs reported on their rates of discharge against medical advice (DAMA), and only two reported on potentially preventable hospitalisations (PPH).
* With regards to other Closing the Gap KPIs selected from the Tier 3 HSPMs for the purpose of the audit: only one reported on access to mental health services, and none on access to drug and alcohol services.

This in spite of the fact that, according to their 2013/14 – 2015/16 health service agreements, whether or not as a Closing the Gap funded service:

1. All HHSs were funded to provide Indigenous Mental Health Services as part of their Community Ambulatory Mental Health Services; and
2. 11 HHSs were funded to provide Indigenous Outreach Services under the Alcohol and Other Drugs Services, and of these five were also funded to provide Indigenous Youth (12-17 years) Treatment Programs.

**Reporting on Indigenous status**:

* While not a Tier 3 HSPM, despite the existence of Queensland Health and AIHW guidelines to improve the identification of Aboriginal and Torres Strait Islander people in health care, and its incorporation as a KPI in the 2012-2013 annual reports of some HHSs, no HHS reported this KPI in their 2014 – 2015 annual report.

1. **Recruitment and employment**

**Aboriginal and Torres Strait Islander participation in the health workforce**:

* All HHSs under their 2013/14-2015/16 service agreements are funded to provide placements for clinical education and training for students, interns and trainees in a range of clinical categories. Given the policy emphasis on employment of Aboriginal and Torres Strait Islander people in HHS health workforces, this provided the perfect opportunity to identify and fund placements for Indigenous Health Workers and Indigenous Liaison Officers. This opportunity was not offered in any of the health service agreements.
* None of the 16 HHSs provided evidence of having a published or downloadable Aboriginal and Torres Strait Islander workforce development policy, strategy or plan comparable to, for example, the State Library of Queensland’s *Aboriginal and Torres Strait Islander Workforce Strategy 2012-2016 –* itself a direct outcomes of the Queensland Government’s *Reconciliation Action Plan 2009-2012* committing all government agencies to implement Aboriginal and Torres Strait Islander employment action plans.
* Only 5 HHS indicated that they have either established or intend to establish some form of Aboriginal and Torres Strait Islander workforce development body.
* Half of the HSSs provided no employment data regarding Aboriginal and Torres Strait Islander participation in their workforce. One HHS far exceeded its employment equity target, while another was just shy of its target.
* While all sixteen HHSs employ Aboriginal and Torres Strait Islander people, of those 8 HHSs that released their Aboriginal and Torres Strait Islander workforce participation data, most Aboriginal and Torres Strait Islander people, including Health Workers and Liaison Officers were employed in managerial and clerical positions, or in operational and support services. Very few Aboriginal and Torres Strait Islander people were employed in front-line or clinical services as doctors and nurses.
* Despite 10 HHSs being funded under their 2013/14 - 2015/16 health service agreements to provide Indigenous hospital liaison services, and the category Aboriginal and Torres Strait Islander health practitioner being recognised by the Australian Health Practitioner Regulation Agency, Queensland Health does not recognise Aboriginal and Torres Strait Islander health workers and liaison officers as constituting an employment category or stream in its own right.
* No data on Aboriginal and Torres Strait Islander health workforce employment was provided in the Queensland Health annual Closing the Gap performance reports for 2014 and 2015.

1. **Financial accountability and reporting: Closing the Gap**

All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services (such as Aboriginal and Torres Strait Islander Health, Indigenous Mental Health Services and Indigenous Outreach Services) are funded under other HHS programs in their service agreements. While the services are identified in the agreements, neither commonwealth nor Queensland funding contributions and expenditure are included in the financial statements or in any other sections of HHS 2014-2015 annual reports. Similarly, no summary of this funding and expenditure is provided in the Queensland Health Closing the Gap progress reports for 2014 and 2015.

Aboriginal and Torres Strait Islander people have the right to expect of the HHSs the same level of performance and public financial accountability as is required by government funding bodies of their community controlled health services (ATSICCHS).

1. **The level of institutional racism within Queensland HHSs**

* Based on the audit results across the five key indicators (participation in governance, policy implementation, service delivery, recruitment and employment, and financial accountability and reporting), 10 of the 16 HHSs rated within the extreme range of institutional racism (that is scoring less than 20 points out of the possible 140), with the remaining six in the very high range (20-39 points out of 140). Thus, all of the 16 HHSs rated in the very high to extremely high levels of institutional racism.
* Out of a possible score of 140 points, scores ranged from 5.5 to 37. Two HHSs scored 10 or less points, 4 HHSs scored more than 30points.

The findings of this report are unacceptable for contemporary health service provision in Australia and they are intended to serve as a catalyst for discussion and action, with individual HHS scores providing a focus on issues to be addressed in consultation with the Aboriginal and Torres Strait Islander community controlled health organisations and their communities within each HHS area.

1. **Examples of best practice**

Despite the bleak assessments a number of HHSs provided examples of best practice which included:

* A number of Aboriginal and Torres Strait Islander community controlled health services (ATSICCHS) hosting HHS board meetings during 2014 and 2015.
* One HHS provided an excellent example of an Aboriginal and Torres Strait Islander community health newsletter.
* One HHS, in collaboration with the local ATSICCHS, had established a system for sharing Indigenous patient medical information between the hospital and the Indigenous health service.
* A number of HHS annual reports provided excellent examples on the reporting of: Closing the Health Gap KPIs; and comparative tables on completion rates of mandatory training modules, including for cultural competency training (CCT) for non-Indigenous staff, and the employment of Aboriginal and Torres strait Islander people according to Queensland Health’s six employment streams.
* One HHS had collaborated with the Aboriginal shire council, community controlled services and the federal government to establish and publish their community health action plan.
* One HHS far exceeded its equity target for the employment of Aboriginal and Torres Strait Islander people, while another HHS fell just shy of it. The equity target is based on the percentage of Aboriginal and Torres Strait Islander people of the total population within a HHS region.
* One HHS had established an Aboriginal and Torres Strait Islander Health Committee to serve alongside its existing community health consultation committees.

**CONCLUDING COMMENTS**

The lesson to be learned from this report is that if Aboriginal and Torres Strait Islander health policies are not reinforced in the relevant legislation, then those primarily charged with implementing them, namely the HHS boards and their executive management teams, as this audit demonstrates, will invariably ignore them.

A statewide healthcare system with greater capacity, co-operation, transparent reporting systems, financial accountability and with patients the focus of attention, is a vision all Queenslanders want to see. This report highlights the barriers to the achievement of this vision for Aboriginal and Torres Strait Islander people in Queensland. The report provides a basis for Aboriginal and Torres Strait Islander leaders to build cooperative and constructive relationships with public health providers to bring real reform within the public health system and make closing the gap targets in health a reality.

# INTRODUCTION

In order to identify and address the institutional barriers to health equity for Aboriginal and Torres Strait Islander people in Queensland’s public hospital and health services, some form of external, evidence-based assessment is necessary to inform the process. To accomplish this, the *Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services* (the Matrix) has been employed. The Matrix, a newly emerging assessment tool still under development, is used to audit federal and state Closing the Gap health policy implementation and accountability in each of Queensland Health’s sixteen hospital and health services (HHS). The criteria employed in the Matrix reflect different elements of the suite of federal and Queensland policies, and the evidence used in the audit process is taken from publicly available documents generated by each HHS. The individual HHS audit results provide a framework for discussion for each HHS with the Aboriginal and Torres Strait Islander community and their community controlled health organisation(s) within the region it serves.

The Introduction outlines the purpose of the report, includes a brief history of the development of the Matrix, and discusses the impact of racism, identified as one of the key social determinants negatively impacting the health and social and mental wellbeing of Aboriginal and Torres Strait Islander people. The barriers that institutional racism in particular create in attempts to achieve health equity for Aboriginal and Torres Strait Islander people in the public health system are identified. The objectives of the audit include the promotion of transparency in Closing the Gap policy implementation and accountability, and the contribution that the Matrix could make to the national goal of a health system free of racism and inequality by reducing the impact of institutional racism on the achievement of health equity for Aboriginal and Torres Strait Islander people. Methodological considerations are also outlined, including limitations to the assessment process – the Matrix, for the purpose of this audit, is not designed to address individual acts of racism and racial discrimination, or the clinical performance of HHSs in terms of access to hospital procedures.

For the purposes of this report the following long-standing definition of Aboriginal and Torres Strait Islander health, one which has had wide currency among Aboriginal and Torres Strait Islander health NGOs and in federal and state and territory Aboriginal and Torres Strait Islander health policies for nearly three decades, is used:

‘Aboriginal health’ means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life.[[3]](#footnote-3)

## Purpose of the report

The purpose of the report is to identify and address institutional barriers to health equity for Aboriginal and Torres Strait Islander people in Queensland’s hospital and health services (HHS). This purpose will be accomplished by employing the *Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services* (the Matrix) to conduct an assessment of each of Queensland’s sixteen HHSs.

It should also be considered that the Matrix was specifically designed to address and contribute to our understanding of institutional racism which has been identified as a barrier to effective healthcare to Aboriginal and Torres Strait Islander people in the public health system (see Section 1.4) and also as a personal response to the Australian Human Rights Commission’s *National Anti-Racism* *Strategy* (2012) and the *Racism. It Stops with* Me and subsequent campaigns. If the Matrix had a different, and for some, a less confronting title, for example *A Matrix for Identifying, Measuring and Monitoring Closing the Gap Policy Implementation and Accountability within Public Hospitals and Health Services,* the results of the assessments and the conclusions reached would still be the same.

## Brief history

The development of the Matrix is a by-product of a confidential report *Addressing Allegations of Discrimination Against Aboriginal and Torres Strait Islander (ATSI) Employees of the Cairns & Hinterland Hospital and Health Service (CHHHS) and Review of Support Avenues for the ATSI Workforce [[4]](#footnote-4)* commissioned by the Chief Executive of the CHHHS in November 2013. In the course of interviews and background research, it became clear that signifiers of institutional racism were also evident, and that elements of important federal and Queensland Aboriginal and Torres Strait Islander Closing the Gap health policies were largely being ignored by the CHHHS. A number of Aboriginal and Torres Strait Islander interviewees were frustrated and demoralised, and felt marginalised by the loss of many of their colleagues during the 2012-13 restructure and the forced redundancy of the Indigenous executive director of the Aboriginal and Torres Strait Islander Health Division and its amalgamation into a “super division”- the Division of Strategy, Planning, Performance and Aboriginal and Torres Strait Islander Health. A number of the interviewees also pointed out that, unlike the Townsville Hospital and Health Service (THHS), there was no Indigenous board member – this for a HHS serving some 40,000 Aboriginal and Torres Strait Islander people in far north Queensland, and in a hospital where, anecdotally, and as a consequence of the disproportionate share of the burden of disease, roughly a third of the patients were Indigenous. However, it was necessary to expose the situation in an objective and constructive way. A literature search of institutional racism on the internet in early 2014 did not reveal the existence of a suitable tool capable of delivering an evidence-based external assessment of the nature and extent of institutional racism as it manifested within a particular organisation or institution, although there were some tools that provided some direction as to how this might be achieved. One such tool was produced by the Seattle Human Services Coalition, *Identifying Institutional Racism Folio: Tools to assist human service organisations identify and eliminate institutional racism in their organization[[5]](#footnote-5)* , and was used to help establish the structure of the Matrix.

The Matrix was developed initially as a national template during February-April 2014, and then adapted to Queensland Health’s legislative and policy environment. The Matrix was trialled on the CHHHS in June 2014.[[6]](#footnote-6) The CHHHS scored 14 points out of a possible 140 – placing it at the extreme end of the scale of institutional racism. The case study was delivered to the CHHHS HSCE, with copies sent to the AHRC and ADCQ. The far northern regional manager of the ADCQ proposed to establish a team, the Optimal Health Project Team, endorsed by the ADCQ’s Commissioner, to address issues raised by the CHHHS Matrix assessment with senior staff of the CHHHS and senior representatives of local Aboriginal and Torres Strait Islander Community Controlled Health Services (ATSICCHS), local public health academics, and the two directors of Bukal Consultancy Services P/L – the authors of the CHHHS case study.

During 2015, the CHHHS Matrix assessment case study was quite widely distributed and was made available on the internet. The Matrix attracted a lot of interest from within Australia and overseas. In September 2015, ADCQ’s Commissioner invited Robyn McDermott, Professor of Public Health Medicine, Centre for Chronic Disease Prevention, Australian Institute of Tropical Health and Medicine to review the Matrix. In her review, Professor McDermott stated:

This is a valuable and important development which can improve transparency, accountability and ultimately the performance of HHS in service delivery to Aboriginal and Torres Strait Islanders.

Further she recommended that:

The Matrix should be reviewed by an expert panel in population and health services to identify areas for improvement in the measures, if any, and make comments on the utility or otherwise of the Matrix in this and other jurisdictions[[7]](#footnote-7)

In February-April 2016, the author conducted a preliminary Matrix assessment of Queensland Health’s 16 HHSs. As a result, the Matrix was substantially revised and renamed the *Bukal Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services* - the Bukal Institutional Racism Matrix (or BIRM). In July 2016, the ADCQ’s Commissioner contracted the author to conduct a full Matrix audit of the state’s HHSs. This is the report of that audit.

The Matrix is still under development and yet to go through a formal validation process. This is the first time that the revised Matrix has been formally used to undertake an assessment of a state/territory health system in Australia, and this assessment should be considered in the context of the validation process (see Section 1.6.3).

## Racism in the public health system

In noting the effects of racism in the health system on the health and wellbeing of Aboriginal and Torres Strait Islander people,the Australian Indigenous Doctors’ Association’s (AIDA) *Policy Statement: Racism in Australia’s health system* states:

Healthcare provider racism can lead to poorer self-reported health status, lower perceived quality of care, underutilisation of health services, delays in seeking care, failure to follow recommendations, societal distrust, interruptions in care, mistrust of providers and avoidance of health care systems.[[8]](#footnote-8)

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.[[9]](#footnote-9)

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.[[10]](#footnote-10)

The vision guiding the Health Planis one in which:

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.[[11]](#footnote-11)

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”.[[12]](#footnote-12)* 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.”[[13]](#footnote-13)

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.[[14]](#footnote-14)

The Close the Gap Campaign Steering Committee (CGCSC) 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.[[15]](#footnote-15)

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”.[[16]](#footnote-16) 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 or more[[17]](#footnote-17) – 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. In this context, Professor Mick Dodson expresses the perennial frustrations of a generation of people who have long sought to bring about changes in the way Indigenous affairs policies and practices are implemented:

In part the unfinished business is the myriad of reports, commissions, inquiries and studies we as a nation have conducted over decades. We’ve had health reports, housing reports, education reports, welfare reports, community violence reports, law reform reports, economic development reports, employment and unemployment reports, Social Justice Commissioner reports, death in custody reports, the taking of children away reports, the list is almost endless… and on top of this we’ve had assessments, evaluations, pilots, trials, umpteenth policies and policy approaches. And all of this paperwork would comfortably fill a couple of modest suburban libraries. And, it’s on the shelf where most of them have stayed. They’ve stayed their unread, unfinished, their recommendations unimplemented, and they’re very much unloved.[[18]](#footnote-18)

The fate of these reports is itself a manifestation of institutional racism.

One of the key messages in a recent report to the National Aboriginal Community Controlled Health Organisation (NACCHO)[[19]](#footnote-19) 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.”[[20]](#footnote-20) 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.[[21]](#footnote-21)**

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.”[[22]](#footnote-22)

In view of the overall situation and mounting evidence of the prevalence of racism in all its various manifestations in the public health system, the CGCSC, which “has long maintained that confronting racism in health services should be a priority for Australian governments”, has recommended in its *Progress and priorities report 2016*:

That a national inquiry into racism and institutional racism in health care settings, and hospitals in particular, and its contribution to Aboriginal and Torres Strait Islander health inequality, is undertaken by the Senate Select Committee on Health.[[23]](#footnote-23)

Issues of racism affect Aboriginal and Torres Strait Islander health workforce employees and patients alike.[[24]](#footnote-24) Of paramount concern is the need to address issues of racism and racial discrimination, both individual/casual and institutional, in the delivery of healthcare services to Aboriginal and Torres Strait Islander people. The CGCSC, in its 2017 report, has again recommended that the Federal Government hold a national inquiry into racism and institutional racism in health care settings, and hospitals in particular, with the findings to be incorporated into the actioning of the *Implementation Plan* of the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*.[[25]](#footnote-25)

## Institutional racism: a barrier to health equity

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.[[26]](#footnote-26) Racism can be expressed through stereotypes (racist beliefs), prejudice (racist emotions) or discrimination (racist behaviours and practices).[[27]](#footnote-27) Racism can occur at three conceptual levels - internalised, interpersonal and institutional - that are interrelated and frequently overlap in practice.[[28]](#footnote-28) Most importantly, as Dudgeon *et al* point out:

An institution can engage in racist practices without any of its members being individually racist. This is an important point to comprehend if we are to understand the damaging health and educational outcomes affecting Indigenous people. The *de jure* and *de facto* rules of an institution, the aggregation of individual behaviours, and institutional culture can all achieve racist outcomes in the absence of a deliberate intention to do so by any individual within the institution.[[29]](#footnote-29)

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.[[30]](#footnote-30) 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 across a state or territory’s public health service/system), their observance and management in the day-to-day operation of an organisation,[[31]](#footnote-31) 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/People and Culture departments and can be closely associated with interpersonal racism.

Accordingly, and for the purposes of developing the Matrix, the NSW Government Department of Education and Communities’ description of institutional racism has been used, which describes institutional racism as a:

…form of racism which [is] 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.[[32]](#footnote-32)

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,[[33]](#footnote-33) interpersonal,[[34]](#footnote-34) 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.[[35]](#footnote-35)

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.”[[36]](#footnote-36)

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.[[37]](#footnote-37) 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, and in doing so, create a self-serving Indigenous industry feeding off the misery of Aboriginal and Torres strait Islander people.[[38]](#footnote-38) 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.[[39]](#footnote-39)

Aboriginal and Torres Strait Islander people as employees working in HHSs that exhibit a very high degree of institutional racism, also suffer consequences – disempowerment, marginalisation and de-moralisation.[[40]](#footnote-40) High levels of institutional racism can foster an institutional culture in which interpersonal and systemic racism can thrive.[[41]](#footnote-41) Furthermore, such a culture can discourage Aboriginal and Torres Strait Islander people from seeking employment in hospitals and health services[[42]](#footnote-42) - 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 the public service level of their employment, 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,[[43]](#footnote-43) 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.[[44]](#footnote-44)

## Diversity of Queensland’s HHSs

One of the challenges for the Matrix is coping with the diversity of Queensland’s 16 HHSs to produce meaningful, consistent and comparable assessments. As indicated by Table 1, there is a huge range in population size and the numbers and percentages of Aboriginal and Torres Strait Islander people within each HHS. For fifteen of the HHSs, there is a basic similarity in that they each serve a geographically defined area whether in urban, regional of remote regions – the exception being the CHQHHS which provides hospital and specialist healthcare services to the children of the whole state. The other notable exception is the TCHHS which, unlike the other HHSs which were all established under the *Hospital and Health Boards Act 2011* (Qld) (HHB Act) on 1 July 2012, was established by the amalgamation of two smaller existing HHSs on 1 July 2014, 6 months into the 2014-2015 reporting period (see Methodology: Section 1.7.1) and therefore could be reasonably expected to not meet some of the criteria, for example, establishing a Reconciliation Action Plan (RAP) and a HHS Aboriginal and Torres Strait Islander health plan within the assessment time-frame. It could also be argued that the TCHHS is also unique among the HHSs. It has by far the highest percentage of Aboriginal and Torres Strait Islander people among the HHSs (overall 64% - and 85% in the Torres Strait - Northern Peninsula Area), a higher use of services based on the burden of disease, and it is the only service provider for the island communities of the Torres Strait, making it virtually function as a state-run Aboriginal and Torres Strait Islander health service.

**Table 1: Qld HHSs Indigenous and non-Indigenous population profile, and location of Aboriginal and Torres Strait Islander Community Controlled Health Services (ATSICCHS)**

**HSS Total Pop. A/TSI A/TSI% ATSICCHSs**

**CH** 283,200 25,5009.04

**CHQ** 1,138,600 94,000 6.5 n/a

**CQ** 228,000 12,5405.52

**CW** 12,400 1,000 8.3 0

**DD** 280,000 11,760 4.2 3

**GC** 551,000 6,600 1.21

**M** 182,000 8,0004.4 3

**MN** 960,000 15,400 1.6 3

**MS** 1,073,40025,4502.02

**NW** 32,600 7,500 23.12

**SW** 26,000 3,100 12.0 3

**SC** 390,000 6,600 1.71

**TC** 25,600 16,40064.02

**T** 240,000 16,800 7.01

**WM** 260,000 9,1003.5 1

**WB** 210,000 7,600 3.6 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**16 4,754,200 173,310 n/a 28[[45]](#footnote-45)**

Another aspect of HHS diversity is provision of healthcare services. For example, Queensland’s major hospitals, with the most comprehensive range of medical and specialist services are located in the major metropolitan HHSs – MNHHS, MSHHS and GCHHS, and provide specialist services to Queenslanders across the state. This contrasts with, for example, the range of services provided by remote area HHSs, such as CWHHS, SWHHS and TCHHS where there is an increasing reliance on telehealth services (often linked to specialists in the metropolitan hospitals) and a greater role in providing primary health care. It is instructive to compare the health service agreements of, for example, the smallest and largest HHSs – CWHHS and MSHHS.

Some of the other highlights of this HHS diversity shown in Table 1 include:

* Overall population size: MSHHS has the largest population (1,073,400) nearly 100 times larger than the smallest, the CWHHS with 12,400 people.
* Aboriginal and Torres Strait Islander population: CHHHS and MSHHS both have around 25,500 Aboriginal and Torres Strait Islander people (although the CHHHS is also the principal provider of many hospital and health care services to the Aboriginal and Torres Strait Islander population of Cape York and the Torres Strait, boosting its Indigenous client base to about 40,000 people). CWHHS has the smallest Indigenous population – 1,000.
* Percentage of Aboriginal and Torres Strait Islander people of the total population: TCHHS has the highest percentage (64%), followed by the NWHHS (23.1%). The GCHHS (1.2%), MNHHS (1.6%) and SCHHS (1.7%) have the lowest proportion of their populations Indigenous.
* Percentages and population size: while the CHHHS has 25,500 Aboriginal and Torres Strait Islander people living within it region constituting 9% of the population, MSHHS has the same number, but constituting 2% of its population. This raises issues, for example, about inclusion/representation in HHS governance and within the consultative structures. While it can be reasonably argued that there should be Indigenous representation on the CHHHS board and that it should have an Indigenous-only consultative body, in the context of overall population diversity, this argument may have less weight with regard to the MSHHS and other HHSs with very low proportions of Aboriginal and Torres Strait Islander people within their general population.
* Aboriginal and Torres Strait Islander community controlled health services (ATSICCHS) in HHS regions: all of the HHSs have at least one ATSICCHS, except the CWHHS which does not have an ATSICCHS operating with its region, and the Torres Strait.

## Objectives of the audit

The primary objectives of the audit are to:

* Promote transparency in Closing the Gap policy implementation and accountability;
* Provide a framework for discussion about institutional racism in the public health sector;
* Further the validation process of the Matrix as an assessment tool;
* Establish base-line scores from which to monitor progress; and
* Contribute to the national goal of a public health system free of racism and inequality.

### Promote transparency in Closing the Gap policy implementation and accountability

During research conducted on the CHHHS in December 2013-January 2014 to find out background information about the operations and culture of the public health system to help inform the preparation of a report concerning allegations of individual racist behaviours against Aboriginal and Torres Strait Islander employees, it became apparent that, in spite of excellent federal and Queensland Closing the Gap policies and frameworks, these were not being implemented in a way that was transparent, clear and consistent to someone outside the system. Furthermore there was great variation in public annual reporting between neighbouring HHSs (THHS, NWHHS, MHHS, CYHHS and CQHHS) regarding what was being disclosed and how it was presented. For example, core Closing the Gap KPIs were not being consistently reported on and in a format that invited easy comparison. There was a universal disregard for financial transparency with regard to disclosure of Closing the Gap commonwealth and Queensland funding contributions, and inconsistent reporting on workforce data regarding the employment of Aboriginal and Torres Strait Islander people. While all this data was being internally recorded by Queensland Health (QH), it was not being publicly disclosed. It was difficult, for example, to find out exactly how a HHS was performing and contributing to Closing the Gap in Indigenous health outcomes via the publication of relevant data sets.

The Matrix addresses these issues by putting in place a set of criteria, which are in turn broken down, for most of the criteria, into sets of sub-criteria that can be consistently applied across all HHSs to measure HHS performance. This will also enable comparisons between HHSs to be made.

### Provide a framework for discussion about institutional racism

Both the Matrix as an assessment tool, and the assessments of HHSs that it produces, can be used to promote discussion at the local HHS level. Despite the scores, Aboriginal and Torres Strait Islander people in some HHS areas may enjoy a good relationship with their HHS and be happy with the healthcare services they receive. Others may see a need for profound change in relation to, for example, inclusion in the governance structure, more effective consultation mechanisms, more Aboriginal and Torres Strait Islander people employed within the HHS, and better standards of public reporting and accountability in the HHS annual report so they get a clear picture of how the HHS is performing in relation to closing their Indigenous health gap.

To facilitate such discussion, the Matrix is designed to do a number of things:

* In a broader sense, enable HHSs to “see what institutional racism looks like”, that is, its identification purpose.
* Measure HHS compliance with federal and Queensland policies for Closing the Gap in Indigenous Health Outcomes to encourage accountability of the HHS to the Aboriginal and Torres Strait Islander community for the health services it provide.
* Encourage and focus discussion and consultation with local Aboriginal and Torres Strait islander communities to reflect both the local circumstances and the manner of their engagement with their local HHS.
* Incorporate examples of best practice within HHSs. Thus it can also be used as an aspirational tool by including things that should be happening to make HHSs 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.[[46]](#footnote-46)
* Enable HHSs within a state/territory, or nationally, to be rated and compared while taking into account different state/territory and local HHS circumstances and characteristics.[[47]](#footnote-47)
* Be used by a HHS as an internal monitoring tool – as a check list or annual report card.
* Enable public health administrators to confront institutionalised 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.[[48]](#footnote-48)

### Further the validation process of the Matrix as an assessment tool

While the Matrix has been brought to the attention of a number of Indigenous peak health bodies (NACCHO, the Lowitja Institute), human rights agencies, government agencies (such as the AIHW) and NGOs (AHHA and SDOHA) and academics, the Matrix has yet to undergo a formal peer review validation process. In her review of the Matrix, Professor McDermott recommended that, following a review by a panel of population health and health service experts, the “Matrix should be tested in other settings in Australia, especially where there is a large proportion of Aboriginal and Torres Strait Islander clients, to validate the measures proposed.” It was also noted in the Close the Gap Campaign Steering Committee *Progress and priorities report 2016* that:

The Close the Gap Campaign welcomes the ongoing work of member the Australian Healthcare and Hospitals Association and its partners to validate the Marrie Institutional Racism Matrix (MIRM). This was developed in 2014 as ‘a tool for external assessment purposes to identify, measure and monitor racism in an institutional setting’ and ‘to provide a measure of 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’. It is hoped the MIRM will make a significant contribution to understanding institutional racism in health services over the next decade.[[49]](#footnote-49)

A further object of this audit is take a preliminary step in the validation process by extending the audit process from its initial trial on just one HHS – the CHHHS – to full jurisdictional level by conducting an audit of all 16 of Queensland Health’s HHSs.

While still in its early stages of development, the Matrix, nevertheless, does offer a possible way forward in our abilities to better understand this form of racism and deal with it. This report, in the form of an audit using the Matrix to measure the nature and extent of institutional racism in Queensland’s HHSs, is a further step in its development and critical appraisal.

It is also hoped that, in spite of the particularly bad audit scores for most of the HHSs, Queensland Health will be a willing participant in the validation process by providing feedback on this, the initial audit, and when the audit process is repeated in two years’ time to assess its effectiveness in bringing about change in the relationships between HHSs and the Aboriginal and Torres Strait Islander people and communities to whom they provide healthcare services.

### Establish baseline scores from which to monitor progress

This objective of the Matrix audit is to provide a set of base-line scores for all 16 HHSs so that future audits can be compared over time – the monitoring function of the Matrix. Notwithstanding that public health system priorities, and federal and state/territory health policies also change over time, once properly established as a credible assessment tool (used either internally by health departments and their HHSs, or externally by monitoring agencies), the Matrix should be able to serve as a tool for monitoring health system performance for the elimination of institutional racism, but also provide a gauge as to the economic costs of racism within the health system (see Section 3.1).

### Contribute to the national goal of a public health system free of racism and inequality

In 2015 the Australian Government released its *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.[[50]](#footnote-50)* Under the domain of health systems effectiveness, Strategy 1B is concerned that:

Mainstream health services are supported to provide clinically competent, culturally safe, accessible, accountable and responsive services to Aboriginal and Torres Strait Islander peoples in a health system that is free of racism and inequality.

One of the actions to support this strategy is that: “Systemic racism and discrimination is better understood, addressed and prevented”, and that by 2018:

System levers and accountability mechanisms established for addressing racism and discrimination have been developed and their implementation promoted.[[51]](#footnote-51)

It is hoped, therefore, that this Matrix audit of Queensland’s HHSs will assist in establishing the kind of system levers and accountability mechanisms necessary for the elimination of racism and inequality in mainstream health services, but particularly the public health system.

## Methodology

This section covers the essential aspects of the methodology, namely:

* The reporting period;
* Use of federal and Queensland Closing the Gap related-policy documents to establish the criteria for assessment;
* The use of publicly available information to provide the evidence for the assessment process;
* Listing of the principal federal, Queensland and local HHS documents referred to both to establish the criteria and sub-criteria, and to carry out the assessment process. Some important documents not located are also identified;
* The scoring system on which the Matrix assessments are based;

and includes some discussion of the methodological issues concerning the above.

### Reporting period 2014-2015

The audit is focused on the 2014-2015 annual reporting period, however it has been extended to include the full years for 2014 and 2015, i.e., a 24 month period. It is acknowledged that many of the documents used to source information for the audit in addition to the 2014-2015 annual report (service agreements, strategic plans, policies, etc.) overlap, either partially or fully, the audit period. Some end within this period, others take effect towards the end and continue into the next few years. Generally information from these “overlapping documents” is used in the audit process to inform the scores. However, as much and as consistently as possible, the audit is restricted to the 2014-2015 24 month period as it is intended that the audit process will be repeated (its monitoring function) for the 2017-18 period. This means that some initiatives that have come into effect earlier during 2016 will not be scored in the audit. For example, an Aboriginal person was appointed to the board of the CHHHS in May 2016, and an Aboriginal and Torres Strait Islander Community Consultative Committee was established in February 2016. These initiatives would improve the CHHHS Matrix score by 15 points, but this improvement will not show up until the next audit.

### Criteria drawn from public policy documents

In the construction of the Matrix only publicly available information generated from commonwealth and Queensland policies and legislation is used. The Matrix exists in two forms:

* A national template using criteria drawn directly from federal policies formulated to implement the *COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (NPACGIHO), for example, the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures* (2011) endorsed by the Australian Health Ministers’ Advisory Council (AHMAC) and the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023.[[52]](#footnote-52)* It also draws on advice from Productivity Commission and Australian Institute for Health and Welfare reports. The national template is described in Section 2.3.
* A State/Territory level adaptation of the national template to incorporate state/territory policies for Closing the Gap on Indigenous Health Outcomes within each jurisdiction. At this point, the template has only been adapted for use in Queensland and incorporates references in the criteria to the *Hospital and Health Boards Act 2011* (Qld) (HHB Act) and Queensland Health policies such as *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Policy and Accountability Framework* (2010) and *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033* (2010). The template as it has been adapted for Queensland Health’s legislative and policy settings will be referred to as the Queensland Health Matrix Template (QHMT) and is described in detail in Section 2.4 of this report. The QHMT is the tool used to conduct the audit of Queensland Health’s 16 HHSs (see Section 4).

### An assessment process based only on publicly available information

As in the construction of the matrix, only publicly available information is used in the assessment/audit process. This information is gleaned from a range of documents that includes HHS annual reports, health service agreements, internally generated documents (such as consumer and community engagement strategies, operational plans), HHS board meeting summaries, community newsletters and websites. Through its reliance on publicly available information, the matrix establishes an assessment process which is open, transparent, verifiable, repeatable and publicly available and which reflects the current health policy environment. Once the matrix settings have been established for a State/Territory jurisdiction, all the HHSs within that jurisdiction can be scored and rated against each other, and periodic assessments can be undertaken as a desk-top exercise to monitor progress towards the elimination of institutional racism within each HHS. Ultimately, the matrix provides assessments of local level HHS accountability for the implementation of commonwealth and jurisdictional policies for Closing the Gap in Indigenous Health Outcomes.

This process invites the notion of a public information availability test. In order to support claims of transparency and accountability, information regarding, for example funding, employment, Closing the Gap KPIs, etc. should be freely and publicly available without having to resort to detailed searches or Freedom of Information requests.

In carrying out the audit no contact was made with any HHS employees or representatives to seek information or comment for the purposes of the audit.

### Documents referred to

The policies and other relevant official documents referred to in this report are listed below:

**Commonwealth Government**

* Australian Health Ministers’ Advisory Council: *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011 – 2015* (2011)
* Australian Health Ministers’ Advisory Council: *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health* (2016)
* Australian Human Rights Commission: *National Anti-Racism Strategy* (2012)
* Australian Government: *National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023.*
* Department of Health: *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (2015)[[53]](#footnote-53)
* Department of Social Services: *Aboriginal and Torres Strait Islander Workforce Strategy and Implementation Plan 2015-2018* (2015)

**Council of Australian Governments (COAG)**

* *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: National Healthcare Agreement* (2009) (NPACGIHO).
* *National Indigenous Reform Agreement (Closing the Gap)* (NIRA) (2008)
* *National Health Reform Agreement* (2011) (NHRA)

**Queensland Government**

* *The Queensland Government Reconciliation Action Plan 2009 – 2012: Reconciliation – it’s everyone’s business*
* *Annual Reporting Requirements for Queensland Government Agencies* (Department of Premier and Cabinet, 2013)
* *Queensland Multicultural Action Plan 2011-2014*
* *State Budget 2014-2015: Service Delivery Statements – Queensland Health* (2014).

**Queensland Health**

* *Health Priorities 2014-2015* (Policy and Planning Branch 2013)
* *Health System Priorities for Queensland 2013-14* (2013)
* *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Policy and Accountability Framework* (2010)
* *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Implementation Plan 2009-10 to 2011-12* (2010)
* *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Investment Strategy 2015-2018* (2015).
* *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* (2010)
* *Aboriginal and Torres Strait Islander Cultural Capability: A guide for improving the identification of Aboriginal and Torres Strait Islander people in health care* (Cultural Capability Team November 2015).
* Queensland Health, 2015a.  *Queensland Aboriginal and Torres Strait Islander cardiac health strategy 2014-2017*.
* *Aboriginal and Torres Strait Islander Health Worker Career Structure* (revised 2009).
* *Blueprint for better healthcare in Queensland* (2013)
* *Health Consumers Queensland …your voice in health: Consumer and Community Engagement Framework* (2012)
* *Department of Health Strategic Plan 2012-16 (2013 update) supporting document* (2013)

**Queensland Health Reports**

* *Annual Report 2014-2015*
* Aboriginal and Torres Strait Islander Health Unit: *Closing the Gap performance report 2014* (2015)
* Aboriginal and Torres Strait Islander Health Unit: *Closing the Gap performance report 2015* (2016)

**Queensland legislation**

* *Hospital and Health Boards Act 2011* (Qld)
* *Hospital and Health Boards Regulations 2012* (Qld)
* *Legislative Standards Act 1992* (Qld)
* *Nature Conservation Act 1992*(Qld)

**Hospital and Health Service Documents**

* *Annual Report 2014- 2015*
* Board Meeting Summaries for 2014 and 2015
* Health Service Agreement 2013/14 – 2015/16 (Since the original agreements for HHSs have undergone periodic revisions, these originals are authorised for reference only).
* Strategic Plan
* Operational Plan
* Consumer and community engagement (strategic) plan

There is some inconsistency across HHSs with regard to the availability of some documents, and the information available. HHS documents have been listed at the end of each audit – the list also includes those that were not able to be found through a search of the relevant HHS website.

### Important policy documents not sighted

Despite best endeavours, these documents have not been sighted:

* *Aboriginal and Torres Strait Islander Workforce Strategy 2012 – 2016. [[54]](#footnote-54)*
* *Closing the Gap funding allocations to* [name of HHS] *Hospital and Health Service for 2013/2014,* File Reference PP003447 (10 May 2013).[[55]](#footnote-55)
* *Queensland Aboriginal and Torres Strait Islander Health Investment Strategy*.[[56]](#footnote-56)

### Scoring system

The scoring system, using simple metrics, is based on five key indicators (see section 2.1) under which a number of criteria have been assigned each addressing a particular federal or Queensland policy element relevant to Closing the Gap in Indigenous health outcomes. Each of the criteria has an assessment value of 10 points – except for the criterion dealing with legal visibility and the HHB Act which is allocated 20 points. Most of the criteria are then broken down into a number of sub-criteria, each with its own point value, but together totalling 10 points.

The scoring system is deliberately weighted around certain priorities 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 the HHSs, as participation at this level will be a major determinant of 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 *Hospital and Health Boards Act 2011* (Qld) (which is given additional weighting to be scored out of 20 points), participation on boards and within the executive management structure (through direct membership on the board, directorate status for Aboriginal and Torres Strait Islander health within the divisional structure and hence membership of the executive management team/group, and whether or not the divisional director is an Indigenous person or not) is a case of “either it exists, or it doesn’t”, in which case either full points for that criterion/sub-criteria are awarded, or none at all.

This principle generally applies throughout for 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 three sub-criteria regarding whether or not there is: (i) an Aboriginal and Torres Strait Islander community consultative body, (ii) a Reconciliation Action Plan for the HHS; and (iii) whether the Aboriginal and Torres Strait Islander health division or unit within the HHS regularly publishes a community newsletter. While the criterion for community engagement is weighted at 10 points, the sub-criteria are weighted respectively at 5 points for a community consultative body, 3 points for a RAP, and 2 points for a newsletter. The overall score out of 10 for this criterion will depend on whether such a consultative body, RAP or newsletter exists or not.

One of the fundamental purposes of the matrix is to encourage reporting of relevant information about progress and initiatives undertaken to close the gap in Indigenous health outcomes, most importantly in HHS annual reports, but also, for example in Queensland Health’s annual closing the gap performance report, so that such information is easily accessible to the public. However, in terms of scoring, this means that some things may be taking place, but they are not being reported in a way which is easily accessible, the information instead being contained in internal HHS and departmental documents and data bases. Perhaps the best example of this, and possibly the most controversial in terms of scoring, concerns the employment of Aboriginal and Torres Strait Islander people in the workforce of a HHS. All the state’s HHSs employ Aboriginal and Torres Strait Islander people, but the reporting of this fact is very poor in the annual reports. The reporting of this information ranges from a full percentage or bar graph breakdown of Aboriginal and Torres Strait Islander participation across QH’s six employment streams/categories[[57]](#footnote-57), to an overall percentage of the workforce (most common), to nothing at all. Despite the fact that Aboriginal and Torres Strait Islander people are employed, if information about their employment is not recorded, or only partially recorded (e.g., an overall percentage but no information regarding their participation in the different employment streams) in the annual report either zero scores will result, or there will be a very diminished score against the relevant criteria and sub-criteria.

Concerning the issue of “legal visibility” in the *Hospital and Health Boards Act 2011* (Qld) (HHB Act), because of the very minimal reference in **s.4(c)(vi)** all HHSs have received a penalty score of only half a point out of a possible score of 20. HHSs are subject to and not responsible for the legislation itself which was created by the Queensland parliament to give effect to Queensland’s commitment to the National Health Reform Agreement. It therefore could be debated as to whether or not it should be included as one of the criteria for scoring in the Matrix as there is nothing individual HHSs can do about it to improve their score. It has been included to encourage more widespread awareness and debate between the HHSs, local Aboriginal and Torres Strait Islander Community Controlled Health Services (ATSICCHS) and the Aboriginal and Torres Strait Islander communities whom they serve about how the HHB Act could be improved to give legislative weight/force to achieving better and speedier outcomes in their endeavours to close the Indigenous health gap.

## Limitations of the Matrix

The Matrix is not designed to assess the incidence of individual acts of racism and racial discrimination, or clinical performance in terms of access to hospital procedures of HHSs.

### Not designed to address individual or casual racism within a HHS

The Matrix is not designed to address or measure the incidence of individual acts of racism and racial discrimination occurring within a HHS. Other assessments tools, such as the *Workplace Diversity and Anti-Discrimination Assessment Tool* developed by Trenerry and Paradies,[[58]](#footnote-58) are better suited for this purpose. However, it is argued that individual racist and discriminatory behaviours and institutional racism cannot be disassociated: very high or extreme levels of institutional racism will create a HHS culture or environment in which individual racist acts and racial discrimination can proliferate. In such environments, Aboriginal and Torres Strait Islander HHS employees can feel marginalised and have little faith in internal procedures for dealing with allegations of racist and discriminatory behaviours.[[59]](#footnote-59)

### Not designed to measure or assess clinical performance within a HHS

Including the Tier 3 Health System Performance Measure (HSPM): 3.06 Access to hospital procedures was contemplated as one of the sub-criteria for the Matrix criterion “Selected Health Service Performance Indicators” (see QHMT notes 23 and 33), however, providing a simple score for this sub-criteria would not be feasible. AHMAC’s *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report* indicates that in the two years to June 2013, excluding care involving dialysis, 59% of hospital episodes for Aboriginal and Torres Strait Islander peoples had a procedure recorded, compared with 80% of hospital episodes for other Australians.[[60]](#footnote-60) For Queensland, the respective figures were 54% for Aboriginal and Torres Strait Islander people and 77% for other Queenslanders. There are some 16 different hospital procedures listed covering 20 categories of principal diagnoses listed in the report.[[61]](#footnote-61) Access to hospital procedures are reported internally to Queensland Health, however, while hospital separations for a range of medical conditions are reported in Queensland Health’s *Closing the Gap Performance report* for 2014 and 2015, comparative data for access to hospital procedures, either for the state as a whole or by HHS, are not recorded.[[62]](#footnote-62)

However, it might be possible for targets to be set for HHSs in their service agreements, as is currently the case for DAMA and PPH, based on an overall reporting score in relation to any principal diagnosis as used in the AHMAC performance framework reports regarding access to hospital procedures.

# THE MATRIX

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 HHSs are to provide culturally secure,[[63]](#footnote-63) responsive,[[64]](#footnote-64) respectful, [[65]](#footnote-65) appropriate and clinically safe health care[[66]](#footnote-66) to Aboriginal and Torres Strait Islander people and their communities.[[67]](#footnote-67)

The Matrix has therefore been developed as a tool for external assessment purposes to provide an objective, evidence-based[[68]](#footnote-68), 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, 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.[[69]](#footnote-69) 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 have been established, 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 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, 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.

The Matrix has been developed to speed up the process of identifying and 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. The Matrix can therefore provide a useful tool for Aboriginal and Torres Strait Islander communities through their peak representative health bodies, such as the Queensland Aboriginal and Islander Health Council (QAIHC) or the Institute for Urban Indigenous Health (IUIH), public health administrators and academics, and human rights agencies and advocates to rate and make accountable the public HHSs that provide healthcare services to, in this instance, Aboriginal and Torres Strait Islander people and their communities.[[70]](#footnote-70)

## The five key indicators of institutional racism

The Matrix has been configured 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) inclusion in governance; (ii) policy implementation; (iii) service delivery; (iv) employment; and (v) financial accountability.[[71]](#footnote-71)

### Inclusion in governance

For the purposes of the Matrix, the governance structure includes the relevant legislation, composition of board memberships as reflective of the expertise required to operate a HHS, and the executive management structure - specifically the basic management structure as reflected in the make-up of the divisions tasked with particular responsibilities within the overall structure of a HSS, and includes the composition or membership of the executive management team or group.

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 as it addresses the critical strategic question at the heart of institutional racism: where does power reside?.[[72]](#footnote-72) 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,[[73]](#footnote-73) 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.

### 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 (NPACGIHO) and *The National Indigenous Reform Agreement* (NIRA) and the suite of policies that the agreements have generated at state/territory levels. 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 community engagement is to be effective. Such information, in the first instance, should be made available in the HHS annual reports.

### Service delivery

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. Effective and culturally safe and appropriate health service delivery to Aboriginal and Torres Strait Islander people also hinges on having a culturally competent non-indigenous health workforce.[[74]](#footnote-74) Evidence is sought as to the existence of a cultural competency training plan or strategy, whether the HHS has the capacity to deliver such training, and the number or percentage of the non-Indigenous workforce to have actually completed training. To assist in the measurement of service delivery a number of Tier 3 Health System Performance Measures (HSPM) have been selected from the *Aboriginal and Torres Strait Islander Health Performance Framework* endorsed by AHMAC in 2011.

### Recruitment and employment

This indicator is focused on whether there is a published plan or strategy for Aboriginal and Torres Strait Islander health workforce development, who has responsibility for ensuring that the plan or strategy is implemented, and the level of Aboriginal and Torres Strait Islander employment assessed against the proportion of Aboriginal and Torres Strait Islander people of the total population in the local HHS area. It is also important to record where Aboriginal and Torres Strait Islander people are being employed within a HHS and at what level. While sometimes employment percentages can be impressive, many Aboriginal and Torres Strait Islander people are employed in clerical positions and in support services (as cleaners, bed washers, patient transporters, etc) and not in front line services as doctors, nurses and in other health professions. Given their important roles within HHSs, Aboriginal and Torres Strait Islander health workers and liaison officers should also be separately identified.

### 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 HHS level by including a financial statement in the annual report as the most appropriate reporting vehicle.

## 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) to further define what is being measured. This increases the objectivity of the assessment by decreasing the likelihood of subjective and inconsistent scoring. The Matrix can thus become more reflective of local HHS circumstances. Sub-criteria can be developed according to the sate/territory jurisdiction with regard to applicable laws, relevant policy settings, particular characteristics of the state/territory, demographics regarding Aboriginal and Torres Strait Islander people and the general population, 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. The Matrix therefore can be made flexible enough for application to health services operating in very different contexts.

## The National 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 HHS governance** (4)

* Legal visibility (5) 20 ?
* Aboriginal and Torres Strait Islander representation at Board level (6) 10 ?
* Inclusion in Executive Management Structure (7) 10 ?

**Total 40 ?**

1. **Policy implementation** (8)

* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes (9) 10 ?
* Community engagement (10) 10 ?
* Public Reporting and Accountability in annual reports (11) 10 ?

**Total 30 ?**

1. **Service delivery** (12)

* Local Aboriginal and Torres Strait Islander Health Plan (13) 10 ?
* Cultural competence (14) 10 ?
* Selected Health System Performance Indicators (15) 10 ?

**Total 30 ?**

1. **Recruitment and employment** (16)

* Aboriginal and Torres Strait Islander health workforce development (17) 10 ?
* Aboriginal and Torres Strait Islander participation in health workforce (18) 10 ?

**Total 20 ?**

1. **Financial Accountability and Reporting** (19)

* Commonweal funding contribution (20) 10 ?
* State/Territory funding contribution (21) 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** Racism is identified as a key social determinant of poor health among Aboriginal and Torres Strait Islander people.[[75]](#footnote-75) Racism in its various forms (individual, casual, 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; Bellear 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. **Five key indicators** The five key indicators focus on common characteristics or identifiers of institutional racism and are designed to measure: (i) empowerment through inclusion in governance; (ii) policy implementation; (iii) service delivery; (iv) employment; and (v) transparency and accountability in funding arrangements.
3. **Criteria used for assessment** 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. **Participation in HHS governance** 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.[[76]](#footnote-76)

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.[[77]](#footnote-77)

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 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.”[[78]](#footnote-78)

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, particularly with regard to inclusion on boards and within executive management structures. 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).

1. **Legal visibility** 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. With the National Health Reform Agreement (NHRA) providing the framework (see Section 5.1.1), the current body of federal, state and territory laws governing hospital and 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.[[79]](#footnote-79) 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 body[[80]](#footnote-80) (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
* 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.[[81]](#footnote-81)

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.

1. **Representation on HHS boards** 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.[[82]](#footnote-82)

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 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.

1. **Inclusion in HHS executive management structure** 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.
2. **Policy implementation** 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.
3. **Closing the Health Gap policy implementation** 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.[[83]](#footnote-83)*
* Australian Government: *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Australian Government Implementation Plan 2007-2013.[[84]](#footnote-84)*
* 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.[[85]](#footnote-85)*
* Department of Health (2015), *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023,* Australian Government, Canberra.

1. **Community engagement** 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.
2. **Public reporting and accountability** 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 effective resource application through funding support, meaningful policy, planning and service development in genuine partnership with Aboriginal and Torres Strait Islander communities.[[86]](#footnote-86)

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.

1. **Service delivery** 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.[[87]](#footnote-87)

1. **Local Aboriginal and Torres Strait Islander health plan** 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… [T]he 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.[[88]](#footnote-88)

Most HHSs 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.[[89]](#footnote-89)**

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.[[90]](#footnote-90) This can only be effectively achieved through a mutually developed and costed health service plan.

1. **Cultural competence** 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.”[[91]](#footnote-91) 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.[[92]](#footnote-92)

The cultural capability of a HHS 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 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.[[93]](#footnote-93) 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.[[94]](#footnote-94)

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.[[95]](#footnote-95)

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 focusing on:

* the institutional capacity to deliver CCT;[[96]](#footnote-96) and
* the number of non-indigenous health workers who have participated in or received CCT.

The Department of Health recently up-dated the AHMAC (2004) Cultural Respect Framework with the release in 2016 of the *Cultural respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health: A National Approach to Building a Culturally Respectful Health System.[[97]](#footnote-97)*

1. **Selected health system performance indicators** Selected health system performance indicators from the *Aboriginal and Torres Strait Islander Health Performance Framework: Health System Performance* (AHMAC, 2012). 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*.[[98]](#footnote-98) The HPF monitors progress in Aboriginal and Torres Strait Islander health outcomes, health system performance and the broader determinants of health.[[99]](#footnote-99) 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. 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.[[100]](#footnote-100)

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.[[101]](#footnote-101) These measures are:

1. Under the matrix key indicator for service delivery:

HSPM Effective/Appropriate/Efficient:

* 3.07 Selected potentially preventable hospital admissions (PPH);[[102]](#footnote-102) and
* 3.08 Cultural competency.

HSPM Responsive:

* 3.09 Discharge against medical advice (DAMA);[[103]](#footnote-103) 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

1. Under the matrix key indicator for participation in organisation leadership/governance:

HSPM Responsive:

* 3.13 Competent governance.

1. Under the matrix key indicator for recruitment and employment:

HSPM Capable:

* 3.20 Aboriginal and Torres Strait Islander people training for health related disciplines

1. **Recruitment and employment** 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 local HHS population equity targets for 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.[[104]](#footnote-104)
2. **Aboriginal and Torres Strait Islander health workforce development** 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 that have a large Aboriginal and Torres Strait Islander population, this seems highly desirable. 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.”[[105]](#footnote-105)
3. **Aboriginal and Torres Strait Islander participation in the health workforce** 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.[[106]](#footnote-106) 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.[[107]](#footnote-107)

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,* and its update, the DoH: *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health.* 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-criteria for each health workforce employment stream or category is warranted.

1. **Financial accountability and reporting** In *The Report of the National Commission of* Audit, it is pointed out that transparency and accountability “are the hallmarks of responsible government.”[[108]](#footnote-108) 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.[[109]](#footnote-109)

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.[[110]](#footnote-110)

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.

1. **Commonweal funding contribution** 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, 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).
2. **State/Territory funding contribution** Each state/territory has indicated their health budget for implementing the health reforms in the COAG Agreement (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.

## Queensland Health Matrix Template (QHMT): Template adapted for Queensland’s Hospital and Health Services (HHS) Legislative and Policy Settings

**Matrix Template adapted for Queensland Health’s legislative and policy settings** (1)

**Key Indicators and Criteria** (2) **Scoring**

* + - 1. **Participation in HHS governance** (3)
* **Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) (HHB Act)**

**and *Hospital and Health Boards Regulation 2012* (Qld) (HHB Regulations)** (4) **Total out of 20**

*-* Recognition of Aboriginal and Torres Strait Islander peoples as the First

Queenslanders (5) 1

* Statement of commitment to Closing the Gap in Aboriginal and Torres

Strait Islander health (6) 2

* Object of the HHB Act to include a provision for delivery of responsive, capable and

culturally competent health care to Aboriginal and Torres Strait Islander people (7) 2

* Aboriginal and Torres Strait Islander membership of HHS Boards (HHSB) (8) 2
* HHS Aboriginal and Torres Strait Islander community engagement strategy (9) 1
* HHS Aboriginal and Torres Strait Islander Community Consultative Committee (10)2
* Recognition of Aboriginal and Torres Strait Islander community controlled

health services (ATSICCHS) (11) 1

* Aboriginal and Torres Strait Islander HHS Plan (12) 1
* Closing the Gap KPIs in HHS Service Agreements (13) 1
* A commitment to Continuous Quality Improvement (CQI) (14) 1
* Ministerial discretionary powers to also apply to Aboriginal and Torres Strait

Islander health in certain circumstances (15)1

* Aboriginal and Torres Strait Islander Closing the Health Gap advisory committee (16)1
* Aboriginal and Torres Strait Islander employment in HHS health workforce (17)2
* Annual reporting (18)1
* Aboriginal and Torres Strait Islander healthcare funding disclosure (19) 1
* **Aboriginal and Torres Strait Islander representation at board level** (20) **Total out of 10**
* **Inclusion in Executive Management Structure** (21) **Total out of 10**
* Aboriginal and Torres Strait Islander Health Division (22) 5
* Indigenous Executive Director 5

**Total 40**

* + - 1. **Policy implementation**
* **Closing the Gap Total out of 10**
* Explicitly identified as a strategic priority in HHS Strategic Plan 5
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (23) 5
* **Community engagement** (24) **Total out of 10**
* Aboriginal and Torres Strait Islander community consultative body 5
* Reconciliation Action Plan (25) 3
* Aboriginal and Torres Strait Islander Health Division/Unit community

newsletter (26) 2

* **Public Reporting and Accountability (via annual report)** (27) **Total out of 10**
* Traditional Owner acknowledgement (28) 1
* Closing the Gap

(i) Separate section in report devoted to Closing the Gap 1

(ii) Reporting on KPIs contained in 2013/14 - 2015/16 service agreement 1

* Policy references (29)

(i) Cultural Capability Framework 1.5

(ii) Making Tracks 1.5

* ATSI health division**/**unit placement on HHS organisational structure/chart 1
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment 1
2. Reference to workforce planning, recruitment, etc. (30) 1

* Other recognition (e.g., awards, scholarships, etc.) 1 **Total 30**

**3. Service delivery**

* **Aboriginal and Torres Strait Islander HHS Plan** (31) **Total out of 10**
* **Cultural competence** (32) **Total out of 10**
* Cultural competency policy/strategy 4
* Capacity to deliver Cultural Competence Training (CCT) 3
* Proportion of non-indigenous staff trained 3
  + - * **Selected Health Service Performance Indicators** (33) **Total out of 10**
* Estimated level of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (34) 2

* Discharges against medical advice (DAMA) (35) 2
* Potentially preventable hospitalisations (PPH) (36) 2
* Access to mental health services (37) 2
* Access to drug and alcohol services (38) 2

**Total 30**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. Recruitment and employment** (39)

* + - * **Aboriginal and Torres Strait Islander health workforce development** (40) **Total out of 10**

- ATSI workforce development policy/strategy 3

- ATSI workforce implementation body 3

- Employment equity (41) 4

* **Aboriginal and Torres Strait Islander participation in the health workforce** (42) **Total out of 10**
* Managerial and clerical 1
* Medical including Visiting Medical Officers (VMOs) 2
* Nurses (43) 2
* Aboriginal and Torres Strait Islander health practitioners, health workers

and liaison officers (44) 2

* Operational and Support Services (45) 1
* Trade and Artisans 1
* Health Practitioners (Professional and Technical) 1

**Total 20**

1. **Financial Accountability and Reporting: Closing the Gap Funding** (46)
   * + - Commonwealth contribution (47) Total out of 10
       - Queensland Contribution (48) Total out of 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. Hospital and Health Services (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.[[111]](#footnote-111) 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.[[112]](#footnote-112)
* 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.[[113]](#footnote-113)
* In relation to Closing the Gap, the desired outcomes sought by the Queensland Department of Health include:

\* 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.[[114]](#footnote-114)

1. To avoid duplication of the notes provided for the national Template (see preceding section), the notes provided here are for aspects that are specifically relevant to Queensland’s public hospitals and health services.
2. **Participation in HHS governance** The Australian Commission on Safety and Quality in Health Care/National Safety and Quality Health Service Standard 2: Partnering with Consumers describes governance as:

… the set of relationships and responsibilities established by a health service organisation between its executive, workforce, and stakeholders (including consumers). Governance incorporates the set of processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered, or controlled. Governance arrangements provide the structure through which the objectives (clinical, social, fiscal, legal, and human resources) of the organisation are set, and by which the objectives are to be achieved. They also specify the mechanism for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help in aligning the roles, interests and actions of different participants in the organisation in order to achieve the organisation’s objectives. The Commission’s definition of governance includes both corporate and clinical governance and where possible promotes the integration of governance functions.[[115]](#footnote-115)

This Key Indicator addresses Tier 3 Health System Performance Measure (HSPM) 3.13 “competent governance” of the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures* (AHMAC, 2012: Figure 1) under the heading “Responsive”. The governance structure for the purpose of the Matrix assessment includes the enabling laws, principally the *Hospital and Health Boards Act 2011* (Qld) and *Hospital and Health Boards Regulation 2012* (Qld), the composition of Hospital and Health Service Boards (HHSB), and an analysis of HHS executive management structures. Very considerable emphasis, therefore, is placed on the need to provide for Aboriginal and Torres Strait Islander representation at the most senior levels of the governance structure.

1. **Legal visibility** The *Hospital and Health Boards Act 2011* (Qld) (HHB Act) and *Hospital and Health Boards Regulation 2012* (Qld) (HHB Reg.). The concept of “legal visibility is employed by Howse in her monograph/report *Legally Invisible – How Australian Laws Impede Stewardship and Governance for Aboriginal and Torres Strait Islander Health* for the Lowitja Institute.[[116]](#footnote-116) 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 HHB Act and the HHB Reg. render Aboriginal and Torres Strait Islander people “legally invisible”. Furthermore, the HHB Act was not drafted in accordance with the fundamental principles referred to in the *Legislative Standards Act* *1992* (Qld) in **s.4(1)** and specifically it does not show that it has “sufficient regard to Aboriginal tradition and Island custom” as required by **s.4(3)(j)**. The *Legislative Standards* *Act* does not provide definitions for “Aboriginal tradition” or “Island custom”, however, the *Aboriginal Land Act 1991* (Qld), in **s.2.03**, defines Aboriginal tradition as:

the body of traditions, observances, customs and beliefs of Aboriginal people generally or of a particular group of Aboriginal people, and includes any such traditions, observances, customs and beliefs relating to particular persons, areas, objects or relationships.

Island custom, referred to in the Torres Strait as “Ailan kastom”, is similarly defined in **s.2.02** of the *Torres Strait Islander Land Act 1991* (Qld). Beliefs and practices regarding health and wellbeing are an integral part of the traditions and customs of Aboriginal and Torres Strait Islander peoples. Except for a brief mention in HHB Act **s.4(c)(vi)** in relation to the principles and objectives of the national health system, no reference is made to Aboriginal and Torres Strait Islander people or their health care and service needs. The wording of HHB Act **s.4(c)(vi)** itself is derived from paragraph 13.e. of the COAG *National Health Reform Agreement* (NHRA) as one of the implementation principles that should underpin National Health Reform (COAG 2011:8). Insofar as the NHRA lays down the statutory blueprint for state/territory public health service legislation, it is the source of the structural conditions that enables institutional racism in HHSs to flourish.[[117]](#footnote-117) The HHB 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 (NPACGIHO). For example, **Schedule 3 Agreements** **Part 1 Agreements with Commonwealth, State or entity** of the HHB Reg. does not include among the list of agreements the COAG NPACGIHO and NIRA.

The single reference in **s.4(c)(vi)** of the HHB Actearns a score of 0.5 points out of 20 for each HHS. Effectively this means that all public hospitals and health services in Queensland that fall under the HHB Act receive a 19.5 point penalty when scored against the criterion of legal visibility in the Matrix. The score for this criterion will remain at 0.5 until the Queensland Government, in consultation with Queensland’s Aboriginal and Torres Strait Islander communities and their peak health bodies[[118]](#footnote-118), amends the HHB Act to incorporate the kinds of suggestions contained in the sub-criteria within the Act to provide the necessary “legal visibility” and legal infrastructure[[119]](#footnote-119) that recognises, includes and empowers Aboriginal and Torres Strait Islander people within the public health sector in the provision of health care services to their communities. These suggestions/sub-criteria, however, are intended to stimulate discussion on ways to improve the HHB Act.

Should the Queensland Government amend the HHB Act along the lines suggested below, this will give the Aboriginal and Torres Strait Islander peoples of Queensland a clear message that the government takes their health and well-being seriously by imposing legal obligations on HHSs to include them in the decision-making and processes for the delivery of health care to their people.

1. **Recognition of Aboriginal and Torres Strait Islander peoples as the First Queenslanders** 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… .[[120]](#footnote-120)

It is appropriate that such recognition is included as a Preamble to the HHB Act.

1. **Statement of commitment to Closing the Gap** The COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (NPACGIHO) was signed by then Premier of Queensland, the Honourable Anna Bligh MP on the 16 February 2009. The Agreement commenced on 1 July 2009 and expired on 30 June 2013. It generated a number of Closing the Gap Health policies at both Commonwealth and state and territory levels. At the Commonwealth level, the principal framework for implementation of the NPACGIHO is the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures* endorsed by the Australian Health Ministers’ Advisory Council in 2011, and reported on annually by the Commonwealth Department of Health. In 2010 Queensland Health issued two policy documents: *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033* (and for which there were both a policy and accountability framework, and an implementation plan for 2009-10 to 2011-12)[[121]](#footnote-121) and the *Cultural Capability Framework 2010 – 2033*. The federal and Queensland policies were formulated with considerable input from Aboriginal and Torres Strait Islander health professionals. With the NPACGIHO in place and the generational span of the *Making Tracks* and *Cultural Capability Framework,* a prime opportunity existed for the Queensland parliament, while drafting the HHB Act, to embed in the legislation one of the five priority areas addressed by the NPACGIHO, namely “making Indigenous health everybody’s business” by introducing “broader health system changes” (COAG 2009:4).
2. **Object of the HHB Act to include: Responsive, capable and culturally competent health care** HHB Act **s.5 Object** states “(1) The object of this Act is to establish a public sector health system that delivers high quality hospital and other health services to persons in Queensland having regard to the principles of the national health system.” The following amendment is suggested. After the words “to persons in Queensland”, the words “, including responsive, capable and culturally safe and appropriate hospital and other health services to Aboriginal and Torres Strait Islander people,” could be inserted.
3. **Aboriginal and Torres Strait Islander membership of HHSBs** HHB Act **s.23 Membership of boards** (of Hospital and Health Boards for Services) states

“(1) A board consists of 5 or more members appointed by the Governor in Council, by gazette notice, on the recommendation of the Minister.

(2) The Minister is to recommend persons the Minister considers have the skills, knowledge and experience required for a Service to perform its functions effectively and efficiently, including –

(a) persons with expertise in health management, business management, financial management and human resource management; and

(b) persons with clinical expertise; and

(c) persons with legal expertise; and

(d) persons with skills, knowledge and experience in primary healthcare; and

(e) persons with knowledge of health consumer and community issues relevant to the operation of the Service; and

(f) where relevant, persons from universities, clinical schools or research centres with expertise relevant to the operations of the Service; and

(g) persons with other areas of expertise the Minister considers relevant to a Service performing its functions.”

This mix of skills, knowledge and experience is adapted from paragraph D16. contained in Schedule D – Local Governance of the NHRA (COAG 2011:46). Under the NHRA, the States are responsible for establishing the legal framework and governance arrangements of public hospital services, including the establishment of Local Hospital Networks (which in Queensland means the hospital and health services) (COAG 2011:6, paragraph 8.a.i.). Since there is no mention within the “appropriate mix of skills and expertise” in paragraph D16 of the NHRA of appropriate experience/expertise with regard to Indigenous health, then there is no expectation that it should be included in **s.23(2)** of the HHB Act.

The following amendment is suggested. Paragraphs (a) to (g) contain no mention of a requirement for at least one of a Board’s members to have experience and expertise in the delivery of health services (or care) to Aboriginal and Torres Strait Islander people and their communities. It is therefore suggested that either:

1. Such a paragraph be inserted into **s.23(2)** which leaves open the possibility that such a person with the necessary experience and expertise may not necessarily be an Aboriginal or Torres Strait Islander person.

or

1. An Aboriginal or a Torres Strait Islander person, with the necessary experience and expertise, be appointed to the Board.

Since **s.23(1)** does not set a maximum number for the size of HHS board memberships, it would appear that there is plenty of scope for option (b) above. Memberships of HHSBs in Queensland currently range between 7 and 10 members, with only three (as at 31 December 2015) having Indigenous representation.

1. **Aboriginal and Torres Strait Islander Community Engagement Strategy** The HHB Act states in **s.40 Engagement strategies** that

“(1) A Service must develop and publish the following strategies –

(a)…….

(b) a strategy (a ***consumer and community engagement strategy***) to promote consultation with health consumers and members of the community about provision of health services by the Service.”[[122]](#footnote-122)

It is suggested that a paragraph (c) be added requiring each Service to develop an Aboriginal and Torres Strait Islander Community Engagement Strategy in consultation with the Aboriginal and Torres Strait Islander community controlled health service(s) and members of the Aboriginal and Torres Strait Islander communities within the Service region. The prescribed requirements for consumer and community engagement strategies are detailed in **s.13** of the HHB Regulation and should apply in the development and implementation of an Aboriginal and Torres Strait Islander Community Engagement Strategy. HHB Regulation **s.13(1)(b)** states:

For section 40(3)(a) of the Act, a consumer and community engagement strategy of a Service must –

Have regard to national and State strategies, policies, agreements and standards relevant to promoting consultation with health consumers and members of the community about the provision of health services by the Service;

In accordance with HHB Regulation **s.13(1)(b)**, regard should be had to the NPACGIHO and the NIRA, the Commonwealth Department of Health  *Aboriginal and Torres Strait Islander Health Performance Framework*, and Queensland Health’s policies such as *Making Tracks,* the *Cultural Capability Framework* and the *Aboriginal and Torres Strait Islander Environmental Health Plan.*

This may require corresponding amendments to **s.40(2)(b)** [re: consultation] and **(3)(b)** [re: accessible publication] of the HHB Act.

10. **HHS** **Aboriginal and Torres Strait Islander Community Consultative Committee:** A new section (**s.40A**) be added to the effect that:

**s.40A A Service to establish an Aboriginal and Torres Strait Islander community consultative committee**

(1) A Service, in consultation with the Aboriginal and Torres Strait Islander community controlled health service(s) and members of the Aboriginal and Torres Strait Islander communities within the Service region, must establish an Aboriginal and Torres Strait Islander community consultative committee with the following functions:

1. Provide names of suitable candidates for appointment to a Service board for consideration by the Minister under section 23; and
2. Provide advice to the Service board on matters relating to the provision of health services to Aboriginal and Torres Strait Islander people and their communities within the Service’s region; and
3. Assist with the development of any protocol established by a Service with an Aboriginal and Torres Strait Island community controlled health service operating within the Service’s region under section 42(1) (see Note 12) in which the Aboriginal and Torres Strait Islander consultative committee is established; and
4. …………….. [more could be added here]

(2) The Service must consult with the Aboriginal and Torres Strait Islander community consultative committee with regard to a service agreement established under section 35 on such matters as the inclusion of agreed Key Performance Indicators drawn from the Australian Health Ministers Advisory Council reporting framework for Closing the Gap on Indigenous Health Outcomes, and funding and reporting arrangements regarding the delivery of health services and health care to Aboriginal and Torres Strait Islander people.

(3) The Service must provide half-yearly reports to the Aboriginal and Torres Strait Islander community consultative committee on the matters contained in sub-section (2), and on any other matters mutually agreed upon by the Service and the Aboriginal and Torres Strait Islander community consultative committee.

[Note: In accordance with **Schedule 1 Conduct of business by boards** under **s.8 Committees**

“(1) the board –

(a) may establish committees of the board for effectively and efficiently performing its functons;”]

11. **Recognition of Aboriginal and Torres Strait Islander community controlled health services** Aboriginal and Torres Strait Islander community controlled health services (ATSICCHS) could be recognised in a number of places in the HHB Act, for example in **s.13 Guiding principles**. The principles include the following:

“(1) The following principles are intended to guide the achievement of this Act’s object-

(h) there should be engagement with clinicians, consumers, community members and local primary health care organisations in planning, developing and delivering public sector health services;”

The inclusion of “including Aboriginal and Torres Strait Islander community controlled health services” after “local primary health care organisations” is a possibility. The term “Aboriginal and Torres Strait Islander community controlled health service” may need to be defined in the Act in **Schedule 2 Dictionary**.

Another example occurs with regard to **s. 42 Protocol with primary healthcare organisations**, which states:

“(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.”

After “local primary healthcare organisations” the words “, including Aboriginal and Torres Strait Islander community controlled health services,” could be added. A protocol established between a Service and an ATSICCHS should meet the prescribed requirements for protocols with local healthcare organisations as detailed in **s.14** of the HHB Regulation.

1. **Aboriginal and Torres Strait Islander HHS Plan** To provide leadership and unity of purpose, the HSCE, together with the chief executive(s) of the ATSICCHS(s) within the HHS region, should negotiate a comprehensive Aboriginal and Torres Strait Islander health plan. While **s.42** of the HHB Act enables HSSs to establish protocols with primary healthcare organisations, Aboriginal and Torres Strait Islander health plans are potentially more comprehensive in their scope. Such plans should be registered with the Chief Executive of the Department of Health who should maintain a register of such plans as part of their functions under **s.45** of the HHB Act. **S.45** should be amended accordingly. For a more complete discussion see Note 31.
2. **Closing the Gap KPIs in HHS Service Agreements** One of the functions of the Chief Executive of the Department of Health under **s.45(k)** of the HHB Act is “to enter into service agreements with the Services”. While health system priorities change over time, an opportunity exists here to include among the functions of the Chief Executive, a function regarding the inclusion of Closing the Gap KPIs in HHS service agreements. See also Note 23.
3. **Commitment to Continuous Quality Improvement** 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.[[123]](#footnote-123)

**s.82 Establishment of quality assurance committees**

“(1) Any of the following may establish a quality assurance committee –

1. for a matter relating to its functions –

……..

1. a Service; or…

**Suggested amendment:**

There should be a new sub-paragraph inserted within **s.82** requiring that all Services (i.e., HHSs) establish a quality assurance committee with the specific functions of evaluating, monitoring and improving the delivery of healthcare by each Service to Aboriginal and Torres Strait Islander people, taking into account such factors as the cultural appropriateness, capability and competency of service delivery.

1. **Ministerial discretionary powers.** There are several opportunities for the Minister to exercise discretionary powers in relation to Aboriginal and Torres Strait Islander heath care and services. These include:

* establishment of ancillary boards (**s.43A** )
* giving directions to a Service (**s.44**)
* appointment of advisers to boards (**s.44A**), including matters to which the Minister may have regard in deciding whether to appoint adviser (**s.44B**)
* establishment of Ministerial advisory committees (**s.278**)

1) With regard to ancillary boards:

**s.43A Minister may establish ancillary board**

**“**(1) The Minister may establish a Hospital and Health Ancillary Board (an ***ancillary board***) to give advice to a Hospital and Health Board in relation to –

1. a public sector hospital; or
2. a public sector health facility; or
3. a public sector health service; or
4. a part of the State.
5. Before establishing an ancillary board the Minister may consult with –

…….

(b) the community who receive services from, or in, the public sector hospital, public sector health facility, public health service or part of the State for which the ancillary board may be established.”

**Suggested amendment:**

Insert after the word “community” in **s.43A(2)(b)** the words “, including the Aboriginal and Torres Strait Islander community,”.

2) Concerning giving directions HHSs

**s.44 Minister may give directions to Service**

“(1) The Minister may give a Service a written direction about a matter relevant to the performance of its functions under this Act, if the Minister is satisfied it is necessary to do so in the public interest.

(2) Without limiting subsection (1), the Minister may direct a Service to give the Minister stated reports and information.”

**Suggested amendment:**

Suggested inclusion in subsection (2) after “and information,” words to the effect: “including performance reports in relation to Closing the Gap on Indigenous Health Outcomes,”.

3) In relation to appointment of advisers to boards

**s.44A Minister may appoint advisers to boards**

“(1) The Minister may appoint a person to be an adviser to a board if the Minister considers that the adviser may assist the board to improve the performance of –

1. the board; or
2. the Service controlled by the board.”

**Suggested amendment:**

Suggested addition could be:

1. the board, or the Service controlled by the board, in relation to Closing the Gap on Indigenous Health Outcomes, such advisor to be an Aboriginal or Torres Strait Islander person with experience and expertise in the delivery of healthcare and health services to Aboriginal and Torres Strait Islander people.

Concerning matters regarding advisory appointments:

**s.44B Matters to which Minister may have regard in deciding whether to appoint adviser**

“In deciding whether to appoint an adviser to a board, the Minister may have regard to the

performance of the board or the Service controlled by the board in relation to the following -

1. the safety and quality of the health services being provided by the Service;
2. the way in which the Service is complying with the service agreement for the Service;
3. the financial management of the Service.”

**Suggested amendment:**

An additional paragraph:

1. the competency of the Service in providing culturally appropriate and safe healthcare and health services to Aboriginal and Torres Strait Islander people.

4) In relation to ministerial appointment of advisory committees:

**s.278 Ministerial advisory committees**

“(1) The Minister may establish the advisory committees the Minister considers appropriate for this Act.”[[124]](#footnote-124)

**Suggested amendment:**

A separate subsection should be added in **s.278** for the establishment of a Closing the Gap committee to provide advice to the Minister for the improvement of health outcomes for Aboriginal and Torres Strait Islander people in Queensland.

1. **Aboriginal and Torres Strait Islander advisory committee** As noted above, the Minister has the discretionary power under **s.278** of the HHB Act to establish advisory committees. However, the HHB Act should be amended to include a “Closing the Gap committee” as a statutory standing committee to provide advice to the Minister.
2. **Aboriginal and Torres Strait Islander employment in the health workforce** One of the national Close the Gap priority tasks, both in the NIRA and the NPACGIHO, is to increase the employment of Aboriginal and Torres Strait Islander people. With regard to HHSs, this is fundamental to improving their cultural competency. It is therefore appropriate to include a provision in the HHB Act to give effect to this.

**s.67 Appointment of health service employees**

“(1) The chief executive may appoint a person as a health service employee in the department, including as an employee of the department working for a Service that is not a prescribed Service.

(2) A Service may appoint a person as a health executive in the Service

(3) A prescribed Service may appoint a person as any health service employee in the Service.

(4) Appointment as a health service employee may be –

(a) on tenure; or

(b) on contract for a fixed term, including as a health executive; or

(c) on a temporary basis; or

(d) on a casual basis.

(5) An appointment under this section may be for full-time or part-time employment.”

**Suggested amendment:**

Suggest the inclusion of a new subsection (6) to the effect that:

“In the appointment of a person under this section as a health service employee, the chief executive, a Service and a prescribed Service must have due regard to the appointment of Aboriginal and Torres Strait Islander people, taking into consideration the need to create identified positions within the department, a Service and a prescribed Service for Aboriginal and Torres Strait Islander people pursuant to section 25 and 105 of the *Anti-Discrimination Act 1991* (Qld).” See also Note 42.

1. **Annual reporting**

HHS annual reporting requirements are set out in the *Annual Report requirements for Queensland Government agencies,* and do not appear in the HHB Act. The characteristics of a quality annual report are that it:

* complies with statutory and policy requirements
* presents information in a concise manner
* is written in plain English
* provides a balanced account of performance – the good and not so good.[[125]](#footnote-125)

All HHS annual reports include a compliance checklist summarising requirements contained in the *Financial Accountability Act 2009* (Qld), *Financial and Performance Management Standard 2009* and the *Annual report requirements for Queensland Government agencies.* In addition there are some 52 other Acts and Regulations relevant to the operations of HHSs and with which they must comply.

In the interests of transparency and accountability for health services provided to Aboriginal and Torres Strait Islander people and their communities, the *Annual Report requirements for Queensland Government agencies* should be amended so that HHS annual reports should contain the following:

* Acknowledgement of Traditional Owners within the HHS region
* Closing the Gap information including:

1. A separate section in the report devoted to Closing the Gap progress, initiatives, etc.
2. Reporting on selected KPIs (as contained, for example, in the Tier 3 reporting requirements summarised in Figure 1: Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures).[[126]](#footnote-126)

* Queensland Health policy references (progress and initiatives towards their implementation):

1. *Making Tracks* (both the *Policy and Accountability Framework* and the *Implementation Plan…..*
2. *Cultural Capability Framework*

* Chart of the organisational structure indicating where Aboriginal and Torres Strait Islander people/units/services, etc., are placed within that structure at executive and managerial levels/capacities.
* Aboriginal and Torres Strait Islander health workforce development, training and employment, including:

1. Implementation of the Queensland Health *Aboriginal and Torres Strait Islander Health Worker Career Structure (revised 2009);*
2. Data on Aboriginal and Torres Strait Islander employment across all QH employment streams/categories (i.e, managerial and clerical, medical including VMOs, nurses, support services, trade and artisans, and health practitioners (professional and technical) and with the inclusion, as a separate stream/category, Indigenous Health Workers (IHWs) and Indigenous Liaison Officers (ILOs);
3. References to Aboriginal and Torres Strait Islander workforce planning, training, recruitment, retention, identified positions, etc.
4. Progress towards achieving local population parity targets regarding numbers of Aboriginal and/or Torres Strait Islander employees as a total of HHS workforce.

* Aboriginal and Torres Strait Islander community engagement, including references to, for example:

1. Advisory, consultative or other committees established by the Board, Chief Executive, Minister, etc.
2. Relationships with Aboriginal and Torres Strait Islander community controlled health services (eg, with respect to any MOUs, HHS plans, strategic plans, etc).
3. HHS Reconciliation Action Plan – progress towards implementation, etc.

* Other recognition (e.g., individual awards, honours, scholarships, etc).

1. **Financial statements regarding Aboriginal and Torres Strait Islander healthcare funding and expenditure**

Given the Premier’s statement regarding, *inter alia,* financial accountability in Queensland Health’s *Blueprint for better healthcare in Queensland* (February 2013), it is appropriate that accountability and transparency regarding Indigenous Closing the Gap funding and expenditure should be specifically included in **Part 3A Funding the public sector health system** of the HHB Act.

**s.53A Purpose** (in relation to Part 3A Funding of public sector health system)

“The main purpose of this part is to enhance the accountability and transparency of the funding of public sector hospitals, other public sector health services, and teaching, training and research related to the provision of health services.”

**Suggested amendment:**

Suggest including at the end of the paragraph “, including funding allocated to Queensland under the COAG National Indigenous Reform Agreement and the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes through Commonwealth Own Purpose Expenses and by the Queensland Government’s Own Purpose Expenses to the public health sector for the purpose of Closing the Gap on Indigenous Health Outcomes.”

It would also be appropriate to amend certain functions of the National Health Funding Pool administrator:

**s.53P Functions of the administrator** (appointed under **s.53K** to the office of administrator of the National Health Funding Pool established under **Division 4, s.53J**)

“(1) The administrator is –

1. To calculate and advise the Treasurer of the Commonwealth of the amounts required to be paid by the Commonwealth into each State pool account of the National Funding Pool under the National Health Reform Agreement (including advice on any reconciliation of those amounts based on subsequent actual service delivery);”

**Suggested amendment:**

After the words “National Health Reform Agreement”, suggest the inclusion of: “and the National Indigenous Reform Agreement and National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes”.

And **s.53P(1)(d)** whereby the administrator is

“(d) To report publicly on the payments made into and from each State pool account and other matters on which the administrator is required to report under this division.”

**Suggested amendment:**

After the words “State pool account” add: ”, including preparation of a separate public report on payments made into and from each State pool account for the purposes of Closing the Gap on Indigenous Health Outcomes,”.

20. **Aboriginal and Torres Strait Islander representation at Board level** In Queensland, under **s.23(1)** of the HHB Act the Minister has the responsibility for recommending to the Governor in Council appointments to the HHS Boards. 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 HHB Act.

How Aboriginal and Torres Strait Islander communities within each of the HHS districts wish to be represented at board level may depend on:

1. the population mix of Aboriginal and Torres Strait Islander people; and
2. the overall percentage of Aboriginal and Torres Strait Islander people within a HHS district as whole.

In the Torres and Cape Hospital and Health Service (TCHHS), Cairns and Hinterland Hospital and Health Service (CHHHS) and Townsville Hospital and Health Service (THHS), and in accordance with the wishes of the respective communities, it may be considered appropriate that both peoples/communities are represented. 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.[[127]](#footnote-127) 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 required to be minuted in accordance with **s.32** and **Schedule 1 Conduct of business by boards**, paragraph **7(1)(a)** of the HHB Act).

With regard to point (ii), under **s.43A(1)** of theHHB Act, 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 (see Note 15). 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.

Having Aboriginal and/or Torres Strait Islander representation on HHSBs should ensure that Aboriginal and Torres Strait Islander health matters have a regular place on board meeting agendas, and may prove to be one of the most cost-effective ways of delivering direction to a HHS in regard to Indigenous health care – ordinary board member remuneration is generally in the range of $30,000 – $50,000 p.a., depending on the HHS.[[128]](#footnote-128)

1. **Inclusion in HHS Executive Management Structure** The executive management structure of a HHS comprises a number of variously named separate divisions, departments or services each with its own head. Together with the Health Service Chief Executive (HSCE), the heads of these entities generally comprise the executive management team or group.[[129]](#footnote-129) *The Queensland Government Reconciliation Action Plan 2009-2012* (p. 21) committed all government agencies to implement Aboriginal and Torres Strait Islander employment action plans to target employment retention and career advancement such that by June 2012 the Queensland Government will:

... increase career advancement and support opportunities to promote state government agencies as an employer of choice for Aboriginal and Torres Strait Islander employees especially at middle and senior levels [emphasis added].

22. **Aboriginal and Torres Strait Islander Health Division** It is argued here that, given the particular priority, organisational complexity, range of stakeholders and oversight necessary to achieve improved HHS Closing the Gap outcomes, each HHS needs to have its own dedicated executive division/department for Aboriginal and Torres Strait Islander health to more effectively manage and monitor the delivery of health care and services to Aboriginal and Torres Strait Islander clients. The Division would be broadly responsible for:

1) Oversight of the Closing the Gap and other Aboriginal and Torres Strait Islander health programs and budgets as per the HHS service agreement (see Tables 14 and 15)

2) Monitoring the quality and safety of health service provision to Aboriginal and Torres Strait Islander clients

3) Monitoring of HHS Closing the Gap performance

4) Strategic leadership and policy development

5) Community engagement and partnerships

6) Systems support

7) Workforce enhancement

8) Service enhancement

9) Program performance and accountability[[130]](#footnote-130)

Such a division could oversee units and personnel responsible, for example, for:

* Intra-HSS interdepartmental liaison
* Aboriginal and Torres Strait Islander health workforce development and deployment
* Delivery of CCT to non-Indigenous HHS employees
* Joint development and oversight with chief executives of ATSICCHSs of the HHS Aboriginal and Torres Strait Islander Health Plan (see Note 31) or other partnership arrangements
* Liaise directly with the Aboriginal and Torres Strait Islander community consultative committee (see Note 24)
* Workplace health and safety (including a focal point for Aboriginal and Torres Strait Islander staff who experience racial harassment and discrimination in the workplace)
* Aboriginal and Torres Strait Islander patient safety and service quality assurance (monitoring access to hospital procedures, minimising DAMA and monitoring patient transition out of HHS care)
* Compile and monitor data and information for inclusion in HHS annual reports
* Liaison with the QH Aboriginal and Torres Strait Islander Health Branch/Unit
* HHS external liaison with Primary Health Networks and other primary health and Allied Health Service providers in regard to Aboriginal and Torres Strait Islander patient care.

Executives, as part of their duties and responsibilities, are required from time to time to prepare reports for the HHS board, and also manage their own divisional budgets. It is also highly desirable that any such executive division/department/unit for Aboriginal and Torres Strait Islander Health be headed by an Aboriginal and/or Torres Strait Islander person.

1. **Closing the Gap KPIs in Health Service Agreements.** The Matrix addresses 10 of the 22 Tier 3: Health System Performance measures (HSPM) listed in the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures* (AHMAC, 2012: Figure 1). An additional measure (Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission) not listed as a HSPM has also been included. The various HSPMs listed below (including “estimated level of completion of Indigenous status”) have been reported from time to time in different HSS annual reports, however, there is no consistency across HHSs, and from year to year. Also there is no consistency in QH’s own annual *Closing the Gap* performance reports (compare, for example, the 2014 and 2015 reports) due to changing health service priorities. In the Queensland Government’s State Budget 2014-15 service delivery statements for Queensland Health, performance statements in relation to Aboriginal and Torres Strait Islander health care are to include the following service areas:

* Primary Health Care: Ratio of PPH – rate of Aboriginal and Torres Strait Islander hospitalisations to rate of non-Aboriginal and Torres Strait Islander hospitalisations
* Ambulatory Care: Percentage of babies born of low birthweight to non-Aboriginal and Torres Strait Islander mothers and Aboriginal and Torres strait Islander mothers
* Acute care: Percentage of DAMA for non-Aboriginal and Torres strait Islander patients and Aboriginal and Torres Strait Islander patients.[[131]](#footnote-131)

Some are included in HHS service agreements. To provide more comprehensive disclosure and improve consistency in reporting over time to enable effective monitoring, the following HSPMs are suggested for inclusion in HHS service agreements:

* The percentage of Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice (DAMA) (HSPM: 3.09) (see Note 35)
* Percentage of potentially preventable hospitalisations (PPH) (HSPM: 3.07) (see Note 36)
* 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 (HSPM: 3.10) (see Note 37)
* Access to drug and alcohol services (HSPM: 3.11) (see Note 38)
* Percentage of non-indigenous workforce staff (in all categories) who have received Cultural Competency Training (HSPM: 3.08) (see Note 32
* Aboriginal and Torres Strait Islander people in the health workforce (in all categories) (HSPM: 3.12) (see Note 42)
* Aboriginal and Torres Strait Islander people training for health related disciplines (HSPM: 3.20) see Note 40)

and

* Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (see Note 34).

Each of these will be further discussed in separate notes below.

However, and based on their inclusion in a number of HHS annual reports for 2012-2013 (THHS, NWHHS, MHHS) – with the exception of “access to drug and alcohol services”, for the purposes of this audit the following six indicators/measures are put forward for inclusion in HHS service agreements:

* The percentage of Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice
* Percentage of potentially preventable hospitalisations
* 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
* Access to drug and alcohol services
* Percentage of non-indigenous workforce staff (in all categories) who have received Cultural Competency Training, as well as
* Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission.

1. **Community Engagement** 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.[[132]](#footnote-132) To assist this process, this criterion includes three sub-criteria: the existence of an Aboriginal and Torres Strait Islander community consultative body, a HHS RAP, and an Aboriginal and Torres Strait Islander community newsletter generated by the relevant section/unit within the HHS.
2. **Reconciliation Action Plan** 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”.[[133]](#footnote-133) Reconciliation Action Plans (RAPs) provide an excellent opportunity to mutually articulate reconciliation statements and commitments incorporating organisational visions, values, goals and strategies. RAPs are essentially internal HHS documents/instruments and can be distinguished from Aboriginal and Torres Strait Islander health plans (see Note 31) which are negotiated between a HHS and an external body, such as an ATSICCHS, to produce specific mutually agreed outcomes. The Queensland Government released its Reconciliation Action Plan in 2009 committing all government agencies to developing their own RAPs, and to report on progress with implementation as part of their annual reports.[[134]](#footnote-134) In establishing the RAP, the Queensland Government acknowledged that, to the Government, reconciliation means *inter alia*:

* taking actions to reduce the gaps in life outcomes and opportunities
* providing fair treatment and transparency in our policies, programs and services
* making it clear that there is no place for racism or discrimination in Queensland
* giving Aboriginal and Torres strait Islander peoples a real say in the decisions that affect their lives and communities
* building a better future by working together.[[135]](#footnote-135)

The Queensland Government’s RAP was built on the following actions:

* Strengthening relationships
* Fostering respect
* Increasing opportunities
* Ensuring accountability[[136]](#footnote-136)

With regard to COAG’s National Aboriginal and Torres Strait Islander reforms with regard to, *inter alia*, early childhood and health, all Queensland agencies were supposed to have strategies in place by December 2009 to put Queensland on track to meet the COAG targets.[[137]](#footnote-137) Queensland Health co-signed with Reconciliation Australia[[138]](#footnote-138) 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.[[139]](#footnote-139)

1. **Aboriginal and Torres Strait Islander Health Division/Unit community newsletter** An excellent way to keep Aboriginal and Torres Strait Islander communities within a HHS region informed about relevant HHS activities, initiatives, health and liaison personnel, clinics, health programs, etc. is through the regular publication of a community-focused newsletter. There are some excellent examples of such publications by a number of HHSs, and this sub-criterion was included on the basis of recognising best practice.
2. **Annual Reports** Annual reports are an important avenue for HHS accountability. As is stated in the *Annual report requirements for Queensland Government Agencies: Requirements for the 2014 – 2015 reporting period* in relation to the purpose of annual reports:

Annual reports are a key accountability document and the principal way agencies report on non-financial and financial performance. The Auditor-General notes that “annual reports support transparency and can drive continuous improvement in performance. Where annual reports incorporate relevant and reliable performance information, they increase trust and confidence in government service delivery”.[[140]](#footnote-140)

The purpose behind this criterion is to encourage HHSs to provide a succinct accurate snap-shot of their performance in Closing the Gap in Indigenous health disparities across a range of KPIs, and to highlight any initiatives that they have undertaken. The sub-criteria included here reflect the kinds/categories of information given in the Townsville Hospital and Health Service *2012-2013 Annual Report*. In effect, for the purpose of developing these sub-criteria, the THHS annual report serves as the model with points allocated accordingly. See also Note 18.

1. **Traditional Owner acknowledgement** Traditional Owner acknowledgement is underpinned by the recognition of Aboriginal and Torres Strait Islander peoples in the Queensland Constitution (see Note 5).
2. **Policy references** The policy references here refer to Queensland Health’s two 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), and the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033.* The expectation here is that HHSs will describe progress made and initiatives undertaken to advance these two policies.
3. **Reference to workforce planning and recruitment, etc.** 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/VET course, mentorships, other training programs, new initiatives, etc.
4. **Aboriginal and Torres Strait Islander health plan** While this criterion emphasises the need for each HHS to establish an Aboriginal and Torres Strait Islander health plan forged between the HSCE and the Chief Executive(s) of the local Aboriginal and Torres Strait Islander community controlled health services ATSICCHS(s), other alternatives include the establishment of protocols, strategies, agreements, frameworks and partnerships.[[141]](#footnote-141) A protocol with local ATSICCHSs could be established under **s.42 Protocol with primary healthcare organisations** of theHHB Act.[[142]](#footnote-142) **S.14** of theHHB Reg. lists the prescribed requirements for a protocol with local primary healthcare organisations (see Note 12).[[143]](#footnote-143) QH frequently uses the term “partnerships” in terms of building relationships with ATSICCHSs. For example, QH emphasises, particularly in relation to improving the patient journey, “[p]artnerships between Indigenous community-controlled health services and HHSs are strongly encouraged.”[[144]](#footnote-144) 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.[[145]](#footnote-145) 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), and set KPIs and other monitoring processes to ensure a commitment to CQI goals and processes. Consistent with many other commonwealth and Queensland Aboriginal and Torres Strait Islander health plans and strategies, they should have a reasonable duration – 10 years is suggested. As with many other statutory HHS plans and strategies, they should be published, and as suggested in Note 12, such plans could be registered with Queensland Health’s Chief Executive.

Two examples of published health plans are given below.

* + - 1. ***Palm Island Health Action Plan 2010-2015***

This plan was prepared by staff of Queensland Health’s Aboriginal and Torres Strait Islander Health Branch in consultation with the Palm Island Aboriginal Shire Council, the Palm Island community and the CEO of the (then) Townsville Health Service District. The plan was also endorsed by the then federal Minister for Indigenous Health. The four action areas addressed by the plan are:

* Action area one – Illness prevention and early intervention
* Action area two – Treating existing illness
* Action area three – Better health services
* Action area four – Social determinants of health.

The plan also puts in place processes for implementation, monitoring and review.

2. **Northern Sydney Local Health District *Aboriginal Health Services Plan 2013-2016***

This plan 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.[[146]](#footnote-146)*

The primary elements of the Northern Sydney Local Health District *Aboriginal Health Services Plan 2013-2016* are:

* Aboriginal and Torres Strait Islander Health Impact Statement
* Coordination of public health services (including allied services) with Aboriginal and Torres Strait Islander community controlled services
* Aboriginal and Torres Strait Islander health workforce development
* Reportable elements/KPIs of plan
* Funding agreements

1. **Cultural competence** This criterion addresses Tier 3 HSPM 3.08 “cultural competency” under the heading “Effective/Appropriate/Efficient”.

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.[[147]](#footnote-147)

[The latter is addressed under Matrix Indicator 4: Recruitment and Employment]. With regard to cultural competency training (CCT), the relevant policy document is Queensland Health’s *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033.* A 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.[[148]](#footnote-148)

As CCT is a mandatory training requirement for all HHS employees, it seems appropriate that QH should include data for all HHSs with respect to CCT and rates of completion, including a comparison with completion rates for other mandatory training requirements (eg, Occupational Violence Prevention, Infection Control (non-clinical), First Response Evacuation Instructions, etc.) in its annual Closing the Gap performance reports.[[149]](#footnote-149) CHQHHS hosted Queensland Health’s statewide Cultural Capability Team to develop the Queensland Health Online Aboriginal and Torres Strait Islander Cultural Practice Program for use by Queensland’s HHSs.[[150]](#footnote-150)

To assist in the scoring of this criterion, the focus is on whether a HHS has developed a specific Aboriginal and Torres Strait Islander cultural competency policy or strategy (over and above the simple online mandatory training course); has in place a body to implement it; and the extent to which it is working assessed in terms of the number of non-Indigenous staff who have completed training.

1. **Selected Health Service Performance Indicators** To assess this criterion, five sub-criteria have been included, four of which have been selected from measures listed in Tier 3: Health System Performance of the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures* (AHMAC, 2012: Figure 1), together with “Indigenous status not stated”.
2. **Indigenous identification** The NHRA, in Schedule B in reference to the Independent Hospital Pricing Authority (IHPA), in para. B13 states:

In determining adjustments to the national efficient price, the IHPA must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including:

1. patient complexity, including Indigenous status.[[151]](#footnote-151)

While not included as a Tier 3 HSPM, nevertheless, much has been written about the need to improve the rates of Indigenous identification in the healthcare system as a policy imperative. Incomplete and inaccurate identification of the Aboriginal and Torres Strait Islander population is commonplace in health administration and clinical information systems in services across Australia.[[152]](#footnote-152) Poor recording of Aboriginal and Torres Strait Islander status results in Aboriginal and Torres Strait Islander people being recorded as ‘non-Indigenous’ or ‘not stated’ within collection systems, and their records not included in monitoring and analysis of health system utilisation and patient outcomes. This in turn under-estimates the burden of disease and service utilisation, and underplays inequalities in health. In addition, it is unknown whether the characteristics of these ‘missing’ individuals are similar or different to those who are identified as Aboriginal and Torres Strait Islander, potentially biasing analysis and reporting.[[153]](#footnote-153) Improving identification rates of Aboriginal and Torres Strait Islander people in health services has been prioritised as part of the COAG commitment to Closing the Gap in the NIRA.[[154]](#footnote-154) QH has issued *A guide for improving the identification of Aboriginal and Torres Strait Islander people in health care* to support and inform HHS staff so that they can “ensure the care and services they provide are both clinically and culturally responsive.”[[155]](#footnote-155) Data on “Indigenous status – reporting of ‘not stated’ on admission” was reported in some 2012-2013 HHS annual reports[[156]](#footnote-156), but not reported on at all in 2014-2015 reports.

1. **DAMA** This sub-criterion addresses Tier 3 HSPM 3.09 “Discharge against medical advice” under the heading “Responsive”.

DAMA 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 DAMA 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).[[157]](#footnote-157) However, not all patients leave over issues of patient care. Some self-discharge to meet cultural and/or family obligations, or a fear of dying away from country or family.

**PPH** This sub-criterion addresses Tier 3 HSPM 3.07 “selected potentially preventable hospital admissions” under the heading “Effective/Appropriate/Efficient”.

PPH = potentially preventable hospitalisations – is the acronym generally used for this KPI in HHS annual reports. 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.[[158]](#footnote-158) 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%).[[159]](#footnote-159)

1. **Access to Mental Health Services** This sub-criterion addresses Tier 3 HSPM 3.10 “Access to mental health services” under the heading “Responsive”.

The Queensland Health *Closing the Gap Performance Report 2015* (p. 48) noted that:

Mental illness is the leading contributor to the Indigenous burden of disease in Queensland, contributing up to one-fifth of the total disease burden. … High levels of psycho-social distress and poor mental health outcomes contribute significantly to poor physical health outcomes. Closing the gap in physical health is unlikely to be achieved without simultaneous effort and improvements in mental health outcomes. … Given the high levels of self-reported psycho-social stress and outcomes against risk factors for mental disorders, this suggests a significant untreated burden of anxiety and depression among Indigenous Queenslanders.

The Queensland Government has developed the *Queensland Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2020* (released during 2016). The Strategy focuses on:

… improving the responsiveness of Queensland Government-run mental health services to address the needs of Aboriginal and Torres Strait Islander Queenslanders with severe mental illness. It will provide direction to HHSs on priority areas for action, and will emphasise the need for effective partnerships between all health service providers, as well as social service providers (*Closing the Gap Performance Report 2015,* p. 51).

Included in earlier HHS service agreements (as reported, for example, in the 2012-2013 annual reports for THHS (p. 54) and MHHS (p. 55)), this KPI is measured in terms of:

The 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 that separation.

This KPI is included in 2013/14 – 2014/15 HHS service agreements for the general population, but does not include a separate KPI for Aboriginal and Torres Strait Islander consumers of acute mental health services. All HHSs were funded to provide Indigenous Mental Health Services as part of their Community Ambulatory Mental Health Services in their 2013/14 – 2014/15 HHS service agreements (see Tables 14 and 15).

1. **Access to Drug and Alcohol Services** This sub-criterion addresses Tier 3 HSPM 3.11 “Access to alcohol and drug services” under the heading “Responsive”. A KPI for this HSPM (for example, something similar to that for access to mental health services) does not appear to have been devised, however, as is noted in the *Aboriginal and Torres Strait Islander Health Performance Framework: 2012 Report*:

Alcohol and drug services provide a variety of treatment interventions for alcohol and other drug use. … Treatment services which reduce harm from alcohol and other drugs can significantly reduce the level of associated diseases such as liver disease; injuries from motor vehicle accidents and assaults; and social disruptions. Reducing drug and alcohol related harm can improve health, social and economic outcomes at both individual and community levels. … Access to alcohol and other drug services by Aboriginal and Torres Strait Islander peoples may be impacted by geography (e.g., physical distance to health services, availability/affordability of transport and quality of roads), the cultural competency of services …, affordability (e.g., of services, pharmaceuticals, and other associated costs such as travel), and availability of services and health professionals.[[160]](#footnote-160)

Those suffering from drug and alcohol abuse can also cause considerable disruption in the wider community, for example, to businesses and tourists, inevitably resulting in law enforcement interventions.[[161]](#footnote-161) A KPI that can measure access to drug and alcohol services for use by HHSs would be particularly useful in gauging the effectiveness of their services, and where resources (staff, facilities, etc.) need to be deployed to better address the problem. Most HHSs were funded to provide Indigenous Outreach Services under the Alcohol and Other Drugs Services program in their HHS service agreements 2013/14 – 2015/16 some also funded to provide Indigenous Youth (12-17 years) Treatment Programs (see Tables 14 and 15).

1. **Recruitment and Employment** In *The Queensland Government Reconciliation Action Plan 2009-2012* (p. 21) with regard to increasing opportunities in public sector employment the required action states that:

All government agencies will implement Aboriginal and Torres Strait Islander employment action plans to target employment retention and career advancement of Aboriginal and Torres Strait Islander employees, in particular to middle and senior levels. Strategies to support this action include, but are not limited to, trainee, graduate, leadership, coaching, mentoring and mobility initiatives, formal study and professional development.

One of the targets by which to achieve this is that by June 2012, the Queensland Government will:

* Increase career advancement and support opportunities to promote state government agencies as an employer of choice for Aboriginal and Torres Strait Islander employees especially at middle and senior levels (p. 21).

In response to this directive, the State Library of Queensland developed the *State Library of Queensland Aboriginal and Torres Strait Islander Workforce Strategy 2012-16* (see p. 3 regarding reference to the Queensland Government’s RAP).

In the *Future workforce strategy for better healthcare in Queensland 2013-*2018, it is pointed out that:

Aboriginal and Torres Strait Islander people are currently under-represented within the Queensland health workforce. This is significant as research indicates that Aboriginal and Torres Strait Islander people are more likely to seek healthcare when provided by their own people. To date, strategies implemented to promote and support entry of Aboriginal and Torres Strait Islander people into the clinical workforce have been slow to achieve significant change.[[162]](#footnote-162)

This Matrix key indicator employs two criteria for the assessment process: Aboriginal and Torres Strait Islander health workforce development, andtheirparticipation across workforce employment categories.

1. **Aboriginal and Torres Strait Islander health workforce development.** This criterion addresses Tier 3 HSPMs:

\* 3.20 “Aboriginal and Torres Strait Islander peoples training for health related disciplines” under the heading “Capable”; and

\* 3.22 “Recruitment and retention of staff” under the heading “Sustainable”

To assist in the scoring of this criterion, the focus is on whether a HHS has developed and published a specific Aboriginal and Torres Strait Islander workforce development policy or strategy (similar to that developed, for example, by the State Library of Queensland – see Note 39); has in place a body to implement it; and the extent to which it is working assessed in terms of workplace equity reflecting the overall percentage of Aboriginal and Torres Strait Islander people within the general population of the HHS region. The primary policy reference here is *Queensland Health Aboriginal and Torres Strait Islander Workforce Strategy 2009-2012.[[163]](#footnote-163)*

1. **Employment equity** 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.[[164]](#footnote-164)

While there are both national (2.6%) and Queensland (3.7%)[[165]](#footnote-165) equity targets for Aboriginal and Torres Strait Islander public sector employment, it is more realistic to focus on local HHS equity targets. Achieving these targets becomes more compelling given the excess burden of disease borne by Aboriginal and Torres Strait Islander people and their communities.

1. **Aboriginal and Torres Strait Islander participation in the health workforce** This criterion addresses Tier 3 HSPM 3.12 “Aboriginal and Torres Strait Islander people in the health workforce” under the heading “Responsive”.

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. The number or percentage of Aboriginal and Torres Strait Islander people employed within each of the 6 QH employment streams should be published in each HHS annual report, and the classification level at which they are employed within the following three categories:

* Executive and Senior Officer roles: CEO, SES, SO1 and SO2 positions
* Middle Manager roles: AO6, AO7 and AO8 positions, or their equivalent.
* Lower Level roles: AO2- AO5 positions.[[166]](#footnote-166)

Queensland Health’s *Aboriginal and Torres Strait Islander Health Worker Career Structure* (revised 2009) (p. 8) provides the classification structure detailing level, title and minimum qualifications for Indigenous Health Workers which might correspond with the above classification levels.

Alternatively, given the considerable policy focus at national and state levels on the urgent need to employ more Aboriginal and Torres Strait Islander people in the health workforce, this employment data could be published for each HHS in Queensland Health’s annual Closing the Gap performance reports for each of the employment streams, including the number of Aboriginal and Torres Strait Islander identified positions for each stream.[[167]](#footnote-167) Neither the 2014 or 2015 performance reports contain this data.

Aboriginal and Torres Strait Islander health practitioners, including ILOs and IHWs, should also be identified and added as a separate employment stream to QH’s six existing employment streams. For the audit purposes, this employment stream has been included as a separate stream.

Additional weighting is given to those employment streams that provide clinical and frontline services.

1. **Aboriginal and Torres Strait Islander nurses** In recognising the value of Indigenous nurses in helping to Close the Gap in Indigenous health, West *et al* 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.”[[168]](#footnote-168)
2. **Aboriginal and Torres Strait Islander health practitioners, health workers and liaison officers** The importance of this category of HHS employees is highlighted by Shaw:

AHWs/ALOs, through their cultural brokerage role, are able to simultaneously help an Aboriginal and Torres Strait Islander patient interact with the hospital setting, and help non-Indigenous staff understand the needs of an Aboriginal or Torres Strait Islander patient. This multidimensional educational/advocacy/advisory role can be key to supporting patients to stay in hospital for the duration of their treatment. …. Premature discharge and subsequent readmission to hospital significantly disrupts patient continuity of care, which is crucial for effective treatment and improved health outcomes.[[169]](#footnote-169)

The National Registration and Accreditation Scheme (operational on 1 July 2010) includes “Aboriginal and Torres Strait Islander health practitioner” among its list of 14 health professions.[[170]](#footnote-170) However, despite this, although a registered profession within Queensland’s clinical workforce[[171]](#footnote-171), Aboriginal and Torres Strait Islander health practitioners are usually included in the operational and administrative officer (managerial and clerical) streams for statistical purposes.[[172]](#footnote-172) Aboriginal and Torres Strait Islander health practitioners (as distinct from the other health professions) are usually referred in Queensland as Aboriginal and Torres Strait Islander Health Workers (ATSIHW). As at 30 June 2015 there were 47 ATSIHWs in Queensland (of a national total of 391) registered with the Australian Health Practitioner Regulation Agency (AHPRA)[[173]](#footnote-173), however no information was provided as to how many of them are employed by HHSs.

With regard to ATSIHWs, 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 (2012, p. 135) 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.

Queensland Health provides the following definition of a Queensland Aboriginal and Torres Strait Islander Health Worker:

A Queensland Aboriginal and Torres Strait Islander Health Worker is an Aboriginal or Torres Strait Islander person who:

* works within a primary health care framework to achieve better health outcomes and better access to health services for Aboriginal and Torres Strait Islander individuals, families and communities
* is required to hold the specified Aboriginal and Torres Strait Islander primary health care qualification
* advocates for the delivery of services in accordance with the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009* (Australian Health Ministers Advisory Council).

Aboriginal and Torres Strait Islander Health Worker positions are ‘identified’ positions (see IRM 1.13-12). There is a genuine occupational requirement that the occupants of these positions are Aboriginal or Torres Strait Islander.[[174]](#footnote-174)

The classification structure ranges from Level 002 (Trainee Health Worker – enrolled in Cert III in Aboriginal and/or Torres Strait Islander Primary Health Care) to Level 009 (Manager Health Worker Services – holding an Advanced Diploma in Aboriginal and /or Torres Strait Islander Primary Health Care).[[175]](#footnote-175)

The other common category for Aboriginal and Torres Strait Islander workforce employees in HHSs are the Aboriginal and Torres Strait Islander Liaison Officers, who generally have a background and/or qualifications in community welfare or social work, and are employed in primarily non-clinical roles, for example,to:

* provide cultural support and intensive case management (where required) for patients and their families
* cultural mentorship and advice to mainstream clinicians managing the healthcare of Aboriginal and Torres Strait Islander patients[[176]](#footnote-176)
* provide or oversee cultural competency training to non-Indigenous staff
* attend to administrative matters (patient travel, accommodation)
* liaise with family members, community health and government services (particularly Centrelink, the police and child welfare);
* respond to specific patient requests for assistance (e.g., interpreter, filling out forms and taking care of other paper-work).

In hospital settings in particular, there is a likelihood that more Aboriginal and Torres Strait Islander people will be employed as Liaison Officers than as Health Workers/Practitioners.

Within this sub-criteria, the distinction should be maintained between Health Workers/Practitioners and Liaison Officers, and employment figures should be provided for both groups.[[177]](#footnote-177)

1. **Operational and Support Services**, in a hospital setting, include: food services (catering), security, cleaners, bed washers, laundry, wardspersons (“wardies”),[[178]](#footnote-178) couriers, mailroom, waste disposal, etc.
2. **Financial accountability and reporting: Closing the Gap funding** This Key Indicator addresses the issue of financial accountability and reporting, and reflects to some extent on the HSPM 3.21 “Expenditure on Aboriginal and Torres Strait Islander health compared to need” under the heading “Sustainable”.

Under the National Health Care Agreement 2012, States and Territories are primarily responsible for the provision of health and emergency services through the public hospital system, as well as having joint funding responsibility with the Commonwealth for public health activities, mental health, sub-acute, Aboriginal and Torres Strait Islander health, research, workforce training, emergency responses and blood and blood products.[[179]](#footnote-179)

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,[[180]](#footnote-180) but also in the annual reports of each of the HHSs in the state.

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.

With regard to the financial arrangements for implementing the COAG NPACGIHO over 4 years, the Agreement states that:

The total cost to all governments of the measures proposed under this National Partnership Agreement is $1.58 billion. Of this, some $805.5 million is proposed as measures funded through the Commonwealth Own Purpose Expenses, and $771.5 million from states/Territories Own Purpose Expenses.[[181]](#footnote-181)

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 2012-2013 - $54.30, for a total budget of $162.22 million.[[182]](#footnote-182)

In terms of reporting, the NPACGIHO states that:

The Commonwealth, states and Territories will each provide a detailed report on an annual basis to each other and Aboriginal and Torres Strait Islander organisations against the benchmarks and timelines, as detailed in the Implementation Plan. Reports against the benchmarks and timelines will provide a summary of activity in relation to the agreed outputs to complement national reporting against the performance benchmarks and indicators outlined in clauses 21 and 22 [of this Agreement] to be complied from national data collections.[[183]](#footnote-183) [emphasis added]

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.

1. **Commonwealth contributions** 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).[[184]](#footnote-184)

1. **Queensland contributions** 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 Framework[[185]](#footnote-185)

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*.[[186]](#footnote-186)

The *Making Tracks …Investment Strategy 2015-2018* notes that:

The Queensland Government will provide more than $200 million over three years (2015-16 to 2017-18) to support a range of targeted effective health services aimed at improving and sustaining health outcomes for Indigenous Queenslanders. Efforts to improve chronic disease and maternal and child health outcomes will be strengthened and new strategies to improve service responses for people with mental illness will be developed and implemented.[[187]](#footnote-187)

However there are no actual details provided in this investment strategy as to how the money will be allocated.

The Queensland contribution from Own Purposes Expenses for 2012-13 of $54.3 million towards the NPACGIHO compares with the order of funding provided in the state budget for 2014-15 for service delivery for Queensland Health for some of its HHSs and the Queensland Mental Health Commission. The CWHHS, for example, has an operating budget of $57.5 million for 2014-15, while the Queensland Mental Health Commission has an operating budget of $8.5 million in 2014-15.[[188]](#footnote-188)

# THE MATRIX AS AN AGENT FOR CHANGE

Institutional racism is the proverbial “elephant in the room” – while everyone acknowledges its presence, nobody knows what to do about it. As Dudgeon *et al* assert, institutionalised racism persists in the institutions and systems that exclude and discriminate against Indigenous people:

In contemporary times, society’s institutions have the power to develop, sustain and enforce specific racialized views of people. The way that a society’s economic, justice, educational and health care systems are applied can disadvantage certain groups of people when these systems do not cater for or consider the cultural values or marginalisation of members of these groups, and thereby become forms of institutionalised racism. Institutionalised racism is embedded in these systems. In the Australian context, the high rates of unemployment, lower average income, high rates of arrest and imprisonment, of poor health, low education and low life expectancy are indicators of the consequence of entrenched institutionalised racism.[[189]](#footnote-189)

Its existence was “officially” acknowledged in 1991 in the report of the Royal Commission into Aboriginal Deaths in Custody[[190]](#footnote-190), and again two decades later in the *Overcoming Indigenous Disadvantage* (OID) 2009 report[[191]](#footnote-191), the 2010 document *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice[[192]](#footnote-192),* the Australian Human Rights Commission’s *National Anti-Racism Strategy[[193]](#footnote-193)*, and in both the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (NATSIHP)[[194]](#footnote-194) and the *Implementation Plan*.[[195]](#footnote-195) Reconciliation Australia canvasses the issue of racism extensively in its recent reports[[196]](#footnote-196), and the 2015 OID report deals briefly with racism – neither addresses institutional racism.[[197]](#footnote-197) While statistics are compiled around surveys of individual attitudes about racism and racial discrimination, nobody has worked out how to “measure” institutional racism. In other words, there is a “data deficit” concerning this form of racism.

There are three reasons why good data is vital:

* For informing public policy development, particularly to inform decision making where it might impact on other sectors;
* For understanding the health and vibrancy – the culture – of a particular sector, particularly in regard to sector trends and what might be driving them; and
* In response to the saying that “what gets measured gets done”, benchmarks need to be established to undertake assessments over time in relation to sector objectives.[[198]](#footnote-198)

One of the key challenges facing both New Zealand’s and Australia’s public health systems identified at the 2007 Melbourne Symposium on *Racism and Indigenous Health* (see section 3.1 following) is developing a methodology capable of addressing both systemic and institutional racism (the terms are often used interchangeably). The Matrix offers such a methodology for evidence-based external assessments with a set of indicators that can be incorporated into the data collection sets of national reporting authorities like Reconciliation Australia, the AIHW, the Productivity Commission and the National Commission of Audit, and that are capable of identifying the existence of institutional racism in the public and private health sectors, measuring the extent to which it exists, and for monitoring progress towards its elimination.

The Close the Gap Campaign Steering Committee (CGCSC), in its 2016 report, has recommended that a national inquiry into racism and institutional racism be undertaken by the Senate Select Committee on Health.[[199]](#footnote-199) The Steering Committee’s 2017 report reiterates this call for a federal inquiry.[[200]](#footnote-200)

This Part briefly examines some of the ways in which the Matrix can be applied by different government agencies and processes to address institutional racism.

## Linking the Matrix to public hospital and health service (HSS) performance

In a discussion paper arising from the *Racism and Indigenous Health* symposium held in November 2007 at the University of Melbourne (the Melbourne symposium) a number of key questions were identified 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.[[201]](#footnote-201) These key research questions concern:

* What is the best way to measure systemic [institutional] racism against Indigenous peoples?[[202]](#footnote-202)
* 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?[[203]](#footnote-203) [[204]](#footnote-204)

The Matrix can address each of these questions in the following ways:

* **What is the best way to measure systemic/institutional racism against Indigenous peoples?**

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.

* **What are the best approaches to addressing systemic/institutional racism against Indigenous peoples?**

As an approach to addressing systemic/institutional racism, the Matrix can be used either by a HHS to measure its own standing according to the Matrix indicators (that is, an internal assessment), or external audits can be undertaken either by, for example, Queensland Health of its HHSs, or an independent body (Indigenous health NGO, research institute) with the results of the Matrix audit publicly reported or published. The audit can be 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.

* **What racist elements of institutions/systems are most amenable to change and how should the fostering of anti-racist cultures and environments be measured?**

The Matrix is based on a set of thirteen criteria, all of which can be, in principle, readily addressed. Some changes can be achieved in relatively short time frames (ie, within 2 years, the recommended time between audits), for example, ensuring Indigenous representation on HHS boards – this can be achieved without changes to the HHB Act, establishing stand-alone Aboriginal and Torres Strait Islander consultative bodies, improving annual reporting of Closing the Gap outcomes. Others will take time, such as: building the cultural competency of a HHS’s non-indigenous workforce; and increasing the participation of Aboriginal and Torres Strait Islander people in that workforce to a level that reflects the proportion of the Indigenous population within the total population, particularly in HHS districts where this is high, as for example in the CHHHS, TCHHS, THHS and NWHHS in Queensland. Amending health services legislation based on a review, depending on the political climate and will, could also happen within a two-year time span.

* **How can we improve health performance as a way of combating systemic/institutional racism against Indigenous peoples in health care?**

The criteria in the Matrix reflect certain federal and state/territory policy directives – and for which in some instances KPIs have been assigned within the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures* and reported on by the AHMAC. The Matrix incorporates a number of Tier 3 Health System Performance Measures (HSPMS) from the HPF. Improvements on these HSPMs will also improve HHS performance in a way that will help combat 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.”[[205]](#footnote-205) 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 improved access to hospital procedures.

* **What are the costs of racism and the savings from anti-racist policy and practice?**

While not specific to Indigenous health, a recent study undertaken at the Alfred Deakin Institute for Citizenship and Globalisation at Deakin University, and cited in the *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health,* found thatracial discrimination has been estimated to cost the Australian economy $44.9 billion, or 3.6 per cent of Gross Domestic Product each year in the decade from 2001 to 2011.[[206]](#footnote-206) The economic cost to the public health system of DAMA is but one of the contributing cost factors. It is estimated that Aboriginal and Torres Strait Islander people self-discharge between 6-19 times the rate of non-Indigenous Australians, with Aboriginal and Torres Strait Islander males aged between 25 and 44, in particular, self-discharging at 20-30 times the rate of non-Indigenous patients.[[207]](#footnote-207) One economic analysis by Henry *et al* (2007) estimated that preventing the majority of DAMA events would produce a saving of $4.7 million over five years in Northern Territory public hospitals. One of the specific factors associated with self-discharge was: “Perceived racist, inappropriate and insensitive behaviour by hospital staff.”[[208]](#footnote-208) In reviewing the available literature, Shaw notes that institutional racism is one of the consistent factors associated with self-discharge in the Aboriginal and Torres Strait Islander population.[[209]](#footnote-209)

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* (HPF)*,* it would seem feasible, however, to ally the periodic 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 HPF. 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, as (i) 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; and (ii) the patient journey across the healthcare service spectrum will be improved because there is better integration and coordination in healthcare delivery between the public and community-controlled health sectors, etc.[[210]](#footnote-210)

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, a cost-benefit to 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.

## Public health sector agencies and processes

Either the Matrix itself, or elements of it, could be incorporated within the reporting and accreditation frameworks and processes of a number of national and state agencies.

### The Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures

Consistent with the strategy that “mainstream health services are supported to provide clinically competent, culturally safe, accessible, accountable and responsive services to Aboriginal and Torres Strait Islander peoples in a health system that is free of racism and inequality” articulated in the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2033* to support the Health Plan’s vision of an “Australian health system … free of racism and inequality”*[[211]](#footnote-211)*, as one of the system levers and accountability mechanisms to be established for addressing racism and discrimination, a performance measure addressing racism in all its forms could be incorporated in the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures.[[212]](#footnote-212)*  Since racism is identified as a key social determinant of Aboriginal and Torres Strait Islander health, it would seem appropriate that performance measures/indicators be incorporated into the HPF’s performance measures. It is suggested that this could be accomplished by:

1. incorporating indicators to measure personal experiences of racism among the Tier 2 Determinants of Health; and
2. Incorporating some indicator, or indicators to measure the presence of institutional racism among the current Tier 3 Health System Performance measures.

**Tier 2 Determinants of Health: socio-economic factors**

While outside of the scope of the Matrix (see section 1.8.1), an indicator which assesses the level of racist behaviours and racial discrimination within HHSs could be included among the socio-economic factors (which addresses such health determinants as: literacy and numeracy, education outcomes for young people, employment, income, etc.) within the Tier 2 Determinants of Health. Such measures should address racism as experienced by both Aboriginal and Torres Strait Islander health workforce employees (across all employment streams), and by Aboriginal and Torres Strait Islander recipients of healthcare services.

**Tier 3 Health System Performance**

The Matrix (post-validation) could be included under 3.13: Competent governance, in its own right, as a new indicator/measure. In terms of governance, this could particularly address issues of Closing the Gap visibility in the relevant health care legislation, Aboriginal and Torres Strait Islander representation on statutory health bodies and in the executive management structures, presence of Aboriginal and Torres Strait Islander consultative bodies, and frequency of substantive Aboriginal and Torres Strait Islander health matters being addressed on governing body agendas.

This would have the flow on effect of having these performance measure addressed in future reports by AHMAC[[213]](#footnote-213), the AIHW[[214]](#footnote-214) and the Productivity Commission in preparing reports for the COAG and the PM&C reports for the annual *Closing the Gap – Prime Minister’s Report*.[[215]](#footnote-215)

Currently these reports fail to adequately address the issue of racism, and particularly institutional and systemic racism as a factor in the provision of government services – also a consequence of the failure to recognise this form of racism in the *Racial Discrimination Act* 1975 (Cth) (RDA) (see section 3.4).

### NATSIHP Implementation Plan

The Australian Government’s *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2013* (the Implementation Plan) is now the primary mechanism for efforts to close the gap in health inequality.[[216]](#footnote-216) In the Implementation Plan, a set of goals are identified to support and complement the achievement of the COAG Closing the Gap targets to improve Indigenous health outcomes. In the context of the Implementation Plan, these goals have been expressed in the acronym SMART: that is, they are “Specific, Measurable, Achievable, Realistic and Time-Bound.”[[217]](#footnote-217) These principles are embodied in the Matrix in so far as the Matrix employs indicators and criteria that are specific, measureable, achievable, realistic and can be time-bound.

The first of the seven domains that cover the broad priorities for Aboriginal and Torres Strait Islander health is “Health Systems Effectiveness.” One of the critical first order priorities detailed under this domain is to map core services to “systematically and comprehensively map out the health needs, workforce requirements and capabilities, and service capacities across Australia.”[[218]](#footnote-218) Also included under Health Systems Effectiveness is a strategy to ensure that mainstream health services

… are supported to provide clinically competent, culturally safe, accessible, accountable and responsive services to Aboriginal and Torres strait Islander peoples in a health system that is free of racism and inequality.

The “Deliverables by 2018” include:

System levers and accountability mechanisms established for addressing racism and discrimination have been developed and their implementation promoted.[[219]](#footnote-219)

The Matrix, as a tool for addressing institutional racism, post-validation, offers a way of systematically mapping institutional racism in the public health system around the country and in a way in which HHS/Local Health District (LHD) audits within each state/territory jurisdiction can be tabulated and compared. Once again, the purpose of such an exercise is not to “name and shame”, but to provide a framework for discussion and action. Individual HHS/LHD audit results can provide a forum for a HHS’s/LHD’s governance representatives and representatives of the ATSICCHS(s) and the Aboriginal and Torres Strait Islander communities within its region to develop strategies and solutions to eliminate institutional racism from the service. Progress can be monitored over time, for example, every two years. This can be carried out as a cost-effective desk-top exercise using the methodology of the Matrix

One of the matters broadly addressed in the Matrix audit in relation to mapping workforce requirements is to provide an assessment of the current employment rates of Aboriginal and Torres Strait Islander people in each of QH’s 16 HHSs against local population equity targets and their deployment across QH’s six employment streams. The assessment also includes a crude estimate of the number of Aboriginal and Torres Strait Islander people that need to be recruited each year for the next 16 years to achieve employment equity and remove the employment gap by 2033.[[220]](#footnote-220)

### Commitment to 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.[[221]](#footnote-221)

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
* A well supported Aboriginal workforce
* Enabling state and federal policy environments.[[222]](#footnote-222)

The Matrix addresses and measures these characteristics to the extent that a HHS:

1. Fosters strong partnerships with the Aboriginal and Torres Strait Islander community, for example, through collaboration with ATSICCHSs to establish health services plans;
2. Includes Aboriginal and Torres Strait Islander representation within its governance structure (for example, as board members, within the executive management structures), and input in decision-making (through Aboriginal and Torres Strait Islander 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.[[223]](#footnote-223)

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 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 progress towards closing the gap in Indigenous health outcomes to the Aboriginal and Torres Strait Islander community in their annual reports, and by working in partnership with ATSICCHSs to establish health plans for the community. Other opportunities for positive change may take longer, such as amending the HHB Act 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 workforce to a level which represents their proportion of the local population.

### National Health Performance Authority: Review of the Performance and Accountability indicators

The review is based on the following principles:

* Where appropriate, indicators should address access to services, quality of service delivery, financial responsibility, patient outcomes and/or patient experience
* The number of indicators will be few in number and be considered against the three RoGS domains of equity, effectiveness and efficiency
* The indicator set should provide feedback on where the system is performing well and areas for improvement
* The preference is for outcomes indicators but process indicators will be considered where good evidence is available.

Performance indicator selection criteria:

1. Policy:

* Relevance and appropriateness for policy makers
* Avoidance of perverse incentives
* Relevance to the National Health Reform Agreement

1. Scientific soundness:

* Valid
* Reliable
* Attributable
* Comparable
* Ability to measure progress over time

1. Efficiency:

* Administratively simple and cost effective.[[224]](#footnote-224)

In terms of the principles of the review, the Matrix provides, or can be recalibrated to provide indicators and criteria for access to services in terms of their effectiveness, and system feedback and monitoring, while identifying where improvements can be made. In that sense, it is outcome oriented using information and data provided by the HHS. It can be used in its current format to provide data on HHSs with regard to:

* cultural competence as measured by the number/proportion of non-Indigenous staff who have completed CCT,
* levels of Aboriginal and Torres strait Islander participation in the health workforce
* financial responsibility, with regard to transparency and accountability in reporting Closing the Health Gap funding and expenditure in HHS annual reports.

The Matrix indicators are designed to deliver on the three RoGS domains of equity, effectiveness and efficiency.

With regard to performance indicators, the Matrix is both relevant and appropriate to policy makers, particularly because it measures policy implementation and accountability. It is relevant to the NHRA insofar it accommodates the NPACGIHO and NIRA which exist in parallel with the NHRA.

With regard to scientific soundness, subject to successful validation and the use of more sophisticated data measuring tools, the Matrix can deliver on each of the criteria for soundness. With regard to efficiency, once the Matrix template is calibrated for a state or territory public health service, all the research can be undertaken as a desk-top exercise, however it does rely on access to publicly available information.

### National Safety and Quality Health Service (NSQHS) Standards: Safety and Quality Improvement Guide

In addressing the new actions in Version 2 of the National Safety and Quality Health Service (NSQHS) Standards that relate to meeting the needs of Aboriginal and Torres Strait Islander people, six actions have been identified. These six actions are incorporated under three of the eight standards. These are: Clinical Governance for Health Service Organisations Standard; Partnering with Consumers Standard; and Comprehensive Care Standard.

**Clinical Governance for Health Service Organisations Standard**

The actions are:

1.2 The governing body ensures that the organisation’s *safety and quality priorities* address the specific health needs of Aboriginal and Torres Strait Islander people.

1.4 The health service organisation *implements and monitors targeted strategies* to meet the organisation’s safety and quality priorities for Aboriginal and Torres Strait Islander people.

1.21 The health service organisation has strategies to improve the *cultural competency and cultural awareness* of the workforce to meet the needs of the Aboriginal and Torres Strait Islander patients

1.33 The health service organisation demonstrates a *welcoming environment* that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people.

**Partnering with Consumers Standard**

2.13 The health service organisation works in *partnership with Aboriginal and Torres Strait Islander communities* to meet their health care needs.

**Comprehensive Care Standard**

5.8 The health service organisation has processes to routinely asks patients if they *identify as Aboriginal or Torres Strait Islander,* and to *record* this information in administrative and clinical information systems.

The Matrix can address and monitor these actions in the following ways. With regard to:

**Action 1.2**: The Matrix measures the governance structure in relation to the legislation, inclusion of Indigenous representation on the governing board, whether the organisation has Aboriginal and Torres Strait Islander Health positioned at divisional level, and whether there is Aboriginal and Torres Strait Islander representation in the Executive management team/group. If these criteria are met, then the organisation will be in the position to have strong Indigenous oversight of its safety and quality priorities.

**Action 1**.**4**: A process for implementing and monitoring targeted strategies can be one of the responsibilities undertaken by the Aboriginal and Torres Strait Islander Health division within a health service organisation as incorporated within the organisation’s Aboriginal and Torres Strait Islander Health Plan. The health plan will also incorporate targets for (i) the achievement of a culturally capable and competent organisation, and (ii) Aboriginal and Torres Strait Islander participation in the health workforce, particularly in clinical and front-line service roles. The Matrix contains criteria that measure and monitor these strategies.

**Action 1.21**: The Matrix includes a criterion with a set of sub-criteria that measures a health service organisation’s level of cultural competency.

**Action 1.33**: The Matrix does not include a criterion (or sub-criteria) to specifically address this issue, primarily because evidence of a *welcoming environment* is difficult to gauge from publicly available information released by a HHS.

**Action 2.13**: Partnership with Aboriginal and Torres Strait Islander communities is addressed in the Matrix within the criterion for community engagement with sub-criteria for an appropriate Aboriginal and Torres Strait Islander consultative mechanism, a RAP and a means of readily being able to circulate information, in this case via a health service organisation community newsletter. The ability to forge a strong partnership between a health service organisation and Aboriginal and Torres Strait Islander community controlled health service providers is embodied in the establishment of a health plan that lays out the goals, strategies, actions and KPIs necessary to meet the health care needs of the Aboriginal and Torres Strait Islander community that the organisation serves.

**Action 5.8**: This is one of the selected health service performance indicators included in the Matrix.

### Australian Institute of Health and Welfare (AIHW)

Whereas AHMAC provides reports against each indicator in the *Aboriginal and Torres Strait Islander Health Performance Framework*, the AIHW aims to provide, in its most recent 2015 report a “comprehensive picture of the health and welfare of Australia’s Indigenous population”.[[225]](#footnote-225) Part 4 of the 2015 report addresses the determinants of health, and it is noted with regard to socioeconomic and environmental factors that:

In 2012-13, 7% of Indigenous adults (an estimated 26,500 people) reported avoiding seeking health care because they had been treated unfairly by doctors, nurses or other staff at hospitals or doctor surgeries.[[226]](#footnote-226)

While the Matrix is not designed to address or measure the incidence of individual acts of racism and racial discrimination occurring within a HHS, it is argued that very high or extreme levels of institutional racism will create a HHS culture or environment in which individual racist acts and racial discrimination can proliferate (see section 1.8.1). Inclusion of indicators that can measure the incidence of individual racism in the HPF, elements of the Matrix with regard to competent governance (addressing the inclusion of Indigenous people in the governance structures of HHSs) and better reporting requirements for cultural competence and employment of Aboriginal and Torres Strait Islander people in health workforces, as measures that will decrease the level of institutional racism, should have the flow on effect of reducing the incidence of racist acts and discrimination by the non-Indigenous workforce thereby improving access to health care and hospital procedures.

### AHMAC: Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health

The *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health* (CRF 2016-2026) contains a section regarding monitoring and reporting on cultural respect actions and refers to a number of Tier 3 Health System Performance indicators in the *Aboriginal and Torres Strait Islander Health Performance Framework* (HPF) that can be used for this purpose. These are:

* 3.08 Cultural competency
* 3.09 Discharge against medical advice (DAMA)
* 3.12 Aboriginal and Torres Strait Islander people in the health workforce
* 3.13 Competent governance
* 3.14 Access to services compared to need
* 3.19 Accreditation
* 3.20 Aboriginal and Torres Strait Islander people training for health related disciplines
* 3.22 Recruitment and retention of staff.[[227]](#footnote-227)

With the exception of 3.14, 3.19 and 3.22, these indicators are among the criteria and sub-criteria employed in the Matrix (see QHMT, Note 23). At a macro level, the Matrix can be interpreted as providing a measurement of cultural competence – overall HHS cultural competence will improve as the level of institutional racism is diminished - the “culture” of the HHS will improve to the extent that Aboriginal and Torres Strait Islander staff and clients alike will be subjected to fewer experiences of racist and racially discriminatory behaviour, whether direct or casual. Indigenous staff, in particular, will generally feel more empowered, included and competent.

However there are significant differences in interpretation, particularly in regard to 3.13 Competent governance. In Domain 1: Whole of Organisation Approach and Commitment, the focus area “Governance and leadership” is concerned with organisational leadership in implementing the CRF 2016-2026.[[228]](#footnote-228) However, in Domain 3: Workforce Development and Training, in the focus area “Aboriginal and Torres Strait Islander leadership”, in response to “What does it look like?”, one of the responses is:

Aboriginal and Torres Strait Islander leadership and participation in decision-making and governance at all levels of the Australian health care system, both within Aboriginal and Torres Strait Islander-specific and mainstream roles and positions.

The Matrix key indicator regarding participation in governance, in addition to assessing the legislative environment, focuses on Aboriginal and Torres Strait Islander participation on HHS boards and in the executive management structures (including Aboriginal and Torres Strait Islander participation at executive management level), and therefore provides a useful measure for this indicator within the context of the CRF 2016-2026.

### Primary Health Networks (PHN)

Getting the delivery of comprehensive Primary Health Care right is a first order priority for the wellbeing of Aboriginal and Torres Strait Islander people.[[229]](#footnote-229) Established in July 2015 to replace Medicare Locals, the Primary Health Networks (PHNs) are designed with a key objective to reduce hospital admissions and to ‘drive down the overall costs to the Budget bottom-line of medical care’[[230]](#footnote-230) by increasing

… the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care. PHNs will achieve these objectives by working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to facilitate improved outcomes for patients.[[231]](#footnote-231)

In March 2016, the Department of Health released a set of guiding principles for PHNs and Aboriginal community controlled health organisations (ACCHOs). The principles address: Closing the Gap; cultural competency; commissioning; engagement & representation; accountability; data & reporting; service delivery; and research.[[232]](#footnote-232)

In Queensland there are seven PHNs.[[233]](#footnote-233) Most of the PHNs embrace a number of HHSs and have working relationships based on mutually developed agreements, MoUs, etc. The Matrix could be of value as both an internal and external assessment tool. Internally the Matrix could be used to guide a PHN’s engagement with (in this case) ATSICCHSs, for example, making sure that ATSICCHSs are represented in the governance structures of the local PHN, ensuring that appropriate Aboriginal and Torres Strait Islander consultative mechanisms are established, and Aboriginal and Torres Strait Islander people are employed in a range of roles within the PHNs. In regard to Aboriginal and Torres Strait Islander employment in PHNs, the CGCSC points out that:

The Primary Health Networks should be a significant direct and indirect employer of Aboriginal and Torres Strait Islander health workers and professionals. The Government also needs to make sure there is a concerted effort to train and prepare the required Aboriginal and Torres Strait Islander workforce to meet what should be, at a minimum, a population parity level of demand for Aboriginal and Torres Strait Islander health workers.[[234]](#footnote-234)

As an external assessment tool, the Matrix could be used to conduct periodic assessments of the HHSs within their region as a (confidential) exercise to catalyse discussions about matters raised by the assessments, and to assess progress towards the elimination of institutional racism.

## Other government reporting agencies

Again, the Matrix, or elements of it, may prove useful to agencies such as Reconciliation Australia, the Productivity Commission and National Commission of Audit for incorporating information and data about institutional racism in their reports.

### Reconciliation Australia

In 2016 Reconciliation Australia published its report *The State of Reconciliation in Australia[[235]](#footnote-235),* with the release later in the year of its *2016 Australian Reconciliation Barometer.[[236]](#footnote-236)* The reports address, *inter alia*, race relations, overcoming racism, equality and equity, and institutional integrity, supported by comprehensive data resulting from surveys of both Aboriginal and Torres Strait Islander community and mainstream experiences, attitudes and perceptions. While surveys in *The State of Reconciliation in Australia* report indicate that, for example, government departments should do more to reduce problems of prejudice (p. 78) and that Australians mostly accept key facts about past injustices resulting, in part, from institutional prejudices (pp. 102-3), the report does not address institutional racism *per se*.

In commenting on the findings in Reconciliation Australia’s *2016 Australian Reconciliation Barometer*, Chief Executive Justin Mohamed stated:

What we are seeing since the first survey in 2008 just after the National Apology to Stolen Generations is that whilst we’ve maintained a lot of goodwill since then, we aren’t moving fast enough on issues of racism and trust. …. This is holding all Australians back from having positive relationships with each other. Part of the problem that our State of Reconciliation in Australia (report) uncovered last year is that we aren’t addressing racism at an institutional level. … The reality is that unless goodwill is followed through with significant reform at an institutional level, Australia will continue to fall short of its full potential as a reconciled nation.[[237]](#footnote-237)

The Matrix, suitably adapted, does offer a way forward for Reconciliation Australia to expose the nature and extent of institutional racism across Australia’s jurisdictions and in their departments responsible for such key areas as child welfare, justice administration, education, employment, and public housing.

### Addressing Overcoming Indigenous Disadvantage 2016 Report gaps

As the Chair of the Steering Committee for the Review of Government Service Provision (SCRGSP) responsible for preparing and publishing the OID reports states: “There is a pressing need for more and better evaluation of Indigenous policies and programs nationally if we are to see improvements in outcomes for Aboriginal and Torres Strait Islander Australians.”[[238]](#footnote-238) In the context of Indigenous health policies and programs, the Matrix is less about an evaluation of such policies, and more about the failures of those agencies, in this case HHSs, charged with implementing them.

With regard to Aboriginal and Torres Strait Islander health, the 3,558 page OID report devotes 417 pages (including copious tables) reporting on eight indicators relevant to the ‘Healthy lives’ strategic area.[[239]](#footnote-239) While acknowledging the impacts of racism on mental health as “a key source of stress and socioeconomic disadvantage faced by Aboriginal people and families, with negative effects on social and emotional wellbeing”[[240]](#footnote-240), the matter of racism is referred to section 5.1 on valuing Indigenous Australians and their cultures under Part 5 Governance, leadership and culture of the OID report.

#### Institutional racism

In spite of the fact that racism is recognised as a key social determinant of health[[241]](#footnote-241), and despite the vision guiding the Australian Government’s *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* of one in which the Australian health system is “free of racism and inequality”[[242]](#footnote-242), the *Overcoming Indigenous Disadvantage* (OID) 2016 Report has little to say about the issue of racism, and nothing at all regarding institutional racism. The little that the report does contain occurs in Part 5 (Governance, leadership and culture) and concerns Aboriginal and Torres Strait Islander Australians aged 15 years and over who felt treated unfairly in the 12 month period 2014-2015: (i) due to their Indigenous status; (ii) most common experiences of unfair treatment; (iii) comparisons by remoteness; (iv) at school (for the 2-14 years age group; and (v, for those aged 18 and over, according to data from the 2013-2014 Aboriginal and Torres Strait Islander Health Survey.[[243]](#footnote-243)

#### Indigenous participation in public sector governance

In the OID report, government governance refers to “governments’ engagement with Aboriginal and Torres Strait Islander Australians”, with the report focussing on “formal arrangements for ‘high level’ engagement between governments and Aboriginal and Torres Strait Islander communities and organisations, in the light of the determinants of good governance.”[[244]](#footnote-244) While the OID report examines Aboriginal and Torres Strait Islander participation in decision-making, it does so from the perspective of governance, self-determination and participation in decision-making. It points out that a critical element of governance is self-determination, and that participation in decision-making is a key exercise of self-determination and empowerment. It highlights external participation as measured by participation in electoral politics, parliamentary processes and in the broader governance environment. The OID reports notes that while “there is general agreement on the importance of Aboriginal and Torres Strait Islander participation in decision-making, there is a lack of data with which to measure this participation.[[245]](#footnote-245)

In terms of future directions in data, the OID report notes that “Australia has over 560 local councils responsible for managing their region and district, yet there is little publicly available information on the number of Aboriginal and Torres Strait Islander councillors.” While the SCRGSP “would like to include information on levels of Aboriginal and Torres Strait Islander representation in local government in future reports”[[246]](#footnote-246), a glaringly obvious area to examine is Aboriginal and Torres Strait Islander participation in public sector governance, particularly in the many commonwealth and state/territory statutory bodies established under their own enabling legislation. As this report reveals, such an examination would need to review the various relevant enabling Acts to gauge the extent to which Aboriginal and Torres Strait Islander interests (as per the objects of the law) and participation in the governance structure (boards, advisory committees, etc) are statutory requirements – that is, the “legal visibility” factor. Following the methodology of this report, it is then a relatively simple matter to examine agency annual reports to gauge direct engagement in the governance structure which includes, particularly, membership of boards, executive management groups and relevant committees. Another indicator could include public service level of Aboriginal and Torres Strait Islander employment. Poor participation in the governance structure is almost inevitably a consequence of the failure to legislate for such participation in the relevant laws.

### National Commission of Audit

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.”[[247]](#footnote-247)
* 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.”[[248]](#footnote-248)
* 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.[[249]](#footnote-249)

The Matrix addresses these issues with criteria regarding, for example, engagement in decision making (under participation in governance), the need for HHSs 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.

## Institutional racism recognised in the *Racial Discrimination Act 1975* (Cth) (RDA)

Ultimately, Australia will not be able to address the complex impacts of institutional racism on the lives of Aboriginal and Torres Strait Islander people, as well as other people belonging to different racial and ethnic groups, until it is recognised as a form of racism in the *Racial Discrimination Act 1975* (Cth) (RDA). Such recognition will provide the necessary powers for the nation’s human rights/anti-discrimination agencies to formally address complaints concerning institutional racism, and compel government departments, agencies and statutory bodies, and private sector entities to adopt policies, strategies and actions to eliminate this form of racism. It will also provide guidance to Human Resources/People and Culture departments across all service sectors in writing their anti-discrimination policies and manuals.

The RDA ratifies the *International Convention on the elimination of all forms of racial discrimination.* Neither instrument identifies institutional or systemic racism as a form of racism. RDA **Section 9: Racial discrimination to be unlawful**, which essentially contains the definition of what constitutes racial discrimination for commonwealth purposes as per Article 1.1 of the Convention,states that:

1. It is unlawful for a person to do any act involving a distinction, exclusion, restriction or preference based on race, colour, descent or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of any human right or fundamental freedom in the political, economic, social, cultural or any other field of public life.

The provision of goods and services is dealt with under **Section 13** of the RDA:

It is unlawful for a person who supplies goods or services to the public or to any section of the public:

1. to refuse or fail on demand to supply those goods or services to another person; or
2. to refuse or fail on demand to supply those goods or services to another person except on less favourable terms or conditions that those upon or subject to which he or she would otherwise supply those goods or services;

by reason of the race, colour or national or ethnic origin of that other person or of any relative or associate of that other person.

With an appropriate definition of what constitutes institutional racism inserted in **Section 3 Interpretation** of the RDA, in principle, it should be a simple matter to add the words “or institution” after “It is unlawful for a person ….” in **s.9(1)**, and amend the remainder of the RDA accordingly.

Until the RDA recognises institutional racism as a form of racism, it will never be adequately addressed by Australia’s human rights agencies and commonwealth, state and territory public and private sector institutions and agencies, including public and private health bodies. The words of Camara Phyllis Jones, contained in the epigraph of this report, as a spur for action, are compelling and worth repeating:

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.[[250]](#footnote-250)

Despite a prodigious literature on the existence and nature of institutional racism, whether the nation’s politicians have the will to legislate to prevent this form of racism remains to be seen. Our collective failure to recognise and address institutional racism ultimately stems from its omission as a form of racism from the RDA.

The call by the Close the Gap Campaign Steering Committee for a national inquiry into racism and institutional racism in health care settings should be heeded, and may serve as a prelude to addressing institutional racism in other domains of service delivery and public life, not only for Aboriginal and Torres Strait Islander people, but for other Australians of different racial and ethnic origin.[[251]](#footnote-251)

# INDIVIDUAL HHS AUDITS

## Cairns and Hinterland Hospital and Health Service

**CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE (CHHHS) MATRIX ASSESSMENT 2014-2015** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

1. **Participation in governance**

* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Cairns and Hinterland Hospital and Health Board (CHHHB) (3)
* Aboriginal representative 5 0
* Torres Strait Islander representative 5 0
* Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 2.5
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 3.0**

1. **Policy implementation**

* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in HHS Strategic Plan (5) 5 0
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 0
* Public Reporting and Accountability (via Annual Report) (10)
* Traditional Owner acknowledgement (11) 1 1
* Closing the Gap

(i) Separate section in report devoted to Closing the Gap (12) 1 0

(ii) Reporting on KPIs contained in 2013/14 - 2015/16 service agreement (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 1
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 0
2. Reference to workforce planning, recruitment, etc.(19) 1 1

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 5**

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1. **Service delivery**

* Aboriginal and Torres Strait Islander health service plan (21) 10 0
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 2
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 3
* Proportion of non-indigenous staff trained (25) 4 0
* Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

Reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 5**

1. **Recruitment and employment**

* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce development policy/strategy (31) 3 2
* Aboriginal and Torres Strait Islander workforce implementation body (32) 3 2
* Employment equity (33) 4 0
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1  0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Practitioners/Workers and Liaison Officers 2 0
* Trade and Artisans 1 0
* Operational/Support Services 1 0
* Health Practitioners (Professional and Technical) 1 0

**Total 20 4**

1. **Financial Accountability and Reporting: Closing the Gap funding** (35)

* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0

**Total 20 0**

**Score 140 17**

**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. **Cairns and Hinterland Hospital and Health Service** The Cairns and Hinterland Hospital and Health Service (CHHHS) has responsibility for providing public hospital and health services within its primary region to over 280,000 people residing within a geographical area covering 141,00 square kilometres from Cairns to Tully in the south, Cow Bay in the north and Croydon in the west. The region covers the municipalities of Cairns Regional Council, Cassowary Coast Regional Council, Tablelands Regional Council, and the Croydon, Mareeba, Douglas, Etheridge, Hinchinbrook and Yarrabah Aboriginal Shire Councils. The Cairns Hospital (CH) is the specialist referral hospital for Far North Queensland, delivering health services across the continuum of care to the people of Cape York Peninsula and the Torres Strait - the primary region of the Torres and Cape Hospital and Health Service (CHHHS *Annual Report 2014-2015,* pp. 7 and 11). The total Aboriginal and Torres Strait Islander population across the two health service districts is about 39,000[[252]](#footnote-252) - more than the total Aboriginal and Torres Strait Islander population of Victoria, and over 7 percent of the total Aboriginal and Torres Strait Islander population of Australia.[[253]](#footnote-253) Aboriginal and Torres Strait Islander people: (i) constitute about 15 per cent of the total Far North Queensland region;[[254]](#footnote-254) (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.[[255]](#footnote-255) The services provided by the CHHHS 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. The Aboriginal and Torres Strait Islander population of the CHHHS region is also served by a number of community-controlled health services: Wuchopperen Health Service (clinics in Cairns, Edmonton and Atherton); Gurriny Yealamucka Health Service Aboriginal Corporation (Yarrabah); Mulungu Aboriginal Corporation Primary Health Care Service (Mareeba); Mamu Health Service Ltd (Innisfail and Ravenshoe). Apunipima Cape York Health Council services the Cape York region, but has its administrative HQ in Cairns, and the Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA) was established by QAIHC members in FNQ as a strategic response to health reform challenges for communities and organisations across the FNQ Region. An historic agreement between CHHHS and the Gurriny Yealamucka Health Service Aboriginal Corporation saw primary health care service in Yarrabah transitioned to community control on 1 July 2014 – a first for Queensland. However, CHHHS continues to offer Emergency, Dialysis, Dental and Specialist Outreach services within Yarrabah’s medical complex (CHHHS *Annual Report 2014-2015,* pp. 9 and 62). The City of Cairns also has a considerable itinerant population of homeless Aboriginal and Torres Strait Islander people, many of whom originate from the various Cape communities, and require medical attention.[[256]](#footnote-256)

The CHHHS maintains an Aboriginal and Torres Strait Islander Health unit – the Aboriginal and Torres Strait Islander Health Strategy, System Support, Performance and Accountability Unit (ATSIHSSSPAU). The unit aims to:

\* Improve the overall health status of Aboriginal and Torres Strait Islander people in the health service catchment area

\* Improve the cultural capability within the Cairns and Hinterland Hospital and Health Service through the development and implementation of sustainable initiatives and strategies addressing Aboriginal and Torres Strait Islander health priorities

\* Lead and support initiatives which promote Aboriginal and Torres Strait Islander workforce participation and recruitment and retention within the Cairns Hinterland Hospital and Health Service.

In addition to the unit Director, the ATSIHSSSPAU management team comprises the following portfolios: A&TSI Health Coordinator; A&TSI Child and Maternal Health Coordinator; Senior Project Officer Cultural Capability; Principal Project Officer Cultural Capability Audit & Compliance; A&TSI Manager Health Worker Services.[[257]](#footnote-257)

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 point out of 20 for all Queensland Health’s 16 HHSs.

3. **CHHHB** The Cairns and Hinterland Hospital and Health Board (CHHHB) comprises 7 members. None of the board members, as profiled in the CHHHS *Annual Report 2014-2015* (pp. 43-45), identifies as an Aboriginal or Torres Strait Islander person, nor lists among their current professional positions any specific connection to an Aboriginal and Torres Strait Islander health organisation, or experience with Aboriginal and Torres Strait Islander health care delivery. However, an Aboriginal person has now been appointed to the CHHHB by the Health Minister in the most recent round of appointments announced in May 2016.[[258]](#footnote-258) Unfortunately, for scoring purposes, this has occurred outside the 2014-2015 audit period. **Score = 0/10.**

4. **Executive Management Structure** The 9 member Executive Management Team (EMT) comprises the HSCE; Chief Finance Officer; Chief Operating Officer; Executive Director People and Culture; Executive Director Strategy, Planning Performance, Aboriginal and Torres Strait Islander Health; Executive Director Medical Services; Executive Director of Nursing, Midwifery and eHealth; Executive Director Allied Health; and the Chair of the Clinical Council (CHHHS *Annual Report 2014-2015,* pp. 48-53). Until 30 June 2013, the CHHHS maintained Aboriginal and Torres Islander Health (ATSIH) as a separate Division with an Indigenous Executive Director.[[259]](#footnote-259) 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, Performance and Planning and Aboriginal and Torres Strait Islander Health (SPPATSIH) under a non-indigenous Executive Director.[[260]](#footnote-260) Thus the Aboriginal and Torres Strait health workforce and clients no longer have Indigenous representation within the CHHHS EMT. According to the diagram depicting “Our Current Services and Organisational Structure” in the CHHHS *Operational Plan 2015-16* (July 2015)(p. 7), Aboriginal and Torres Strait Islander Health has lost its directorate status,and has been reconfigured as the ATSIHSSSPAU (see Note 1) Scoring: Aboriginal and Torres Strait Islander Health directorate status – as it is not a “stand-alone” division, **score = 2.5/5.** Aboriginal/Torres Strait Islander Executive Director – no, **score = 0/5.**

1. **Closing the Gap health outcomes and the CHHHS Strategic Plan** The CHHHS *Strategic Plan 2013-2017* (2015 Review) articulates 8 objectives built around: Quality and Safety; Integration; Engagement; Workforce; Sustainability; Decision Making; Information Technology; and Recognition.[[261]](#footnote-261) For progress made during 2014-15 see the CHHHS *Annual Report 2014-2015* (pp. 40-41). Neither makes reference to Closing the Gap as a strategic priority. **Score = 0/5.**
2. **Closing the Gap KPIs included in health service agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, 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 (PPH) (p. 41); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 42). **Score = 2/5.**
3. **Aboriginal and Torres Strait Islander consultative body** The CHHHS *Annual Report 2014-2015* (p. 47) states that:

In 2014-15, the Board identified an opportunity to enhance the cultural capability of the Health Service and approved the formation of an additional Community Consultation Committee focused on Aboriginal and Torres Strait Islander Health.

The Aboriginal and Torres Strait Islander Health Committee will also report to the Board through the Community Advisory Group. Recruitment for this committee will align with the membership renewal process of the geographical hubs and is expected to start in October 2015.

The Aboriginal and Torres Strait Islander Health Community Consultation Committee will be added to the three existing Community Consultation Committees representing the Trinity, Cassowary and Hinterland hubs. The CHHHS did not advertise for expressions of interest for membership of this committee until early 2016, so technically, in terms of the 2014 – 2015 audit period, the establishment of this committee, welcome as it is, is outside the stipulated audit period. **Score = 0/5.**

1. **RAP** The Queensland Government released its Reconciliation Action Plan in 2009 committing all government agencies to developing their own RAP. 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.[[262]](#footnote-262) Queensland Health co-signed with Reconciliation Australia[[263]](#footnote-263) 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. No reference is made in the publicly available information either from Reconciliation Australia or the CQHHS concerning the existence of a RAP. **Score = 0/3.**
2. **ATSI Health Division/Unit Community newsletter** While the CHHHS website maintains a news portal, this is more for media releases, news events and reports. According to the website neither the CHHHS nor the ATSIHSSSPAU publishes a regular newsletter.[[264]](#footnote-264) **Score = 0/2.**
3. **Annual Report** The sub-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.*
4. **Traditional Owner acknowledgement** The CHHHS *Annual Report 2014-2015* (p. 2) contains the following Traditional Owner acknowledgement:

The Cairns and Hinterland Hospital and Health Service respectfully acknowledges the traditional owners and custodians both past and present of the land and sea which we service; and declare the Cairns and Hinterland Hospital and Health Service’s commitment to reducing inequalities between Indigenous and non-Indigenous health outcomes in line with the Australian Government’s Close the Gap initiative.

**Score = 1/1.**

1. **Closing the Gap section** The CHHHS *Annual Report 2014-2015* does not contain a section devoted to reporting on progress, initiatives, etc., with regard to Closing the Gap. **Score = 0/1.**
2. **Reporting on KPIs** The CHHHS *Annual Report 2014-2015* (pp. 20-21)does not disclose information regarding any of the Closing the Gap KPIs contained in the CHHHS *Health Service Agreement 2013/14 – 2015/16* (pp 41 – 42). **Score = 0/1.**
3. **Policy references** 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.
4. **Cultural capability framework** The CHHHS *Annual Report 2014-2015* contains no explicit reference 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. **Score = 0/1.5.**
5. **Making Tracks** The CHHHS *Annual Report 2014-2015* does not contain any information with regard to Making Tracks progress or initiatives. **Score = 0/1.5.**
6. **Organisational structure** The CHHHS *Annual Report 2014-2015* (pp. 52-53) provides a 2 page layout of its organisational structure locating Aboriginal and Torres Strait Islander Health with the portfolio of the Executive Director of Strategy, Performance and Planning. It also locates three Indigenous Clinical Leads together with Medical Nursing and Allied Health within the CHHHS’s Hinterland, Cassowary and Trinity hubs. However, in the CHHHS *Operational Plan 2015-2016* (July 2015 update), Aboriginal and Torres Strait Islander Health and the three Indigenous Clinical Leads have been dropped from the organisational chart: “Our Current Services and Organisational Structure” (p. 7). However, the assessment for this sub-criterion relates only to the annual report.**Score = 1/1.**
7. **Employment** In the section on Our People, providing information regarding the CHHHS workforce (CHHHS *Annual Report 2014-2015*, pp. 54-60), no information is given regarding the level of Aboriginal and Torres Strait Islander participation**. Score = 0/1.**
8. **Workforce planning** In the CHHHS *Annual Report 2012-2013,* (p. 22), reference was made to “Establishing a strategy to increase our Aboriginal and Torres Strait Islander workforce will be a key emphasis in 2013-2014.” The CHHHS *Annual Report 2014-2015* (pp. 59-60) indicates that:

In 2015 there is greater emphasis on Indigenous employee development with the implementation of the school-based indigenous trainee program. This program has nine school-based trainees and four full-time trainees placed throughout the Health Service, with similar numbers expected for the program in 2016.

**Score = 1/1.**

1. **Awards, recognition, etc.** The CHHHS *Annual Report 2014-2015* makes reference to the celebration of Recognition Week from 7 September 2015 (p. 56) and announced the joint winners of the Patsy Bjerregaard Award for Clinical Excellence in Allied Health (p. 60). Unlike in the CHHHS *Annual Report 2012-2013* (p. 46), no mention is made of any awards, recognition, etc., made to Aboriginal and Torres Strait Islander employees. **Score = 0/1.**
2. **Aboriginal and Torres Strait Islander Health Plan** The CHHHS has a hospital and health service plan for the period 2012-2026[[265]](#footnote-265) 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.[[266]](#footnote-266) 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 31), 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. According to the publicly available information, none exists**.** **Score = 0/10.**
3. **Cultural competence** Cultural competency is key to effective health system performance in delivering healthcare to Aboriginal and Torres Strait Islander clients. 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.[[267]](#footnote-267)

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 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.[[268]](#footnote-268)

1. **CCT policy/strategy** The CHHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). The ATSIHSSSPAU has both a Cultural Capability Workforce Advisor and a Principal Project Officer Cultural Capability Audit & Compliance (see Note 1), which suggests that they have a policy or strategy in place, although the document has not been located on the CHHHS website. **Score = 2/3**
2. **Capacity to deliver CCT.** Training in the Cultural Practice Program was listed among other programs (such as induction, orientation, key health and safety programs, driver safety, code of conduct, ethics, and fire safety training) in the CHHHS *Annual Report 2014-2015* (p. 56) as a mandatory requirement. Ideally all CHHHS staff should undertake cultural competency training at least once every two years. Since there are currently 5,280 full-time, part-time and casual employees in the CHHHS (CHHHS *Annual Report 2014-2015*, p. 54), this roughly translates into CCT for over 2,600 staff per year. Designated staff within the ATSIHSSSPAU are responsible for organizing and delivering CCT within the CHHHS (see Note 23). **Score = 3/3.**
3. **Proportion of non-Indigenous staff to receive CCT** No data concerning this KPI is provided in the CHHHS *Annual Report 2014-2015*. **Score = 0/4.**
4. **Indigenous status** Indigenous status – specifically the reporting of ‘not stated’ on admission. Not reported in the CHHHS *Annual Report 2014-2015.[[269]](#footnote-269)*  **Score = 0/2.**
5. **DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provided the following data for 2013-2014 for the CHHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

2.63% 2.60% 2.70% 2.20% 2.78% 1.80% 3.08% 1.40%

All of the quarterly rates have been exceeded and have shown a worsening trend. However, data on DAMA rates were not published for the current assessment period (2014-15) in either the CHHHS *Annual Report 2014 – 2015* (see “Our Operational Performance”, pp. 20-21) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*.[[270]](#footnote-270) **Score = 0/2.**

1. **PPH** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provided the following data for 2013-2014 for the CHHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

19.80% 17.70% 16.70% 17.70% 19.10% 17.70% 16.80% 17.70%

The CHHHS bettered the quarterly targets in two quarters. However, data on PPH rates were not published for the current assessment period (2014-15) in either the CHHHS *Annual Report 2014 – 2015* (see “Our Operational Performance”, pp. 20-21) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*.  **Score = 0/2.**

1. **Access to mental health services** Access to mental health services measured in terms of the 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 that separation. The CHHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 26) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the CHHHS *Annual Report 2014-2015* (refer pp. 20-21)*.* **Score = 0/2.**
2. **Access to drug and alcohol services** The CHHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 26) to provide both Indigenous Outreach Services and Indigenous Youth (12-17 years) Treatment Programs under the Alcohol and Other Drug Services program. Not reported in the CHHHS *Annual Report 2014-2015.* **Score = 0/2.**
3. **ATSI workforce development policy/strategy** The CHHHS *Strategic Workforce Plan 2014 – 2019* (mentioned in the CHHHS *Annual Report 2014 – 2015*, p. 56) is structured around six key strategies, two of which concern: development of workforce planning capability and practice; and diversity. The annual report notes the “greater emphasis on Indigenous employee development with the implementation of the school-based indigenous trainee program.”(p. 59). A key focus area across the ATSIHSSSPAU is workforce enhancement with a designated manager for A&TSI Health Worker Services, however, a formal policy/strategy has not been sighted on the CHHHS website (see also Note 19). **Score = 2/3.**
4. **ATSI workforce development implementation body** See Note 31. **Score = 2/3.**
5. **Employment equity** According to the CHHHS *Annual Report 2014 – 2015* (p. 36) there were 4,352 FTE staff in the service as at 30 June 2015 (MOHRI headcount = 5,280) (p. 54). Aboriginal and Torres Strait Islander people constitute around 9% of the total population served by the CHHHS (p.11) within its strict geographical boundary, therefore on a basis of equity the target for participation in the CHHHS workforce is around 400. However, because the CHHHS provides a range of secondary and tertiary hospital services to the Aboriginal and Torres Strait Islander population in the Torres Strait and Cape York regions, the total Aboriginal and Torres Strait Islander population served by the CHHHS is around 15% of the total FNQ regional population. Based on this figure, the CHHHS should have over 600 Aboriginal and Torres Strait Islander employees. While it is obvious that the CHHHS currently employs Aboriginal and Torres Strait people in various capacities, no data (number or percentage) has been provided either in the 2014-15 annual report, or on the CHHHS website, to enable a score to be given. **Score = 0/4.**
6. **Workforce participation.** Instead of the usual 6 employment streams defined by QH, the CHHHS employs four: Nursing and Midwifery; Medical; Non-Clinical (operational services, admin, etc.); and Health Practitioners (CHHHS *Annual Report 2014 – 2015,* p. 54). The section on “Our People” (pp. 54-60) provides no data on overall Aboriginal and Torres Strait Islander participation in the CHHHS workforce. However, previously there had been a decline in the Aboriginal and Torres Strait Islander health workforce –from 4.25% in June 2010 to 2.97% in December 2013.[[271]](#footnote-271) This potentially compromises the delivery of culturally safe and appropriate healthcare and health service delivery to Aboriginal and Torres Strait Islander clients.[[272]](#footnote-272) While clearly employing Aboriginal and Torres Strait Islander people in various capacities across the workforce, as no data has been provided for their participation in the CHHHS workforce across the various employment streams, including a stream for Aboriginal and Torres Strait Islander Health Practitioners/Health Workers and Liaison Officers, a penalty score has resulted (see Note 33). It is noted that the CHHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous hospital liaison services (see Note 37). **Overall** **score = 0/10.**
7. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
8. **Commonwealth contribution** Neither the financial statements contained in the CHHHS *Annual Report 2014 – 2015* nor the CHHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the CHHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**
9. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the CHHHS has an operating budget of $667.3 million for 2014-15.[[273]](#footnote-273) To support the delivery of the Making Tracks priorities and in accordance with CHHHS *Service Agreement 2013/14-2015/16*,[[274]](#footnote-274) 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 heal 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)[[275]](#footnote-275), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within CHHHS annual reports in the interests of public accountability and transparency**.** The CHHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the CHHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**CHHHS documents consulted**

* CHHHS *Annual Report 2012-2013*,
* CHHHS *Annual Report 2014-2015*,
* CHHHS *Operational Plan 2015-16* (July 2015 – and updated annually).
* CHHHS *Strategic Plan 2014-2018* (revised 2015)
* CHHHS *Strategic Plan 2013-2017* (2015 Review)
* CHHHS *Consumer and Community Engagement Strategy July 2015 – June 2017: A planned approach to engaging with our consumers and community* (Version 1.2 - July 2015).(AR 2014/15, p. 61)
* CHHHS *Service Agreement 2013/14 – 2015/16.*
* CHHHB Board meeting summaries for:

1. 2014: 26 February; 26 March; 30 April; 28 May; 25 June; 23 July; 27 August; 24 September; 22 October; 26 November; and 17 December.[[276]](#footnote-276)
2. 2015: 28 January; 25 February; 25 March; 29 April; 27 May; 24 June; 29 July; 26 August; 23 September; 21 October; 18 November; and no board meeting scheduled December.

**CHHHS documents not sighted**

* CHHHS *Strategic Workforce Plan 2014 – 2019* (referred to in 2014/15 annual report, p. 55)
* ‘Closing the Gap funding allocations to Cairns and Hinterland Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: CHHHS *Service Agreement 2013/14-2015/16 – November 2013 Revision*, p. 42).

* CHHHB Board meeting summary for January 2014.

## Children’s Health Queensland Hospital and Health Service

**CHILDREN’S HEALTH QUEENSLAND HOSPITAL AND HEALTH SERVICE (CHQHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

* + - 1. **Participation in governance**
* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Children’s Health Queensland Hospital and Health Board (CHQHHB) (3)
* Indigenous representative 10 0
* Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Children’s Health – Directorate Status 5 0
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 0.5**

* + - 1. **Policy implementation**
* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 0
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 1
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 0
* Public Reporting and Accountability (via Annual Report) (10)
* Traditional Owner acknowledgement (11) 1 1
* Closing the Gap

(i) Separate section in report devoted to Closing the Gap (12) 1 1

(ii) Reporting on KPIs contained in 2013/14 - 2015/16 service agreement (13) 1 0

* Policy references (14)
* (i) Cultural Capability Framework (15) 1.5 1.5
* (ii) Making Tracks (16) 1.5 0
* Organisational structure (ATSI unit placement within) (17) 1 0
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 1
2. Reference to workforce planning, recruitment, etc.(19) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 1 **Total 30 6.5** 
  + - 1. **Service delivery**
* Aboriginal and Torres Strait Islander health plan (21) 10 0
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 3
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 3
* Proportion of non-indigenous staff trained (25) 4 0
* Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

Reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPHs) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 6**

* + - 1. **Recruitment and employment**
* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce development policy/strategy (31) 3 0
* Aboriginal and Torres Strait Islander workforce implementation body (32) 3 0
* Employment equity (33) 4 0.5
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1  0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Practitioners/Health Workers and Liaison Officers 2 0
* Trade and Artisans 1 0
* Operational/Support Services 1 0
* Health Practitioners (Professional and Technical) 1 0

**Total 20 0.5**

* + - 1. **Financial Accountability and Reporting: Closing the Gap funding** (35)
* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0 **Total 20 0**

**Score 140 13.5**

**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. **Children’s Health Queensland Hospital and Health Service** The Children’s Health Queensland Hospital and Health Service (CHQHHS) is a specialist statewide hospital and health service dedicated to caring for children and young people (from birth to 18 years) from across Queensland and northern New South Wales (CHQHHS *Annual Report 2014-2015,* pp. 6 and 9). Queensland’s children comprise 25% of the state’s total population, of whom approximately 6 – 7% are of Aboriginal and/or Torres Strait Islander origin (CHQHHS *Service Agreement 2013/14 – 2015/16,* p 20). Aboriginal and Torres Strait Islander children also have a disproportionate burden of disease. For example, a national study (which included data from the University of Queensland’s Mater Research Institute and the Lady Cilento Children’s Hospital) has found that Indigenous children are three times more likely to be admitted to a hospital intensive care unit (ICU) for a serious infection than non-Indigenous children and are twice as likely to die from one.[[277]](#footnote-277) The Lady Cilento Children’s Hospital serves as the hub of the CHQHHS, supported by the Child and Youth Community Health Service, Child and Youth Mental Health Service and statewide paediatric outreach and telehealth services (CHQHHS *Annual Report 2014-2015,* p. 50). For Aboriginal and Torres Strait Islander children, the statewide services include Indigenous Ear Health (the Deadly Ears program) (pp. 42 and 54), and Indigenous Respiratory Outreach Care (p. 54), and the CHQHHS hosts the Aboriginal and Torres strait Islander Cultural Capability Unit/Team (p. 56). The CHQHHS also maintains an Aboriginal and Torres Strait Islander Health Liaison Service, as part of the hospital’s social work department, supporting Aboriginal and Torres Strait Islander families through their journey at the hospital (p. 55). Under the Forensic Adolescent Mental Health and Alcohol and Other Drugs Program, CHQHHS runs the Forensic Transition Program, funded under the Queensland Indigenous Health Investment Strategy, to provide transitional support and assistance to young Aboriginal and Torres Strait Islander clients for a one-month period upon release from the Brisbane Youth Detention Centre. Aboriginal and Torres Strait Islander young people constitute between 50 – 55 per cent of those incarcerated at the Centre (p. 46). Indigenous child health is also one of the six overarching themes guiding the eight research priorities for 2014-15 at CHQHHS (p. 61). Currently research to reduce the disparity of lung health in Australian Indigenous and New Zealand Maori children is being undertaken in collaboration with the NHMRC Centre for Excellence in Indigenous Lung Health partners. Risk factors and cultural context for respiratory illness in urban Indigenous children, utilising Indigenous methodologies, is also an important area of research (p. 63). CHQHHS provides a number of Aboriginal and Torres Strait Islander Services through its staff of Indigenous Liaison Officers. There are also a number of Aboriginal and Torres Strait Islander peak health and childcare organisations located within the greater Brisbane metropolitan region: the Queensland Aboriginal and Islander Health Council (QAIHC), the Institute for Urban Indigenous Health (IUIH), the Centre for Excellence for Indigenous Health (Inala), and Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP).

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** in the HHB Act earns 0.5 point out of 20 for all Queensland Health’s HHSs.

3. **CHQHHB** The Children’s Health Queensland Hospital and Health Board (CHQHHB) consists of 10 members. None of the board members, as profiled in the CHQHHS *Annual Report 2014-2015,* (pp. 66 - 67), identifies as an Aboriginal or Torres Strait Islander person, or lists in their professional background any specific connection to an Aboriginal and Torres Strait Islander health organisation or experience in Aboriginal and Torres Strait Islander health care service delivery**. Score = 0/10.**

4. **Executive Management Structure** The Executive Management Team (EMT) comprises 11 members: the HSCE; General Manager Operations; Chief Finance Officer; Executive Director Medical Services; Executive Director Nursing Services; Executive Director Allied Health; Executive Director Office of Strategy Management; Chief Information Officer; Executive Director People and Culture; Executive Director Development and Commissioning; and Senior Director Communications and Engagement. Apart from the HSCE, none are profiled in the CHQHHS *Annual Report 2014-2015* (p. 68), however, most of the 2014-2015 EMT are profiled in the CHQHHS *Annual Report 2013-2014* (pp. 49-50) and on the CHQHHS website.[[278]](#footnote-278) As profiled, none of the EMT members identifies as an Aboriginal or Torres Strait Islander person or has any specific connection to an Aboriginal and Torres Strait Islander health organisation or experience in Aboriginal and Torres Strait Islander health care service delivery.Aboriginal and Torres Strait Islander Health/Closing the Gap is not specifically listed among the responsibilities of any members of the EMT (CHQHHS *Annual Report 2014-2015,* Financial Statements, pp. 23 - 25). There is no stand-alone executive division for Aboriginal and Torres Strait Islander health. **Combined score for the two sub-criteria = 0/10.**

5. **Closing the Gap health outcomes and the CHQHHS Strategic Plan** The CHQHHS’s *Children’s Health Queensland* *Strategic Plan 2013-2017* (2015 update), apart from a minor reference to the Deadly Ears Indigenous ear health program (p. 4), contains no other references to Aboriginal and Torres Strait Islander (children’s) health. It is not mentioned among the eight goals listed in the 2015 update (p. 3), or among the ten key priorities for 2015-16 (p. 5). The plan lists 6 strategic directions: (i) lead the provision of quality health care for children and young people; (ii) build strong partnerships and engagement for improved health outcomes; (iii) build an empowered and engaged workforce; (iv) define and implement the statewide paediatric role; (v) enhance financial management; and (vi) enhance research and learning culture), encompassing some 44 KPIs (pp. 6-11). None involves a KPI for some aspect of Indigenous children’s health. **Score = 0/5.**

1. **Closing the Gap KPIs included in health service agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the CHQHHS *Service Agreement 2013/14 – 2015/16* for this triennium identifies only one: Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 39**). Score = 1/5.**
2. **Aboriginal and Torres Strait Islander consultative body** The peak consumer advisory body of the CHQHHS is the Family Advisory Council (FAC) (CHQHHS *Annual Report 2014-2015*, pp. 32 and 48) which meets monthly “to provide input to key Children’s Health Queensland (CHQ) priorities and issues as well as proactively identify opportunities to improve our services” (p. 32). One of the achievements listed in relation to Closing the Gap is the establishment during 2014-15 of two groups committed to improving CHQHHS healthcare for Aboriginal and Torres Strait Islander people through constructive partnerships:

* CHQ Aboriginal and Torres Strait Islander Health Advisory Group
* The CHQ Aboriginal and Torres Strait Islander Leadership Group (p. 56).

However it is not known whether there is a relationship here with the FAC, although the FAC encourages applications for membership from, *inter alia*, Aboriginal and Torres Strait Islander representatives.[[279]](#footnote-279) Attempts to find information concerning the ATSI health advisory and leadership groups on the CHQHHS website, specifically about membership/representation and terms of reference, and more generally for the FAC have been unsuccessful. As this assessment is about promoting transparency in policy implementation and accountability, a penalty score has resulted.  **Score = 0/5.**

1. **RAP** 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.[[280]](#footnote-280) Queensland Health co-signed with Reconciliation Australia[[281]](#footnote-281) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No reference is made in the publicly available information either from Reconciliation Australia or the CHQHHS concerning the existence of a RAP. **Score = 0/3.**
2. **Aboriginal and Torres Strait Islander Health Division/Unit Community newsletter** CHQHHS publishes*Developments*, a newsletter for referring General Practitioners, and provides regular news up-dates through its website, however, nothing was found in regard to a newsletter directed to Queensland’s Aboriginal and Torres Strait Islander population.[[282]](#footnote-282) **Score = 0/2.**
3. **Annual Report** The sub-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.*
4. **Traditional Owner acknowledgement** The CHQHHS *Annual Report 2014-2015* (p. ii) contains the following acknowledgement:

We acknowledge the Turrabul and Jagera people the traditional custodians of this land. We pay our respect to Elders past and present. We pay respect to the cultural authority held and shared by colleagues across Queensland*.*

**Score = 1/1.**

1. **Closing the Gap section** The CHQHHS *Annual Report 2014-2015* contains a section specifically devoted to Closing the Gap (pp. 54-56), and which is also identified in the Table of Contents of the report. **Score = 1/1.**
2. **Reporting on KPIs** The CHQHHS *Annual Report 2014-2015* (p. 47) did not disclose information regarding any of the Closing the Gap KPIs in its performance statement. **Score = 0/1.**
3. **Policy references** For the CHQHHS, 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.
4. **Cultural capability framework** In accordance with the CHQHHS *Service Agreement 2013/14 – 2015/16* (p.27), with reference to the Aboriginal and Torres Strait Islander Cultural Capability Team, CHQHHS will host the following statewide functions:

* Implementation of the Aboriginal and Torres Strait Islander Cultural Capability Framework
* Provision of expert cultural advice and brokerage as required across the Queensland public health system
* Monitor the Aboriginal and Torres Strait Islander Cultural Practice Program (A&TSICPP) and Hospital and Health Service performance
* Lead continuous quality improvement of A&TSICPP including E-Learning tool and A&TSICPP online resources
* Develop a suite of best practice tools including education materials, guidelines and handbook for caring for Aboriginal and Torres Strait Islander patients.

In carrying out the agreement, CHQHHS has hosted Queensland Health’s statewide Cultural Capability Team for the past two years. The team’s role is to “lead the implementation of the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* within Children’s Health Queensland and statewide.” The Cultural Capability Team completed the development of the Queensland Health Online Aboriginal and Torres Strait Islander Cultural Practice Program (<http://atsicpp.carbon-media.com.au>) in 2014-15. (CHQHHS *Annual Report 2014-2015,* p. 56). **Score = 1.5/1.5.**

1. **Making Tracks** The CHQHHS *Annual Report 2014-2015* does not contain any information with regard to Making Tracks progress or initiatives. **Score = 0/1.5.**
2. **Organisational structure** The organisational governance chart in the CHQHHS *Annual Report 2014-2015 (*p.65) does not provide the level of detail required to place the Aboriginal and Torres Strait Islander Liaison Service (p. 55) or the newly established CHQ Aboriginal and Torres Strait Islander Health Advisory Group and the CHQ Aboriginal and Torres Strait Islander Leadership Group (see Note 7) within the structure. **Score = 0/1.**
3. **Employment** The CHQHHS workforce comprised 3,074 FTE staff at 30 June 2015, of whom 0.92 per cent (or about 30 people) identified themselves as an Aboriginal or Torres Strait Islander person (CHQHHS *Annual Report 2014-2015*, p. 72). **Score = 1/1.**
4. **Workforce planning** The CHQHHS *Annual Report 2014-2015* does not contain any reference to workforce planning, recruitment, etc. regarding its Aboriginal and Torres Strait Islander workforce. **Score = 0/1.**
5. **Awards, recognition, etc.** The *Children’s Health Queensland Reward and Recognition Plan 2015-2017* provides a framework for encouraging and rewarding staff achievements and successes (CHQHHS *Annual Report 2014-2015,* p. 75). An award for service was given in relation to the Deadly Ears Program (p. 22), itself an award-winning program that has more than halved the rate of *otitis media* (or middle ear disease) in Aboriginal and Torres Strait Islander children in remote communities (p. 42). **Score = 1/1.**
6. **Aboriginal and Torres Strait Islander health plan** There is no reference in the publicly available information to the existence of a CHQHHS Aboriginal and Torres Strait Islander Children’s Health Plan. Given the size, diversity and geographic spread of Aboriginal and Torres Strait Islander communities in Queensland, the number of community controlled health services and other health facilities (diversionary centres, drug and alcohol rehabilitation centres), the urgent need to build the Aboriginal and Torres Strait Islander health workforce capacity (see Note 31 below), and the need to strategically plan and coordinate service delivery between the CHQHHS and the community services to improve cultural safety and support the patient journey, a coherent plan could be considered an absolute requirement. **Score = 0/10.**
7. **Cultural competence** Cultural competency is key to effective health system performance in delivering healthcare to Aboriginal and Torres Strait Islander clients. 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.[[283]](#footnote-283)

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 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.[[284]](#footnote-284)

1. **Cultural competency policy/strategy** The CHQHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). The CHQHHS has been mandated by QH in its CHQHHS *Service Agreement**2013/14 – 2015/16* (p.27)to establish anAboriginal and Torres Strait Islander Cultural Capability Framework and to “lead the implementation of the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* within Children’s Health Queensland and statewide.” **Score = 3/3**
2. **Capacity to deliver CCT** In carrying out the service agreement (see Note 15), CHQHHS has hosted Queensland Health’s statewide Cultural Capability Team for the past two years. The team’s role is to “lead the implementation of the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* within Children’s Health Queensland and statewide.” Presumably the team has the capacity to deliver CCT to the non-Indigenous staff at the CHQHHS. **Score = 3/3.**
3. **Proportion of non-Indigenous staff to receive** **CCT** The CHQHHS employs some 3,074 FTE staff. The Aboriginal and Torres Strait Islander Cultural Capability Team delivers monthly sessions to CHQHHS staff (CHQHHS *Annual Report 2014-2015,* pp. 56), however, no data concerning this KPI for the actual number/percentage of non-Indigenous staff who have been trained is provided in the *Annual Report*. A penalty score results. **Score = 0/4**.
4. **Indigenous status** Indigenous status – specifically the Reporting of ‘not stated’ on admission. Not reported in the CHQHHS *Annual Report 2014-2015.* **Score = 0/2.**
5. **DAMA** The CHQHHS *Service Agreement 2013/14 – 2015/16* (p. 39) includes a KPI for Aboriginal and Torres Strait Islander discharge against medical advice. However, no data on DAMA were published in the Performance Statement in the CHQHHS *Annual Report 2014-2015* (p. 47). Similarly, and unlike for all of the other HHSs, no data was published in Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) **Score = 0/2**.
6. **PPH** The CHQHHS *Service Agreement 2013/14 – 2015/16* (p. 39) does not includes a KPI for Aboriginal and Torres Strait Islander potentially preventable hospitalisations. Accordingly, no data on PPH were published in the Performance Statement in the CHQHHS *Annual Report 2014-2015* (p. 47). ). Similarly, and unlike for all of the other HHSs, no data was published in Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29). **Score = 0/2**.
7. **Access to mental health procedures** Access to mental health proceduresmeasured in terms ofthe 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 that separation. This Closing the Gap KPI is not reported in the CHQHHS *Annual Report 2014-2015* (refer p. 47)*.* **Score = 0/2.**
8. **Access to drug and alcohol services** Not reported in the CHQHHS *Annual Report 2014-2015.* Score = 0/2.
9. **ATSI workforce development strategy/policy** No reference is made in the publicly available information to the existence of an Aboriginal and Torres Strait Islander health workforce strategy developed by the CHQHHS. **Score = 0/3.**
10. **ATSI workforce implementation body** As in Note 31, no reference was found regarding such a body. **Score = 0/3.**
11. **Employment equity** Aboriginal and Torres Strait Islander children make up approximately 6% of Queensland’s children (CHQHHS *Annual Report 2014-2015,* p. 55). The CHQHHS workforce comprised 3,074 FTE staff at 30 June 2015, of whom 0.92% identify themselves as Aboriginal or Torres Strait Islander (p. 72). Based on employment equity principles for the state as a whole and taking note of the population percentage of Aboriginal and Torres Strait Islander children, Aboriginal and Torres Strait Islander people should constitute about 6% of the workforce, or about 180 people. **Score = 0.5/4.**
12. **Workforce participation** While clearly employing Aboriginal and Torres Strait Islander people, the CHQHHS *Annual Report 2014-2015* (p. 72), however, provides no breakdown of Aboriginal and Torres Strait Islander participation across the various QH employment streams – CHQHHS omits the Trade and Artisans stream. For future reporting purposes an employment category/stream for Indigenous Health Practitioners/Health Workers and Liaison Officers is suggested for inclusion in CHQHHS annual reports. It is also noted that the CHQHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous hospital liaison services (see Note 37). A penalty score has resulted. **Overall score = 0/10.**
13. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
14. **Commonwealth contribution** Neither the financial statements contained in the CHQHHS *Annual Report 2014 – 2015* nor the CHQHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the CHQHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**
15. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the CHQHHS has an operating budget of $460.8 million for 2014-15.[[285]](#footnote-285) To support the delivery of the Making Tracks priorities and in accordance with CHQHHS *Service Agreement 2013/14-2015/16* (p. 26), the CHQHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

* Mental health services
* Child and maternal health services
* Indigenous hospital liaison services
* Indigenous cultural capability services

Details of the CHQHHS Closing the Gap budget for the next financial year are contained in the memo entitled ‘Closing the Gap funding allocations to Children’s Health Queensland Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013), however, attempts to access this document have been unsuccessful. Under specific funding commitments, total funding of $4,100,000 was committed for the Deadly Ears Program as part of the 2013/14 service agreement value (p. 30). Queensland Closing the Gap funding allocations should be disclosed within CHQHHS annual reports in the interests of public accountability and transparency**.** The CHQHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to QH’s Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the CHQHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**CHQHHS documents consulted**

* CHQHHS *Annual Report 2014-2015*
* CHQHHS *Annual Report 2013-2014*
* CHQHHS *Strategic Plan 2013-2017* (2015 Update).
* CHQHHS *Service Agreement 2013/14 – 2015/16*
* CHQHHB Board meeting summaries for 2015: 29 January; 26 February; 26 March; 30 April; 28 May; 25 June; 30 July; 27 August; 24 September; 29 October; and 26 November.

**CHQHHS documents not sighted**

* CHQHHB Board meeting summaries for 2014 and December 2015.
* ‘Closing the Gap funding allocations to Children’s Health Queensland Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)
* Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: CHQHHS *Service Agreement 2013/14-2015/16*, p. 39).
* Queensland Indigenous Health Investment Strategy
* *Children’s Health Queensland Research Strategy 2013-2016.*

## Central Queensland Hospital and Health Service

**CENTRAL QUEENSLAND HOSPITAL AND HEALTH SERVICE (CQHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

* + - 1. **Participation in governance**
* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Central Queensland Hospital and Health Board (CQHHB) (3)
* Indigenous representative 10 0
* Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 0
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 0.5**

* + - 1. **Policy implementation**
* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 0
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 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 contained in 2013/14 - 2015/16 service agreement (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
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 0
2. Reference to workforce planning, recruitment, etc.(19) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 2**
  + - 1. **Service delivery**
* Aboriginal and Torres Strait Islander health plan (21) 10 0
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 1.5
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 1.5
* Proportion of non-indigenous staff trained (25) 4 0
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

Reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 3**

* + - 1. **Recruitment and employment**
* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce development policy/strategy (31) 3 1
* Aboriginal and Torres Strait Islander workforce implementation body (32) 3 1.5
* Employment equity (33) 4 2
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1 0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Practitioners/Health Workers and Liaison Officers 2 0
* Trade and artisans 1 0
* Operational/Support Services 1 0
* Health Practitioners (Professional and Technical) 1 0 **Total 20 4.5**
  + - 1. **Financial Accountability and Reporting: Closing the Gap funding** (35)
* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0 **Total 20 0**

**Score 140 10**

**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. **Central Queensland Hospital and Health Service** The Central Queensland Hospital and Health Service (CQHHS) has responsibility for providing public hospital and health services from Gladstone in the south, inland to the Southern and Central Highlands and north along the Capricorn Coast to a population of around 228,000 people, residing within a geographical area covering 114,000 square kilometres (CQHHS *Annual Report 2014-15*, p. 3; CQHHS *Service Agreement 2013/14 – 2015/16,* p. 20). The 2011 census identified Central Queensland as having 5.5% of its population identifying as Aboriginal and Torres Strait Islander (CQHHS *Annual Report 2014-15*, p. 3).[[286]](#footnote-286) This places the Aboriginal and Torres Strait Islander population at about 12,500 people, and includes the Aboriginal community of Woorabinda (pop. 970) 170km southwest of Rockhampton, where CQHHS maintains a MPHS (CQHHS *Annual Report 2014-2015*, p. 4). About half of the Aboriginal and Torres Strait Islander people in the CQHHS region live in Rockhampton.[[287]](#footnote-287)

The CQHHS has two primary healthcare Aboriginal and Torres Strait Islander community controlled health services operating within its region: Bidgerdii Aboriginal and Torres Strait Islander Corporation Community Health Service Central Queensland Region (Bidgerdii) (Rockhampton), and Nhulundu Wooribah Indigenous Health Organisation Incorporated (Nhulundu Wooribah) (Gladstone, Boyne Island, Tannum Sands and Calliope). The Central Queensland Regional Aboriginal and Islander Community Controlled Health Organisation (CQ RAICCHO) was established by QAIHC members in the CQ Region to respond to regional challenges for community controlled services and communities.

The CQHHS does not appear to have an Aboriginal and Torres Strait Islander Health Unit/Service within its operational structure.[[288]](#footnote-288)

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 point out of 20 for all Queensland Health’s HHSs.

3. **CQHHB** The Central Queensland Hospital and Health Board (CQHHB) comprises 9 members, none of whom identify as Aboriginal or Torres Strait Islander, and none whom, as profiled in the CQHHS *Annual Report 2014-15* (pp. 5-9) 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. **Score = 0/10.**

4. **Executive Management Structure** The Management Team comprised of 12 members on 30 June 2015, however, a new 10-member structure came into effect from 1 July 2015. Aboriginal and Torres Strait Islander health is not listed in any of their portfolio responsibilities, although Indigenous training and development and cultural awareness programs are the responsibility of the Executive Director Workforce. The 2014-15 directorate covers the following: Quality and Safety; Chief Finance Officer; Workforce; Infrastructure and Support Services; Operations and Innovation; Nursing and Midwifery; Subacute, Ambulatory and Community Services; Rockhampton Hospital; Medical Services Gladstone Hospital; Rural Health Services; and Mental Health, Alcohol and Other Drugs Service. There is no directorate that specifically covers Aboriginal and Torres Strait Islander health services. (CQHHS *Annual Report 2014-15*, pp. 15, 93 and 104). **Score = 0/10.**

5. **Closing the Gap health outcomes and the CQHHS Strategic Plan** The CQHHS *Strategic Plan 2014-2018* (revised 2015)[[289]](#footnote-289) makes no reference to Aboriginal and Torres Strait Islander health or Closing the Gap. **Score = 0/5.**

* + - 1. **Closing the Gap KPIs included in health service agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the CQHHS *Service Agreement 2013/14 – 2015/16* for this triennium identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 40); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 41). On this basis, two points out of five are awarded. **Score = 2/5.**
      2. **Aboriginal and Torres Strait Islander consultative body** Reference is made in the CQHHS *Annual Report 2014-*2015 (p. 40) to the Central Queensland Consumer and Community Advisory Council and the Consumer Advisory Networks, however, the CQHHS website provides no information about these entities.[[290]](#footnote-290) In the CQHHS *Annual Report 2014- 2015,* CQHHS *Strategic Plan 2014-2018* (revised 2015) and the CQHHS *Consumer and Community Engagement Strategy 2014 – 2018* no mention is made of any specific Aboriginal and Torres Strait Islander consultative body. References to engagement are limited to, for example, in the CQHHS *Consumer and Community Engagement Strategy 2014 – 2018,* in terms of the objective to support meaningful engagement to ensure safe, reliable services, to: “1.4 Ensure engagement is inclusive of indigenous and CALD communities”. Further, in regard to engaging with diverse communities: “To ensure meaningful and accessible engagement with the culturally and linguistically diverse population in Central Queensland, CQHHS will follow the below protocols: [which include] Provide staff with access to adequate training to ensure cultural competence.” An example of such engagement is provided in the CQHHS *Annual Report 2014- 2015* (p. 52):

The health service strengthened its relationship with the local Aboriginal and Torres Strait Islander community through a cultural placement ceremony at the New Ward Block at Rockhampton Hospital. A wall in the reception area of the Cancer Therapy Centre is lined with photographs of significant places and items of significance to all 10 Traditional Owners and Torres Strait Islander groups across Central Queensland Health. Special flag-raising ceremonies have been organised at all hospitals in the region and the Aboriginal and Torres Strait Islander flags now fly alongside the Australian flag to show the health service’s commitment to provide culturally appropriate care.

Real engagement, in terms of providing continuous and constructive input into the delivery of culturally appropriate health care to the Aboriginal and Torres Strait Islander community, and a mechanism to provide feed-back to the community, would need to demonstrate more constructive means of engagement than the examples above, especially as no data was supplied in the CQHHS 2014-15 annual report on the success of its cultural competency training for non-Indigenous staff (see Note 25)**. Score = 0/5.**

* + - 1. **RAP** 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.[[291]](#footnote-291) Queensland Health co-signed with Reconciliation Australia[[292]](#footnote-292) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No reference is made in the publicly available information either from Reconciliation Australia or the CQHHS concerning the existence of a RAP. **Score = 0/3.**
      2. **ATSI Health Division/Unit community newsletter**. While the CQHHS website maintains a news portal, no evidence was found of either a CQHHS newsletter, or a newsletter published for the region’s Aboriginal and Torres Strait Islander communities. In fact it was difficult to find any references at all on the website concerning Aboriginal Torres Strait Islander health, provision of services, and contacts for Aboriginal and Torres Strait Islander Health Workers and Liaison Officers.[[293]](#footnote-293) **Score = 0/2.**

1. **Annual Report** The CQHHS *Annual Report 2014-15*, overall, provides very little information concerning Aboriginal and Torres Strait Islander health related matters (eg, KPIs, employment, involvement, etc).
2. **Traditional Owner acknowledgement** There is no Traditional Owner acknowledgement in the CQHHS *Annual Report 2014-2015.* **Score = 0/1.**
3. **Closing the Gap section** None exists in the CQHHS *Annual Report 2014-15.* **Score = 0/1.**
4. **Reporting on KPIs** None exists in the CQHHS *Annual Report 2014-15.* Tier 1 KPIs are reported on p. 34, however, none of these are specific to Aboriginal and Torres Strait Islander health. **Score = 0/1.**
5. **Policy references** For the CQHHS, 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.
6. **Cultural capability framework** No specific reference to this policy is made in the CQHHS *Annual Report 2014-15.* **Score = 0/1.5**
7. **Making Tracks** No specific reference to this policy is made in the CQHHS *Annual Report 2014-15.* **Score = 0/1.5.**
8. **Organisational structure** The organisational structure described in the CQHHS *Annual Report 2012-13* (p. 17) has a Strategic Executive Team and an Operational Executive Team: the latter includes an Indigenous Health Advisor as a member. Only a chart of the Executive Management Structure is included in the CQHHS *Annual Report 2014-15* (p. 104). The position of any Aboriginal and Torres Strait Islander health unit/position is therefore not shown. **Score = 0/1.**
9. **Employment** No data on Aboriginal and Torres Strait Islander employment in the CQHHS workforce is included in the CQHHS *Annual Report 2014-2015* (refer pp. 3, 23 and 46)*.* However, the CQHHS *Annual Report 2012-2013* (p. 28) reports that 3% of its workforce is made up of people who identify as Aboriginal and Torres Strait Islanders. **Score = 0/1.**
10. **Workforce planning** Apart from the reference to the Executive Director Workforce including responsibility for “Indigenous training and development, and cultural awareness programs for the Health Service” (p. 93), no other reference is made to Indigenous workforce planning, recruitment, etc. in terms of a policy/strategy in the CQHHS *Annual Report 2014-15*. **Score = 0/1.**
11. **Awards, recognition, etc.** In the CQHHS *Annual Report 2012-13* (p. 28), one of the initiatives referred to is the establishment of Aboriginal and Torres Strait Islander Staff Recognition Awards, however,no references are made to any Aboriginal or Torres Strait Islander staff receiving awards, scholarships, etc. in the CQHHS *Annual Report 2014-15.* **Score = 0/1.**
12. **Aboriginal and Torres Strait Islander Health Plan.** While there is no mention in the CQHHS *Annual Report 2014-2015*, CQHHS *Strategic Plan 2014-2018* (revised 2015) or CQHHS *Consumer and Community Engagement Strategy 2014 – 2018* of the existence of some form of Aboriginal and Torres Strait Islander Health Plan or other instrument, this is, however incorporated within the Central Queensland Health Plan developed through a partnership between the Central Queensland Medicare Local (CQML) and CQHHS. The first, long term plan (with a ten year horizon) developed for the Central Queensland region, Priority 4 of the Central Queensland whole-of-system priorities has the goal of: “Working in partnership with Aboriginal and Torres Strait Islander community-controlled organisations, plan and implement regional and local initiatives to close the gap”. The first headline action is to:

Develop a Central Queensland Aboriginal and Torres Strait Islander Health Plan in partnership with ACCHOs to identify, implement and drive regional and local solutions for Aboriginal and Torres Strait Islander people…..”.

(CQML and CQHHS *Central Queensland Health Plan*, pp. 4 and 31-33). This plan focuses on primary healthcare, however, with the demise of Medicare Locals and a different configuration of primary health care coordination under Primary Health Networks, the good intention of developing a Central Queensland Aboriginal and Torres Strait Islander Health Plan has not eventuated.

It is noted that CQHHS has established the One Gladstone Health Plan (CQHHS *Annual Report 2014-2015*, p. 56) which is essentially a plan to better coordinate and improve the provision of a range of specialist and clinical services between CQHHS, Gladstone Hospital and Mater Hospital in Gladstone.A search of the CQHHS website has failed to reveal the existence of aCentral Queensland Aboriginal and Torres Strait Islander Health Plan. **Score = 0/10.**

1. **Cultural competence** Cultural competency is key to effective health system performance in delivering healthcare to Aboriginal and Torres Strait Islander clients. 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.[[294]](#footnote-294)

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 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.[[295]](#footnote-295)

1. **Cultural Competency Policy/Strategy** In the CQHHS *Annual Report 2012-13* (p. 28), an Aboriginal and Torres Strait Islander Cultural Respect Policy G 12 is referred to, however,no information is supplied as to whether it is part of an on-line training program, whether it involves direct instruction with Aboriginal and Torres Strait Islander trainers, or a combination of both. The CQHHS *Annual Report 2014-15* makes no mention of this policy. **Score = 1.5/3.**
2. **Capacity to deliver CCT** While the CQHHS *Consumer and Community Engagement Strategy 2014-2018* states that, in order to engage with the diverse population in Central Queensland, CQHHS will engage in the protocols that include, *inter alia*, providing staff with access to adequate training to ensure cultural competence. However, it is assumed that this training will encompass a number of CALD groups, and not just cultural competence training regarding the Aboriginal and Torres Strait Islander communities. No mention is made about the CQHHS’s capacity to deliver CCT, target numbers, etc. **Score = 1.5/3.**
3. **Proportion of non-Indigenous staff to receive CCT** Like the requirement regarding the Code of Conduct for the Queensland Public Service, for which employees are required to repeat training every two years (CQHHS *Annual Report 2014-15,* p. 48), ideally all CQHHS staff should undertake cultural competency training at least once every two years. Based on the MOHRI headcount, there are over 3,200 employees in the CQHHS (CQHHS *Annual Report 2014-15,* p. 46), this roughly translates into CCT for over 1,600 staff per year. No data concerning this KPI is provided in the CQHHS *Annual Report 2014 – 2015*. **Score = 0/4.**
4. **Indigenous status** Indigenous status– specifically the reporting of ‘not stated’ on admission. Not reported in the CQHHS *Annual Report 2014-2015.* **Score = 0/2.**
5. **DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the CQHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

3.87% 3.10% 2.30% 2.80% 5.01% 2.40% 3.19% 2.10%

CQHHS bettered the target for only one quarter. Despite being included in the CQHHS *Service Agreement 2013/14-2015/16* (p. 41), data on DAMA rates were not published for the current assessment period (2014-15) in either the CQHHS *Annual Report 2014 – 2015* (see Tier 1 Key Performance Indicators p. 34) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

1. **PPH** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the CQHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

16.50% 17.70% 17.60% 17.70% 19.80% 17.70% 20.30% 17.70%

CQHHS bettered the target for two quarters. Despite being included in the CQHHS *Service Agreement 2013/14-2015/16* (p. 40), data on PPH rates were not published for the current assessment period (2014-15) in either the CQHHS *Annual Report 2014 – 2015* (see Tier 1 Key Performance Indicators p. 34) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

1. **Access to mental health services** measured in terms of the 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 that separation. The CQHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 26) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the CQHHS *Annual Report 2014-2015* (refer p. 34)*.* **Score = 0/2.**
2. **Access to drug and alcohol services** The CQHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 27) to provide Indigenous Outreach Services under the Alcohol and Other Drug Services program. Not reported in the CQHHS *Annual Report 2014-2015.* **Score = 0/2.**
3. **ATSI Workforce development policy/strategy** The CQHHS *Annual Report 2012-2013* (p. 28) identifies among its initiatives to ensure a fair and equitable workplace for all its employees, the implementation of an Aboriginal and Torres Strait Islander Health Worker Career Structure and the creation of an Aboriginal and Torres Strait Islander Workforce Advisory Group (see also Note 18). The CQHHS *Annual Report 2014 – 2015* provides no further information regarding, for example, the effectiveness of this career structure and results achieved to date. The four major strategic objectives of the CQHHS Workforce Plan 2015 do not address the need to increase Aboriginal and Torres Strait Islander participation in the CQHHS workforce (CQHHS *Annual Report 2014 – 2015*, p. 46). Attempts to locate both the CQHHS Workforce Plan 2015 and the People Strategy 2014-2016 via a website search have been unsuccessful. Because the 2014 – 2015 report provides no information, a penalty results. **Score = 1/3.**
4. **ATSI Workforce Implementation body** Although not mentioned in the *Annual Report 2014-2015*, 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”]. The *You Pla, Me Pla* mentoring program is a key initiative of the Aboriginal and Torres Strait Islander Workforce Strategy 2009-2012 to help retain, support and develop Aboriginal and Torres Strait Islander staff within Queensland Health (CQHHS, *Annual Report 2012-*2013, p. 3). It is assumed that this mentoring strategy is still operating, however, because the 2014 – 2015 report provides no information, a penalty results. **Score = 1.5/3.**
5. **Employment equity** As at 30 June 2015, the CQHHS employed 2,598 full-time equivalent staff (CQHHS *Annual Report 2014 – 2015*. p. 3). Aboriginal and Torres Strait Islander people constitute around 5.5% of the total population served by the CQHHS, therefore on a basis of equity the target for participation in the CQHHS workforce is 143. Based on the 2012/13 rate of 3%, there currently would be around 75-80 Aboriginal and Torres Strait Islander people employed. In order to achieve parity with regard to closing the employment gap by 2033, this would mean adding some 4 or 5 Aboriginal and Torres Strait Islander staff per year for approximately the next 16 years. The current employment rate is slightly less than half of the equity target. **Score 2/4.**
6. **Workforce participation** Also unlike the 2012-2013 report, the CQHHS *Annual Report 2014 – 2015* provides no data on Aboriginal and Torres Strait Islander participation in the CQHHS workforce, although there are obviously Aboriginal and Torres Strait Islander people employed in the various QH employment streams listed under this criterion, an additional stream – Indigenous Health Practitioners/Health Workers and Liaison Officers – has been included as a category in its own right instead of being included in the Managerial and clerical stream. It is also noted that the CQHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous hospital liaison services (see Note 37).The CQHHS *Annual Report 2014 – 2015* (pp. 46 – 48) provides no data for staff participation across the employment streams, therefore there is no information for Aboriginal and Torres Strait Islander participation in the CQHHS workforce. **Overall score = 0/10.**
7. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
8. **Commonwealth contribution** Neither the financial statements contained in the CQHHS *Annual Report 2014 – 2015* nor the CQHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the CQHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**
9. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the CQHHS has an operating budget of $466.0 million for 2014-15.[[296]](#footnote-296) To support the delivery of the Making Tracks priorities and in accordance with CQHHS *Service Agreement 2013/14-2015/16*, the CQHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

* child and maternal health services
* sexual and reproductive health services
* Indigenous hospital liaison services

More details of the CQHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to Central Queensland Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (CQHHS *Service Agreement 2013/14-2015/16*, p. 27), however, attempts to access this document have been unsuccessful. Queensland Closing the Gap funding allocations should be disclosed within CQHHS annual reports in the interests of public accountability and transparency**.** The CQHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Commonwealth or Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the CQHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10**.

**CQHHS documents consulted**

* CQHHS *Annual Report 2012-2013*,
* CQHHS *Annual Report 2014-2015*,
* CQHHS *Strategic Plan 2014-2018* (revised 2015)
* CQHHS *Consumer and Community Engagement Strategy 2014 – 2018*
* CQHHS *Service Agreement 2013/14 – 2015/16.*
* CQHHS and CQML *Central Queensland Health Plan*, n.d.
* CQHHS and CQML *Protocol between Central Queensland Hospital and Health service and Medicare Local* (November 2012).
* CQHHB Board meeting resolutions for:

1. 2014: 7 February; 21 March; special board meeting 26 March; no meeting in April; 2 May; 30 May; 27 June; special board meeting 18 July; 25 July; 22 August; no meeting in September; 24 October; 21 November; and 19 December.
2. 2015: no meeting in January; 6 February; 27 March; no meeting in April; 1 May; 29 May; 26 June; 31 July; no meeting in August; 4 September; 25 September; 30 October; 27 November; and 18 December.

**CQHHS documents not sighted**

* CQHHS Health Service Plan 2011 – 2026/27 (referred to in the CQHHS 2012/13 annual report, p. 124)
* CQHHS Workforce Plan 2015 (referred to in the CQHHS 2014/15 annual report, p. 46) Searched 1/12/2016.
* People Strategy 2014 - 2016 (referred to in the CQHHS 2014/15 annual report, p. 46) Searched 1/12/2016.
* One Gladstone Health Plan (referred to in the CQHHS 2014/15 annual report, p. 56)

‘Closing the Gap funding allocations to Central Queensland Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: CQHHS *Service Agreement 2013/14-2015/16*, p. 41).

## Central West Hospital and Health Service

**CENTRAL WEST HOSPITAL AND HEALTH SERVICE (CWHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

* + - 1. **Participation in governance**
* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Central West Hospital and Health Board (CWHHB) (3)
* Indigenous representative 10 0
* Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 0
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 0.5**

* + - 1. **Policy implementation**
* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 0
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 5
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 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 1

(ii) Reporting on KPIs contained in 2013/14 - 2015/16 service agreement (13) 1 1

* Policy references (14)
* (i) Cultural Capability Framework (15) 1.5 1.5
* (ii) Making Tracks (16) 1.5 1
* Organisational structure (ATSI unit placement within) (17) 1 0
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 1
2. Reference to workforce planning, recruitment, etc.(19) 1 0.5

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 13** 
  + - 1. **Service delivery**
      * Aboriginal and Torres Strait Islander health service plan (21) 10 5
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 3
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 3
* Proportion of non-indigenous staff trained (25) 4 4
  + - * Selected Health service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 2
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 17**

* + - 1. **Recruitment and employment**
* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce development policy/strategy (31) 3 0
* Aboriginal and Torres Strait Islander workforce implementation body (32) 3 0
* Employment equity (33) 4 4
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1 1
* Medical and other health professionals 2 0
* Nurses 2 0.5
* Indigenous Health Workers and Liaison Officers 2 0
* Operational/Support Services 1 1
* Trade and artisans 1 0
* Health Practitioners (Professional and Technical) 1 0 **Total 20 6.5**
  + - 1. **Financial Accountability and Reporting: Closing the Gap funding** (35)
* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0 **Total 20 0**

**Score 140 37**

**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. **Central West Hospital and Health Service** The Central West Hospital and Health Service (CWHHS) (aka Central West Health) covers some 396,650 square kilometres (approximately 24% of the state but only 0.3% of the population) and includes the communities of remote central western Queensland from Tambo in the southeast to Boulia in the northwest. CWHHS has responsibility for providing public hospital and health services within its primary region to approximately 12,400 people, 8.3% of whom (or about 1,000 people) identify as being of Aboriginal or Torres Strait Islander origin, and, in terms of total population, is the smallest of Queensland’s sixteen HHSs. The HHS provides region-wide services including for Aboriginal and Torres Strait Islander Health. It is noted, however, that the Aboriginal and Torres Strait Islander population “continue to experience greater health inequality as a result of limited access to culturally appropriate health services.” (CWHHS *Annual Report 2014 – 2015,* pp. 2, 6, 8 and 21; CWHHS *Service Agreement 2013/14 – 2015/16,* pp.20 and 24-5). The CWHHS does not appear to have an ATSICCHS located within its region.

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 point out of 20 for all Queensland Health’s 16 HHSs.

3. **CWHHB** The Central West Hospital and Health Board (CWHHB) consists of 7 members, none of whom, according to their profiles, identify as Aboriginal or Torres Strait Islander, or have experience in the delivery of health care or services to Aboriginal and/or Torres Strait Islander people (CWHHS *Annual Report 2014 – 2015,* pp. 39-40). **Score = 0/10**.

4. **Executive Management Structure** The Executive Management Team (EMT) comprises 5 members, none of whom, according to their profiles, identify as Aboriginal or Torres Strait Islander. However the Chief Executive has experience as acting Chief Operating Officer and Chief Financial Officer with the Cape York Hospital and Health Service (before it was amalgamated with the Northern Peninsula-Torres HHS to become the Torres and Cape HHS as of July 2014), and also has experience in developing Aboriginal health services. Together with the Chief Executive, the EMT comprises the Executive Director Medical Services; the Chief Finance Officer; the Manager of People and Culture (upgraded to Director as of August 2015); and the Executive Director Nursing and Midwifery Services (CWHHS *Annual Report 2014 – 2015,* pp. 42-43 and 48). There is no stand-alone division of Aboriginal and Torres Strait Islander health and, consequently, no Indigenous executive director. **Score = 0/10.**

5. **Closing the Gap health outcomes and the CWHHS Strategic Plan** In identifying the key risks and challenges for the next five years, the CWHHS *Strategic Plan 2014-2018* (p. 5) also notes:

**Indigenous health** – eight per cent of the central west’s population continue to experience greater health inequality as a result of limited access to culturally appropriate health services.

The *Strategic Plan* (pp. 3 and 5), however, does not mention Closing the Gap in Aboriginal and Torres Strait Islander Health Outcomes among the 6 strategic objectives (and their outcomes/measures of success) for the CWHHS (pp. 6-7).[[297]](#footnote-297) There is no reference to Aboriginal and Torres Strait Islander people or to initiatives for Closing the Gap. **Score = 0/5.**

* + - 1. **Closing the Gap KPIs included in Health Service Agreement** Of the five Tier 3 HSPM Closing the Gap KPIs listed in Note 23 of the QHMT, the CWHHS *Service Agreement 2013/14 – 2015/16*  for this triennium identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 35); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 35). The CWHHS *Health Service Agreement* includes a third: Aboriginal and Torres Strait Islander low birthweight babies (p. 36), however this KPI is not included in the QHMT for the purposes of this assessment/audit, and therefore is not included in the score (see QHMT Note. 23)[[298]](#footnote-298) **Score = 2/5.**
      2. **Aboriginal and Torres Strait Islander consultative body** The CWHHS *Consumer and Community Engagement Strategy 2016 – 2019* emphasises the role of Community Advisory Networks to enable consultation, involvement and collaboration with the various levels of administration and service delivery of the CWHHS. The strategy’s engagement principles include designing “engagement processes to include smaller communities and to support the involvement of all residents including….our Indigenous communities.” The CWHHS *Annual Report 2014 – 2015* (p. 18) also notes that Central West Health has established an Indigenous health and wellbeing working group chaired and directed by local Indigenous members to:

….monitor implementation of the Closing the Gap plan and support a culturally sensitive and responsive health system.

Elsewhere in the annual report, it is stated that Central West Health;

… has established mechanisms to engage with Aboriginal and Torres Strait Islander communities and attends the twice annual sitting of the Barcaldine Negotiating Table. The health service also supports Indigenous leaders in convening a health and wellbeing committee to explore cultural safety and health outcome improvements to health services (p. 21).

Whether the working group will advocate for a stand-alone Aboriginal and Torres Strait Islander advisory/consultative body remains to be seen, but the intention that some form of consultative process/mechanism has been established by CWHHS and the Aboriginal and Torres Strait Islander community is clear. **Score = 5/5.**

* + - 1. **RAP** 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, all agencies were supposed to have strategies in place for early childhood and health by December 2009 to put Queensland on track to meet the COAG targets.[[299]](#footnote-299) Queensland Health co-signed with Reconciliation Australia[[300]](#footnote-300) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No reference is made in the publicly available information either from Reconciliation Australia or the CWHHS concerning the existence of a RAP. **Score = 0/3.**
      2. **ATSI Health Division/Unit community newsletter.** While the CWHHS website maintains a news portal, no evidence was found of either a CWHHS newsletter, or a newsletter published for the region’s Aboriginal and Torres Strait Islander communities.  **Score = 0/2.**
      3. **Annual Report** The sub-criteria for this criterion concerning 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.* Nevertheless, while not fulfilling all the sub-criteria, the CWHHS *Annual Report* *2014-2015* does make mention of a number of additional ways in which the CWHHS is serving the Aboriginal and Torres Strait Islander people with in its area, for example, the fact that the region’s Aboriginal and Torres Strait Islander children have one of the highest immunisation rates in Australia (p. 5), and several references to visits from the Indigenous cardiac and respiratory outreach programs (p. 15) to Boulia (p. 28) and Winton (p. 36), and support for culturally appropriate care at, for example, Bedourie (p. 25) and Birdsville (p. 26).
      4. **Traditional Owner acknowledgement** The CWHHS *Annual Report* *2014-2015* provides no Traditional Owner acknowledgement. **Score = 0/1.**
      5. **Closing the Gap section** While not listed in the Table of Contents, the CWHHS *Annual Report* *2014-2015* contains a section on Closing the Gap (p. 21). **Score = 1/1.**
      6. **Reporting on KPIs** The CWHHS *Annual Report* *2014-2015,* and in accordance with the CWHHS *Health Service Agreement 2013-14 – 2015/16* (pp. 35-36), reports on the following Closing the Gap KPIs (p. 21):
* The proportion of Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice (DAMA);
* The number of Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH)

The Annual Report 2014 – 2015 (pp. 21 and 49) also provides data regarding the:

* Percentage of non-Indigenous staff who participated in the Aboriginal and Torres Strait Islander Cultural Practice Program.

The *Annual* Report also includes the following information regarding child and maternal health (p. 21):

Data is not yet available on child and maternal health results for 2014-15, though the most recent 2013-14 dataset indicates the region is on track with Closing the Gap targets for reducing low birth weight babies (seven per cent) and attendance at antenatal classes (37 per cent). However, mothers smoking at any stage during pregnancy was over 50 per cent and this is four times the equivalent rate for non-Indigenous mothers.

**Score = 1/1.**

* + - 1. **Policy references** For the CWHHS, 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 Govern ment’s long-term strategy to close the health gap by 2033 and achieve sustainable gains for Aboriginal and Torres Strait Islander people in Queensland.
      2. **Cultural capability framework** The CWHHS *Annual Report* *2014-2015* (p. 49) mentions that:

Central West Health also continued to implement the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework. The training aims to build cross-cultural knowledge and skills, helping to improve access to delivery of mainstream health services and programs to the Aboriginal and/or Torres Strait Islander people of the central west service area.

**Score = 1.5/1.5.**

* + - 1. **Making tracks** The CWHHS *Annual Report* *2014-2015* makes no specific reference to *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders,* however, the report makes mention of both the COAG National Partnership Agreement on Closing the Gap in Indigenous Disadvantage and the COAG National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes(p. 21), the strategic intent of both of which are included in Making Tracks. The section on Closing the Gap (p. 21) provides data on 3 of the KPIs contained in Making Tracks. **Score = 1/1.5.**
      2. **Organisational structure** The organisation chart in the CWHHS *Annual Report* *2014-2015* (p. 43) does not indicate the existence of any Aboriginal and Torres Strait Islander Health Unit (or other form of responsible body). **Score = 0/1.**
      3. **Employment** The CWHHS *Annual Report* *2014-2015* (p. 47) provides data on Aboriginal and Torres Strait Islander participation in the CWHHS workforce (see Note 33). **Score = 1/1.**
      4. **Workforce planning** While no mention is made in the CWHHS *Annual Report* *2014-2015* regarding recruitment, training, etc., of Aboriginal and Torres Strait Islander people for the CWHHS, at a participation level of 23.8% (p. 47), it is already the highest of any Queensland HHS, however, it would be appropriate to see some initiative in place to attract, for example, Aboriginal and Torres Strait Islander medical professionals and more nurses, perhaps with speciality in rural and remote nursing, telehealth, cancer and renal care. **Score = 0.5/1.**
      5. **Awards, recognition, etc.** No awards, etc. to Aboriginal and Torres Strait Islander people were mentioned in the CWHHS *Annual Report* *2014-2015*. **Score = 0/1.**
      6. **Aboriginal and Torres Strait Islander Health Plan.** The CWHHS *Annual Report 2014-2015* (p. 18), mentions the existence of a “Closing the Gap plan”.As also mentioned in Note 7, the CWHHS has established an Indigenous health and well-being working group chaired and directed by local Indigenous members to monitor implementation of the plan. However, it is not sure whether the plan exists in published form and it has not been located on the CWHHS website. **Score 5/10.**
      7. **Cultural competence** Cultural competency is key to effective health system performance in delivering healthcare to Aboriginal and Torres Strait Islander clients. 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.[[301]](#footnote-301)

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 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.[[302]](#footnote-302)
  + - 1. **Cultural competency policy/strategy** The CWHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). With, at 90%, one of the highest rates of non-Indigenous staff to receive CCT (see Note 24) , and with the HHS supporting an Indigenous health and wellbeing working group/committee (see Note 7), all the hallmarks of a cultural competency policy and strategy are evident **Score = 3/3.**
      2. **Capacity to deliver Cultural Competency Training** The CWHHS *Annual Report 2014 – 2015* (pp. 21 and 49) records that: “Two additional cultural practice workshops were delivered in 2014-15, bringing the total number of current staff who have completed the program to 294, equivalent to around 80 per cent of all Central West Health employees.” Elsewhere, in reference to the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework, the report states that “24 more staff have completed training during the year; 90 per cent of all staff have now completed this training”. This suggests that the CWHHS has the capacity to provide CCT to all its staff on a regular basis. **Score = 3/3.**
      3. **Proportion of non-Indigenous staff to receive CCT**  Whether at 80 or 90%, this is the highest rate of CCT of all Queensland HHSs. **Score = 4/4.**
      4. **Indigenous status** Completion of Indigenous status – reporting of ‘not stated’ on admission. Not reported in the CWHHS *Annual Report 2014-2015.* **Score = 0/2**.
      5. **DAMA** The CWHHS *Annual Report 2014 – 2015* (p. 21) made the following statement regarding the rate of DAMA:

There were 10 discharges against medical advice out of 231 Indigenous admissions, or 4.3 per cent of admissions, which was below the target of less than 5 per cent. The long term trend is continuing to reduce the gap.

DAMA rates were not published in Queensland Health’s *Closing the Gap performance report 2015 [[303]](#footnote-303),* but were recorded in the previous year’s Closing the Gap report (p. 29) which provided the following data for the CWHHS for 2013-14:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

3.70% 1.40% 4.30% 1.30% 0.00% 1.20% 3.33% 1.10%

The CWHHS is one of the few HHSs to report its DAMA rates in its 2014-2015 annual report and showing a positive result. **Score = 2/2.**

* + - 1. **PPH** The CWHHS *Annual Report 2014 – 2015* (p. 21) made the following statement regarding the rate of PPH:

There were 90 reported preventable hospitalisations in the central west, representing an unacceptably high 25 per cent of admissions of Indigenous people. This indicator actually increased when compared to the previous year, although the last quarter of the year was a marked improvement at 20.4 per cent. Almost all cases related to chronic disease.

PPH rates were not published in Queensland Health’s *Closing the Gap performance report 2015,* but were recorded in the previous year’s Closing the Gap report (p. 29) which provided the following data for the CWHHS for 2013-14:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

20.40% 17.70% 15.90% 17.70% 24.70% 17.70% 24.70% 17.70%

The CWHHS is one of a few HHSs to report its PPH rates in its 2014-2015 annual report. The score is based on the data provided in the 2014-2015 annual report which noted the unacceptably high rate of PPH. **Score = 0/2.**

* + - 1. **Access to mental health services** measured in terms of the 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 that separation. The CWHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 24) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the CWHHS *Annual Report 2014-2015* (refer p. 21)*.* **Score = 0/2.**
      2. **Access to drug and alcohol services** The CWHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 24) to provide Indigenous Outreach Services under the Alcohol and Other Drug Services program. Not reported in the CWHHS *Annual Report 2014-2015.* **Score = 0/2.**
      3. **ATSI workforce development policy/strategy** The publicly available documents sighted provide no information concerning the existence of a CWHHS Aboriginal and Torres Strait Islander health workforce strategy, although the fact that 23.8% of the CWHHS workforce is Indigenous – nearly 3 times the level for parity, suggests that a strategy (even if informal) is in place (see Notes 18 and 19). However, the score is based on the public availability of such a policy or strategy, and therefore a penalty score has resulted. **Score = 0/3.**
      4. **ATSI Workforce implementation body.** In such a small HHS, it is debatable whether there should be a formal body (unit/committee/working group) to oversee the recruitment, training and employment of Aboriginal and Torres Strait Islander people in the CWHHS workforce, particularly as its Indigenous employment figures are already exemplary. However, the public information sighted does not reveal the existence of such a body. **Score = 0/3.**
      5. **Employment equity** At 23.8%, the employment rate for Aboriginal and Torres Strait Islander people in the CWHHS is exemplary. Aboriginal and Torres Strait Islander participation in the health workforce at the CWHHS exceeds the equity target, based on the percentage of Aboriginal and Torres Strait Islander people in the overall CWHHS area population of 8.3%. **Score = 4/4.**
      6. **Workforce participation.** The CWHHS *Annual Report 2014 – 2015* (p. 47) provides data for four categories: Non-clinical; Medical; Nursing; and Health Professionals. The non-clinical category presumably amalgamates data normally identified under the managerial and clerical, operational services, and trade and artisan employment streams. The report summarises Aboriginal and Torres Strait Islander participation in the workforce as follows:

The Central West Health full time equivalent (FTE) workforce 2014-15 was 323 and focussed more resources to frontline operations. More than eleven percent of Central West Health’s operational staff identify as being an Aboriginal and/or Torres Strait Islander person, as do more than 10 per cent of administrative staff and 2.8 per cent of nursing staff.

The weighting in terms of points allocated for each of the employment streams also reflects the need to ensure that Aboriginal and Torres Strait Islander people are participating in frontline/clinical services as doctors, dentists, medical specialists, nurses, health practitioners, psychologists, physiotherapists, etc. As their participation exceeds parity, maximum scores are therefore given for the operational and administrative (managerial and clerical) streams. No references are made to the numbers/percentages of Indigenous Health Workers/Health Practitioners and Liaison Officers, and who should be identified as constituting a separate employment stream in future reports. **Overall score = 2.5/10.**

* + - 1. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
      2. **Commonwealth contribution** Neither the financial statements contained in the CWHHS *Annual Report 2014 – 2015* nor the CWHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the CWHHS’s Closing the Gap programs or their acquittal. **Score = 0/10**
      3. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the CWHHS has an operating budget of $57.5 million for 2014-15.[[304]](#footnote-304) To support the delivery of the Making Tracks priorities and in accordance with CWHHS *Service Agreement 2013/14-2015/16*, the CWHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:
* mental health services
* chronic disease management services
* sexual and reproductive health services
* continuous quality improvement activities
* Indigenous cultural capability services

More details of the CWHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to Central West Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (CWHHS *Service Agreement 2013/14-2015/16*, pp. 24-25), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within CWHHS annual reports in the interests of public accountability and transparency**.** The CWHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the CWHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**CWHHS documents consulted**

* CWHHS *Annual Report 2014-2015*,
* CWHHS *Annual Report 2014-2015*,
* CWHHS *Strategic Plan 2014-2018*
* CWHHS *Consumer and Community Engagement Strategy 2016 – 2019*
* CWHHS *Service Agreement 2013/14 – 2015/16.*
* CWHHB Board Communiques for 2015: 28 August; 24 September; 22 October; 26 November; and 17 December.

**CWHHS documents not sighted**

‘Closing the Gap funding allocations to Central West Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

* Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: CWHHS *Service Agreement 2013/14-2015/16*, p. 35).
* CWHHB Board Communiques for 2014, and 2015 for months of January – July.

## Darling Downs Hospital and Health Service

**DARLING DOWNS HOSPITAL AND HEALTH SERVICE (DDHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

**Participation in governance**

* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Darling Downs Hospital and Health Board (DDHHB) (3)
* Indigenous representative 10 0
* Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 0
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 0.5**

**Policy implementation**

* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 5
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 0
* Public Reporting and Accountability (via Annual Report) (10)
* Traditional Owner acknowledgement (11) 1 1
* Closing the Gap

(i) Separate section in report devoted to Closing the Gap (12) 1 0

(ii) Reporting on KPIs contained in 2013/14 - 2015/16 service agreement (13) 1 0

* Policy references (14)
* (i) Cultural Capability Framework (15) 1.5 1.5
* (ii) Making Tracks (16) 1.5 1
* Organisational structure (ATSI unit placement within) (17) 1 0.5
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 0
2. Reference to workforce planning, recruitment, etc.(19) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 11**

**Service delivery**

* Aboriginal and Torres Strait Islander Health Service Plan (21) 10 0
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 3
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 3
* Proportion of non-indigenous staff trained (25) 4 2.5
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 8.5**

**Recruitment and employment**

* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander employment policy/strategy (31) 3 0
* Aboriginal and Torres Strait Islander employment implementation body (32) 3 0
* Employment equity (33) 4 0
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1 0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Workers and Indigenous Liaison Officers 2 0
* Operational/Support Services 1 0
* Trade and artisans 1 0
* Health Practitioners (Professional and Technical) 1 0

**Total 20 0**

**Financial Accountability and Reporting: Closing the Gap Funding** (35)

* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0 **Total 20 0**

**Score 140 20**

**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. **Darling Downs Hospital and Health Service** The Darling Downs Hospital and Health Service (DDHHS) covers a predominantly rural region approximately 90,000 square kilometres in area encompassing the South Burnett, Cherbourg, Toowoomba, Southern Downs, Goondiwindi and Western Downs Local Government Areas and the community of Taroom. A significant part of the Surat Basin coal and coal seam gas lies in the western section of this region. The DDHHS serves a population of about 280,000 people, of whom 4.2 per cent, or 11,700, are Aboriginal and Torres Strait Islander (DDHHS *Annual Report 2014-2015,* p.9; DDHHS *Service Agreement 2013/14 – 2015/16*, p. 20). The DDHHS has four ATSICCHSs operating within its region: (i) Cherbourg Regional Aboriginal and Islander Community Controlled Health Service/Barambah Regional Medical Service (Aboriginal Corporation) (Cherbourg and surrounding communities in the South Burnett region); (ii) Goolburri Aboriginal Health Advancement Company Ltd (Toowoomba); (iii) Carbal Medical Centre (an Aboriginal & Torres Strait Islander Community Controlled Medical Service managed by Darling Downs Shared Care Association Incorporated) (Toowoomba and Warwick – opened Feb. 2016); and (iv) Goondir Aboriginal and Torres Strait Islanders Corporations for Health Services (Goondir Health Services) (Dalby and Oakey – also has a clinic in St George in the SWHHS region). The Cherbourg Women’s and Children’s Service facility was opened in February 2015. The Service was established with funding of $860,000 provided by the DDHHS and the Department of Health as a facility operated by DDHHS (DDHHS *Annual Report 2014-2015,* p.38).

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 point out of 20 for all Queensland Health’s 16 HHSs.

3. **DDHHB** The DDHHB comprises 9 non-executive members none of whom identify as Aboriginal or Torres Strait Islander nor declare any specific experience in Aboriginal and Torres Strait Islander health care service delivery in their profiles, however, the deputy chair has had some executive experience in the former Qld Department of Aboriginal and Islander Advancement (DDHHS *Annual Report 2014-2015,* p.62-66). **Score = 0/10.**

4. **Executive Management Structure** The Executive Management Team (EMT) comprises 9 members: the Chief Executive and 8 members with the following portfolios: Executive Director Nursing and Midwifery Services; Executive Director Medical S ervices; Executive Director Allied Health; General Manager Toowoomba Hospital; Executive Director Mental Health; General Manager Rural; Executive Director Workforce; and Chief Finance Officer. There is no separate stand-alone Aboriginal and Torres Strait Islander Health Division, and therefore no Aboriginal and/or Torres Strait Islander executive director. None of the members of the EMT have identified particular experience in Aboriginal and Torres Strait Islander health care in their profiles, and Aboriginal and Torres Strait Islander health is not listed among their particular responsibilities (DDHHS *Annual Report 2014-2015,* p.73-75 and 119-123). **Score = 0/10.**

5. **Closing the Gap health outcomes and the DDHHS Strategic Plan** The DDHHS *Strategic Plan 2015-2019*, with regard to the delivery of quality healthcare, aims to “reduce impact of chronic disease including Closing the Gap for Indigenous peoples” by:

3.2 Partner[ing] with the community to implement the Closing the Gap strategy and Cultural Capability framework

3.3 Provid[ing] staff training to deliver culturally and socially appropriate care.

With regard to ensuring that their processes are clear, the DDHHS will

Collaborate with primary health care and other service providers

1.4 Collaborate with Aboriginal Medical Services to deliver culturally appropriate care.

(DDHHS *Strategic Plan 2015-2019* [1689.v2|06/2015). **Score = 5/5.**

6. **Closing the Gap KPIs included in health service agreement** Of the five Closing the Gap KPIs listed in QHMT Note 23, the DDHHS *Service Agreement 2013/14 – 2015/16* for this triennium identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 41); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 42). **Score = 2/5.**

7. **Aboriginal and Torres Strait Islander consultative body** Under the current DDHHS consumer and community engagement charter and strategy no specific Aboriginal and Torres Strait Islander consultative body or mechanism is identified. In the DDHHS Consumer Council Charter, Aboriginal and Torres Strait Islander consumers are not specifically represented within the DDHHS Consumer Council Structure, its various linking bodies, and are not provided for in the list of appointment categories, which includes, for example, a representative each for Aged Care and Mental Health (DDHHS *Consumer Council Charter* [as approved by the DDHHB, 7 December 2015], pp. 2,3 and 6). In fact Aboriginal and Torres Strait Islander people are not mentioned as a consumer group within the whole document, although it is quite possible that they could be represented within any one of the linkage groups (e.g., forum groups, hospital auxiliaries, advisory groups, etc.), but it is not a requirement. Similarly, and in line with the Health Consumers Queensland (2012) *Consumer and Community Engagement Framework* (Brisbane, Queensland Government), Aboriginal and Torres Strait Islander people are only mentioned within the context of Principle 5: Diversity together with, for example, people with a disability, older persons, younger persons, people from culturally and linguistically diverse backgrounds (DDHHS *Consumer and Community Engagement Strategy*[as approved by the DDHHB, 7 December 2015], p. 6), although they are listed among the 30 regional and local community stakeholder groups embraced by the DDHHS (p. 16). **Score = 0/5.**

8. **RAP** 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, all agencies were supposed to have strategies for early childhood and health in place by December 2009 to put Queensland on track to meet the COAG targets.[[305]](#footnote-305) Queensland Health co-signed with Reconciliation Australia[[306]](#footnote-306) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No reference is made in the publicly available information either from Reconciliation Australia or the DDHHS concerning the existence of a RAP. **Score = 0/3.**

**9. ATSI Health Division/Unit community newsletter** While the DDHHS website maintains a news portal, no evidence was found of either a DDHHS newsletter, or a newsletter published for the region’s Aboriginal and Torres Strait Islander communities.  **Score = 0/2.**

10. **Annual Report** The DDHHS *Annual Report 2014-2015* contains a number of references to Aboriginal and Torres Strait Islander health achievements, for example, the re-establishment of the Cherbourg Health Service to provide services for women’s and children’s health (pp. 11, 38); the success of the “Tackle Flu Before It Tackles You” program (p. 17); and Breastscreen service (pp. 15 and 51)*.*

11. **Traditional Owner acknowledgement** The DDHHS *Annual Report 2014-2015* (p. ii) includes the following acknowledgement: “Darling Downs Hospital and Health Service respectfully acknowledges the traditional owners of the land on which its sites stand.” **Score = 1/1.**

12. **Closing the Gap section** The DDHHS *Annual Report 2014-2015* does not contain a specific section devoted to Closing the Gap initiatives or achievements. **Score = 0/1.**

1. **Reporting on KPIs** The Service Delivery Statements contained in the DDHHS *Annual Report 2014-2015* (p. 59-60) do not include performance against KPIs for DAMA and PPH. **Score = 0/1.**
2. **Policy references** For the DDHHS, 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.
3. **Cultural capability framework** The DDHHS *Annual Report 2014-2015* (p. 16) records that:

The DDHHS Aboriginal and Torres Strait Islander Cultural Capability Plan has been a key focus in 2014-15. As a result there has been a 43 per cent improvement in the number of staff who have accessed and completed the Cultural Practice Program. In 2014-15, 3,337 staff completed the program which supports staff to provide care in culturally appropriate and sensitive ways.

The DDHHS identifies such training as one of the requirements for all employees in order to meet legislative obligations. The Cultural Practice Program is delivered through the Darling Downs Learning On-Line (DD-LOL) system (p. 28). The annual report also records that:

Mandatory Cultural Practice Training was delivered face-to-face at a junior doctor education session for the first time. The district facilitator delivered the session. Attendance was exceptional and feedback was positive (p. 48).

**Score = 1.5/1.5.**

1. **Making Tracks** The DDHHS *Annual Report 2014-2015* has reported on one of the 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 (see Note 15); and (ii) Engage Aboriginal and Torres Strait Islander health service providers and communities in the development and delivery of all health services. **Score = 1/1.5**
2. **Organisational structure** No Aboriginal and Torres Strait Islander Health Unit, or similar body, is located on the diagram of the Structure of Services and Functions presented in the DDHHS *Annual Report 2014-2015* (p. 32), although Cherbourg is identified within the South Burnett Cluster within the rural division. **Score = 0.5/1.**
3. **Employment** The section on the workforce in the DDHHS *Annual Report 2014-2015* (pp. 27-30) contains no data on Aboriginal and Torres Strait Islander employment. **Score = 0/1.**
4. **Workforce planning** No reference is made in the DDHHS *Annual Report 2014-2015* (see pp. 27-30)about the recruitment, training and employment of Aboriginal and Torres Strait Islander people. **Score = 0/1.**
5. **Awards, recognition, etc.** The DDHHS *Annual Report 2014-2015* contains a number of references to awards (pp. 26, 30 and 42). None of the recipients are identified as Aboriginal or Torres Strait Islander, nor are there any awards mentioned that are specifically for Aboriginal and Torres Strait Islander employees. **Score = 0/1.**
6. **Aboriginal and Torres Strait Islander Health Plan** There is no reference in the publicly available information to the existence of a DDHHS Aboriginal and Torres Strait Islander Health Plan. Given the size, diversity and geographic spread of Aboriginal and Torres Strait Islander communities in the DDHHS region, the number of community controlled health services and other health facilities, the urgent need to build the Aboriginal and Torres Strait Islander health workforce capacity (see Notes 31 - 34 below), and the need to strategically plan and coordinate service delivery between the DDHHS and the community services to improve cultural safety and support the patient journey, a coherent plan could be considered an absolute requirement. **Score = 0/10.**
7. **Cultural competence** Cultural competency is key to effective health system performance in delivering healthcare to Aboriginal and Torres Strait Islander clients. 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.[[307]](#footnote-307)

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 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.[[308]](#footnote-308)

1. **Cultural competency policy/strategy**. The DDHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). The Cultural Practice Program (CCP) is one of eleven mandatory training requirements for the DDHHS. As stated in Note 15 above, the DDHHS Aboriginal and Torres Strait Islander Cultural Capability Plan has been a key focus in 2014-15 (DDHHS *Annual Report 2014-2015,* pp. 16 and 29). **Score = 3/3**.
2. **Capacity to deliver CCT.** Together with a number of other training programs (e.g., Patient-Centred Care, Work Health and Safety), CCP is delivered through the Darling Downs Learning On-Line (DD-LOL) system (DDHHS *Annual Report 2014-2015,* p. 28). However, questions about the efficacy of on-line presentation of CCP training still arise. However, it is the most efficient way of ensuring that the maximum number of staff receives such training. **Score 3/3.**
3. **Proportion of non-Indigenous staff to receive CCT** Based on a “headcount of 4,996 employees” which includes some 2,000 part-time employees, and that under the Aboriginal and Torres Strait Islander Cultural Capability Plan, 3,337 staff completed the Cultural Practice Program, a 43% improvement on 2013/2014, this indicates a success rate of 60% (DDHHS *Annual Report 2014-2015,* pp. 16 and 27-28). However, it should be noted that the CPP completion rates lag significantly behind the completion rates for most of the other 10 modules (for example, DDHHS Orientation, Infection Control, Occupational Violence, etc.) (see p. 29 in particular). **Score = 2.5/4.**
4. **Indigenous status** Not reported in the DDHHS *Annual Report 2014-2015.* **Score = 0/2.**
5. **DAMA** The Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the DDHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

4.52% 3.50% 5.00% 2.90% 4.18% 2.40% 4.08% 1.80%

DDHHS was listed among those HHSs that have “persistently high DAMA rates with little or no change throughout the year” (p. 30). Data on DAMA rates were not published for the current assessment period (2014-15) in either the DDHHS *Annual Report 2014 – 2015* or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

1. **PPH** The Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the DDHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

19.30% 17.70% 19.10% 17.70% 16.50% 17.70% 16.60% 17.70%

DDHHS showed significant improvement over the reporting period to better the target in two quarters, however,data on PPH rates were not published for the current assessment period (2014-15) in either the DDHHS *Annual Report 2014 – 2015* or Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*.  **Score = 0/2.**

1. **Access to mental health services** Access to mental health services is measured in terms of the 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 that separation. The DDHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 27) to provide Indigenous Mental Health Services.This Closing the Gap KPI is not reported in the DDHHS *Annual Report 2014-2015* (refer p. 59)*.* **Score = 0/2.**
2. **Access to drug and alcohol services** The DDHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 27) to provide both Indigenous Outreach Services and Indigenous Youth (12-17 years) Treatment Programs under the Alcohol and Other Drug Services program. Not reported in the DDHHS *Annual Report 2014-2015.* **Score = 0/2.**
3. **ATSI workforce development policy/strategy** Both the DDHHS *Annual Report 2014-2015* and the DDHS *Strategic Plan 2015-2019* (particularly in relation to the Strategic Objective: Ensure Dedicated Trained Staff) are silent with regard to the existence of, or development of an Aboriginal and Torres Strait Islander workforce development policy/strategy. **Score = 0/3.**
4. **ATSI workforce implementation body** Consistent with Note 31, there is no special body established to implement an Aboriginal and Torres Strait Islander employment policy/strategy. **Score = 0/3.**
5. **Employment equity** The DDHHS has an Occupied Full-Time Equivalent (FTE) of 3,916 staff (DDHHS *Annual Report 2014-2015,* p. 27), however there is no data presented on Aboriginal and Torres Strait Islander employment. Aboriginal and Torres Strait Islander people represent 4.2 per cent of the total population in the region served by the DDHHS. This means there should be around 160 Aboriginal and Torres Strait Islander employees in the DDHHS workforce. In order to achieve parity with regard to closing the employment gap by 2033, this would mean adding some 10 Aboriginal and Torres Strait Islander staff per year for approximately the next 16 years. Since no data has been provided, the **score = 0/4.**
6. **Workforce participation** The DDHHS *Annual Report 2014-2015*, in the section on the workforce (pp. 27-30), provides no data on Aboriginal and Torres Strait Islander participation in the DDHHS workforce, including within the different employment streams. It is noted that the DDHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous hospital liaison services (see Note 37) and therefore, together with IHWs, ILOs should be categorised for future reporting as a separate employment stream. Therefore, a score of 0 is given for each of the employment categories. **Score = 0/10.**
7. **Financial Accountability and Reporting: Closing the Gap Funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
8. **Commonwealth contribution** Neither the financial statements contained in the DDHHS *Annual Report 2014 – 2015* nor the DDHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the DDHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**
9. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the DDHHS has an operating budget of $616.5 million for 2014-15.[[309]](#footnote-309) To support the delivery of the Making Tracks priorities and in accordance with DDHHS *Service Agreement 2013/14-2015/16* (p. 28), the DDHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

* mental health services
* child and maternal health services
* chronic disease management services
* smoking and alcohol prevention activities
* sexual and reproductive health services
* Indigenous hospital liaison services
* Indigenous cultural capability services

More details of the DDHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to Darling Downs Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (DDHHS *Service Agreement 2013/14-2015/16*, p. 28), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within DDHHS annual reports in the interests of public accountability and transparency**.** The DDHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the DDHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**DDHHS documents consulted**

* DDHHS *Annual Report 2014-2015*,
* DDHHS *Annual Report 2014-2015*,
* DDHHS *Strategic Plan 2014-2018* (revised 2015)
* DDHHS *Consumer and Community Engagement Strategy 2014 – 2018*
* DDHHS *Service Agreement 2013/14 – 2015/16.*
* DDHHB Board meeting summaries for:

1. 2014: 29 January; 25 February; 25 March; 29 April; 27 May; 24 June; 29 July; 26 August; 30 September; 28 October; and 9 December.
2. 2015: 28 January; 24 February; 31 March; 28 April; 26 May; 30 June; 28 July; 24 August; 29 September; no meeting held in November; and 7 December.

**DDHHS documents not sighted**

* DDHHB Board meeting summaries for November 2014, and October 2015.
* ‘Closing the Gap funding allocations to Darling Downs Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: DDHHS *Service Agreement 2013/14-2015/16*, p. 42).

## Gold Coast Hospital and Health Service

**GOLD COAST HOSPITAL AND HEALTH SERVICE (GCHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

* + - 1. **Participation in governance**
* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Gold Coast Hospital and Health Board (GCHHB) (3)
* Indigenous representative 10 0
* Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 0
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 0.5**

* + - 1. **Policy implementation**
* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 0
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 5
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 1
* 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 contained in 2013/14 - 2015/16 service agreement (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
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 1
2. Reference to workforce planning, recruitment, etc.(19s) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 9** 
  + - 1. **Service delivery**
      * Aboriginal and Torres Strait Islander health plan (21) 10 0
      * Cultural competence (22)
* Cultural competency policy/strategy (23) 3 3
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 1.5
* Proportion of non-indigenous staff trained (25) 4 0
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 4.5**

* + - 1. **Recruitment and employment**
* Aboriginal and Torres Strait Islander Health Workforce Development
* Aboriginal and Torres Strait Islander employment policy/strategy (31) 3 0
* Aboriginal and Torres Strait Islander employment implementation body (32) 3 0
* Employment equity (33) 4 3.5
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1 0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Workers and Indigenous Liaison Officers 2 0
* Trade and artisans 1 0
* Operational/Support Services 1 0
* Health Practitioners (Professional and technical) 1 0

**Total 20 3.5**

* + - 1. **Financial Accountability and Reporting: Closing the Gap funding** (35)
* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0 **Total 20 0**

**Score 140 17.5**

**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. **Gold Coast Hospital and Health Service** The Gold Coast Hospital and Health Service (GCHHS) (aka Gold Coast Health) area extends from the New South Wales border in the south to the Coomera region in Queensland and north to the Logan River, and serves a primary catchment population of about 551,000 of whom about 1.2%, or 6,600 people identify as Aboriginal or Torres Strait Islander (about 3.8% of Queensland’s total Aboriginal and Torres Strait Islander population) (GCHHS *Annual Report 2014-2015*, p. 9; GCHHS *Service Agreement 2013/14 – 2015/16,* p. 20). The Gold Coast has one Aboriginal and Torres Strait Islander community controlled health service, Kalwun Health Service with centres located in Miami, Oxenford and Bilinga.[[310]](#footnote-310) As one of its initiatives for 2014-15, GCHHS is formalising a partnership with the North West HHS which:

… recognises that by working together, the parties will be able to identify opportunities and specific initiatives to improve health outcomes for the community with a particular focus on improving the outcomes for Indigenous communities in North West Queensland.[[311]](#footnote-311)

The GCHHS maintains an Aboriginal and Torres Strait Islander Health Service (ATSIHS) which:

… works in partnership with Aboriginal and Torres Strait Islander families, families and community members accessing the Gold Coast Hospital and Health Service (GCHHS) hospitals and community centres to reach their ultimate health and wellbeing by providing an effective, confidential and culturally capable health care service.

ATSIHS provides targeted programs and services that include:

* Hospital Liaison
* Dietetics (appointments and clinics) and nutrition (Promotion, Bush Tucker, Calendar Needs Assessment)
* Child, Youth and Maternal Health (Parenting Programs, Antenatal Programs, Well Baby Health Checks)
* Chronic Disease (Heart Health, Mungulli)
* Yari-Coorara Social and Emotional Wellbeing Team.

ATSIHS promotes Aboriginal and Torres Strait Islander culture through delivery of the Cultural Practice Program and works closely with hospital and community services to ensure culturally capable care for Aboriginal and Torres Strait Islander clients.[[312]](#footnote-312)

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 point out of 20 for all Queensland Health’s 16 HHSs.

3. **GCHHB** The GCHHB comprises 7 members. However, and unusually, the GCHHS *Annual Report 2014-2015* provides no biographical details regarding its board members (see pp 35 and 62). However according to their profiles provided on the Queensland Health website, none identify as an Aboriginal or Torres Strait Islander person, or have specific experience in health care or service delivery to Aboriginal and/or Torres Strait Islander people or their communities.[[313]](#footnote-313) **Score = 0/10.**

4. **Executive Management Structure** The Executive Management Team (EMT) comprises 8 members: the Chief Executive, and 7 members who are responsible for the following portfolios: Centre for Health and Innovation; Clinical Governance, Education and Research; Governance, Risk and Commercial Services; People, Systems and Performance; Operations; Strategy and Planning; and Finance and Business Services (GCHHS *Annual Report 2014-2015*, pp. 38-9 and 63-4). Again, and unusually, no biographical details concerning members of the EMT are contained in the Annual Report. There is no stand-alone executive division for Aboriginal and Torres Strait Islander health.  **Score = 0/10.**

5. **Closing the Gap Health outcomes in the GCHHS Strategic Plan** GCHHS *Strategic Plan 2013-2017* (2015 Update) contains no explicit reference to either the federal or state Closing the Gap policy documents. However, it does state that: “In line with state government objectives, Gold Coast Health will work to address the disproportionate levels of disadvantage experienced by minority groups including Aboriginal and Torres Strait Islander peoples, particularly as it relates to health outcomes” (p. 5). Elsewhere, the Plan notes that there are “over 45 different cultural groups and many more among our community with diverse needs” (p. 10). Presumably Aboriginal and Torres Strait Islander peoples are included among those 45 cultural groups. Similarly, the strategic objectives of the GCHHS listed among the Queensland Government’s service delivery statements for Queensland Health in the 2014-15 budget, contain no specific reference to Indigenous health/Closing the Gap.[[314]](#footnote-314) **Score = 0/5.**

6. **Closing the Gap KPIs in the Health Service Agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the GCHHS *Service Agreement 2013/14 – 2015/16,* for this triennium, identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 39); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 40). **Score = 2/5.**

7. **Aboriginal and Torres Strait Islander consultative body** Under the current GCHHS community engagement and consultative structure within the Division for People, Systems and Performance, Aboriginal and Torres Strait Islander peoples have the opportunity for input into the GCHHS via the Gold Coast Health Consumer Advisory Group. The *Gold Coast Health Consumer Advisory Group: Application pack for new members* (p. 8)lists 18 areas of interest in the Registration Form, none of which specifically references Indigenous health, although an applicant has the option, under “Other” to specify this. During 2013-2015, the membership of the Gold Coast Health Consumer Advisory Group grew from six to 29 members[[315]](#footnote-315). However, the Gold Coast Karulbo Aboriginal and Torres Strait Islander Health Partnership Advisory Group (GCKASTIHPAG) – Kalwun Health service, Krurungal and Aboriginal and Torres Strait Islander Health (GCHHS) have worked together over the past few years to improve collaboration between each of the services and also to increase the profile within the Gold Coast region. This has been achieved:

Through community consultation and planning sessions the core services and network members have identified key areas as priorities where working groups and staff who specialise in those areas have been established to progress these [priorities which] include: Partnerships, Elders, Promotion, Youth, Social and Emotional Wellbeing, Education and Workforce.[[316]](#footnote-316)

Through its partnership status with GCHHS, it effectively has official status. **Score = 5/5.**

8. **RAP** 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, all agencies were supposed to have strategies in place for early childhood and health by December 2009 to put Queensland on track to meet the COAG targets.[[317]](#footnote-317) Queensland Health co-signed with Reconciliation Australia[[318]](#footnote-318) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No reference is made in the publicly available information either from Reconciliation Australia or the GCHHS concerning the existence of a RAP. **Score = 0/3.**

**9. ATSI Health Division/Unit community newsletter.** The GCHHS publishes a bimonthly newsletter *healthwaves+* as a service to the wider Gold Coast community. With regard to items concerning Indigenous health, references to Aboriginal and/or Torres Strait Islander people or events (such as NAIDOC), etc., a sample of 6 issues[[319]](#footnote-319) revealed only three such references - two advertising the same event in different issues.[[320]](#footnote-320) There is no specific GCHHS newsletter for the Aboriginal and Torres Strait Islander community, however, Karulbo, with its strong connection to GCHHS, posts health news from time to time on its website (see Note 7). **Score = 1/2.**

1. **Annual Report** The GCHHS *Annual Report 2014-2015* is almost silent regarding the Indigenous community within its area, containing only three references, one in the context of Harmony Day celebrations in March 2015 during which more than “800 staff enjoyed a healthy lunch as they learnt about indigenous culture, watch Japanese dancing….”(p. 22), and two in relation to Indigenous employment in the GCHHS workforce (pp. 25 and 27). However, the GCHHS appears to enjoy a strong relationship with the Gold Coast Aboriginal and Torres Strait Islander community through the GCKASTIHPAG (see Note 7). It would be good to see this highlighted in future annual reports.
2. **Traditional Owner acknowledgement** There is no TO acknowledgement in the GCHHS *Annual Report 2014-2015*. **Score = 0/1.**
3. **Closing the Gap section** There is no section on Closing the Gap in the GCHHS *Annual Report 2014-2015*. **Score = 0/1.**
4. **Reporting on KPIs** In the Service Performance summary on p. 11 of the GCHHS *Annual Report 2014-2015*, no data is included on the Closing the Gap KPIs for PPH and DAMA as per the GCHHS *Service Agreement 2013/14 – 2015/16* (pp. 39-40). **Score = 0/1.**
5. **Policy references** For the GCHHS, 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.
6. **Cultural capability framework** No reference to the *Cultural Capability Framework* appears in theGCHHS *Annual Report 2014-2015.* **Score = 0/1.5.**
7. **Making Tracks** No reference to the *Making Tracks* policy framework appears in theGCHHS *Annual Report 2014-2015.* **Score = 0/1.5.**
8. **Organisational structure** In the 2 page layout of the organisational structure in the GCHHS *Annual Report 2014-2015* (pp. 38-39) no Indigenous health service entity is listed. **Score = 0/1.**
9. **Employment** In the section describing GCHHS as an “equal opportunity employer”, figures from May 2015 “show 1.03 per cent of Gold Coast Health employees are Aboriginal and Torres Strait Islander” (GCHHS *Annual Report 2014-2015* (pp. 25 and also 27). **Score = 1/1.**
10. **Workforce planning** No reference is made in the GCHHS *Annual Report 2014-2015* to any specific recruitment strategy targeting Aboriginal and Torres Strait Islander people. **Score = 0/1.**
11. **Awards, recognition, etc.** No reference is made in the GCHHS *Annual Report 2014-2015* to any awards, scholarships, etc. that may have been made to Aboriginal and/or Torres Strait Islander people by the GCHHS. **Score = 0/1.**
12. **Aboriginal and Torres Strait Islander health plan** In 2013 the Gold Coast Primary Health Care Protocol was negotiated between the GCHHS, Gold Coast Medicare Local (GCML)[[321]](#footnote-321), General Practice Gold Coast and the Gold Coast Primary Care Partnership Council.[[322]](#footnote-322) The purpose of the Protocol is:

… to build on the existing formal partnership between the Gold Coast Hospital and Health Service (GCHHS) and the Gold Coast Medicare Local (GCML), engaging other leading primary care organisations on the Gold Coast (p. 3).

According to the Protocol, a partnership exists between Karulbo: Aboriginal and Torres Strait Islander Partnership Advisory Council and GCHHS and GCML in which:

Kalwun Health Service, Krurungal and Indigenous Health (QH) have worked together over the past few years to improve collaboration between each of the services & also to increase their profiles within the Gold Coast region (p. 6).

Currently no evidence has emerged in the publicly available information of the existence of an Aboriginal and Torres Strait Islander Health Plan negotiated between Karulbo/Kalwun Health Service and the GCHHS for the region, however, the Protocol might serve as a template or basis for such a plan. **Score = 0/10.**

1. **Cultural competence** Cultural competency is key to effective health system performance in delivering healthcare to Aboriginal and Torres Strait Islander clients. 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.[[323]](#footnote-323)

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 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.[[324]](#footnote-324)

1. **Cultural competency policy/strategy.** The GCHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). No evidence has been found in information published by the GCHHS that it has an Aboriginal and Torres Strait Islander cultural competency policy or strategy to deliver CCT to its non-Indigenous staff. However, Kalwun Health Service informs that responsibility for delivering the GCHHS Cultural Practice Program is undertaken by its Aboriginal and Torres Strait Islander Health Service (see Note 1). **Score = 3/3.**
2. **Capacity to deliver CCT.** Ideally all GCHHS staff should undertake cultural competency training at least once every two years. There are 7,668 (FTE 6,412) staff employed in the GCHHS (*Annual Report 2014- 2015*, p. 24). This roughly translates into CCT for over 3,800 staff per year. While the ATSIHS is responsible for delivering CCT there is no published information as to how effective the training is in terms of the numbers that receive CCT each year or the method of delivery. **Score = 1.5/3.**
3. **Proportion of non-Indigenous staff to receive CCT** There is no published data concerning the numbers of non-Indigenous employees who have completed CCT. **Score = 0/4.**
4. **Indigenous status** Completion of Indigenous status – reporting of ‘not stated’ on admission.This performance indicator has not been reported on. **Score = 0/2.**
5. **DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the GCHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

1.98% 1.60% 2.20% 1.30% 0.77% 1.10% 2.50% 0.90%

GCHHS was listed among five HHSs that have “maintained relatively low rates of DAMA” (p. 30). Data on DAMA rates were not published for the current assessment period (2014-15) in either the GCHHS *Annual Report 2014 – 2015* or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*.[[325]](#footnote-325) **Score = 0/2.**

1. **PPH** The Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the GCHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

14.10% 17.70% 8.70% 17.70% 10.60% 17.70% 10.40% 17.70%

The GCHHS has consistently bettered its quarterly targets. Data on PPH rates were not published for the current assessment period (2014-15) in either the GCHHS *Annual Report 2014 – 2015* or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*.[[326]](#footnote-326)  **Score = 0/2.**

1. **Access to mental health services** Access to mental health services measured in terms of the 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 that separation. The GCHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 26) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the GCHHS *Annual Report 2014-2015* (refer p. 59)*.* **Score = 0/2.**
2. **Access to alcohol and drug services** The GCHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 26) to provide Indigenous Outreach Services under the Alcohol and Other Drug Services program. This performance indicator has not been reported on. **Score = 0/2.**
3. **ATSI employment policy/strategy** The GCHHS *Annual Report 2014 – 2015* makes no mention of the existence of a comprehensive Aboriginal and Torres Strait Islander workforce strategy. **Score = 0/3**
4. **ASTI employment implementation body** Consistent with Note 31,no mention is made of such a body. **Score = 0/3.**
5. **Employment equity** The GCHHS *Annual Report 2014-2015* (pp.24-25) indicates a figure of 6,412 full-time equivalent employees. Based on 1.03% of the workforce being Indigenous, 66 of those employees are Aboriginal and/or Torres Strait Islander. To achieve parity based on Aboriginal and Torres Strait Islander people constituting 1.2% of the total resident Gold Coast population, the figure should be 77. In terms of this criterion, the GCHHS is (one of the) best performers, and could achieve parity in a relatively short time. **Score = 3.5/4.**
6. **Workforce participation according to employment streams.** While obviously employing Aboriginal and Torres Strait Islander people, the GCHHS has, nevertheless failed to provide data on Aboriginal and Torres Strait Islander participation across employment streams. It is also noted that the GCHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous hospital liaison services (see Note 37), and therefore, together with IHWs, ILOs should be categorised as a separate employment stream in future reports. **Score = 0/10.**
7. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
8. **Commonwealth contribution** Neither the financial statements contained in the GCHHS *Annual Report 2014 – 2015* nor the GCHHS *Health Service Agreement 2013/14 – 2-15/16* disclose the Commonwealth contributions to the GCHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**
9. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the GCHHS has an operating budget of $1.064 billion for 2014-15.[[327]](#footnote-327) To support the delivery of the Making Tracks priorities and in accordance with GCHHS *Service Agreement 2013/14-2015/16*, the GCHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

* chronic disease management services
* Indigenous hospital liaison services
* Indigenous cultural capability services

More details of the GCHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to Gold Coast Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (GCHHS *Service Agreement 2013/14-2015/16*, pp. 26-27), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within GCHHS annual reports in the interests of public accountability and transparency**.** The GCHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the GCHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**GCHHS documents consulted**

* GCHHS *Annual Report 2014-2015*,
* GCHHS *Strategic Plan 2014-2018* (revised 2015)
* GCHHS *Consumer and Community Engagement Strategy 2014 – 2018*
* GCHHS *Service Agreement 2013/14 – 2015/16.*
* GCHHS *Gold Coast Primary Health Care Protocol* (Approved by GCHHB 29 October 2013)
* GCHHB Board meeting summaries for:

1. 2014: 4 February; 4 March; 1 April; 6 May; 3 June; 1 July; 14 August; 2 September; 7 October; and 4 November.
2. 2015: 3 February; 3 March; 7 April; 5 May; 2 June; 7 July; 4 August; and 1 September.

* Gold Coast Health (n.d.) *Consumer Advisory Group: Application Pack for new members*
* GCHHS local health newsletter *healthwaves+*
* Gold Coast Health (n.d.) *Community and Consumer Engagement: 2013-15 summary highlights*

**GCHHS documents not sighted**

* Memo ‘Closing the Gap funding allocations to Gold Coast Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: GCHHS *Service Agreement 2013/14-2015/16*, p. 40).

GCHHS Board summaries for December 2014, and January, October; November; and December.

## Mackay Hospital and Health Service

**MACKAY HOSPITAL AND HEALTH SERVICE (MHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

**Participation in governance**

* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Mackay Hospital and Health Board (MHHB) (3)
* Indigenous representative 10 0
  + - * Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 0
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 0.5**

**Policy implementation**

* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 0
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 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 0.5

(ii) Reporting on KPIs contained in 2013/14 - 2015/16 service agreement (13) 1 1

* 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 1
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 0.5
2. Reference to workforce planning, recruitment, etc.(19) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 5**

**Service delivery**

* + - * Aboriginal and Torres Strait Islander health service plan (21) 10 0
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 0
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 0
* Proportion of non-indigenous staff trained (25) 4 0
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 2
* Potentially preventable hospitalisations (PPH) (28) 2 2
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 4**

**Recruitment and employment**

* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce development policy/strategy (31) 3 0
* Aboriginal and Torres Strait Islander workforce implementation body (32) 4 0
* Employment equity (33) 4 0
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1 0.5
* Medical including VMOs 2 0.5
* Nurses 2 0.5
* Indigenous Health Workers and Liaison Officers 2 0
* Trade and artisans 1 0
* Operational/Support Services 1 0.5
* Health Practitioners (Professional and Technical) 1 0

**Total 20 2**

**Financial Accountability and Reporting: Closing the Gap funding** (35)

* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0 **Total 20 0**

**Score 140 11.5**

**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. **Mackay Hospital and Health Service** The Mackay Hospital and Health Service (MHHS) has responsibility for providing public hospital and health services within its primary region to approximately 182,000 people residing within a geographical area covering 90,360 sq km area from Bowen in the north to St Lawrence in the south, west to Clermont and north-west to Collinsville. Proserpine and the Whitsundays are also included in this region. The Aboriginal and Torres Strait Islander population numbers around 8,000 - about 4.4% of the overall population (MHHS *Annual Report 2014 – 2015*, p. 9; see also MHHS *Service Agreement 2013/14 – 2015/16*, p. 20 – population statistics vary slightly from Annual Report: population = 180,424, ATSI population = 3.9%). The MHHS provides an integrated approach to service delivery across acute, primary health and other community based services including Aboriginal and Torres Strait Islander programs (MHHS *Annual Report 2014 – 2015*, p. 9) Three Aboriginal and Torres Strait Islander community controlled health services operate in the MHHS area: Girudala Community Cooperative Society Ltd (Bowen, Collinsville and Proserpine); Aboriginal and Torres Strait Islander Community Health Service (Mackay Ltd) (Mackay); Mudth-Niyleta Aboriginal and Torres Strait Islander Corporation (Sarina). There is also a significant South Sea Islander community in the MHHS area (MHHS *Consumer and Community Engagement Strategy 2014 – 2017,* p. 13). In the MHHS *Consumer and Community Engagement Strategy 2014 – 2017* (p. 16), it is noted that:

The most significant health conditions contributing to the disease burden within the region are cancer, mental health issues and cardiovascular disease. The incidence of these illnesses, together with chronic respiratory disease is particularly high in the local Indigenous population.

The MHHS maintains an Aboriginal and Torres Strait Islander Health Unit (ATSIHU) to

… ensure the development and delivery of culturally appropriate services and models of health care to Aboriginal and Torres Strait Islander people and families by providing support, advice and direction to Queensland Health staff of the Mackay Hospital and Health Service.

The ATSIHU provides a number of services and programs, including:

\* a Hospital Liaison Service to provide culturally appropriate, non-clinical support to inpatients and their families during their hospital stay at the Mackay Base, Sarina, Proserpine and Bowen Hospitals

\* hospital transport service (Mackay Base Hospital)

\* Community Generalist Health Service (with a male and a female Indigenous Health Worker)

\* Maternal and Infant Health Service

\* working with Mackay Community Health (with Indigenous Health Workers across various areas: Home and Community Care; Mental Health Services; Child, Youth and Family Health Services; Sexual Health Services).

\* Deadly Choices Program (a program which informs Aboriginal and Torres Strait Islander participants about staying strong and healthy, maintaining health lifestyles and making positive life choices).[[328]](#footnote-328)

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 point out of 20 for all Queensland Health’s 16 HHSs.

3. **MHHB** The Mackay Hospital and Health Board (MHHB) comprises 8 members, none of whom according to their profiles identifies as an Aboriginal or Torres Strait Islander person, however, one of the board members lists Aboriginal health as one of their specialist areas (MHHS *Annual Report 2014 – 2015*, pp. 32-33). **Score = 0/10.**

4. **Executive Management Structure** The Executive Management Team (EMT) comprises 8 members: the Chief Executive and 7 members responsible for the following directorates: Teaching, Training and Research and District Director of Nursing Services; Finance, Procurement and Infrastructure; People and Culture; Clinical Governance and Chief Medical Officer; Operations Mackay; Clinical and Corporate Support; and Rural Services (MHHS *Annual Report 2014 – 2015*, pp. 31, 40-41 and Financial Statements p. 5-28). The profiles of each of the EMT members reveal no particular experience or expertise in Aboriginal and Torres Strait Islander health care delivery.[[329]](#footnote-329) There is no separate Executive Directorate for Aboriginal and Torres Strait Islander health. **Score = 0/10.**

5. **Closing the Gap health outcomes and the MHHS Strategic Plan** The MHHS *Strategic Plan 2014-2018* (2015 update) is silent on Closing the Gap in Aboriginal and Torres Strait Islander health outcomes as a strategic priority. In fact, no mention is made of Aboriginal and Torres Strait Islander people in the strategic plan. This contrasts markedly with the *Mackay Hospital and Health Service Strategic Plan 2013 –* 2017 presented in the MHHS *Annual Report 2012 – 2013* (p. 10) where a focus on Closing the Gap is an integral part of the plan. **Score = 0/5.**

6. **Closing the Gap KPIs included in health service agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the MHHS *Service Agreement 2013/14 – 2015/16* for this triennium only identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 39); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 40). **Score = 2/5.**

7. **Aboriginal and Torres Strait Islander consultative body** Based on the published information there does not appear to bean Aboriginal and Torres Strait Islander Consultative body to provide independent input into the MHHS. The point is made in the MHHS*Consumer and Community Engagement Strategy 2014-2017* [May 2014 V2.1] that:

Traditionally, people who experience significant disadvantage are disengaged from the health system and are often considered a population who is challenging to reach and engage. As such, targeted engagement strategies are required to enable engagement with marginalised people to ensure health service delivery meets their needs and leads to healthier communities. (p. 15).

At the top of the list of eight vulnerable groups identified in the Strategy are Aboriginal and Torres Strait Islander people. In the MHHS *Annual Report 2014 – 2015*, it is noted that the MHHB maintains the following 8 committees to support the functions of the Board: Executive Committee; Audit and Risk Committee; Finance Committee; Safety and Quality Committee; Strategic and Service Planning Committee; Risk Committee; Finance and Audit Committee; and Patient Safety and Quality Committee (pp. 35-39). The Patient Safety and Quality Committee is responsible for implementing the Consumer and Community Engagement Strategy (MHHS*Consumer and Community Engagement Strategy 2014-2017*, p. 9 and MHHS *Annual Report 2014 – 2015,* p. 39). In addition to the MHHB committees, there are four Health Service Committees: Mackay Hospital and Health Service Executive Committee; Clinical Governance Committee; Credentialing and Scope of Clinical Practice Committee; and the Education and Research Council (p. 42). Given the excess burden of disease born by Aboriginal and Torres Strait Islander people in the MHHS area, their marginal and vulnerable status, and their difficulty in getting their health concerns properly heard, it seems appropriate that they should have their own consultative body as either a board committee, or as a Health Service Committee. It is also instructive to note that while the Mackay Aboriginal and Torres Strait Islander Health Service (MATSIHS) was one of the bodies consulted during the formulation of the MHHS Consumer and Community Engagement Strategy, neither the MATSIHS nor the Girudala Community Cooperative Society Ltd and Mudth-Niyleta Aboriginal and Torres Strait Islander Corporation were listed as “partners and stakeholders which provide consistent support to the MHHS and are instrumental to the implementation of our consumer and community engagement activities.” (MHHS*Consumer and Community Engagement Strategy 2014-2017,* pp. 8 and 16). **Score = 0/5.**

8. **RAP** 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, all agencies were supposed to have strategies in place for early childhood and health by December 2009 to put Queensland on track to meet the COAG targets.[[330]](#footnote-330) Queensland Health co-signed with Reconciliation Australia[[331]](#footnote-331) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005**.** No reference is made in the publicly available information either from Reconciliation Australia or the MHHS concerning the existence of a RAP. **Score = 0/3.**

**9. ATSI Health Division/Unit community newsletter.** A search of the MHHS website[[332]](#footnote-332) revealed no Aboriginal and Torres Strait Islander Health Unit community newsletter, although the website does maintain a “Newsroom”. **Score = 0/2.**

1. **Annual Report** The MHHS *Annual Report 2014 – 2015* contains few references to Aboriginal and Torres Strait Islander health, and is in direct contrast to the substantive entries contained in its earlier *Annual Report 2012 – 2013.*
2. **Traditional Owner acknowledgement** The MHHS *Annual Report 2014 – 2015* contains no acknowledgement of the Aboriginal Traditional Owners of the area. **Score = 0/1.**
3. **Closing the Gap section** The MHHS *Annual Report 2014 – 2015* contains two small “closing the gap” sections devoted to the delivery of: (i) the Deadly Choices program to 73 young people in eight secondary schools in Mackay, Bowen, Dysart, Mirani and Moranbah (p. 16); and (ii) achieving national Aboriginal and Torres Strait Islander closing the gap targets with specific reference to DAMA and PPH rates (p. 18). By comparison, the MHHS *Annual Report 2012 – 2013* lists “Indigenous Health” as a separate section in the table of Contents which refers to a 2-page summary “Our performance: Indigenous Health” with reference to 8 KPIs (pp. 47-48), with further data provided on 4 of those KPIs on p. 55 – see Note 13. **Score = 0.5/1.**
4. **Reporting on KPIs** As required by the MHHS *Service Agreement 2013/14 – 2015/16* (pp. 39-40), the MHHS *Annual Report 2014 – 2015* provides data on only two Closing the Gap KPIs: PPH and DAMA (p. 18). However, it is noted that the MHHS *Annual Report 2012 – 2013* (pp. 47-8 and 55) contains data on the following KPIs and could serve as a model for Closing the Gap reporting:

* KPI 1: Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (as part of the identifiers training project based on separations) (pp. 47 and 55)
* KPI 2: 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 (pp. 48 and 55)
* KPI 3: The proportion of Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice (quarterly data provided) (p. 55)
* KPI 4: Percentage of Aboriginal and Torres Strait Islander Cultural Practice Program participants (p. 55).
* KPI 5: The number of Indigenous Hospital Liaison Officers, including gender specific for Aboriginal and Torres Strait Islander Officers (p. 48)
* KPI 6: The number of Aboriginal and Torres Strait Islander people as a percentage of the total HHS workforce: using MOHRI Occupied Head count (p. 56)
* KPI 7: Number of potentially preventable hospitalisations (Indigenous patients) (no data)
* KPI 8: Increase Indigenous participation in Breast Screening Queensland Service Catchment (p. 48)

Based on the 2 KPIs reported in the MHHS*Annual Report 2014-2015*:  **Score = 1/1.**

1. **Policy references** For the MHHS, 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.
2. **Cultural capability framework** No specific references were made to the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* in the MHHS *Annual Report 2014 – 2015*, and more particularly to the need to build a culturally competent non-indigenous workforce in order to build the capacity of the MHHS to deliver culturally safe and appropriate healthcare to Aboriginal and Torres Strait Islander people. **Score = 0/1.5.**
3. **Making Tracks** No specific references were made to *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders* in the MHHS *Annual Report 2014 – 2015*. **Score = 0/1.5.**
4. **Organisational structure** Indigenous Health is located within the diagram of the MHHS organisation structure (MHHS *Annual Report 2014 – 2015*, p. 31) as one of eight entities under the Directorate of Clinical Governance and the Chief Medical Officer. In the MHHS *Annual Report 2012 – 2013* (p. 22), there is a quasi directorate/division for Regional Indigenous Health listed among the other directorates (e.g., People and Culture, Clinical Services, Allied Health, etc). The MHHS*Consumer and Community Engagement Strategy 2014-2017* [May 2014 V2.1], makes reference to the Regional Indigenous Operations Policy Management Unit (p. 8). **Score = 1/1.**
5. **Employment** The MHHS *Annual Report 2014 – 2015* (p. 28) contains a reference to Aboriginal and Torres Strait Islander participation in the MHHS workforce via a bar chart: EEO Census Data – Mackay HHS % staff as at June 2015. However, no overall percentages or precise numbers of the Aboriginal and Torres Strait Islander people employed in the MHHS workforce are given. See also Note 34. **Score = 0.5/1.**
6. **Workforce planning** In the section regarding “Our people” in the MHHS *Annual Report 2014 – 2015* (pp. 28 - 30) no specific reference is made to any workforce planning or recruitment of Aboriginal and Torres Strait Islander people. **Score = 0/1.**
7. **Awards, recognition, etc.** The MHHS *Annual Report 2014 – 2015* makes no reference to awards, scholarships, etc. given to any of its employees**. Score = 0/1.**
8. **Aboriginal and Torres Strait Islander Health Plan –** Based on publicly available information, there appears to be no Aboriginal and Torres Strait Islander Health Plan, MoU, protocol or formal agreement between the MHHS and the three Indigenous community controlled health services in the area to strategically plan and coordinate service delivery between the MHHS and the community services to improve cultural safety and support the patient journey. A coherent plan or similar instrument could be considered an absolute requirement. **Score = 0/10.**
9. **Cultural competence** Cultural competency is key to effective health system performance in delivering healthcare to Aboriginal and Torres Strait Islander clients. 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.[[333]](#footnote-333)

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 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.[[334]](#footnote-334)

1. **Cultural competency policy/strategy.** The MHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). Thepublicly available information suggests that no such policy/strategy exists. No mention is made as to whether the ATSIHU (see Note 1) has a role in formulating and implementing CCT policy. **Score = 0/3.**
2. **Capacity to deliver CCT** The MHHS *Annual Report 2012 – 2013* (p. 55) provides the following data in regard to achievement of Closing the Gap escalation indicators: Percentage of Aboriginal and Torres Strait Islander Cultural Practice Program participants by facility - Target = 12.5%; Actual = 1.0%.This suggests that the MHHS has limited capacity to deliver CCT. The MHHS *Annual Report 2014-2015* provides no information on CCT. **Score = 0/3.**
3. **Proportion of non-Indigenous staff to receive CCT** No data is provided in the MHHS *Annual Report 2014 – 2015* for CCT regarding the number of non-Indigenous staff who have completed CCT. It is not mentioned in regard to staff performance development (p. 30). **Score = 0/4.**
4. **Indigenous status** Estimated levels of completion of Indigenous status.While this indicator was reported on in the MHHS *Annual Report 2012-2013* (p. 55) – also refer Note 13, it is not included in the *Annual Report 2014-2015.* **Score = 0/2.**
5. **DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the MHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

1.03% 1.40% 2.50% 1.40% 1.82% 1.40% 1.41% 1.40%

MHHS was listed among the four HHSs that have “maintained relatively low rates of DAMA” (p. 30).[[335]](#footnote-335) The MHHS *Annual Report 2014 – 2015* (p. 18) records that: “In 2014-15 the Mackay HHS rate of discharge against medical advice was 1.6% compared to a state average of 3.6%.” **Score = 2/2.**

1. **PPH** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the MHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

14.10% 17.70% 13.80% 17.70% 12.70% 17.70% 10.90% 17.70%

The MHHS *Annual Report 2014 – 2015* (p. 18) records that for 2014-15: “… the rate of potentially preventable hospitalisations for Aboriginal and Torres Strait Islander patients was 10.8% compared to a state average of 16.9%.” **Score = 2/2.**

1. **Access to mental health services** measured in terms of the 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 that separation. The MHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 26) to provide Indigenous Mental Health Services. While included in the MHHS *Annual Report 2012-2013* (p. 55),this Closing the Gap KPI is not reported in the MHHS *Annual Report 2014-2015* (refer pp. 23-24)*.* **Score = 0/2.**
2. **Access to drug and alcohol services** this Closing the Gap KPI is not reported in the MHHS *Annual Report 2014-2015* (refer pp. 23-24)*.* **Score = 0/2.**
3. **ATSI workforce development policy/strategy** Based on the published information the MHHS does not appear to havean Aboriginal and Torres Strait Islander health workforce strategy or a body to implement it, although this may well be one of the roles of the Regional Indigenous Operations Policy Management Unit referred to in the MHHS*Consumer and Community Engagement Strategy 2014-2017* (p. 8). **Score = 0/3.**
4. **ATSI workforce implementation body.** The publicly available information sighted does not reveal the existence of such a body. See also Note 31. **Score = 0/3.**
5. **Employment equity.** With no data regarding overall numbers or percentages of Aboriginal and Torres Strait Islander people employed in the MHHS workforce has been provided, it is difficult to make comments about employment equity. Aboriginal and Torres Strait Islander people constitute 4.4% of the overall population, and the MHHS employs some 1,865 staff (permanent, temporary and casual) (as at 30 June 2015) (MHHS *Annual Report 2014-2015,* p. 28). This means the MHHS should employ around 76 Aboriginal and Torres Strait Islander people. **Score = 0/4.**
6. **ATSI workforce participation** According to the bar-chart for Equal Employment Opportunity (EEO) Census Data Mackay HHS % staff as at 30 June 2015, Aboriginal and Torres Strait Islander people are employed in all employment classification streams, except Trade and artisans (MHHS *Annual Report 2014 – 2015*, p. 28). However, in the absence of actual percentages, it is difficult to gauge the actual level of participation of Aboriginal and Torres Strait Islander people in the MHHS workforce. However, the MHHS *Annual Report 2012 – 2013* (p. 56) provides Aboriginal and Torres Strait Islander workforce participation in a more useful and accurate format according to Queensland Health classification streams:

**Classification Stream ATSI Non-English speaking People with disabilities**

**Managerial & Clerical 3.06% 5.56% 2.78%**

**Medical (incl VMOs) 1.38% 19.85% 0.92%**

**Nursing 1.42% 7.31% 2.51%**

**Operational 3.06% 7.13% 2.29%**

**Trades & Artisans 0% 0% 0%**

**HP, Professional**

**& Technical 0.95% 7.37% 2.84%**

Given the purpose of this criterion is to encourage full reporting and transparency with regard to Aboriginal and Torres Strait Islander participation in the MHHS workforce, if the data on Aboriginal and Torres Strait Islander employment had been presented in the same format as in the 2012-2013 report, but with the inclusion of a category specifically for Aboriginal and Torres Strait Islander Health Workers and Liaison Officers, a much better score would have resulted. It is also noted that the MHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous hospital liaison services (see Note 37). **Overall score = 2/10.**

1. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
2. **Commonwealth contribution** Neither the financial statements contained in the MHHS *Annual Report 2014 – 2015* nor the MHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the MHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**
3. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the MHHS has an operating budget of $320 million for 2014-15.[[336]](#footnote-336) To support the delivery of the Making Tracks priorities and in accordance with MHHS *Service Agreement 2013/14-2015/16*, the MHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

* child and maternal health services
* sexual and reproductive health services
* chronic disease management services
* Indigenous hospital liaison services
* Indigenous cultural capability services

More details of the MHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to Mackay Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (MHHS *Service Agreement 2013/14-2015/16*, p. 27), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within MHHS annual reports in the interests of public accountability and transparency**.** The MHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the MHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**MHHS documents consulted**

* MHHS *Annual Report 2014-2015*,
* MHHS *Annual Report 2014-2015*,
* MHHS *Strategic Plan 2014-2018* (revised 2015)
* MHHS *Consumer and Community Engagement Strategy 2014 – 2018*
* MHHS *Service Agreement 2013/14 – 2015/16.*
* MHHB Board meeting summaries for:

1. 2014: 23 January; 22 February; 27 March; no meeting in April; 1 May; 22 May; 26 June; 24 July; 26 August; 25 September; 23 October; 27 November; and 18 December.
2. 2015: 29 January; 26 February; 26 March; 23 April; 28 May; 24 June; 23 July; 27 August; 24 September; 22 October; and 26 November.

**MHHS documents not sighted**

Memo ‘Closing the Gap funding allocations to Mackay Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: MHHS *Service Agreement 2013/14-2015/16*, p. 40).

MHHB Board meeting summary December 2015.

## Metro North Hospital and Health Service

**METRO NORTH HOSPITAL AND HEALTH SERVICE (MNHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

**Participation in governance**

* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Metro North Hospital and Health Board (MNHHB) (3)
* Indigenous representative 10 0
* Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 2.5
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 3**

**Policy implementation**

* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 1
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 2
* 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 contained in 2013/14 - 2015/16 service agreement (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 1
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 0
2. Reference to workforce planning, recruitment, etc.(19) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 6**

**Service delivery**

* Aboriginal and Torres Strait Islander health plan (21) 10 0
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 3
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 1
* Proportion of non-indigenous staff trained (25) 4 0
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 4**

**Recruitment and employment**

* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander employment policy/strategy (31) 3 2
* Aboriginal and Torres Strait Islander employment implementation body (32) 3 3
* Employment equity (33) 4 0
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1 0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Practitioners/Health Workers and Liaison Officers 2 0
* Operational/Support Services 1 0
* Trade and artisans 1 0
* Health Practitioners (Professional and Technical) 1 0 **Total 20 5**

**Financial Accountability and Reporting: Closing the Gap funding** (35)

* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0 **Total 20 0**

**Score 140 18**

**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. **Metro North Hospital and Health Service** The Metro North Hospital and Health Service (MNHHS) covers an area covering 4,157 square kilometres extending from the Brisbane River to north of Kilcoy. MNHHS has responsibility for providing public hospital and health services within its primary region to approximately 960,000 people, 1.6% of whom (or about 15,400 people) are of Aboriginal and Torres Strait Islander origin, and about 8.7% of Queensland’s total Indigenous population (MNHHS *Service Agreement 2013/14 – 2015/16,* p. 20). The MNHHS is also served by 3 ATISCCHSs: Moreton Aboriginal and Torres Strait Islander Community Health Service (MATSICHS) (Caboolture), the Institute for Urban Indigenous Health (IUIH) (Bowen Hills), and the Aboriginal and Torres Strait Islander Community Health Service Brisbane Northgate Clinic. MATSICHS operates clinics at Caboolture, Morayfield, Strathpine and Deception Bay. IUIH integrates four ATSICCHSs in South East Queensland: Moreton Aboriginal and Torres Strait Islander Community Health Service (Caboolture); Aboriginal and Torres Strait Islander Community Health Service Brisbane Ltd (Wooloongabba); Kambu (Ipswich); Kalwun Health Service (Gold Coast); and Yulu-Burri-Ba (Stradbroke Island and Capalaba).

The MNHHS has a Metro North Aboriginal and Torres Strait Islander Health Unit. Indigenous Hospital Liaison Services are maintained at the Royal Brisbane and Women’s Hospital (RBWH), The Prince Charles Hospital (TPCH), and Caboolture and Redcliffe hospitals (MNHHS *Annual Report 2014-2015*, p. 39) and Improving the Patient Journey teams/Regional and Remote Indigenous Patient Journey Care Coordinators based at the RBWH and TPCH for patients, family or community members coming to Brisbane for treatment.[[337]](#footnote-337) The Unit also includes an Indigenous Strategic Development Team (*TALK-About* March 2015 edition*,* p. 3).

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 point out of 20 for all Queensland Health’s 16 HHSs.

3. **MNHHB** The Metro North Hospital and Health Board (MNHHB) consists of 8 members, none of whom, according to their profiles, identify as Aboriginal or Torres Strait Islander, or have experience in the delivery of health care or services to Aboriginal and/or Torres Strait islander people (MNHHS *Annual Report 2014 – 2015,* pp. 23-26, and 67). **Score = 0/10**.

4. **Executive Management Structure** The Senior Executive Leadership Team (SELT), as at June 30 2015, has 23 members. The Team consists of the Chief Executive; Executive Director Operations; Chief Finance Officer; Executive Director Clinical Governance, Safety, Quality and Risk; Executive Director Clinical Services; Executive Director System Support; three Professional Leads (Executive Director Medical Services; Executive Director Nursing and Midwifery Services; and Executive Director Allied Health); eight Directorate Executive Directors (Executive Director Royal Brisbane and Women’s Hospital; Executive Director The Prince Charles Hospital; Executive Director Redcliffe Hospital; Executive Director Caboolture and Kilcoy Hospitals; Executive Director Ambulatory, Community, and Indigenous Health Service; Executive Director Oral Health services; Executive Director Mental Health Services; and Executive Director Medical Imaging); and five Clinical Stream Executive Directors (Executive Director Medicine; Executive Director Surgery; Executive Director Critical Care; Executive Director Cancer Care; Executive Director Women’s and Children’s; and Executive Director Heart and Lung). The position description for the Executive Director Ambulatory, Community, and Indigenous Health Service is also described as Executive Manager and Director of Nursing, Community, Indigenous and Subacute Services and responsible for the “management of the efficient, effective and economic administration of the operations of Primary Health, Community Health and Aged Care within the Health Service” (p. 69). There is no stand-alone division responsible for Aboriginal and Torres Strait Islander Health within the MNHHS, however, it is acknowledged that Indigenous Health exists at directorate level, but within a composite portfolio. **Score = 2.5/5.**

Unlike most of the other HSSs, none of the SELT members, except for the HSCE, are profiled in the MNHHS *Annual Report 2014 – 2015* (pp. 27-28 and 69) or on the MNHHS website[[338]](#footnote-338), so there is no information to confirm whether or not any of the members identifies as an Aboriginal or Torres Strait Islander person, or whether they have specific experience in the delivery of health care services to Aboriginal and Torres Strait Islander people. A penalty score results. **Score = 0/5.**

5. **Closing the Gap health outcomes and the MNHHS Strategic Plan** Apart from mentioning dedicated units that provide, *inter alia*, Aboriginal and Torres Strait Islander health services and opportunities to align the Commonwealth agenda ‘closing the gap’ “to our commitment to the Metro North Aboriginal and Torres Strait Islander communities” both the MNHHS *Strategic Plan 2015-2019* and the MNHHS *Health Strategy 2015-2020* (p. 5) contain no further mention of any explicit commitment to Closing the Gap within the strategic objectives, despite the opportunities in the latter to do so in Strategic Priority 04: Other service priorities (p. 16-17) and Strategic Priority 05: Work in partnership to better connect care across the system (pp. 18-19). **Score = 1/5.**

6. **Closing the Gap KPIs included in Health Service Agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the MNHHS *Service Agreement 2013/14 – 2015/16* for this triennium identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 43); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 44). **Score = 2/5.**

7. **Aboriginal and Torres Strait Islander consultative body** Currently the principal community and consumer engagement consultative mechanisms are the Community Board Advisory Group and the Partnering with Consumers Leaders Group (MNHHS *Connecting for Health: Strategy for inclusive engagement, involvement and partnerships 2016 -2018,* pp. 12 and 15). The *Connecting for Health* strategy came into effect January 2016, but makes no mention of a separate Aboriginal and Torres Strait Islander consultative body. Also there is no specific mention of the existence of a stand-alone Aboriginal and Torres Strait Islander community consultative body, or the intention to establish such a body. **Score = 0/5.**

1. **RAP** 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.[[339]](#footnote-339) Queensland Health co-signed with Reconciliation Australia[[340]](#footnote-340) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No reference is made in the publicly available information either from Reconciliation Australia or the MNHHS concerning the existence of a RAP. **Score = 0/3.**
2. **Aboriginal and Torres Strait Islander Health Division/Unit community newsletter** The MNHHS Aboriginal & Torres Strait Islander Health Unit publishes a bi-monthly community newsletter, *Talk-About,* which covers program updates, events, community stories and staff profiles.[[341]](#footnote-341) This is a substantial publication of around 30 pages, and sets the benchmark for HHS newsletters. **Score = 2/2.**
3. **Annual Report** The sub-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) *Annual Report.* *2012-2013.* Apart from referring to the operation and achievements of the Indigenous Hospital Liaison Service (p. 39), the MNHHS *Annual Report 2014 – 2015* is virtually devoid of any information with regard to its performance in health care service delivery to the Aboriginal and Torres Strait Islander population within its area.
4. **Traditional Owner acknowledgement** The MNHHS *Annual Report 2014 – 2015* contains no Traditional Owner acknowledgement. **Score = 0/1.**
5. **Closing the Gap section** The MNHHS *Annual Report 2014 – 2015* neither mentions anywhere in the report, or contains a separate section on progress, initiatives, etc. with regard to Closing the Gap. **Score = 0/1.**
6. **Reporting on KPIs** The MNHHS *Annual Report 2014 – 2015* provides no data on its Service Agreement Closing the Gap KPIs for PPH and DAMA (see MNHHS *Service Agreement 2013/14 – 2015/16,* pp. 43-4). **Score = 0/1.**
7. **Policy references** For the MNHHS, 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.
8. **Cultural capability framework** The MNHHS *Annual Report 2014 – 2015* contains no explicit reference to the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* or progress or initiatives undertaken. **Score = 0/1.5**.
9. **Making Tracks** The MNHHS *Annual Report 2014 – 2015* does not contain any reference to or information with regard to *Making Tracks* progress or initiatives. **Score = 0/1.5**
10. **Organisational structure** The MNHHS *Annual Report 2014 – 2015* (p. 20) locates the clinical directorate for Ambulatory, Community and Indigenous Health Service on the chart of its organisational management structure. **Score = 1/1.**
11. **Employment** The MNHHS *Annual Report 2014 – 2015* provides no data on Aboriginal and Torres Strait Islander health workforce participation (see p. 36). **Score 0/1.**
12. **Workforce planning** The MNHHS *Annual Report 2014 – 2015* makes no reference to any strategy to increase Aboriginal and Torres Strait Islander participation in the MNHHS workforce. **Score = 0/1.**
13. **Awards, recognition, etc.** A number of awards recipients are mentioned in the MNHHS *Annual Report 2014 – 2015* (pp. 11, 14 and 23), however no Aboriginal or Torres Strait Islander recipients are mentioned. **Score = 0/1.**
14. **Aboriginal and Torres Strait Islander Health Plan** As recorded in Note 1 above, there are a number of ATSICCHSs operating in the MNHHS area. However, according to current publicly available information, nowhere is there any mention of some formal agreement, protocol, plan, or MOU with any of these health services in place. However, the MNHHS *Connecting for Health: Strategy for inclusive engagement, involvement and partnerships 2016 -2018* came into effect January 2016, and does include as an action: “Targeted strategies for Aboriginal and Torres Strait Islander communities” with a performance measure in which “Metro North has an action plan for addressing local Aboriginal and Torres Strait Islander health issues”. This is to be achieved by the MNHHS Aboriginal and Torres Strait Islander (A&TSI) Health Unit in partnership with local A&TSI organisations and communities (p. 17). As this does not fall within the 2014-2015 audit timeframe no points can be given, although this initiative augurs well for a future audit.  **Score = 0/10.**
15. **Cultural competence** 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.[[342]](#footnote-342)

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 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.[[343]](#footnote-343)

1. **Cultural competency policy/strategy** The MNHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). As in Note 15, the MNHHS *Annual Report 2014 – 2015* contains no explicit reference to the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* or progress or initiatives undertaken. However, the A&TSIHU has been delivering an online Cultural Practice eLearning Program since 2013.[[344]](#footnote-344) **Score = 3/3.**
2. **Capacity to deliver CCT:** Ideally all MNHHS staff should undertake cultural competency training at least once every two years. Since there are over 13,500 full-time equivalent employees in the MNHHS (MNHHS *Annual Report 2014 – 2015*, p. 36) this roughly translates into CCT for over 6,750 staff per year. After two years of running the Cultural Practice eLearning Program, a milestone of 5,000 participants was achieved in September 2015, which is significantly lower than the suggested target. **Score = 1/3.**
3. **Proportion of non-Indigenous staff to receive CCT** The MNHHS *Annual Report 2014 – 2015* provides no KPI data on the number of non-Indigenous staff who have received CCT. **Score = 0/4.**
4. **Indigenous status** Indigenous status – specifically the reporting of ‘not stated’ on admission. Not reported in MNHHS *Annual Report 2014-2015.[[345]](#footnote-345)*  **Score = 0/2**
5. **DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the MNHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

3.38% 3.70% 4.30% 3.20% 4.37% 2.60% 4.17% 2.10%

The MNHHS has bettered the target for only one quarter. Despite being included in the MNHHS *Service Agreement 2013/14-2015/16* (p. 44), data on DAMA rates were not published for the current assessment period (2014-15) in either the MNHHS *Annual Report 2014 – 2015* (see Non-financial performance: An overview, pp. 16-17) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

1. **PPH** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the MNHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

13.80% 17.70% 14.70% 17.70% 13.30% 17.70% 14.70% 17.70%

The MNHHS has bettered the target for each quarter. Despite being included in the MNHHS *Service Agreement 2013/14-2015/16* (p. 43), data on PPH rates were not published for the current assessment period (2014-15) in either the MNHHS *Annual Report 2014 – 2015* (see Non-financial performance: An overview, pp. 16-17) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

1. **Access to mental health services** Access to mental health servicesmeasured in terms of the 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 that separation. The MNHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 28) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the MNHHS *Annual Report 2014-2015.* **Score = 0/2.**
2. **Access to drug and alcohol services.** The MNHHS was funded under its *Service Agreement 2013/14 – 2015/16* (pp. 28-29) to provide both Indigenous Outreach Services and Indigenous Youth (12-17 years) Treatment Programs under the Alcohol and Other Drug Services program. Under the latter, MNHHS as charged with hosting the Indigenous Youth Alcohol and Other Drug Treatment Network Support Service (Closing the Gap) – Dovetail (statewide). This Closing the Gap KPI is not reported in the MNHHS *Annual Report 2014-2015.*  **Score = 0/2.**
3. **ATSI workforce policy/strategy** While not mentioned in the MNHHS *Annual Report 2014-*2015 (see Note 19), in the March 2015 edition of *TALK-About,* the Indigenous Strategic Development Team, as part of its 2015 business plan, includes the “Creation of an MNHHS Aboriginal and Torres Strait Islander Employment Strategy to increase the number of Indigenous Australians working within our facilities.”(p. 3). While the intention is clear, this strategy has not been sighted. **Score = 2/3.**
4. **ATSI employment implementation body.** Presumably the Indigenous Strategic Development Team mentioned in Note 31 would be the responsible body. **Score= 3/3**
5. **Employment equity**  According to the MNHHS *Annual Report 2014 – 2015* (p. 36) there are about 13,500 FTE employees in the service, however, the report contains no data on Aboriginal and Torres Strait Islander participation in the MNHHS workforce. Aboriginal and Torres Strait Islander people constitute around 1.6% of the total population served by the MNHHS, therefore on a basis of equity the target for participation in the MNHHS workforce is 216. As no data has been given in the annual report, no calculation can be made on what numbers need to be employed on an annual basis over the next 16 years in order to achieve parity with regard to closing the employment gap by 2033. **Score 0/4.**
6. **Workforce participation** While it is clear that there are a number of Aboriginal and Torres Strait Islander employees in the MNHHS workforce, many based at the major hospitals (eg, the Ngarrama Royal Midwifery Group Practice at the Royal Brisbane and Women’s Hospital), no formal data has been provided in the MNHHS *Annual Report 2014 – 2015* (p. 36), either in terms of an overall percentage, or in terms of their participation in QH’s six employment streams, to enable a score. An additional stream for Aboriginal and Torres Strait Islander Health Practitioners/Health Workers and Liaison Officers has been added as a category in its own right instead of IHWs and ILOs being in the Managerial and clerical stream for future reporting. It is also noted that the MNHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous hospital liaison services (see Note 37). **Overall score = 0/10.**
7. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
8. **Commonwealth contribution** Neither the financial statements contained in the MNHHS *Annual Report 2014 – 2015* nor the MNHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the MNHHS’s Closing the Gap programs or their acquittal. **Score = 0/10**.
9. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the MNHHS has an operating budget of $2.088 billion for 2014-15.[[346]](#footnote-346) To support the delivery of the Making Tracks priorities and in accordance with MNHHS *Service Agreement 2013/14-2015/16*, the MNHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

* child and maternal health services
* smoking and alcohol prevention activities
* sexual and reproductive health services
* Indigenous cardiac and respiratory outreach services
* Indigenous hospital liaison services
* Indigenous cultural capability services

More details of the MNHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to Metro North Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (MNHHS *Service Agreement 2013/14-2015/16*, pp. 29-30), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within MNHHS annual reports in the interests of public accountability and transparency**.** The MNHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the MNHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**MNHHS documents consulted**

* MNHHS *Annual Report 2013-2014*,
* MNHHS *Annual Report 2014-2015*,
* MNHHS *Strategic Plan 2015-2019*
* MNHHS *Health Strategy 2015-2020*
* MNHHS *Consumer and Community Engagement Strategy 2014 – 2018****.***
* MNHHS *Connecting for Health: Strategy for inclusive engagement, involvement and partnerships 2016 -2018,*
* MNHHS *Service Agreement 2013/14 – 2015/16.*
* MNHHB Board meeting summaries for:

1. 2014: 4 February; 4 March; 1 April; 6 May; 3 June; 1 July; 5 August; 2 September; 7 October; 25 November; and 16 December.
2. 2015: 3 February; 3 March; 7 April; 5 May; 2 June; 7 July; 4 August; 1 September; 6 October; and 16 December.

* MNHHS Aboriginal & Torres Strait Islander Health Unit newsletter, *Talk-About,* Issues: March 2015; July 2015; and October/November 2015.

**MNHHS documents not sighted**

Memo ‘Closing the Gap funding allocations to Metro North Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: MNHHS *Service Agreement 2013/14-2015/16*, p. 44).

MNHHB Board meeting summaries for January 2014, and January and November 2015.

## Metro South Hospital and Health Service

**METRO SOUTH HOSPITAL AND HEALTH SERVICE (MSHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

**Participation in governance**

* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Metro South Hospital and Health Board (MSHHB) (3)
* Indigenous representative 10 0
* Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 0
* Aboriginal/Torres strait Islander Executive Director 5 0

**Total 40 0.5**

**Policy implementation**

* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 0
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 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 contained in 2013/14 - 2015/16 service agreement (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
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 1
2. Reference to workforce planning, recruitment, etc.(19) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 3**

**Service delivery**

* Aboriginal and Torres Strait Islander health service plan (21) 10 0
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 0
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 0
* Proportion of non-indigenous staff trained (25) 4 0
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 0**

**Recruitment and employment**

* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce policy/strategy (31) 3 0
* Aboriginal and Torres Strait Islander workforce implementation body (32) 3 0
* Employment equity (33) 4 2
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1 0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Practitioners/Health Workers and Liaison Officers 2 0
* Operational and Support Services 1 0
* Trade and artisans 1 0
* Health Practitioners (Professional and Technical) 1 0 **Total 20 2**

**Financial Accountability and Reporting: Closing the Gap funding** (35)

* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0 **Total 20 0**

**Score 140 5.5**

**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. **Metro South Hospital and Health Service** The Metro South Hospital and Health Service (MSHHS) (aka Metro South Health) primary catchment region includes all of Brisbane City south of the Brisbane River, Redland City, Logan City, Beaudesert City and the eastern portion of the Scenic Rim, and has responsibility for providing public hospital and health services to just over 1 million people. It also services a regional catchment for higher level services and a statewide catchment for super speciality services. 2% of the MSHHS population, or about 25,500 people, is estimated to be of Aboriginal and Torres Strait Islander origin (MSHHS *Service Agreement 2013/14 – 2015/16*, p. 20; MSHHS *Annual Report 2014 – 2015,* p. 13). The Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care, a Queensland Health facility, also known as the Inala Indigenous Health Service is located in the MSHHS area[[347]](#footnote-347), as are the Aboriginal and Torres Strait Islander Community Health Service Brisbane Ltd (ATSICHS Brisbane) and Yulu Burri-Ba Aboriginal Corporation for Community Health (based at Dunwich, North Stradbroke Island, also services the Indigenous communities in Capalaba and Wynnum). ATSICHS Brisbane has clinics in Wooloongabba, Acacia Ridge, Browns Plains, Logan Woodridge Mums & Bubs and Northgate (in the MNHHS area).

The Aboriginal and Torres Strait Islander Coordination Team (ATSICT) in the Health Equity and Access Unit at MSHHS ensures the delivery of quality, coordinated health strategies, programs and services for the Aboriginal and Torres Strait Islander community. The work of the ATSICT includes:

Enabling Metro South Health services to increase health care access for Aboriginal and Torres Strait Islander peoples and improve their health;

Analysing service data to identify and develop strategies that can improve the health of Aboriginal and Torres Strait Islander peoples;

Developing and maintaining Aboriginal and Torres Strait Islander health networks within Metro South Health and across external organisations

Developing resources and delivering capability training that increases the competence of Metro South Health services to provide culturally responsive and safe care for Aboriginal and Torres Strait Islander peoples;

Enabling Metro South services and facilities to meet Closing the Gap targets and accreditation standards; and

Partnering with Aboriginal and Torres Strait Islander community organisations to promote healthy eating in the community and workplaces.[[348]](#footnote-348)

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 points out of 20 for all Queensland Health’s 16 HHSs.

3. **MSHHB** The Metro South Hospital and Health Board (MSHHB) consists of 7 members, none of whom, according to their profiles, identify as Aboriginal or Torres Strait Islander, or have experience in the delivery of health care or services to Aboriginal and/or Torres Strait islander people (MSHHS *Annual Report 2014 – 2015,* pp. 19 and 21 - 24). **Score = 0/10.**

4. **Executive Management Structure** The Executive Management Team (EMT) consists of 12 members and include the following: Chief Executive; Executive Director PAH-QEII Health Network; Executive Director Logan-Bayside Health Network; Executive Director Addiction and Mental Health Services; Executive Director Clinical Governance; Chief Finance Officer; Executive Director Corporate Services Metro South Health; Chief Information Officer; Executive Director Planning, Engagement and Reform; Executive Director Nursing and Midwifery Services; Executive Director Medical Services; and Executive Director of Allied Health Services. According to their profiles, none of the Executive Management Team identifies as an Aboriginal or Torres Strait Islander person, and none claim specific experience in the delivery of health care services to Aboriginal and Torres Strait Islander people (MSHHS *Annual Report 2014 – 2015,* pp. 27-29 and 110-11). There is no stand-alone division responsible for Aboriginal and Torres Strait Islander Health within the MSHHS. **Score = 0/10.**

5. **Closing the Gap health outcomes in the MSHHS Strategic Plan.** The MSHHS *Strategic Plan 2012-2016* has not yet been sighted.However, as summarised in theMSHHS *Annual Report 2014 – 2015* (p. 51), the 9 strategic objectives do not include a specific objective concerned with Closing the Gap. **Score = 0/5.**

**Closing the Gap KPIs listed in Health Service Agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the MSHHS *Service Agreement 2013/14 – 2015/16* for this triennium identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 43); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 44). **Score = 2/5.**

**Aboriginal and Torres Strait Islander consultative body** The MSHHS *Annual Report 2014 – 2015* (pp. 33-43) refers to some 21 entities (committees, networks, meetings, groups, etc.) overseen by members of the Executive Management Team. While Aboriginal and Torres Strait Islander people would be able to participate on some of these bodies (for example, the Human Research Ethics Committee – see. p. 38), there is no dedicated stand-alone Aboriginal and Torres Strait Islander consultative/advisory body listed among these entities. **Score = 0/5.**

**RAP** 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.[[349]](#footnote-349) Queensland Health co-signed with Reconciliation Australia[[350]](#footnote-350) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No reference is made in the publicly available information either from Reconciliation Australia or the MSHHS concerning the existence of a RAP. **Score = 0/3.**

**Aboriginal and Torres Strait Islander Health Division/Unit community newsletter.**  MSHHS publishes a quarterly newsletter *Your Health.* The ATSICT does not publish its own newsletter for the Aboriginal and Torres Strait Islander community. **Score = 0/2.**

**Annual Report** The sub-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.*

**Traditional Owner acknowledgement** No Traditional Owner acknowledgement is given in the MSHHS *Annual Report 2014 – 2015*. **Score = 0/1**.

**Closing the Gap section** There is no separate section devoted to Closing the Gap initiatives, outcomes, etc., in the MSHHS *Annual Report 2014 – 2015*. **Score = 0/1.**

**Reporting on KPIs** The MSHHS *Annual Report 2014 – 2015* (pp. 74-75) provides no data for any Closing the Gap KPIs. **Score = 0/1.**

**Policy references** For the MSHHS, 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.

**Cultural capability framework** The MSHHS *Annual Report 2014 – 2015* contains no explicit reference to the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033*. **Score = 0/1.5.**

**Making Tracks** The MSHHS *Annual Report 2014 – 2015* contains no explicit reference to the *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Policy and Accountability Framework.* **Score = 0/1.5.**

**Organisational structure** There is no Aboriginal and Torres Strait Islander Health Unit/Service located on the MSHHS organisational chart (MSHHS *Annual Report 2014 – 2015,* see p. 18). **Score = 0/1.**

**Employment** As of June 2015, 0.95 per cent of the staff employed in the MSHHS identify themselves as an Aboriginal and/or Torres Strait Islander person (MSHHS *Annual Report 2014 – 2015,* p. 79). **Score = 1/1.**

**Workforce planning** The MSHHS *Annual Report 2014 – 2015* makes no mention of any workforce planning, recruitment, etc., regarding Aboriginal and Torres Strait Islander people**. Score = 0/1.**

**Awards, recognition, etc.** The MSHHS *Annual Report 2014 – 2015* (p. 63) states that:

Reward and recognition plays an important role in attracting and retaining quality staff across Metro South Health and is critical to the health service’s ongoing commitment to improving workforce culture. Metro South Health has developed a comprehensive reward and recognition program….

No awards/recognition specifically recognising Aboriginal and Torres Strait Islander employees (perhaps a NAIDOC award) is among the award categories listed. **Score = 0/1.**

**Aboriginal and Torres Strait Islander Health Plan** The MSHHS *Strategic Plan 2012-2016* (referred to in MSHHS *Annual Report* *2014 - 2015*, p. 51) has not yet been sighted. Of the 9 strategic objectives identified in the Metro South Health *Strategic Plan 2012-2016* (2013 revised version), and summarised in the MSHHS *Annual Report 2014 – 2015* (p. 51), none refers to Closing the Gap in Indigenous Health Outcomes. According to the *Metro South Health Strategic Plan 2015-2019* (p.12) in relation to Focus Area 3: Improved health system integration, Aboriginal and Torres Strait Islander health is to be considered within the focus of “[M]oving from a current, fragmented system towards a more integrated, coordinated healthcare network.” This will entail completing key enabling plans (such as Closing the Gap Plan, Multicultural Plan and Disability Plan) to support improvement in the equity and access to services for these community members (p. 16). However, no target date for completion (for any of these plans) has been set (see p. 19). Also mentioned in the *Annual Report* (p. 68) in relation to organisational excellence (Strategic objective 7) that:

To ensure planning and health service delivery is coordinated, Metro South Health has formed ‘Working Together Agreements’ or ‘Partnership Protocols’ with both the Greater Metro South Brisbane Medicare Local and the West Moreton Oxley Medicare Local.

As the Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care, ATSICHS Brisbane and Yulu Burri-Ba Aboriginal Corporation for Community Health operate within the MSHHS area, it seems appropriate that some form of agreement or protocol should have been established. In terms of collaboration with primary health care providers, the MSHHS *Annual Report 2014-2015* (p. 53) states:

Building collaborative partnerships is key to delivering services that are accountable and responsive to the needs of the local community. Together, Metro South Health and the Greater Metro South Brisbane Medicare Local and West Moreton Medicare Local played an essential role in the planning, delivery and management of health services in the Metro South region during 2014-2015.

Again the question must be asked as to why the two Aboriginal and Torres Strait Islander medical services were not included in the planning, delivery and management of health services in the Metro South region, given the high national priority given to Closing the Gap in Indigenous Health Outcomes. The evidence suggests that there is no Aboriginal and Torres Strait Islander health plan (or agreement , MoU or protocol) currently in existence, although, hopefully it will be by 2018, in which case an improved score will result in the next audit. **Score = 0/10.**

**Cultural competence** Cultural competency is key to effective health system performance in delivering healthcare to Aboriginal and Torres Strait Islander clients. 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.[[351]](#footnote-351)

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 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.[[352]](#footnote-352)

**Cultural competency policy/strategy:** The MSHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). With regard to workforce policy and governance within the MSHHS, the Metro South Health Workforce Services Policy Framework has been developed to give effect to the creation or amendment of workforce services policies, procedures and guidelines and is managed by a specific process detailed in the Policy Framework Management Procedure. The framework contains fifteen workforce services overarching policies. A cultural competency policy is not included (MSHHS *Annual Report 2014-2015*, p. 80). **Score = 0/3**

**Capacity to deliver CCT** Ideally all MSHHS staff should undertake cultural competency training at least once every two years. Since, according to the MOHRI headcount, there are over 14,000 employees in the MSHHS (MSHHS *Annual Report 2014 – 2015,* p. 78) this roughly translates into CCT for over 7,000 staff per year. There is no reference in the publicly available information as to whether CCT training is taking place, or whether the MSHHS has the capacity to deliver it. **Score = 0/3.**

**Proportion of non-Indigenous staff to receive CCT** The MSHHS *Annual Report 2014 – 2015* provides no KPI data on the numbers/proportion of non-Indigenous staff who have completed CCT. **Score = 0/4.**

**Indigenous status** Indigenous status – specifically the reporting of ‘not stated’ on admission. Not reported in the MSHHS *Annual Report 2014-2015*. **Score = 0/2.**

**DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the MSHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

3.83% 2.80% 3.10% 2.40% 3.59% 2.00% 3.04% 1.60%

MSHHS was listed among those HHSs that have “persistently high DAMA rates with little or no change throughout the year” (p. 30). Despite being included in the MSHHS *Service Agreement 2013/14-2015/16* (p. 44), and the eradication of DAMA gap for Aboriginal and Torres strait Islander people continuing to be a priority[[353]](#footnote-353), data on DAMA rates were not published for the current assessment period (2014-15) in either the MSHHS *Annual Report 2014 – 2015* (see Service Agreement – Tier 1 key performance indicators, pp. 74-75)[[354]](#footnote-354) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

**PPH** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the MSHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

14.40% 17.70% 14.00% 17.70% 14.70% 17.70% 15.20% 17.70%

The MSHHS has bettered all four quarterly targets. Despite being included in the MSHHS *Service Agreement 2013/14-2015/16* (p. 43), data on PPH rates were not published for the current assessment period (2014-15) in either the MSHHS *Annual Report 2014 – 2015* (see Service Agreement – Tier 1 key performance indicators, pp. 74-75)[[355]](#footnote-355) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

**Access to mental health services** measured in terms of the 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 that separation. The MSHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 28) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the MSHHS *Annual Report 2014-2015* (refer pp. 74-75)*.* **Score = 0/2.**

**Access to drug and alcohol services.** The MSHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 28) to provide Indigenous Outreach Services under the Alcohol and Other Drug Services program. This Closing the Gap KPI is not reported in the MSHHS *Annual Report 2014-2015*.  **Score = 0/2**

**ATSI Health workforce policy/strategy:** While no mention is made in the MSHHS *Annual Report 2014-2015*of an Aboriginal and Torres Strait Islander workforce policy or strategy, one of the key reforms completed in 2014-2015 was:

… the implementation of a consistent, integrated and supported structure for Aboriginal and Torres Strait Islander Hospital Liaison Officers (p. 83).

A comprehensive workforce policy/strategy, however, would seek to ensure that Aboriginal and Torres Strait Islander people would be recruited, trained and employed across all employment streams, as doctors, nurses, technicians, managers, etc.

**Score = 0/3.**

**ATSI workforce implementation body** No reference is made in the public available information referring to such a body. **Score = 0/3**.

**Employment equity** According to the MSHHS *Annual Report 2014 – 2015* (p. 78) there are nearly 11,850 FTE staff in the service. Aboriginal and Torres Strait Islander people constitute around 2.0% of the total population served by the MSHHS, therefore on a basis of equity the target for participation in the MSHHS workforce is 240. As Aboriginal and Torres Strait Islander people constitute 0.95% of the MSHHS workforce (that is about 110 of the total employees), this means that the current number of staff is roughly 50% of parity, therefore at least 8 new Aboriginal and Torres Strait Islander staff would need to be employed on an annual basis over the next 16 years in order to achieve parity with regard to closing the employment gap by 2033. **Score = 2/4.**

**Workforce participation** While 0.95 per cent of the staff employed in Metro South Health identify themselves as Aboriginal and/or Torres Strait Islander (MSHHS *Annual Report 2014 – 2015,* p. 79), no information is available in terms of their participation in the different employment streams (see breakdown of workforce across employment streams on p. 77), except to note that the annual report (p. 55) makes reference to:

…establishing Aboriginal and Torres Strait Islander patient journey officers to work with the community and Metro South Health services to plan and review the delivery of health care to Aboriginal and Torres Strait Islander patients.

In Note 31 above, mention is also made of Aboriginal and Torres Strait Islander Hospital Liaison Officers (p. 83). For the purposes of scoring, Aboriginal and Torres Strait Islander patient journey officers are seen as having similar roles to liaison officers. While Aboriginal and Torres Strait Islander people are clearly employed in the MSHHS, no formal data has been provided in the MNHHS *Annual Report 2014 – 2015* (p. 36), either in terms of an overall percentage, or in terms of their participation in the different employment streams, to enable a score. An additional stream for Aboriginal and Torres Strait Islander Health Practitioners/Health Workers and Liaison Officers has been included as a category in its own right instead of IHWs and ILOs being in the Managerial and clerical stream for future reporting purposes. **Overall** **Score = 0/10.**

**Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.

**Commonwealth contribution** Neither the financial statements contained in the MSHHS *Annual Report 2014 – 2015* nor the MSHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the MSHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**

**Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the MSHHS has an operating budget of $1.890 billion for 2014-15.[[356]](#footnote-356) To support the delivery of the Making Tracks priorities and in accordance with MSHHS *Service Agreement 2013/14-2015/16*, the MSHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

* child and maternal health services
* chronic disease management services
* continuous quality improvement activities
* sexual and reproductive health services
* Indigenous cultural capability services

More details of the MSHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to Metro South Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (MSHHS *Service Agreement 2013/14-2015/16*, p. 29), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within MHHS annual reports in the interests of public accountability and transparency**.** The MSHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the MSHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**MSHHS documents consulted**

* MSHHS *Annual Report 2013-2014*,
* MSHHS *Annual Report 2014-2015*,
* MSHHS *Strategic Plan 2014-2018* (revised 2015)
* MSHHS *Consumer and Community Engagement Strategy 2014 – 2018*
* MSHHS *Service Agreement 2013/14 – 2015/16.*
* MSHHB Board meeting summaries for:

1. 2014: 28 January; 25 February; 25 March; 29 April; 22 May; 24 June; 29 July; 18 August; 30 September; 28 October; and 25 November.
2. 2015: 20 January; 24 February; 31 March; 28 April; 26 May; 30 June; 28 July; 25 August; 29 September; 27 October; no board meeting held in November; and 1 December.

**MSHHS documents not found**

* Metro South Health Strategic Workforce Plan 2012-2017 (referred to in MSHHS 2014/15 annual report, p. 81)
* Metro South Health Strategic Plan 2012-2016 (referred to in MSHHS 2014/15 annual report, p. 51)
* Metro South Health Workforce Services Policy Framework (referred to in MSHHS 2014/15 annual report, p. 80)

‘Closing the Gap funding allocations to Metro South Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: MSHHS *Service Agreement 2013/14-2015/16*, p. 44).

MSHHB Board meeting summary for December 2014.

## North West Hospital and Health Service

**NORTH WEST HOSPITAL AND HEALTH SERVICE (NWHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

* + - 1. **Participation in governance**
* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* North West Hospital and Health Board (NWHHB) (3)
* Aboriginal representative 10 10
* Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 0
* Aboriginal/Torres Strait islander Executive Director 5 0

**Total 40 10.5**

* + - 1. **Policy implementation**
* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 4
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 0
* Public Reporting and Accountability (via Annual Report) (10)
* Traditional Owner acknowledgement (11) 1 1
* Closing the Gap

(i) Separate section in report devoted to Closing the Gap (12) 1 0

(ii) Reporting on KPIs contained in 2013/14 - 2015/16 service agreement (13) 1 0

* Policy references (14)

(i) Cultural Capability Framework (15) 1.5 1.5

(ii) Making Tracks (16) 1.5 1.5

* Organisational structure (ATSI unit placement within) (17) 1 1
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 0
2. Reference to workforce planning, recruitment, etc.(19) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 1 **Total 30 12**
  + - 1. **Service delivery**
* Aboriginal and Torres Strait Islander health service plan (21) 10 0
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 1
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 3
* Proportion of non-indigenous staff trained (25) 4 0
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 4**

* + - 1. **Recruitment and employment**
* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce policy/strategy (31) 3 1.5
* Aboriginal and Torres Strait Islander employment implementation body (32) 3 3
* Employment equity (33) 4 0
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1 0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Practitioners/Health Workers and Liaison Officers 2 0
* Operational and Support services 1 0
* Trade and Artisans 1 0
* Health Practitioners (Professional and Technical) 1 0 **Total 20 4.5**
  + - 1. **Financial Accountability and Reporting: Closing the Gap Funding** (35)
* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0 **Total 20 0**

**Score 140 31**

**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**

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**Notes:**

1. **North West Hospital and Health Service** The North West Hospital and Health Service (NWHHS) has responsibility for providing public hospital and other health services to the communities of North West Queensland. It serves a population of around 33,000 people distributed across a geographical area covering 300,000 square kilometres, providing services across one regional hospital (Mt Isa), two MPHSs, three rural/remote hospitals, four primary health clinics and five community health centres. Around 7,000 people identify as Indigenous, comprising 23.1 percent of the people living in the North West compared to 3.6 percent within all of Queensland. The Indigenous population is concentrated in the two Local Government Areas of Doomadgee (1,185) and Mornington Island (1,005), and Mt Isa (3,206), Cloncurry (702) and Carpentaria (757). Three Local Government Areas have populations in which more than 85 percent of the population are in the most disadvantaged quintile according to the Index of Relative Socio-Economic Disadvantage: Mornington Island (100%), Doomadgee (97.8%) and Carpentaria (87.4%) (NWHHS *Annual Report 2014 – 2015*, pp. ii and 13 – 14. Based on 2011 Census). The NWHHS provides a comprehensive range of community and primary health services, including aged care assessment; Aboriginal and Torres Strait Islander health programs; child and maternal health services; alcohol, tobacco and other drugs services; home care services; community health nursing, sexual health service, allied health, oral health and health promotion programs.[[357]](#footnote-357) The median age of death for Aboriginal and Torres Strait Islander people living in the NWHHS region is 53 years compared to the non-Indigenous rate of 73 years.[[358]](#footnote-358)

There are two ATSICCHSs operating in the NWHHS area: the Mt Isa Aboriginal Community Controlled Health Service (trading as Gidgee Healing) which also operates a Mobile Health Clinic in Normanton[[359]](#footnote-359), and the Injilinji Aboriginal and Torres Strait Islander Corporation for Children and Youth Services (Mt Isa). There is also the Ngukuthati Children and Family Centre (Mt Isa) where the NWHHS provides a number of services (antenatal classes, immunisation clinics, etc) (NWHHS *Annual Report 2014-2015,* pp. 52-3).

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 point out of 20 for all Queensland Health’s 16 HHSs.

3. **NWHHB** The NWHHB comprises 8 members, one of whom is Aboriginal, and who also serves as a director of Gidgee Healing (NWHHS *Annual Report 2014 – 2015*, p. 40). **Score = 10/10.**

4. **Executive Management Structure** The Executive Management Group (EMG) comprises 6 members: Health Service Chief Executive; Executive Director Nursing and Midwifery; Executive Director Medical Services; Chief Operating Officer; Chief Finance Officer; and Executive Director People and Performance (NWHHS *Annual Report 2014 – 2015*, p. 43-44 and p. 38). There is no executive division for Aboriginal and Torres Strait Islander health and, according to their profiles, none of the EMG members identifies as an Aboriginal or Torres Strait Islander person.However, the Executive Director People and Performance“hasexperience in statewide Indigenous health roles”(p. 44). **Score = 0/10.**

5. **Closing the Gap health outcomes and the NWHHS Strategic Plan** According to the section “Our strategic direction” contained in the NWHHS *Annual Report 2014-2015* (p. 31), the strategy is underpinned by a number of national and state agreements, strategies and plans which include:

* *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*
* *National Indigenous Reform Agreement*
* *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033: policy and accountability frameworks*
* *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 - 2033*

In the NWHHS *Strategic plan 2012 – 2016* (reviewed June 2015), the Closing the Gap policy is not explicitly mentioned, however, reference is made to some of its elements (p. 2). On this basis, four points out of five are awarded. **Score = 4/5.**

1. **Closing the Gap KPIs included in the Health Service Agreement** Of the five Closing the Gap KPIs selected for inclusion in the Matrix (see QHMT, Note 23), only 2 (DAMA and PPH) are included in the NWHHS *Health Service Agreement* *2013/14 – 2015/16*(p. 38). However, a third KPI: Aboriginal and Torres Strait Islander low birthweight babies, and which is not among the five selected in the QHMT for the audit, has been included in the service agreement (p. 38).  **Score = 2/5.**
2. **Aboriginal and Torres Strait Islander consultative body** Engagement with communities in the NWHHS area is primarily through a Consumer Advisor who sits on high level planning groups, and regional advisory panels that a number of North West communities (such as Julia Creek, Cloncurry, Normanton and Karumba) have chosen to establish to formally engage with local health providers, including the NWHHS (NWHHS *Annual Report 2014 – 2015*, p. 15). Whether such regional advisory panels have been established in communities like Doomadgee and Mornington Island is not stated. The NWHHB established an Engagement Committee, as a board committee, in 2013 (NWHHS *Annual Report 2014 – 2015*, pp. 41-2). The Indigenous member of the NWHHB is currently a member of that committee (NWHHB, *Engagement Committee: a North West Hospital and Health Board Committee - Terms of Reference (Charter),* p. 6). The NWHHS does not appear to have a dedicated Aboriginal and Torres Strait Islander community consultative/advisory body as such. **Score = 0/5.**
3. **RAP** 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.[[360]](#footnote-360) Queensland Health co-signed with Reconciliation Australia[[361]](#footnote-361) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No references are made in the published information available from Reconciliation Australia or the NWHHS concerning the existence of a RAP. **Score = 0/3.**
4. **Aboriginal and Torres Strait Islander Health Division/Unit community newsletter.** A search of the NWHHS website has failed to reveal the existence of a Aborignal and Torres strait Islasnder community newsletter.[[362]](#footnote-362) **Score = 0/2**
5. **Annual report** The NWHHS *Annual Report 2014 – 2015.* The annual report is noteworthy for its inclusiveness of the Aboriginal and Torres Strait Islander people of the service area. For example, the report contains detailed descriptions of the breakdown of the numbers and percentages of Aboriginal and Torres Strait Islander people in the region’s 10 main population centres (p.12), and the particular Traditional Owner groups associated with those centres (pp. 18-29). Also well documented are NAIDOC celebrations and awards (pp. i and 8), Board visits to communities with high Aboriginal and Torres Strait Islander populations, such as Mornington Island and Burketown (pp. 8 and 11), and clinical outreach and health promotion services to Doomadgee and Mornington Island and community controlled health centres (p. 53).
6. **Traditional Owner acknowledgement** The NWHHS *Annual Report 2014 – 2015* (p. i) contains the following acknowledgement of Traditional Owners:

The North West Hospital and Health Service respectfully acknowledges the traditional owners and custodians both past and present of the land, sea and waterways which we service and declare the North West Hospital and Health Service’s commitment to reducing inequalities between Indigenous and non-Indigenous health outcomes in line with the National Indigenous Reform Agreement (Closing the Gap).

**Score = 1/1**

1. **Closing the Gap section** The NWHHS *Annual Report 2014 – 2015* does not contain a separate section devoted to Closing the Gap. **Score = 0/1.**
2. **Reporting on KPIs** Unlike the NWHHS *2012-2013 Annual Report* (p. 36) which reported on the following Closing the Gap KPIs:

* Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission
* 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 NWHHS *Annual Report 2014-2015* contains no such information in its performance statement (see p.36). **Score = 0/1.**

1. **Policy references** For the NWHHS, 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.
2. **Cultural capability framework** Reference is made tothe *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* (NWHHS *Annual Report 2014 – 2015*, p. 31) in the context of the NWHHS’s strategic direction. **Score = 1.5/1.5.**
3. **Making Tracks** Reference is made to both the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* and the *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033: policy and accountability framework* (NWHHS *Annual Report 2014 – 2015*, p. 31). It is also noted that the NWHHS *2012-2013 Annual Report* (pp. 46-47) 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. **Score = 1.5/1.5.**
4. **Organisational structure** The NWHHS *Annual Report 2014 – 2015*, p. 38). While there is no Indigenous Health Unit as such located on the organisation chart, there is a number of references to medical and nursing services provided at Doomadgee and Mornington Island, and Indigenous child health services provided as part of Community services, and to the position of NWHHS Cultural Advisor (see also p. 57 re: Cultural Advisor’s role). **Score = 1/1.**
5. **Employment** No data on Indigenous employment provided in the NWHHS *Annual Report 2014 – 2015* (see pp. 49-50). As at 30 June 2015, 664 full time equivalent staff were employed by the NWHHS (p 50). **Score = 0/1.**
6. **Workforce planning** With reference to the NWHHS’s strategic direction, under Strategic Priority 2: Implement priority strategies to recruit and retain staff, no specific mention is made of recruiting and training Aboriginal and Torres Strait Islander people for the workforce (NWHHS *Annual Report 2014 – 2015*, p. 33). **Score = 0/1.**
7. **Awards, recognition, etc.** See NWHHS *Annual Report 2014 – 2015* (pp. I and 54). 10 Indigenous staff were recognised for their achievements during the NWHHS NAIDOC day celebrations held on 8 July 2014, and the awarding of two Puggy Hunter Memorial Scholarships to NWHHS Indigenous staff. **Score = 1/1.**
8. **Aboriginal and Torres Strait Islander Health Plan** Commencing in July 2015, a new Cultural Advisor role has been established to guide current and future strategic and operational directions of the NWHHS with regard to the health needs and directions of the Aboriginal and Torres Strait Islander community. During 2015-2016, the Cultural Advisor will have a key role in developing and Aboriginal and Torres Strait Islander strategic health plan (NWHHS *Annual Report 2014 – 2015*, p. 57 – see also NWHHS *Strategic plan 2012-2016* (reviewed June 2015)*,* Strategic Priority 4, p.2). As this plan is not in place for the 2014-15 audit period, a penalty score of 0 results, but it does augur well with regard to a future audit. **Score = 0/10.**
9. **Cultural competence** 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.[[363]](#footnote-363)

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 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.[[364]](#footnote-364)

1. **Cultural competency policy/strategy.** The NWHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). In terms of Strategic Priority 4: Implementation of state and national health priorities to enhance and produce better health for the individual, family and community, with the objective of providing culturally appropriate and equitable health care, one of the strategies is to engage Aboriginal and Torres Strait Islander health service providers and communities in the delivery of all health services. This strategy will be enhanced through the engagement and leadership of a Cultural Advisor (NWHHS *Annual Report 2014-2015,* p. 34; NWHHS *Strategic plan 2012-2016* (reviewed June 2015) (p. 2). However, nothing is stated about a cultural competency policy in terms of training the non-Indigenous staff as per the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033.*  **Score = 1/3.**
2. **Capacity to deliver CCT** As in Note 21,the position of Cultural Advisor has been created.Presumably the Cultural Advisor will, *inter alia*, and with the assistance of local Elders from the many Traditional Owner groups located within the NWHHS service area, oversee the delivery of CCT to the non-Indigenous staff.The magnitude of this task of delivering CCT to the nearly 700 NWHHS staff can be compared with that of delivering CCT to the non-Indigenous staff of the major metropolitan HHSs with in excess of 10,000 employees (eg, MNHHS = 13,500; MSHHS = 14,000).On this basis, the NWHHS has the capacity to deliver regular face-to-face CCT to its staff. **Score = 3/3.**
3. **Proportion of non-Indigenous staff to receive CCT** In the NWHHS *Annual Report 2012-2013* ( p. 36) it was stated that the NWHHS is still developing its capacity to deliver CCT and noted the staff percentage of those who had received CCT was 9% as at June 2013. The NWHHS *Annual Report 2014-2015* provides no data on the number of non-Indigenous staff who have completed CCT. **Score = 0/4.**
4. **Indigenous status** Although included in the NWHHS *Annual Report 2012 – 2013* (p. 36),Indigenous status – specifically the reporting of ‘not stated’ on admission, was not reported in the NWHHS *Annual Report 2014 – 2015*. **Score = 0/2.**
5. **DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the NWHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

4.53% 5.20% 4.40% 4.40% 4.15% 3.50% 3.99% 2.70%

The NWHHS has bettered and equalled the targets for two of the quarters. Despite being included in the NWHHS *Service Agreement 2013/14-2015/16* (p. 38), data on DAMA rates were not published for the current assessment period (2014-15) in either the NWHHS *Annual Report 2014 – 2015* (see Performance Statement, p. 36) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

1. **PPH** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the NWHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

20.10% 17.70% 17.90% 17.70% 20.30% 17.70% 19.60% 17.70%

While by no means the worst performer among the HHSs, NWHHS persistently failed to reach the target, however, a “marked improvement” in Aboriginal and Torres Strait Islander PPHs was noted for 2014-15 (NWHHS *Annual Report 2014 – 2015,* p. 15). Despite being included in the NWHHS *Service Agreement 2013/14-2015/16* (p. 38), data on PPH rates were not published for the current assessment period (2014-15) in either the NWHHS *Annual Report 2014 – 2015* (see Performance Statement, p. 36) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

1. **Access to mental health services** Access to mental health servicesmeasured in terms ofthe 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 that separation. The NWHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 25) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the NWHHS *Annual Report 2014-2015.* **Score = 0/2.**
2. **Access to drug and alcohol services** The NWHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 25) to provide both Indigenous Outreach Services and Indigenous Youth (12-17 years) Treatment Programs under the Alcohol and Other Drug Services program. Not reported in the NWHHS *Annual Report 2014 – 2015*. **Score = 0/2.**
3. **Aboriginal and Torres Strait Islander workforce development policy/strategy** In 2012-13 the NWHHS established an Aboriginal and Torres Strait Islander Workforce Development Unit (NWHHS *Annual Report 2012-2013,* p.25). While no information is presented in the NWHHS *Annual Report 2014- 2015,* the fact that the Unit was established, suggests a strategy for the unit to carry out its mandate, however, such a strategy has not been formally sighted. **Score = 1.5/3.**
4. **ATSI employment implementation body.** The Aboriginal and Torres Strait Islander Workforce Development Unit assists:

* with the realignment of Aboriginal Health Workers to clinical areas in order to meet the needs of clients, families and the community as a whole; and
* AHWs to progress through their formal qualifications, gain exposure to a variety of clinical specialty areas, and allow staff to gain competency in necessary clinical skills (NWHHS *Annual Report 2012-2013,* p.25).

It is assumed that the Aboriginal and Torres Strait Islander Workforce Development Unit is still operating.[[365]](#footnote-365) **Score = 3/3.**

1. **Employment equity.** The Aboriginal and Torres Strait Islander population in the region served by the NWHHS is 23.1% of the total, they should therefore constitute 23.1% of the NWHHS workforce. Based on current NWHHS employment figures of 664 FTE staff (NWHHS *Annual Report 2014-2015,* p. 50), there should be about 140 Aboriginal and Torres Strait Islander employees in the NWHHS. In order to achieve parity with regard to closing the employment gap by 2033, this would mean adding some 8 Aboriginal and Torres Strait Islander staff per year for approximately the next 16 years. The NWHHS *Annual Report 2014-2015* provides no data on Aboriginal and Torres Strait Islander participation in its workforce. **Score = 0/4.**
2. **Workforce participation** No data has been provided in the NWHHS*Annual Report 2014-2015* (see Our staff, p. 50)regarding Aboriginal and Torres Strait Islander participation in the health workforce by employment category.However**,** according to NWHHS *Annual Report 2014-2015,* the Mornington Island Hospital and Primary Health Clinic includes Aboriginal and Torres Strait Islander health workers and nurses (p. 20), while the Doomadgee Hospital employs Aboriginal health workers (p. 21), and there is a trainee Aboriginal health worker at the Dajarra Primary Health Clinic (p. 25).TheNWHHS, *Annual* Report *2012-2013* profiled a doctor with local Kalkadoon, Waanyi and Gunggalida ancestry (p. 30). In addition to QH’s six employment streams, an additional stream for Aboriginal and Torres Strait Islander Health Practitioners/Health Workers and Liaison Officers has been included as a category in its own right instead of IHWs and ILOs being included in the Managerial and clerical stream for future reporting purposes. This would be particularly relevant for the NWHHS given the role of the Aboriginal and Torres Strait Islander Workforce Development Unit in the development of, *inter alia*, the clinical skills of ATSI Health Workers (see Note 32). Unfortunately, in the absence of official employment stream data, no score can be given. **Score = 0/10.**
3. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
4. **Commonwealth contribution** Neither the financial statements contained in the NWHHS *Annual Report 2014 – 2015* nor the NWHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the NWHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**
5. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the NWHHS has an operating budget of $140.5 million for 2014-15.[[366]](#footnote-366) To support the delivery of the Making Tracks priorities and in accordance with NWHHS *Service Agreement 2013/14-2015/16* (p. 26), the NWHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

* child and maternal health services
* chronic disease management services
* sexual and reproductive health services
* smoking and alcohol prevention activities
* Indigenous cultural capability services

More details of the NWHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to North West Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (NWHHS *Service Agreement 2013/14-2015/16*, p. 26), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within NWHHS annual reports in the interests of public accountability and transparency**.** The NWHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the NWHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**NWHHS documents consulted**

* NWHHS *Annual Report 2012-2013*,
* NWHHS *Annual Report 2014-2015*,
* NWHHS *Strategic Plan 2014-2018* (revised 2015)
* NWHHS *Consumer and Community Engagement Strategy 2014 – 2018*
* NWHHB *Engagement Committee - a North West Health Board Committee: Terms of Reference (Charter).* Endorsed 18/12/2014.
* NWHHS *Service Agreement 2013/14 – 2015/16.*
* NWHHB Board meeting summaries for:

1. 2014: 29 January; and 28 February.
2. 2015: 6 February; 20 March (however, the board summaries for February and March are identical); 16 April; 20 May; 30 June; 22-23 July; 21 August; no meetings in September and October; 5-6 November; and 4 December.

**NWHHS documents not found**

Memo ‘Closing the Gap funding allocations to North West Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: NWHHS *Service Agreement 2013/14-2015/16*, p. 38).

NWHHB Board meeting summaries for 2014: March - December; and January 2015.

## South West Hospital and Health Service

**SOUTH WEST HOSPITAL AND HEALTH SERVICE (SWHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

* + - 1. **Participation in governance**
* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* South West Hospital and Health Board (SWHHB) (3)
* Indigenous representative 10 **0?**
* Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 0
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 0.5**

* + - 1. **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
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 4
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 0
* Public Reporting and Accountability (via Annual Report) (10)
* Traditional Owner acknowledgement (11) 1 1
* Closing the Gap

(i) Separate section in report devoted to Closing the Gap (12) 1 0

(ii) Reporting on KPIs contained in 2013/14 - 2015/16 service agreement (13) 1 0.5

* 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
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 0
2. Reference to workforce planning, recruitment, etc.(19) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 9.5**
  + - 1. **Service delivery**
* Aboriginal and Torres Strait Islander health plan (21) 10 2
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 0
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 0
* Proportion of non-indigenous staff trained (25) 4 0
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 20
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 2**

* + - 1. **Recruitment and employment**
* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce policy/strategy (31) 3 0
* Aboriginal and Torres Strait Islander employment implementation body (32) 3 0
* Employment equity (33) 4 0
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1 0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Practitioners/Health Workers and Liaison Officers 2 0
* Operational and Support Services 1 0
* Trade and Artisans 1 0
* Health Practitioners (Professional and Technical) 1 0 **Total 20 0**
  + - 1. **Financial Accountability and Reporting: Closing the Gap funding** (35)
* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0

**Total 20 0**

**Score 140 12**

**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**

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**Notes:**

1. **South West Hospital and Health Service** The South West Hospital and Health Service (SWHHS) has responsibility for providing public hospital and health services within its primary region to over 26,000 people residing within a geographical area covering 319,000 square kilometres within rural south west Queensland. The area shares its border with NSW, SA and the Northern Territory and covers 21 per cent of Queensland. Indigenous Australians make up 12% of the population – about 3,100 people. The HHS has a primary clinical hub located in Roma and two secondary hubs located in Charleville and St George. These larger facilities also provide outreach services to a number of smaller centres (SWHHS *Annual Report 2014-2015,* pp. 4 and 6; SWHHS *Service Agreement 2013/14 – 2015/16,* p. 20). The region is also served by the Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health (CWAATSICH) which has clinics in Charleville, Roma, Mitchell and Quilpie[[367]](#footnote-367), the Cunnamulla Aboriginal Corporation for Health (CACH)[[368]](#footnote-368) and the Goondir Aboriginal and Torres Strait Islander Corporation for Health Services (Goondir Health Services). Goondir Health Services is based in Dalby in the DDHHS area, but maintains a clinic in St George.

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 point out of 20 for a Queensland Health’s 16 HHSs.

3. **SWHHB** The SWHHB comprises 9 members (SWHHS *Annual Report 2014 – 2015,* pp. 18-22). One of the newly appointed board members is a private mental health professional providing services to the Goondir Health Service in St George, as well as in other locations (p. 20). The profiles of the other board members do not reveal any specific experience with regard to the delivery of health and medical services to Aboriginal and Torres Strait Islander people. Also, according to their profiles, none of the board members identify as an Aboriginal or Torres Strait Islander person. **Score = 0/10**.

4. **Executive Management Structure** The Executive Management Team (EMT), including the Chief Executive, comprises 8 members with the following portfolios: Chief Finance Officer; Chief Operations Officer; Executive Director Medical Services; Executive Director Community and Allied Health; Director People and Culture; Executive Director Nursing; and Nursing Director Quality and Safety (SWHHS *Annual Report 2014 – 2015,* p. 12 and 24-26). The profiles of the EMT members do not reveal any specific experience with regard to the delivery of health and medical services to Aboriginal and Torres Strait Islander people. There is no Executive Division of Aboriginal and Torres Strait Islander Health. According to their profiles, none of the EMT members identify as an Aboriginal or Torres Strait Islander person. **Score = 0/10.**

5. **Closing the Gap health outcomes and the SWHHS Strategic Plan** The SWHHS *Strategic Plan 2014-2018* (2015 update), in relation to the strategic objective of person centred care, includes the supporting strategy: “Improve the health and well being of Aboriginal and Torres Strait Islander people”, with “performance against targets in partnership with Aboriginal Medical Services (including the Deadly Choices strategy)” (p. 2). This somewhat vague statement of strategy, without explicit reference to Closing the Gap targets (eg, in relation to child health, life expectancy, employment, cultural competency, etc) is not deserving of full points. **Score = 2/5.**

* + - 1. **Closing the Gap KPIs included in Health Service Agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the SWHHS *Service Agreement 2013/14 – 2015/16* for this triennium identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 36); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 36). However, a third KPI: Aboriginal and Torres Strait Islander low birthweight babies, and which is not among the five selected in the QHMT for the purposes of the audit, has been included in the service agreement (p. 37). **Score = 2/5**
      2. **Aboriginal and Torres Strait Islander consultative body** The SWHHS has established a system of 12 Community Advisory Networks (CANs) throughout the region (SWHHS *Annual Report 2014-2015*, pp. 5 and 23). CAN Chairs link to Board meetings as the Board and executive rotate meetings around the district.[[369]](#footnote-369) The SWHHS *Consumer and Community Engagement Framework 2015-2018* notes as one of its performance areas: “Foster inclusion of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities,…”. One of the mechanisms to achieve this is that: “Consumer Advisory Networks are representative of their communities”, with the target of “100% of Community Advisory Networks are representative based….”. While there appears to be no Aboriginal and Torres Strait Islander consultative body as such, nevertheless, given the SWHHS commitment to inclusion of Aboriginal and Torres Strait Islander representation within the CANs, and supported by three ATSICCHS, the Indigenous community should be able to find that its voice is heard at Board and executive levels. **Score = 4/5.**
      3. **RAP** 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.[[370]](#footnote-370) Queensland Health co-signed with Reconciliation Australia[[371]](#footnote-371) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No reference is made in the publicly available information either from Reconciliation Australia or the SWHHS concerning the existence of a RAP. **Score = 0/3.**
      4. **Aboriginal and Torres Strait Islander Health Division/Unit community newsletter.** While the SWHHS issues regular media releases, a search of the website failed to find references to a newsletter either for the general community, or more specifically, for the Aboriginal and Torres Strait Islander community in the SWHHS area. **Score = 0/2.**
      5. **Annual Report** The SWHHS *Annual Report 2014 – 2015* contains little hard data on how the health service is performing in terms of closing the gap, employment, cultural competency, etc. However, it does highlight its strong relationship with the local ATSICCHSs. The report contains a Feedback Survey with questions regarding: level of detail; writing style; presentation; value of the information; quality of the report; and report user category (p. 40).
      6. **Traditional Owner acknowledgement** The SWHHS “respectfully acknowledges the traditional owners and custodians past and present of the land we service.” (SWHHS *Annual Report 2014 – 2015,* p. 2). **Score = 1/1.**
      7. **Closing the Gap section** Along with its acknowledgement to traditional owners, the SWHHS declares its commitment to the Closing the Gap Initiative targets to: (i) close the gap in life expectancy within a generation (by 2031); and (ii) halve the gap in mortality rates for Indigenous children under five by 2018 (SWHHS *Annual Report 2014 – 2015,* p. 2). However, there is no separate or discrete section in the annual report devoted to progress in either of these indicators or other Closing the Gap in Indigenous Health KPIs, or Closing the Gap initiatives undertaken by the SWHHS. **Score = 0/1.**
      8. **Reporting on KPIs** The SWHHS *Annual Report 2014 – 2015* (p. 14) has reported a “reduction in Aboriginal and Torres Strait Islander preventable hospitalisations” but with no supporting data (see Note 28). No data on other Closing the Gap KPIs are reported. **Score = 0.5/1.**
      9. **Policy references** For the SWHHS, 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.
      10. **Cultural capability framework** No explicit reference is made to the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* in the SWHHS *Annual Report 2014-2015.*  **Score = 0/1.5**
      11. **Making Tracks** No explicit reference is made to the *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033* with respect to either the Accountability or Implementation Frameworks in the SWHHS *Annual Report 2014-2015*. **Score = 0/1.5.**
      12. **Organisational structure** The minimalist diagram of the SWHHS organisation structure does not locate an Aboriginal and Torres Strait Islander health unit or similar facility within its organisation, nor is one mentioned anywhere else in the annual report. **Score = 0/1.**
      13. **Employment** No data is provided on Aboriginal and Torres Strait Islander employment in the SWHHS workforce (SWHHS *Annual Report 2014-2015,* p. 30). **Score = 0/1.**
      14. **Workforce planning** While data is provided on nursing, medical and TAFE student support, none refers to Aboriginal and Torres Strait Islander training and recruitment (SWHHS *Annual Report 2014-2015,* p. 32). **Score = 0/1.**
      15. **Awards, recognition, etc.** The 2014 Staff Excellence Awards have a number of categories including a Leadership and Culture Award and a Closing the Gap Award, however, it is not stated whether any of the recipients of these and the other awards and the nominees are Aboriginal and/or Torres Strait Islander (SWHHS *Annual Report 2014-2015,* p. 32).**Score = 0/1.**
      16. **Aboriginal and Torres Strait Islander Health Plan** There are a number of references in the SWHHS *Annual Report 2014 – 2015* to the effect that the SWHHS maintains a number of partnerships with Aboriginal medical services “to help improve health service coordination for Indigenous communities” (p. 14. See also pp. 4 and 10). The SWHHS Board Chair and HSCE, jointly reporting on their commitment to collaboratively plan and deliver health services with other health care providers, note that:

…we have made significant progress in partnering with two of our local Aboriginal medical services – the Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health (CWAATSICH) and the Cunnamulla Aboriginal Corporation for Health (CACH) (p. 4).

It is assumed that these partnerships involve some form of formal agreement, eg. an MOU, protocol, etc, however, no information has been found about the status and content of these partnerships. **Score = 2/10.**

* + - 1. **Cultural competence** Cultural competency is key to effective health system performance in delivering healthcare to Aboriginal and Torres Strait Islander clients. 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.[[372]](#footnote-372)

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 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.[[373]](#footnote-373)
  + - 1. **Cultural competency policy/strategy** The SWHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). It is stated in the SWHHS *Annual Report 2014-2015* that : “It is also important that culturally responsible health services are delivered. An Aboriginal and Torres Strait Islander Cultural Practice Program [ATSICPP] is mandatory for all staff to instil in them the knowledge and skills to support culturally capable care”(p. 14). However, there is no policy or strategy to back up this statement as to how mandatory cultural competency training is to be delivered **Score = 0/3**
      2. **Capacity to deliver CCT.** Ideally all SWHHS staff should undertake cultural competency training at least once every two years. Since there are over 875 employees (including casual, permanent and temporary) in the SWHHS (SWHHS *Annual Report 2014-2015*, p. 30), this roughly translates into CCT for over 400 staff per year. No information has been provided concerning who is responsible for the ATSICPP or the capacity of the SWHHS to deliver it. **Score = 0/3.**
      3. **Proportion of non-Indigenous staff to receive CCT** No data has been provided on the actual number of non-Indigenous employees that have completed training under the ATSICPP. **Score = 0/4.**
      4. **Indigenous status** Data on estimated levels of completion of Indigenous status not provided in theSWHHS *Annual Report 2014-2015.* **Score = 0/2.**
      5. **DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the SWHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

2.86% 4.60% 5.70% 3.60% 2.67% 2.60% 8.33% 1.60%

SWHHS bettered the quarterly targets for one quarter. Despite being included in the SWHHS *Service Agreement 2013/14-2015/16* (p. 36), data on DAMA rates were not published for the current assessment period (2014-15) in either the SWHHS *Annual Report 2014 – 2015* (see Objectives and performance indicators, p. 14[[374]](#footnote-374)) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*.  **Score = 0/2.**

* + - 1. **PPH** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the SWHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

20.70% 17.70% 23.20% 17.70% 15.40% 17.70% 24.50% 17.70%

SWHHS bettered the quarterly targets for one quarter. Despite being included in the SWHHS *Service Agreement 2013/14-2015/16* (p. 36) and reporting a “reduction in Aboriginal and Torres strait Islander preventable hospitalisations”, data on PPH rates were not published for the current assessment period (2014-15) in either the SWHHS *Annual Report 2014 – 2015* (see Objectives and performance indicators, p. 14) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*.  **Score = 0/2.**

* + - 1. **Access to mental health services** measured in terms of the 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 that separation. The SWHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 25) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the SWHHS *Annual Report 2014-2015.* **Score = 0/2.**
      2. **Access to drug and alcohol services** The SWHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 25) to provide Indigenous Outreach Services under the Alcohol and Other Drug Services program. Not reported in theSWHHS *Annual Report 2014-2015.* **Score = 0/2.**
      3. **ATSI workforce development policy/strategy** There is no mention in the SWHHS *Annual Report 2014-2015* or the SWHHS *Strategic Plan 2014-2018* (2015 update) of a work force development policy/strategy for Aboriginal and Torres Strait Islander people, neither is there any information available on the SWHHS website.[[375]](#footnote-375) **Score = 0/3.**
      4. **ATSI employment implementation body** As for Note 31. **Score = 0/3.**
      5. **Employment equity** At the 30 June 2015, SWHHS had a full-time equivalent staff establishment of 703.67 (SWHHS *Annual Report 2014-2015,* p. 30, however, there is some variance as the FTE figure is recorded as 689 on p. 16). To achieve parity based on Aboriginal and Torres Strait Islander people constituting 12% of the total resident SWHHS area population, there would need to be some 84 Aboriginal and Torres Strait Islander people employed in the SWHHS workforce. No data has been provided. **Score = 0/4.**
      6. **Workforce participation.** No data is provided on Aboriginal and Torres Strait Islander participation in the SWHHS workforce in QH’s six employment categories (SWHHS *Annual Report 2014-2015,* see Our people, pp. 30 and 32). In addition to QH’s six employment streams, an additional stream for Aboriginal and Torres Strait Islander Health Practitioners/Health Workers and Liaison Officers has been included as a category in its own right instead of IHWs and ILOs being included in the Managerial and clerical stream for future reporting purposes. Unfortunately, in the absence of official employment stream data, a penalty score results. **Overall score = 0/10.**
      7. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
      8. **Commonwealth contribution** Neither the financial statements contained in the SWHHS *Annual Report 2014 – 2015* nor the SWHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the SWHHS’s Closing the Gap programs or their acquittal. **Score =0/10.**
      9. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the SWHHS has an operating budget of $118.9 million for 2014-15.[[376]](#footnote-376) To support the delivery of the Making Tracks priorities and in accordance with SWHHS *Service Agreement 2013/14-2015/16*, the SWHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:
* mental health services
* chronic disease management services
* sexual and reproductive health services
* continuous quality improvement activities
* Indigenous cultural capability services

More details of the SWHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to South West Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (SWHHS *Service Agreement 2013/14-2015/16*, p. 25), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within SWHHS annual reports in the interests of public accountability and transparency. Queensland Closing the Gap funding allocations should be disclosed within SWHHS annual reports in the interests of public accountability and transparency**.** The SWHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the SWHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**SWHHS documents consulted**

* Department of Health *South West Monthly Performance Report, July 2015.*
* SWHHS *Annual Report 2013-2014*,
* SWHHS *Annual Report 2014-2015*,
* SWHHS *Strategic Plan 2014-2018* (revised 2015)
* SWHHS *Consumer and Community Engagement Strategy 2014 – 2018*
* SWHHS *Community and Consumer Engagement Strategy: Annual Evaluation June 2016.*
* SWHHS *Service Agreement 2013/14 – 2015/16.*
* SWHHB Board updates for:

1. 2014: 20 January; 24 February; 24 March; 28 April; 26 May; 23 June; 28 July; 25-26 August; 22 September; 27 October; 24-25 November; and 15 December.
2. 2015: 19 January; 23-24 February; 23 March; 27 April; 25 May; 29 June; 27 July; 24 August; 28 September; 26-27 October; and 23-24 November.

**SWHHS documents not found**

Memo ‘Closing the Gap funding allocations to South West Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: SWHHS *Service Agreement 2013/14-2015/16*, p. 36).

SWHHB Board update for December 2015.

## Sunshine Coast Hospital and Health Service

**SUNSHINE COAST HOSPITAL AND HEALTH SERVICE (SCHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

**Participation in governance**

* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Sunshine Coast Hospital and Health Board (SCHHB) (3)
* Indigenous representative 10 0
  + - * Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 0
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 0.5**

**Policy implementation**

* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 1
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 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 contained in 2013/14 - 2015/16 service agreement (13) 1 0

* Policy references (14)
* (i) Cultural Capability Framework (15) 1.5 0.5
* (ii) Making Tracks (16) 1.5 0
* Organisational structure (ATSI unit placement within) (17) 1 0
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 1
2. Reference to workforce planning, recruitment, etc.(19) 1 1

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 5.5**

**Service delivery**

* Aboriginal and Torres Strait Islander health plan (21) 10 5
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 2
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 3
* Proportion of non-indigenous staff trained (25) 4 3
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 13**

**Recruitment and employment**

* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce policy/strategy (31) 3 1
* Aboriginal and Torres Strait Islander employment implementation body (32) 3 3
* Employment equity (33) 4 4
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical1 1
* Medical and other health professionals (inc. VMOs) 2 2
* Nurses 2 2
* Indigenous Health Practitioners/Health Workers and Liaison Officers 2 0
* Trade and Artisans 1 0
* Operational/Support Services 1 1
* Health Practitioners (Professional and Technical) 1 1 **Total 20 15**

**Financial Accountability and Reporting: Closing the Gap funding** (35)

* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0 **Total 20 0**

**Score 140 34**

**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. **Sunshine Coast Hospital and Health Service** The Sunshine Coast Hospital and Health Service (SCHHS) area includes the Sunshine Coast, Gympie and Noosa local government areas, stretching to Gympie as its northern boundary, south to Caloundra and out to Kilkivan in the west, an area of some 10,020 square kilometres. SCHHS is the major provider of public health services, health education and research to a population of about 390,000, of whom Aboriginal and Torres Strait Islander people account for 1.7 per cent, or about 6,600 people. It is also noted that the SCHHS has:

… a higher than average percentage of Aboriginal and Torres Strait Islander people in the 0-19 years age group than the Queensland average. This age group represents 50 per cent of the total Aboriginal and Torres Strait Islander population in the Sunshine Coast Hospital and Health Service region.

(SCHHS *Annual Report 2014 – 2015,* pp. 10-12).

The North Coast Aboriginal Corporation for Community Health (NCACCH) provides a range of primary care service to the Aboriginal and Torres Strait Islander communities of the Sunshine Coast and Gympie.[[377]](#footnote-377)

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 of a point out of 20 for each of the 16 HHSs.

3. **SCHHB** The Sunshine Coast Hospital and Health Board (SCHHB) consists of 8 members, none of whom, according to their profiles, identify as Aboriginal or Torres Strait Islander, or have experience in the delivery of health care or services to Aboriginal and/or Torres Strait islander people (SCHHS *Annual Report 2014 – 2015,* pp. 14 and 16 - 19). **Score = 0/10.**

4. **Executive Management Structure** The Executive Management Team (EMT) comprises 9 members: the Health Service Chief Executive (HSCE); Executive Director Planning and Capacity Development; Chairperson Clinical Council; Executive Director Medical Services; Executive Director Nursing and Midwifery Services; Executive Director Clinical Services; Executive Director Human Resources; Chief Finance Officer; and Chief Information Officer (SCHHS *Annual Report 2014 – 2015,* pp. 22-26). While none of the EMT identifies as an Aboriginal person or as a Torres Strait Islander, the HSCE has a stated commitment to Aboriginal and Torres Strait Islander health (pp. 5 and 22). However, none of the responsibilities of the EMT, as listed on p. 85, includes specific responsibility for Aboriginal and Torres Strait Islander health/Closing the Gap. There is no executive division for Aboriginal and Torres Strait Islander Health. **Score = 0/10.**

5. **Closing the Gap health outcomes and the SCHHS Strategic Plan** While the Chair and HSCE include the North Coast Aboriginal Corporation for Community Health as one of the partners of the SCHHS in their introductory message (p. 4), the SCHHS *Strategic Plan 2013-2017* (Updated February 2014) does not specifically include among its five “care” focused strategic objectives any mention of Aboriginal and Torres Strait Islander health care (p. 10) . The diagram of the SCHHS Strategic Planning Framework under SCHHS Operational Plan (Annual) identifies 5 Functional Area Operational Plans, 9 Enabling Plans (1-5 years) and 7 Service Group Operational (Annual) Plans. A Closing the Gap plan is not listed among any of these plans. Under Strategic Objective 2: Care is safe, accessible, appropriate and reliable, one of the strategies (2.3) entails implementing the whole of government plans and priorities, which includes Closing the Gap. However, the performance indicators that are required to be met or exceeded are those contained in the Service Agreement, which in terms of Closing the Gap, refer only to the KPIs for PPH and DAMA (p. 12) – see Note 6. Also the SCHHS *Interim Strategic Plan 2012 – 2016* contains no reference at all to Closing the Gap or to Aboriginal and Torres Strait Islander health or community**. Score = 1/5.**

**Closing the Gap KPIs included in Health service Agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the SCHHS *Service Agreement 2013/14 – 2015/16* for this triennium identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 39); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 40). **Score = 2/5.**

**Aboriginal and Torres Strait Islander consultative body** The principal mechanisms for consumer and community engagement established by the SCHHS *Consumer and Community Engagement Strategy and Implementation Plan 2013-2016* are: (i) the Consumer Advisory Group (CAG) that is representative of the community; and (ii) the Critical Friends Groups established for specific issues, projects or improvement activities regarding service planning and care delivery (pp. 11, 14 and 26). The CAG, which meets quarterly,

…will provide oversight and advice at the organisational level on the ongoing development and implementation of the strategy to support, encourage and facilitate meaningful consumer and community engagement in the SCHHS (pp. 10-11 and 14).

The SCHHS *Annual Report 2014 – 2015* (p. 26) refers to at least 6 strategic committees (Clinical Council; Patient Safety and Quality Committee; Health Planning and Infrastructure Committee; Safe Practice and Environment Committee; Information, Communication and Technology Committee; and Education Council) to assist the EMT in the performance of its responsibilities. No reference has been found in the publicly available information to a separate Aboriginal and Torres Strait Islander consultative body. **Score = 0/5.**

**RAP** 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.[[378]](#footnote-378) Queensland Health co-signed with Reconciliation Australia[[379]](#footnote-379) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No reference has been found in the publicly available information to a SCHHS RAP**. Score = 0/3.**

**Aboriginal and Torres Strait Islander Health Division/Unit community newsletter** A search of the SCHHS website does not reveal the existence of a newsletter, however, the SCHHS regularly issues media releases, and likewise, there is no newsletter published for the Aboriginal and Torres Strait Islander community.[[380]](#footnote-380) The North Coast Aboriginal Corporation for Community Health (NCACCH) publishes a quarterly newsletter – *NCACCH News.* **Score= 0/2.**

**Annual Report** The sub-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.*

**Traditional Owner acknowledgement** The SCHHS *Annual Report 2014 – 2015* contains noTraditional Owneracknowledgement. **Score = 0/1.**

**Closing the Gap section** The SCHHS *Annual Report 2014 – 2015* does not contain a section on Closing the Gap. **Score = 0/1.**

**Reporting on KPIs** The comprehensive section containing the Service Delivery Statement and the SCHHS performance against KPIs in the SCHHS *Annual Report 2014 – 2015* (pp. 47-53) provides no performance data on Closing the Gap KPIs. **Score = 0/1.**

**Policy references** For the SCHHS, 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.

**Cultural capability framework** Other than within a reference to Mandatory Training Compliance with regard to the Aboriginal and Torres Strait Islander Cultural Practice Program in the SCHHS *Annual Report 2014 – 2015* (pp. 38 and 42), 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 SCHHS to deliver culturally safe and appropriate healthcare to Aboriginal and Torres Strait Islander people. **Score = 0.5/1.5.**

**Making Tracks** The SCHHS *Annual Report 2014 – 2015* does not contain any information with regard to Making Tracks progress or initiatives. **Score = 0/1.5.**

**Organisational structure** No Aboriginal and Torres Strait Islander health unit/service is located on the organisation chart (SCHHS *Annual Report 2014 – 2015,* p. 14). **Score = 0/1.**

**Employment** The SCHHS *Annual Report 2014 – 2015* (pp. 27 and 36) provides comprehensive information on Aboriginal and Torres Strait Islander employment in the SCHHS workforce (see Note 35). **Score = 1/1.**

**Workforce planning** In the SCHHS *Annual Report 2014 – 2015* (pp. 27 and 36) commitment is expressed to increase the Aboriginal and Torres Strait Islander workforce above its current level of 1.45% to an above parity level of 2.13**%. Score = 1/1.**

**Awards, recognition, etc.** The SCHHS *Annual Report 2014 – 2015* makes no reference to awards, etc., to any of its staff, including Aboriginal and Torres Strait Islander employees. **Score = 0/1.**

**Aboriginal and Torres Strait Islander Health Plan** The SCHHS *Annual Report 2014 – 2015* (p. 27) makes mention of the *Sunshine Coast Hospital and Health Service Diversity Plan 2014-2015* which has been approved with implementation ongoing. The Diversity Plan includes an *Aboriginal and Torres Strait Islander Health Action Plan* (Closing the Gap). The SCHHS lists NCACCH as a principal partner[[381]](#footnote-381) while the SCHHS *Consumer and Community Engagement Strategy and Implementation Plan 2013-2016* (p. 18) indicates the existence of an MoU between the two organisations as one of its current core engagement mechanisms and activities. However, neither the plan nor the MoU have been sighted. **Score = 5/10.**

**Cultural competence** 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.[[382]](#footnote-382)

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 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.[[383]](#footnote-383)

**Cultural competency policy/strategy.** The SCHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). One of the ten objectives of the SCHHS *Consumer and Community Engagement Strategy and Implementation Plan 2013-2016* (p. 16) is to improve cultural competence, communication and partnership with Aboriginal and Torres Strait Islander communities”, employing as one of its measures the “number of staff who have participated in cultural competency training” (p. 11). As this is not a stand-alone strategy but embedded within a larger plan, a diminished score has resulted. **Score = 2/3.**

**Capacity to deliver CCT** CCT is one of 14 mandatory training modules for employees listed for Mandatory Training Compliance (SCHHS *Annual Report 2014 – 2015,* p. 42). Ideally all SCHHS staff should undertake cultural competency training at least once every two years. Since there are over 5,000 employees (MOHRI Headcount) in the SCHHS (SCHHS *Annual Report 2014 – 2015,* p. 31), this roughly translates into CCT for over 2,500 staff per year. The SCHHS set a target of 70% for non-Indigenous completion of the Aboriginal and Torres Strait Islander Cultural Practice Program in order to meet its Mandatory Training Compliance target, with 50.8% of the staff participating in the 2014-2015 reporting period (p. 38). This indicates that the SCHHS has the capacity to deliver CCT. **Score = 3/3.**

**Proportion of non-Indigenous staff to receive CCT** Measured against its own target of 70% for non-Indigenous completion of the Aboriginal and Torres Strait Islander Cultural Practice Program in order to meet its Mandatory Training Compliance target, the SCHHS achieved a participation rate of 50.8% (p. 38). **Score = 3/4.**

**Indigenous status** Estimated levels of completion of Indigenous status.This KPI was not reported on in the SCHHS *Annual Report 2014-2015.* **Score = 0/2.**

**DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the SCHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

1.88% 1.70% 2.50% 1.50% 1.41% 1.40% 2.03% 1.20%

While the SCHHS was one of the HHSs to have “maintained relatively low rates of DAMA” (p. 30) it has, nevertheless, failed to reach the quarterly targets.Despite being included in the SCHHS *Service Agreement 2013/14-2015/16* (p. 40), data on DAMA rates were not published for the current assessment period (2014-15) in either the SCHHS *Annual Report 2014 – 2015* (see Service Delivery Statement, pp. 47-51) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

**PPH** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the SCHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

16.20% 17.70% 13.30% 17.70% 11.10% 17.70% 12.00% 17.70%

For this KPI, SCHHS was one of the best performers among the HHSs, with a positive trend over the period, to better all quarterly targets. However, despite being included in the SCHHS *Service Agreement 2013/14-2015/16* (p. 39), data on PPH rates were not published for the current assessment period (2014-15) in either the SCHHS *Annual Report 2014 – 2015* (see Service Delivery Statement, pp. 47-51) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*.  **Score = 0/2.**

**Access to mental health services** Access to mental health servicesmeasured in terms ofthe 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 that separation. The SCHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 26) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the SCHHS *Annual Report 2014-2015.* **Score = 0/2.**

**Access to drug and alcohol services** The SCHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 26) to provide Indigenous Outreach Services under the Alcohol and Other Drug Services program. This Closing the Gap KPI is not reported in the SCHHS *Annual Report 2014-2015.* **Score = 0/2.**

**ATSI workforce development policy/strategy:** The SCHHS *Annual Report 2014 – 2015* (p. 31) states that:

Increasing Aboriginal and Torres Strait Islander representation in employment and reducing the overall level of disadvantage among Indigenous Australians is an integral part of the health service’s commitment to closing the gap between Indigenous and non-Indigenous Australians.

Elsewhere, in Note 21, the existence of an *Aboriginal and Torres Strait Islander Health Action Plan* (Closing the Gap) is noted. However, as the plan is unsighted, it is not clear whether it also includes a recruitment and training plan. **Score = 1/3.**

**ATSI workforce implementation body.** The SCHHS *Employee Engagement Strategy 2013- 2016* (p. 16) mentions the existence of the Aboriginal and Torres Strait Islander Workforce Advisory Group. **Score 3/3.**

**Employment equity:** 73 staff identify as Aboriginal and/or Torres Strait Islander, constituting 1.45 per cent of health service employees (which is just below the parity figure of 1.7%) (SCHHS *Annual Report 2014 – 2015,* pp. 27 and 36). However, the SCHHS *Annual Report 2014 – 2015* (p. 27) also notes that: “This is a slight decrease from the previous year, and is below our target of 2.13 per cent of our workforce.” According to the SCHHS *Annual Report 2014 – 2015* (p. 31) there are 3,923 FTE staff in the service. Aboriginal and Torres Strait Islander people constitute around 1.7% of the total population served by the SCHHS, therefore on a basis of equity the target for participation in the SCHHS workforce is around 70, however, the SCHHS reports that it has 73 Aboriginal and Torres Strait Islander employees (p. 27). The annual report also notes that: “We are aware that a number of Aboriginal and Torres Strait Islander staff have not identified as such and we are encouraging them to do so.” (p. 36). While the SCHHS has set a participation target above population parity of 2.13%, in effect equity has already been achieved. **Score = 4/4.**

**Workforce participation** SCHHS is one of a very few HHSs to provide a percentage graph of Aboriginal and Torres Strait Islander employment across QH’s 6 employment streams (SCHHS *Annual Report 2014-2015*, p. 36). Aboriginal and Torres Strait Islander people are employed in all Queensland Health employment streams, except in the trade and artisan stream, and with the highest concentration in the operation stream. An additional stream – Indigenous Health Practitioners/Health Workers and Liaison Officers – has been included as a category/stream in its own right instead of IHWs and ILOs being included in the Managerial and clerical stream. It is also noted that the SCHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous hospital liaison services (see Note 37). It is recommended that the SCHHS also publish data for this stream in future annual reports. **Score = 7/10.**

**Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.

**Commonwealth contribution** Neither the financial statements contained in the SCHHS *Annual Report 2014 – 2015* nor the SCHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the SCHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**

**Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the SCHHS has an operating budget of $695.5 million for 2014-15.[[384]](#footnote-384) To support the delivery of the Making Tracks priorities and in accordance with SCHHS *Service Agreement 2013/14-2015/16*, the SCHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

* sexual health services
* Indigenous hospital liaison services
* Indigenous cultural capability services

More details of the SCHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to Sunshine Coast Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (SCHHS *Service Agreement 2013/14-2015/16*, p. 27), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within SCHHS annual reports in the interests of public accountability and transparency. The SCHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the SCHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**SCHHS documents consulted**

* SCHHS *Annual Report 2013-2014*,
* SCHHS *Annual Report 2014-2015*,
* SCHHS *Strategic Plan 2013-2017* (Updated February 2014)
* SCHHS *Interim Strategic Plan 2012 -2016*
* SCHHS *Consumer and Community Engagement Strategy 2014 – 2018*
* SCHHS *Service Agreement 2013/14 – 2015/16.*
* SCHHB Board meeting summaries for:

1. 2014: 4 February; 4 March; 1 April; 6 May; 3 June; 1 July; 5 August; 19 August (extraordinary meeting); 2 September; 7 October; 4 November; and 2 December.
2. 2015: 3 February; 3 March; 7 April; 5 May; 2 June; 7 July; 4 August; 6 October; and 3 November.

* SCHHS *Employee Engagement Strategy 2013- 2016*
* SCHHS *Consumer and Community Engagement Strategy and Implementation Plan 2013-2016*

**SCHHS documents not sighted**

* *Aboriginal and Torres Strait Islander Health Action Plan* (Closing the Gap).
* *Sunshine Coast Hospital and Health Service Diversity Plan 2014-2015*
* *Sunshine Coast Hospital and Health Service’s Health Service Plan 2012 – 2022.* (referred to in the SCHHS *Annual Report* *2014-2015*, p. 54).
* Queensland Aboriginal and Torres Strait Islander Health Investment Strategy

Memo ‘Closing the Gap funding allocations to Sunshine Coast Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: SCHHS *Service Agreement 2013/14-2015/16*, p. 40).

SCHHB Board meeting summaries for January 2014; and January, September and December 2015.

## Torres and Cape Hospital and Health Service

**TORRES AND CAPE HOSPITAL AND HEALTH SERVICE (TCHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

* + - 1. **Participation in governance**
* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Torres and Cape Hospital and Health Board (TCHHB) (3)
* Aboriginal representative 5 5
* Torres Strait Islander representative 5 5
* Executive ManagementStructure (4)
* Aboriginal and Torres Strait Islander Health – Directorate Status 5 0
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 10.5**

* + - 1. **Policy implementation**
* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 4
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 1
* 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 1

(ii) Reporting on KPIs contained in 2014/15 - 2015/16 service agreement (13) 1 1

* Policy references (14)
* (i) Cultural Capability Framework (15) 1.5 0
* (ii) Making Tracks (16) 1.5 0.5
* Organisational structure (ATSI unit placement within) (17) 1 0
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 0
2. Reference to workforce planning, recruitment, etc.(19) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 9.5**
  + - 1. **Service delivery**
* Aboriginal and Torres Strait Islander health plan (21) 10 5
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 0
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 0
* Proportion of non-indigenous staff trained (25) 4 0
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0.5
* Access to mental health services (29) 2 2
* Access to drug and alcohol services (30) 2 0

**Total 30 7.5**

* + - 1. **Recruitment and employment**
* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce policy/strategy (31) 3 2
* Aboriginal and Torres Strait Islander employment implementation body (32) 3 0
* Employment equity (33) 4 0
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1  0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Practitioners/Health Workers and Liaison Officers 2 0
* Trade and Artisans 1 0
* Operational/Support Services 1 0
* Health Practitioners (Professional and Technical) 1 0 **Total 20 2**
  + - 1. **Financial Accountability and Reporting: Closing the Gap funding** (35)
* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0

**Total 20 0**

**Score 140 29.5**

**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. **Torres and Cape Hospital and Health Service** The Torres and Cape Hospital and Health Service (TCHHS) was established on 1 July 2014 following the amalgamation of the Torres Strait-Northern Peninsula HHS (TS-NPHHS) and the Cape York HHS (CYHHS). The TCHHS region covers over 180,000 square kilometres across 13 local government areas, extending including the Aboriginal communities of Wujal Wujal and Kowanyama in the south to, and including 18 populated Torres Strait Islands. It is one of the largest providers of health services to Aboriginal and Torres Strait Islander people. Before amalgamation the population serviced by the TS-NPHHS was estimated to be around 11,000 people, of whom approximately 85% identified as Aboriginal and/or Torres Strait Islander (TS-NPHHS *Annual Report 2012-2013*, p. 3), and the CYHHS population was estimated to be around 14,400, of whom 51% identified as Aboriginal or Torres Strait Islander (CYHHS *Annual Report 2012-2013*, p. 11). The TCHHS provides public health services within its primary region to approximately 25,600 people, of whom 64% (or about 16,400 people) identify as Aboriginal and/or Torres Strait Islander, with most Indigenous residents living within discrete Aboriginal and/or Torres Strait Islander communities throughout Cape York Peninsula and the Torres Strait islands. The majority of the residents reside in the most disadvantaged quintile highlighting the relative social disadvantage of the region. This is reflected in health disparities such as poor life expectancy and high levels of chronic disease. In addition to the resident population, the area receives approximately 30,000 visits per year from people in the coastal areas of the Western Province of Papua New Guinea (TCHHS *Annual Report 2014 – 2015,* pp. 5 and7; TCHHS *Strategic Plan 2015-2019;* TCHHS *Service Agreement 2014/15 – 2015/16,* p. 19). Two community controlled Indigenous health organisations also provide services to people in the mainland part of the region: Apunipima Cape York Health Council (Apunipima) and the Northern Peninsula Area Family and Community Services Aboriginal and Torres Strait Islander Corporation (NPAFCSATSIC). There is no community controlled health service operating in the Torres Strait.

In terms of its strategic directions, the TCHHS for 2014-2015 will specifically focus on the following objectives:

* build an integrated and sustainable healthcare organisation that the community trusts
* improve health outcomes for all, while closing the health gap for Aboriginal and Torres Strait Islander people
* deliver innovative and effective healthcare that meets the cultural, social and health needs of far north Queenslanders
* enhance partnerships with community-controlled and other health providers to ensure that services across the region are coordinated, integrated and high quality.[[385]](#footnote-385)

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 point out of 20 for all Queensland Health’s 16 HHSs.

3. **TCHHB** The Torres and Cape Hospital and Health Board (TCHHB) comprises 7 members, three of whom are Aboriginal and/or Torres Strait Islander (<http://www.health.qld.gov.au/torres-cape/html/our-board.asp> accessed 3/03/2016. TCHHS *Annual Report 2014 – 2015,* pp. 22-23). **Score = 10/10.**

4. **Executive Management Structure** The Executive Leadership Team (ELT) comprises 7 members: HSCE; Executive Director of Nursing and Midwifery; Executive Director of Medical Services; Executive Director People and Culture; Chief Financial Officer; Executive General Manager (North); and Executive General Manager (South). There is no executive division for Aboriginal and Torres Strait Islander Health (TCHHS *Annual Report 2014 – 2015,* pp. 19-20, and Financial Statements, pp. 25-28). This contrasts with the Executive Leadership Team of the former CYHHS which included the Executive Director Indigenous Health and Outreach Services (CYHHS *Annual Report 2012 – 2013,* pp. 23-24). **Score = 0/5.** There is no Aboriginal or Torres Strait Islander person serving in the capacity of Executive Director. **Score = 0/5.**

5. **Closing the Gap health outcomes in TCHHS Strategic Plan** The TCHHS *Strategic Plan 2015-2019* does not include among its 4 objectives, an objective giving strategic priority for Closing the Gap. However, with regard to the second objective of providing innovative and effective healthcare focusing specifically on the cultural, social and health needs of Torres Strait and Cape York communities, one of the measures concerns “continu[ing] to develop strategies from “Making Tracks” towards closing the gap in health outcomes for Indigenous Queenslanders by 2033”. With regard to the fourth objective: Develop and empower our workforce to ensure staff are both capable and focused on meeting service and community needs, measures include: (i) development and implementation of Aboriginal and Torres Strait Islander learning and development plan; and (ii) development and implementation of Indigenous Health Worker plan. However, these initiatives are consistent with Closing the Gap. **Score = 4/5.**

* + - 1. **Closing the Gap KPIs included in Health Service Agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the TCHHS *Service Agreement 2014/15 – 2015/16* only identifies one: Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 50). However, in the *Deed of Amendment August 2015* PPH and DAMA are both included (p. 52). **Score = 2/5.**
      2. **Aboriginal and Torres Strait Islander consultative body** The publicly available information, including TCHHS *Annual Report 2014 – 2015,* makes no reference to the need for, or existence ofan Aboriginal and Torres Strait Islander community consultative body. With three Indigenous board members and an overwhelming proportion of the population served by the TCHHS being Aboriginal people and Torres Strait Islanders, such a consultative body might not be considered necessary. However, for the sake of scoring consistency across all HHSs, and in the absence of any references to such a consultative body, a zero score has resulted. **Score = 0/5.**
      3. **RAP** 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.[[386]](#footnote-386) Queensland Health co-signed with Reconciliation Australia[[387]](#footnote-387) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No reference is made in the publicly available information either from Reconciliation Australia or the TCHHS concerning the existence of a RAP, however, given that the TCHHS only came into being on 1 July 2014, this would hardly be considered a priority. Nevertheless, for the sake of consistency, a score must be given. **Score = 0/3.**
      4. **Aboriginal and Torres Strait Islander Health Division/Unit community newsletter.** The TCHHS publishes a bi-monthly newsletter *You-Me-Health*for the general community, however, given the very high content levels relevant to the Aboriginal and Torres Strait Islander peoples and communities of the TCHHS region, it functions effectively as an Aboriginal and Torres Strait Islander community newsletter. **Score = 1/2.**
      5. **Annual Report** The sub-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.*
      6. **Traditional Owner acknowledgement** The TCHHS *Annual Report 2014 – 2015* does not include an acknowledgement to the Traditional Owners. **Score = 0/1*.***
      7. **Closing the Gap section** The TCHHS *Annual Report 2014 – 2015* (pp. 17-18) contains a section, under 4.4 Service areas, service standards and other measures including a performance statement Table, specifically reporting on progress with regard to Closing the Gap in relation to the NIRA, NPACGIHO and the National Partnership Agreement for Indigenous Early Childhood Development. In section 4.4.1 it also provides data for national KPIs monitoring the major health issues affecting the regular client population of Indigenous-specific primary health care services, especially those of maternal health, early childhood and the prevention, early detection and ongoing management of chronic diseases. **Score = 1/1.**
      8. **Reporting on KPIs** The TCHHS *Annual Report 2014 – 2015,* in the Service Delivery Statement (p. 17), does not include data on Closing the Gap KPIs, however, the report notes that:

In 2014-15 Torres and Cape HHS achieved above benchmark performance for some of its Key Performance Indicators which monitor the major health issues affecting the regular client population of Indigenous-specific primary health care services, especially those for maternal health, early childhood and the prevention, early detection and ongoing management of chronic diseases.

In this regard, the report provides data for completion of 2 year cervical screening, and completion of 6 month and 12 month testing for Type 2 diabetic clients. It also includes reference to both Indigenous and non-Indigenous PPHs – the only Closing the Gap KPI included in theTCHHS *Service Agreement 2014/15 – 2015/16* (p. 50). The annual report recognises that “further improvement is still required to meet the target of 7.7%, and specifically for Aboriginal and/or Torres Strait Islander residents” (p. 18). **Score = 1/1.**

* + - 1. **Policy references** For the TCHHS, 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.
      2. **Cultural capability framework** The TCHHS *Annual Report 2014 – 2015* contains no explicit reference 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 TCHHS to deliver culturally safe and appropriate healthcare to Aboriginal and Torres Strait Islander people. **Score = 0/1.5.**
      3. **Making Tracks** While the TCHHS *Annual Report 2014 – 2015* (p. 15) refers to *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders* no information with regard to Making Tracks progress or initiatives is provided. **Score = 0.5/1.5.**
      4. **Organisational structure** The chart of the TCHHS Governance – Management and Structure (TCHHS *Annual Report 2014 – 2015*, p. 19) does not locate any Aboriginal and Torres Strait Islander Health unit/service within the management structure. This contrasts with the management structure contained in the CYHHS *Annual Report 2012 – 2013* (p. 22) which locates the portfolio for Indigenous Health and Outreach Services within its corporate governance structure. **Score = 0/1.**
      5. **Employment** The TCHHS *Annual Report 2014 – 2015* (pp. 30-31) provides no data on Aboriginal and Torres Strait Islander health workforce participation. **Score = 0/1.**
      6. **Workforce planning** No specific reference to workforce planning, recruitment, etc., of Aboriginal and Torres Strait Islander people for the TCHHS workforce is made in the TCHHS *Annual Report 2014 – 2015*. **Score = 0/1.**
      7. **Awards, recognition, etc.** The TCHHS *Annual Report 2014 – 2015* makes no reference to any awards, recognition etc. given to Aboriginal and/or Torres Strait Islander employees. **Score = 0/1.**
      8. **Aboriginal and Torres Strait Islander Health Plan** According to the TCHHS *Annual Report 2014 – 2015* (p. 12), the TCHHS has established “significant, collaborative partnerships with … key stakeholders” which include Apunipima and the NPAFCSATSIC. It is unclear whether these partnerships entail formal agreements, plans, MoUs, etc. as no information was available on the TCHHS website. **Score = 5/10.**
      9. **Cultural competence** Cultural competency is key to effective health system performance in delivering healthcare to Aboriginal and Torres Strait Islander clients. 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.[[388]](#footnote-388)

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 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.[[389]](#footnote-389)
  + - 1. **Cultural competency policy/strategy.** The TCHHS is funded in its 2014/15 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). The publicly available information does not make reference to any particular program to provide this (mandatory) training. **Score = 0/3**
      2. **Capacity to deliver CCT:** Ideally all TCHHS staff should undertake cultural competency training at least once every two years. The TCHHS had, at 30 June 2015, a total, occupied full-time equivalent (FTE) of 836 across all classification streams (TCHHS *Annual Report 2014 – 2015*, p.30). This roughly translates into CCT for about 400 staff per year. However, reference to CCT delivery has not been found in the publicly available information. **0/3.**
      3. **Proportion of non-Indigenous staff to receive CCT** The publicly available information, including the TCHHS *Annual Report 2014 – 2015,* does not make reference to the number of non-Indigenous employees that have completed CCT. **Score = 0/4.**
      4. **Indigenous status** Estimated levels of completion of Indigenous statusnot reported in the TCHHS *Annual Report 2014-2015.* **Score = 0/2.**
      5. **DAMA** TheTCHHS *Service Agreement 2014/15 – 2015/16* (p. 50) does not include a KPI for DAMA, consequently no data on DAMA rates were published in the TCHHS *Annual Report 2014 – 2015* (see p. ??) or the Queensland Health’s *Closing the Gap performance report 2015*. However, the *Closing the Gap performance report 2014* (p. 29) provides the following for the former Cape York and TS-NPA HHS regions:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

Cape York 0.97% 2.00% 3.20% 1.70% 1.23% 1.40% 1.78% 1.10%

TS-NPA 0.47% 0.80% 1.20% 0.80% 0.34% 0.80% 0.00% 0.80%

However, because no data for DAMA has been published for 2014-2015 no score can be awarded. **Score = 0/2.**

* + - 1. **PPH** TheTCHHS *Service Agreement 2014/15 – 2015/16* (p. 50) include a KPI for PPH. Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following for the former Cape York and Torres-NPA HHS regions:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

Cape York 20.10% 17.70% 16.10% 17.70% 18.00% 17.70% 24.60% 17.70%

TS-NPA 18.50% 17.70% 21.20% 17.70% 19.50% 17.70% 17.50% 17.70%

The TCHHS *Annual Report 2014 – 2015* (p. 18) identified, among the indicators that required improvement:

Reducing the number of potentially preventable hospitalisations through the provision of quality primary health care.

In 2014-15, the HHS significantly reduced the percentage of potentially preventable hospitalisations (total) from 11.9% to 8.9%; and recognises that further improvement is still required to meet the target of 7.7%, and specifically for Aboriginal and Torres Strait Islander residents.

The score awarded reflects that while there is significant improvement in the overall rates of PPH, it does not specifically identify the rates for Aboriginal and Torres Strait Islander people. Given that the previous 2013-14 target was 17.70%, and that the CYHHS had significantly exceeded this target in the June quarter of 2014, while the TS-NPAHHS had only slightly bettered it, this suggests that the rates for PPH for Aboriginal and Torres Strait Islander people within the TCHHS region would be significantly higher than the overall improvements indicated in the TCHHS *Annual Report 2014-2015*. **Score = 0.5/2.**

* + - 1. **Access to mental health services** Access to mental health servicesmeasured in terms ofthe 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 that separation. The TCHHS was funded under its *Service Agreement 2014/15 – 2015/16* (p. 29) to provide Indigenous Mental Health Services. This Closing the Gap KPI is reported in the TCHHS *Annual Report 2014-2015* (refer p. 17, Table 1)*.* **Score = 2/2.**
      2. **Access to drug and alcohol services** Not reported in the TCHHS *Annual Report 2014-2015.* **Score = 0/2.**
      3. **Aboriginal and Torres Strait Islander workforce development policy/strategy** While the Cape York HHS *Annual Report 2012-2013* (p. 35) provided no data on Aboriginal and Torres Strait Islander participation in its 368 FTE workforce, the Torres Strait-Northern Peninsula HHS *Annual Report 2012-2013* indicated that, of the staff surveyed, Aboriginal and Torres Strait Island people constituted 32.65% of TS-NPHHS workforce (given as 392 FTE positions at the 30 June 2013)(pp. 18-19). It was also reported (p. 17) that the priority in 2012-13 was to “build capacity and to provide internal staff development programs across the TS-NP HHS”, and that career entry programs resulted in:
* Indigenous administration staff enrolment and completion of:
* 5 x Certificate IV in Business
* 14 x Diploma in Management
* 1 x Advanced Diploma in Business
  + - * Employment of 12 health worker trainees all completing Certificate III in Aboriginal and/or Torres Strait Islanders in Primary Health Care.

TCHHS *Annual Report 2014 – 2015* (p.30), provides no data on Aboriginal and Torres Strait Islander participation in the TCHHS workforce. The TCHHS *Strategic Plan 2015-2019* states, as its fourth objective: “Develop and empower our workforce to ensure staff are both capable and focused on meeting service and community needs.” One of the key strategies for this objective is to: “Maximise training opportunities to boost local Aboriginal and Torres Strait Islander workforce.” Measures to implement this strategy include: (i) development and implementation of Aboriginal and Torres Strait Islander learning and development plan; and (ii) development and implementation of Indigenous Health Worker plan. The TCHHS *Annual Report 2014 – 2015* (p.30) indicates that: “Torres and Cape HHS has developed a comprehensive Workforce Plan that aims to ensure the workforce is dynamically and directly linked to organisational goals, including the future direction of the Service.” Presumably this plan includes measures to boost the local Aboriginal and Torres Strait Islander workforce. However, the plan is unsighted and does not appear on the TCHHS website. A one point penalty results. **Score = 2/3.**

* + - 1. **ATSI employment implementation body** No reference has been found in the publicly available information regarding such a body. **Score = 0/3.**
      2. **Employment equity** The TCHHS had, at 30 June 2015, a total, occupied full-time equivalent (FTE) of 836 across all classification streams (TCHHS *Annual Report 2014 – 2015*, p.30). Aboriginal and Torres Strait Islander people constitute around 64% of the total population served by the TCHHS (p.7), therefore on a basis of equity the target for participation in the TCHHS workforce is around 500. As no data is publicly available, this criterion can’t be rated. **Score = 0/4.**
      3. **ATSI workforce participation** The publicly available information, including the TCHHS *Annual Report 2014 – 2015* (p.30), provides no data on Aboriginal and Torres Strait Islander participation in the TCHHS workforce. While clearly employing proportionately a quite substantial number of Aboriginal and Torres Strait Islander people across a number of employment streams, failure to disclose the nature and level of this participation has resulted in a penalty score. **Score = 0/10.**
      4. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
      5. **Commonwealth contribution** Neither the financial statements contained in the TCHHS *Annual Report 2014 – 2015* nor the TCHHS *Health Service Agreement 2014/15 – 2015/16* disclose the Commonwealth contributions to the TCHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**
      6. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the TCHHS has an operating budget of $171.7 million for 2014-15.[[390]](#footnote-390) In accordance with TCHHS *Service Agreement 2014/15-2015/16* (p. 37) with specific funding allocated under the Queensland Aboriginal and Torres Strait Islander Health Investment Strategy, the TCHHS has been funded for $2,751,276 for 2014/2015, and as outlined in memorandum PS000559, to provide the following services:
* Child and maternal health services
* Continuous quality improvement activities (hosted initiative)
* Sexual and reproductive health services
* Indigenous cultural capability services
* Administrative support for the Torres Strait Hostel

In addition to the 2014/2015 funding the TCHHS will receive:

* $1,020,000 for continuous quality improvement (deferred from 2013/2014). This is a hosted project undertaken by the HHS
* $60,000 for the Indigenous Health Outcomes National Partnership Agreement (deferred from 13/14) to deliver remaining outcomes for this project.

Under specific funding allocated for the Torres Strait Health Protection Strategy – Saibai Island Health Clinic, the TCHHS will receive $3,200,000 deferred from 2013/14 to be spent in 2014/15 for the provision of healthcare to provide better management of communicable diseases (p. 36).

The *Service Agreement* (p. 31) also notes that:

More details on the specific funding and reporting requirements to address Aboriginal and Torres Strait Islander health disparities are available in the memorandum titled *2014-2015 to 2015-2016 Closing the Gap funding allocations to Torres Strait and Northern Peninsula Area*, file reference PS000559, and *2014-2015 to 2015-2016 Closing the Gap funding allocations to Cape York Hospital and Health Service*, file reference PS000559.

Queensland Closing the Gap funding allocations, and how they were spent (for example, the allocation for the provision of each of the above services/activities), should be disclosed within TCHHS *Annual Report 2014 – 2015* in the interests of public accountability and transparency. The TCHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the TCHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score= 0/10.**

**TCHHS documents consulted**

* TCHHS *Annual Report 2014-2015*
* CYHHS *Annual Report 2012-2013*
* TCHHS *Strategic Plan 2015-2019*
* Torres Strait-Northern Peninsula HHS *Annual Report 2012-2013*
* TCHHS *Service Agreement 2014/15 – 2015/16.*
* TCHHS *Service Agreement 2014/15 – 2015/16: Deed of Amendment August 2015.*

**TCHHS documents not sighted**

* TCHHB *Board Meeting Summaries* for 2014 and 2015
* TCHHS Workforce Plan (referred to TCHHS *Annual Report 2014-2015*, p. 30).
* *2014-2015 to 2015-2016 Closing the Gap funding allocations to Torres Strait and Northern Peninsula Area*, file reference PS000559, and *2014-2015 to 2015-2016 Closing the Gap funding allocations to Cape York Hospital and Health Service*, file reference PS000559.
* QH *Queensland Aboriginal and Torres Strait Islander health investment strategy 2013-16*
* *Blueprint for better health outcomes for Aboriginal and Torres Strait Islander people in Queensland* (currently under development)(referred to in TCHHS *Service Agreement 2014/15 – 2015/16,* p. 30)

## Townsville Hospital and Health Service

**TOWNSVILLE HOSPITAL AND HEALTH SERVICE (THHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

**Participation in governance**

* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* Townsville Hospital and Health Board (THHB) (3)
* Indigenous representative 10 10
* Executive Management Team (4)
* Aboriginal and Torres Strait Islander Health – Directorate Status 5 0

- Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 10.5**

**Policy implementation**

* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 5
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 5
* Reconciliation Action Plan (8) 3 0
* Indigenous Health Service Group community newsletter (9) 2 0
* Public Reporting and Accountability (via Annual Report) (10)
* Traditional Owner acknowledgement (11) 1 1
* Closing the Gap

(i) Separate section in report devoted to Closing the Gap (12) 1 1

(ii) Reporting on KPIs contained in 2013/14 - 2015/16 service agreement (13) 1 0

* Policy references (14)
* (i) Cultural Capability Framework (15) 1.5 1
* (ii) Making Tracks (16) 1.5 0
* Organisational structure (ATSI unit placement within) (17) 1 1
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 1
2. Reference to workforce planning, recruitment, etc.(19) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 17**

**Service delivery**

* Aboriginal and Torres Strait Islander health plan (21) 10 5
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 0
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 0
* Proportion of non-indigenous staff trained (25) 4 0
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 20
* Access to drug and alcohol services (30) 2 0

**Total 30 5**

**Recruitment and employment**

* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce policy/strategy (31) 3 2
* Aboriginal and Torres Strait Islander employment implementation body (32) 3 0
* Employment equity (33) 4 1.5
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical1  0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Practitioners/Health Workers and Liaison Officers 2 0
* Trade and Artisans1 0
* Operational/Support Services 1 0
* Health Practitioners (Professional and Technical) 1 0 **Total 20 3.5**
  1. **Financial Accountability and Reporting: Closing the Gap funding** (35)
* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0  **Total 20 0**

**Score 140 36**

**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. **Townville Hospital and Health Service** The Townsville Hospital and Health Service (THHS) has responsibility for providing public hospital and health services within its primary region to a population of over 240,000 people, 7% of whom (about 16,800) are Aboriginal and Torres Strait Islander people, residing within a geographical area covering more than 148,000 square kilometres (8.5% of the total area of Queensland) (THHS *Annual Report 2014 – 2015,* pp. 27-28; THHS *Service Agreement 2013/14 – 2015/16*, p. 20). The Townsville Hospital is the main referral hospital and also provides tertiary hospital services to the North, Central and Far North Queensland regions with a catchment population of approximately 650,000 [THHS *Strategic Plan 2014-2018* (2015 Update) (unpaginated)]. The THHS has responsibility for the Joyce Palmer Health Service on Palm Island, a deed of grant in trust (DOGIT) community of about 5,000 people, operating under the Palm Island Aboriginal Shire Council.[[391]](#footnote-391) A $6.5 million infrastructure investment on Palm Island has been made for accommodation and van enclosure, mobile health clinic and community clinic (THHS *Annual Report 2014 – 2015,* p.29).In 2011, the Palm Island Aboriginal Shire Council released the *Palm Island Health Action Plan 2010-*2015 which could serve as a model/template for not only other Aboriginal and Torres Strait Islander shire councils in Queensland, but also for Queensland’s ATSICCHSs in partnership with their respective HHSs. The Townsville Aboriginal & Torres Strait Islander Corporation for Health Services operates as a local community controlled health service within the region served by the THHS.

The THHS, as part of its organisational structure, has an Indigenous Health Service Group headed by the Service Group Director – Indigenous Health and Professor Indigenous Health who is a member of the Senior Management Team (see also Note 4).

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 of a point out of 20 for each of the 16 HHSs.

3. **THHB** The Townsville Hospital and Health Board (THHB) comprises 10 members, one of whom is Indigenous, and another member has specific experience delivering health care to Aboriginal and Torres Strait Islander people (THHS *Annual Report 2014 – 2015,* pp. 34-36). A second Indigenous representative was appointed to the THHB and attended their first THHB meeting on 23 November 2015 (THHB *Summary of key issues discussed and decisions made by the Board, Townsville Hospital and Health Board Meeting 23 November 2015*). **Score = 10/10.**

4. **Executive Management Structure** The Executive Management Group of 8 is comprised of the Chief Executive, Chief Operating Officer, Chief Finance Officer and 5 Executive Directors. The five directorates are: Clinical Governance; Human Resources and Engagement; Medical Services; Nursing and Midwifery Services; and Programmes Management. There is also a Senior Management Team of 14 members comprising the Executive Management Group plus 6 Service Group Directors, one of which is the Indigenous Health Service Group Director. The Service Groups are: Health and Well Being; Indigenous Health; Medical; Mental Health; Rural Hospitals; and Surgical (THHS *Annual Report 2014 – 2015,* pp. 37, 40 and 78 in particular for the Executive Management Group). While the Indigenous Health Service Group Director is a member of the Senior Management Team and is a significant inclusion in the governance structure, it still falls short of full directorate status with membership in the Executive Management Group.

**Scoring:** The Indigenous Health Service Group, as it is not a “stand-alone” executive level division, **score = 2.5/5.** The Indigenous Health Service Group Director is not an Aboriginal or Torres Strait Islander person: **score = 0/5.**

5. **Closing the Gap health outcomes and the THHS Strategic Plan** The THHS *Strategic Plan 2014-2018* (2015 Update) contains a number of references to Closing the Gap, the most important of which is under the Strategic Pillar: Build Healthier Communities, in which reference is made to the National Partnership Agreement Closing the Gap in Indigenous Health Outcomes, *Making Tracks: towards Closing the Gap in health outcomes for Indigenous Queenslanders by 2033*, and the Palm Island Health Action Plan 2010 – 2015.[[392]](#footnote-392) It is also noted in the THHS *Health Service Plan 2012-2017* (p. 7) that: “The Closing the Gap initiative is a key directive for the Townsville HHS to 2027.” **Score = 5/5.**

* + - 1. **Closing the Gap KPIs included in health service agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the THHS *Service Agreement 2013/14 – 2015/16* for this triennium identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 41); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 42). **Score = 2/5.**
      2. **Aboriginal and Torres Strait Islander consultative body** The Health Service Chief Executive, in her overview, refers to the Aboriginal and Torres Strait Islander Leadership Advisory Committee which “has set a clear direction for improving cultural capability in its widest definition and with our Board’s infrastructure investment and focus we have the best opportunity in a generation to *Closing the Gap* faster” (THHS *Annual Report 2014 – 2015,* p. 5). Mention is also made of the Palm Island Health Advisory Group formed to give community input into health service delivery at the Joyce Palmer Health Service.[[393]](#footnote-393)TheTHHS *Consumer & Community Engagement Strategy 2016-2018* (p. 19) also refers to the Aboriginal and Torres Strait Islander Health Leadership Advisory Council which provides input into the THHB’s Executive Committee for Safety and Quality and partners with the broader Consumers & Community Committee. **Score = 5/5.**
      3. **RAP** The Queensland Government released its Reconciliation Action Plan in 2009 committing all government agencies to developing their own RAPs. According 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.[[394]](#footnote-394) Queensland Health co-signed with Reconciliation Australia[[395]](#footnote-395) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No references have been found in the published information, including the Reconciliation Australia RAP register for Queensland, indicating that THHS has a RAP. **Score = 0/3.**
      4. **ATSI Health Division/Unit community newsletter.** While the THHS regularly provides media releases,a search of the THHS website has failed to reveal the existence of either a regular THHS newsletter, or an Aboriginal and Torres Strait Islander community letter published by the Indigenous Health Service Group.[[396]](#footnote-396) **Score = 0/2.**
      5. **Annual Report** 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.*
      6. **Traditional Owner acknowledgement** The THHS *Annual Report 2014 – 2015* (p. 1) includes the following acknowledgement: “The Townsville Hospital and Health Service respectfully acknowledges the traditional owners and custodians both past and present of the land and sea which we service and declare the Townsville Hospital and Health Service commitment to reducing inequalities between Indigenous and non-Indigenous health outcomes in line with the Australian Government’s *Closing the Gap* initiative.” **Score = 1/1.**
      7. **Closing the Gap section** The THHS *Annual Report 2014 – 2015* (p. 14) contains a section on Closing the Gap, reporting that it has delivered on some 12 programs under the umbrella of both the National Partnership Agreement initiatives on *Closing the Gap* in Indigenous Health Outcomes and the Aboriginal and Torres Strait Islander Health Investment Strategy. **Score = 1/1.**
      8. **Reporting on KPIs** In contrast to the THHS *Annual Report 2012-2013,* the THHS *Annual Report 2014 – 2015* contains no Closing the Gap KPI data (see p. 47 regarding Service Delivery Standards).The 2012 – 2013 report provided data 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 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
* 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.

**Score = 0/1.**

* + - 1. **Policy references** For the THHS, 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.
      2. **Cultural capability framework** One explicit reference is made to the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* in the THHS *Annual Report 2014 – 2015* (p. 14) as one of the programs being delivered under the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes and the Aboriginal and Torres Strait Islander Health Investment Strategy, however there is no further description as to how the Framework, or what parts of it, are being implemented. **Score 1/1.5.**
      3. **Making Tracks** No explicit reference to, or information regarding Making Tracks progress or initiatives, is reported in the THHS *Annual Report 2014 – 2015*. **Score 0/1.5**.
      4. **Organisational structure** The organisation chart in the THHS *Annual Report 2015 – 2015* (p. 37) shows an Indigenous Health Service Group, the director of which is a member of the Senior Management Team. **Score = 1/1.**
      5. **Employment** The THHS *Annual Report 2014 – 2015* (p. 54), under the section on Workforce profile, indicates that Aboriginal and Torres Strait Islander staff comprise 3.02 per cent of the workforce. **Score = 1/1.**
      6. **Workforce planning** No reference to workforce planning, recruitment, etc. is made in the THHS *Annual Report 2014 – 2015* (pp. 53- 55). **Score = 0/1.**
      7. **Awards, recognition, etc.** No awards or other recognition for Aboriginal and Torres Strait Islander staff was recorded in the THHS *Annual Report 2014 – 2015*. **Score = 0/1.**
      8. **Aboriginal and Torres Strait Islander Health Plan** The THHS *Strategic Plan 2014-2018* (2015 Update) includes a reference to the *Palm Island Health Action Plan 2010 – 2015* in the context of Strategic Pillar: Focus on Individual Health Outcomes. With regard to the Palm Island health plan:

On 20 October 2011, the Statement of Intent for the *Palm Island Health Action Plan 2010 – 2015* was signed by the Commonwealth Government, Queensland Health and the Palm Island Aboriginal Shire Council. The aim of the *Palm Island Health Action Plan 2010 – 2015* is to identify, in consultation with the community, the health needs for Palm Island and to prioritise the actions required by the Commonwealth Government, Queensland Government, Palm Island Aboriginal Shire Council and community to ‘close the gap’ and improve health outcomes for people living on Palm Island.[[397]](#footnote-397)

However, no reference is made to the existence of any plan, agreement, etc. with the Townsville Aboriginal & Torres Strait Islander Corporation for Health Services (TATSICHS) which provides primary health care and other services to the greater Aboriginal and Torres Strait Islander community within the THHS area, and a search of the THHS website has also been unsuccessful. For scoring purposes, the existence of the *Palm Island Health Action Plan 2010 – 2015* is acknowledged, however, the lack of a plan drawn up between the THHS and the TATSICHS draws a penalty. **Score = 5/10.**

* + - 1. **Cultural competence** 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.[[398]](#footnote-398)

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 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.[[399]](#footnote-399)
  + - 1. **Cultural competency policy/strategy:** The THHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). Noting that THHS has developed a *Cultural Capability Companion* to provide a “practical approach for Townsville HHS to implement the capability framework and delivering services that close the gap” (THHS *Annual Report 2012 – 2013,* p. 37), and has in place an Indigenous Health Service Group (THHS *Annual Report 2014 – 2015,* p. 37), it is assumed that one of its responsibilities would be to oversee CCT. However, no mention is made in the THHS *Annual Report 2014-15* on progress made under this initiative. **Score = 0/3.**
      2. **Capacity to deliver CCT:** Ideally all non-Indigenous THHS staff should undertake cultural competency training at least once every two years. Since there are over 5,800 employees by headcount in the THHS (THHS *Annual Report 2014 – 2015,* p. 53), this roughly translates into CCT for over 2,900 staff per year.However, there is no published information at hand that indicates the status and capacity to deliver CCT. **Score = 0/3.**
      3. **Proportion of non-Indigenous staff to receive CCT** The THHS *Annual Report 2012 – 2013* (p. 54) records that the 27% of the staff received CCT (against a target of 30%). While it is assumed that CCT is still ongoing, no such data is recorded in the THHS *Annual Report 2014 – 2015.* **Score = 0/4.**
      4. **Estimated levels of completion of Indigenous status.** While this Closing the Gap KPI is recorded in the THHS *Annual Report 2012-2013* (pp. 51 and 54), it is not reported in the THHS *Annual Report 2014-2015.* **Score = 0/2.**
      5. **DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the THHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

4.88% 4.10% 4.60% 3.40% 6.42% 2.70% 5.29% 2.00%

THHS was listed among the four HHSs that have “persistently high DAMA rates with little or no change throughout the year” (p. 30). Despite being included in the THHS *Service Agreement 2013/14-2015/16* (p. 42), data on DAMA rates were not published for the current assessment period (2014-15) in either the THHS *Annual Report 2014 – 2015* (see Service delivery standards, p. 47) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2**

* + - 1. **PPH** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the THHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

18.50% 17.70% 19.90% 17.70% 19.20% 17.70% 19.00% 17.70%

While by no means the worst performer among the HHSs, THHS persistently failed to reach the target. Despite being included in the THHS *Service Agreement 2013/14-2015/16* (p. 41), data on PPH rates were not published for the current assessment period (2014-15) in either the THHS *Annual Report 2014 – 2015* (see Service delivery standards, p. 47) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*.  **Score = 0/2.**

* + - 1. **Access to mental health services.** The THHS *Annual Report 2012-2013*(p. 54) reported on the 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 that separation. The THHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 27) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the THHS *Annual Report 2014-2015.* **Score = 0/2.**
      2. **Access to drug and alcohol services** The THHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 27) to provide both Indigenous Outreach Services and Indigenous Youth (12-17 years) Treatment Programs under the Alcohol and Other Drug Services program. This Closing the Gap KPI is not reported in the THHS *Annual Report 2014-2015.* **Score = 0/2.**
      3. **ATSI workforce development policy/strategy** The THHS *Strategic Plan 2014-2018* (2015 Update), in reference to its Strategic Pillar: Maintain an Exceptional Workforce, identifies as one of its strategies:

Collectively improve participation rates of Aboriginal and Torres Strait Islanders in our workforce by developing and embedding a dedicated ‘Indigenous Employment Strategy’.

Among the underpinning plans, reference is made to *The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (ATSIHWNSF) 2011-2015[[400]](#footnote-400)*, and the *Aboriginal and Torres Strait Islander Workforce Strategy 2012-2016* (not sighted). While the intention to develop the strategy is clear, the document has not been sighted. **Score = 2/3.**

* + - 1. **ATSI workforce implementation body** According to the THHS *Annual Report 2012 – 2013* (p. 37)the THHS established the Aboriginal and Torres Strait Islander Employment Committee (ATSIEC). The THHS *Annual Report 2014 – 2015* makes no mention of ATSIEC, and neither, in its section on workforce planning with regard to key strategies to attract and retain a skilled and capable workforce (p. 54), does it specifically mention the need to recruit and train Aboriginal and Torres Strait Islander people. In fact, the Aboriginal and Torres Strait Islander workforce, in percentage terms, declined slightly from 2013/14 to 2014/15 (see Note 33). **Score = 0/3.**
      2. **Employment equity** From a participation rate of 3.17% in 2012-13 (THHS *Annual Report 2012 – 2013,* p. 37) the Aboriginal and Torres Strait Islander participation rate in the THHS workforce declined marginally to 3.02% in 2014 – 15 (THHS *Annual Report 2014 – 2015,* p. 54). For the THHS as at 30 June 2015, the MOHRI Occupied FTE is 4,946. Of that number, based on Aboriginal and Torres Strait Islander people constituting 3.02% of the workforce, the number of Aboriginal and Torres Strait Islander employees would number about 150. As Aboriginal and Torres Strait Islander people constitute about 7% of the total population served by the THHS, there should be around 350 Aboriginal and Torres Strait Islander people in the THHS workforce. In order to achieve parity with regard to closing the employment gap by 2033, this would mean adding some 12 or 13 Aboriginal and Torres Strait Islander staff per year for approximately the next 16 years. Based on the employment equity principle for the region as a whole, the number of Aboriginal and Torres Strait Islander employees is less than half of what it should be. **Score = 1.5/4**.
      3. **Workforce participation** No data is provided in the THHS *Annual Report 2014 – 2015* (see. pp. 53-55)regarding Aboriginal and Torres Strait Islander participation in QH’s six employment streams. An additional stream for Aboriginal and Torres Strait Islander Health Practitioners/Health Workers and Liaison Officers has been included as a new sub-criterion in its own right for future reporting purposes instead of such practitioners/workers being included in the Managerial and clerical stream. It is also noted that the THHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous hospital liaison services (see Note 37). While clearly employing Aboriginal and Torres Strait Islander people, as the THHS *Annual Report 2014 – 2015* (p. 53) provides no data for their participation across the employment stream, a penalty score results. **Overall score = 0/10.**
      4. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
      5. **Commonwealth contribution** Neither the financial statements contained in the THHS *Annual Report 2014 – 2015* nor the THHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the THHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**
      6. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the THHS has an operating budget of $758.1 million for 2014-15.[[401]](#footnote-401) To support the delivery of the Making Tracks priorities and in accordance with THHS *Service Agreement 2013/14-2015/16* (November 2013 Revision, p. 27), the THHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:
* mental health services
* child and maternal health services
* sexual and reproductive health services
* smoking and alcohol prevention activities
* continuous quality improvement activities
* chronic disease management services
* Indigenous hospital liaison services
* Indigenous cultural capability services

More details of the THHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to Townsville Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within THHS annual reports in the interests of public accountability and transparency. Both federal and Queensland Closing the Gap funding allocations should be disclosed within THHS annual reports in the interests of public accountability and transparency**.** The THHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the THHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10**.

**THHS documents consulted**

* THHS *Annual Report 2014-2015*
* THHS *Annual Report 2012-2013*
* THHS *Townsville Hospital and Health Service Health Service Plan 2012-2027.*
* THHS *Strategic Plan 2014-2018* (2015 update)
* THHS *2012-2016 Strategic Plan* (2013 update)
* THHS *Consumer & Community Engagement Strategy 2016-2018*
* THHS *Service Agreement 2013/14 – 2015/16.*
* THHS *Service Agreement 2013/14 – 2015/16* (November 2013 Revision)*.*
* THHB Board meeting summaries for:

1. 2014: 28 January; 24 February; 24 March; 28 April; 26 May; 23 June; 28 July; 25 August; 22 September; 27 October; 24 November; and 15 December.
2. 2015: 27 January; 23 February; 23 March; 27 April; 25 May; 22 June; 27 July; 24 August; 28 September; 26 October; and 23 November.

* *Palm Island Health Action Plan 2010-2015*

**THHS documents not found**

* Aboriginal and Torres Strait Islander Health Investment Strategy (see Note 12)
* THHS *Consumer and Community Engagement Strategy 2013 – 2015* (Listed on THHS website, but appears to have been removed. Access sought 9/12/2016).
* THHS *Strategic Workforce Plan 2014-2018* (referred to in THHS *Strategic Plan 2014-2018* (2015 update)
* *Aboriginal and Torres Strait Islander Workforce Strategy 2012-2016*. (QLD’s ??)
* *Cultural Capability Companion*

Memo ‘Closing the Gap funding allocations to Townsville Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: THHS *Service Agreement 2013/14-2015/16*, p. 42).

THHB Board meeting summary for 21 December 2015.

## West Moreton Hospital and Health Service

**WEST MORETON HOSPITAL AND HEALTH SERVICE (WMHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

**Participation in governance**

* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* West Moreton Hospital and Health Board (WMHHB) (3)
* Indigenous representative 10 0
* Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 0
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 0.5**

**Policy implementation**

* Closing the Gap in Aboriginal and Torres Strait Islander health outcomes
* Explicitly identified as a strategic priority in Strategic Plan (5) 5 0
* Closing the Gap KPIs explicitly referred to in Health Service Agreement (6) 5 2
* Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 0
* Public Reporting and Accountability (via Annual Report) (10)
* Traditional Owner acknowledgement (11) 1 1
* Closing the Gap

(i) Separate section in report devoted to Closing the Gap (12) 1 0.5

(ii) Reporting on KPIs contained in 2013/14 - 2015/16 service agreement (13) 1 0

* Policy references (14)
* (i) Cultural Capability Framework (15) 1.5 0
* (ii) Making Tracks (16) 1.5 1.5
* Organisational structure (ATSI unit placement within) (17) 1 0
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 0
2. Reference to workforce planning, recruitment, etc.(19) 1 0

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 5**

**Service delivery**

* Aboriginal and Torres Strait Islander health plan (21) 10 5
* Cultural competence (22)
* Cultural competency policy/strategy (23) 3 0
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 0
* Proportion of non-indigenous staff trained (25) 4 0
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 5**

**Recruitment and employment**

* Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander employment policy/strategy (31) 3 0
* Aboriginal and Torres Strait Islander employment implementation body (32) 3 0
* Employment equity (33) 4 0
* Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1 0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Workers and Liaison Officers 2 0
* Operational/Support Services 1 0
* Trade and artisans 1 0
* Health Practitioners (Professional and Technical) 1 0 **Total 20 0**

**Financial Accountability and Reporting: Closing the Gap funding** (35)

* Commonwealth contribution (36) 10 0
* Queensland contribution (37) 10 0 **Total 20 0**

**Score 140 10.5**

**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. **West Moreton Hospital and Health Service** WMHHS covers a region of 9,521 square kilometres and extends from Ipswich to Boonah in the south, west to Gatton and Laidley, north to Esk and east to Wacol. The HHS provides healthcare to about 260,000 people, of whom about 9,100, or 3.5% of the population, are Aboriginal and/or Torres Strait Islander (WMHHS *Annual Report 2014 – 2015*. p. 8; WMHHS *Service Agreement 2013/14 – 2015/16*, p. 20; WMHHS *Strategic Plan 2015-19: Path to Excellence*, p. 3). As recorded in the WMHHS *Health Service Plan 2013 - 26/*27 (p. 5), Aboriginal and Torres Strait Islander people generally have lower health status:

\* their hospitalisation rate is 2.1 times the rate of non-Indigenous hospital admission; and

\* their rate of death is 2.7 times the non-Indigenous death rate.

WMHHS provides mental health services to a number of correctional centres within the greater Brisbane metropolitan area, and has the primary responsibility in Queensland for Offender Health Services. In May 2015, Queensland’s prison population was about 7,000 (excluding youth detention), an approximate increase of 45% since July 2012 (WMHHS *Annual Report 2014 – 2015*. pp. 8 and 29; WMHHS *Service Agreement 2013/14 – 2015/16*, p. 26). Aboriginal and Torres Strait Islander youth make up approximately 60% of the detainees at the Brisbane Youth Detention Centre, 75% of whom are male, and with approximately 25% under 15 years (WMHHS *Health Service Plan 2013 - 26/*27, p. 35).

WMHHS also provides a range of integrated health services and specialised alcohol and other drug services at the Cherbourg Community Mental Health Service – in the Cherbourg Aboriginal Shire Council which is located in the Darling Downs HHS area (WMHHS *Service Agreement 2013/14 – 2015/16*, p. 26). Ipswich-based Kambu Aboriginal and Torres Strait Islander Corporation for Health (Kambu Health), an Indigenous community controlled health organisation, provides a range of primary health care services to the Aboriginal and Torres strait Islander community within the WMHHS region.

According to the publicly available information, WMHHS does not appear to have a dedicated unit for Aboriginal and Torres Strait Islander health/liaison services within its organisational structure.[[402]](#footnote-402)

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** of the HHB Act earns 0.5 point out of 20 for each of the 16 HHSs.

3. **WMHHB** The WMHHB comprises 7 non-executive members, none of whom, as profiled in the WMHHS *Annual Report* *2014-2015* (pp. 10-12) lists among their current professional positions any specific connection to an Aboriginal and Torres Strait Islander health organisation, or specific experience related to Aboriginal and Torres Strait Islander healthcare delivery. According to their profiles, none of the board members claims Aboriginal and/or Torres Strait Islander heritage. **Score = 0/10.**

4. **Executive Management Structure** The Executive Management Team (EMT) comprises 7 members. In addition to the Chief Executive, there are 6 Executive Directors responsible for Clinical Services; Mental Health and Specialised Services; Medical Services, Clinical Governance, Education and Research; Workforce; Finance and Business Services; and Governance, Risk and Legal (WMHHS *Annual Report* *2014-2015,* pp. 22-23 and 77). There is no stand-alone division for Aboriginal and Torres Strait Islander Health, and none of the executive position descriptions specifically lists Aboriginal and Torres Strait Islander health among their responsibilities (p. 78). Unusually, none of the Executive Management Team are profiled in the WMHHS *Annual Report* *2014-2015*, and efforts to find their profiles on the WMHHS website have proven fruitless*.[[403]](#footnote-403)* As this assessment is concerned with transparency via easy access to information, a penalty score has resulted. **Score = 0/10.**

5. **Closing the Gap health outcomes and the WMHHS Strategic Plan** The WMHHS *Strategic Plan 2015-2019* has the following objectives:

\* Excellence in patient and family centred care

\* Excellence in service delivery through innovation, research and lifelong learning

\* Provide an agile, resilient health service that anticipates and responds to need

\* Enable staff to be their best and give their best

\* Remain commercially astute

\* Implement integrated governance and systems that transform the delivery of healthcare excellence now and in the future

Apart from mentioning a strong relationship with community partner Kambu Aboriginal and Torres Strait Islander Corporation for Health through a partnership protocol (p. 4), the Strategic Plan makes no other reference to Aboriginal and Torres Strait Islander health, Closing the Gap, etc.

**Score = 0/5.**

**Closing the Gap KPIs included in health service agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the WMHHS *Service Agreement 2013/14 – 2015/16* for this triennium identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 40); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 41). **Score = 2/5.**

**Aboriginal and Torres Strait Islander consultative body** The WMHHS has established a Community Advisory Council (CAC) as the peak body for the community engagement for West Moreton (WMHHS *Consumer and Community Engagement Strategy 2015-17: Partnering with consumers and our community*, p. 25 ). Its role is to:

…provide consolidated advice and recommendations to the West Moreton Hospital and Health Board on decisions about the planning, design, delivery and evaluation of health care across the health service.

The membership of the CAC is formed from Community Reference Groups (CRGs) which were formed in 2014 and are based in Ipswich, Boonah, Laidley, Gatton and Esk (WMHHS *Annual Report 2014-2015*, p. 30; WMHHS *Consumer and Community Engagement Strategy 2015-17: Partnering with consumers and our community*, p. 26 ). The primary role of the CRGs is to:

…bring the voice of the patient/consumer, carer and the community into the planning, design, delivery and evaluation of health care within West Moreton Hospital and Health Service.

There is also aMental Health Consumer and Carer Advisory Group to provide a formal independent group, which promotes consumer and carer/family involvement in the planning and monitoring of the West Moreton Mental Health and Specialised Services Division (p. 26). No mention is made of an Aboriginal and Torres Strait Islander consultative body within this consumer and community engagement framework to provide independent advice to the WMHHB through the CAC. **Score = 0/5**

**RAP** 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.[[404]](#footnote-404) Queensland Health co-signed with Reconciliation Australia[[405]](#footnote-405) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No references are made in the published information available from Reconciliation Australia or the WMHHS concerning the existence of a RAP. **Score = 0/3.**

**ATSI Health Division/Unit community newsletter.** While the WMHHS maintains a news portal at its website, it does not publish a newsletter, and there is no Aboriginal and Torres Strait Islander community newsletter. **Score =0/2**

**Annual Report** The sub-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.*

**Traditional Owner acknowledgement** The WMHHS *Annual Report 2014 – 2015* acknowledges the Jagera, Yuggera, Ugarapul peoples (p. 2). Such acknowledgement also occurs in the WMHHS *Operational Plan 2015 – 16* (p. 4). **Score = 1/1.**

**Closing the Gap section** The WMHHS *Annual Report 2014 – 2015* contains no specific section on Closing the Gap, however, the policy is mentioned in passing on p. 29 and a summary of initiatives with regard to Indigenous Health Outcomes is given on pp. 32-33. **Score = 0.5/1**.

**Reporting on KPIs** In its reporting on performance on pp. 27-28, the WMHHS *Annual Report 2014 –* 2015 makes no reference to Closing the Gap KPIs, although the WMHHS is required to report on Aboriginal and Torres Strait Islander potentially preventable hospitalisations and discharges against medical advice (WMHHS *Service Agreement 2013/14 – 2015/*16, pp. 40-41).**Score = 0/1.**

**Policy references** For the WMHHS, 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.

**Cultural capability framework** The WMHHS *Annual Report 2014 – 2015* contains no specific reference 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 WMHHS to deliver culturally safe and appropriate healthcare to Aboriginal and Torres Strait Islander people. **Score = 0/1.5**.

**Making Tracks** While the *Making* Tracks policy is not specifically referenced, WMHHS has reported on delivering an “innovative project for Indigenous Continuous Quality Improvement” citing the *Numbulli Yalwa* (or “*All together talking*”) project which has resulted in a formal partnership between Kambu Health, the Institute for Urban Indigenous Health and WMHHS (WMHHS *Annual Report 2014 – 2015*, pp. 32-33). This would appear to implement two of the 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. See also Note 7. **Score = 1.5/1.5.**

**Organisational structure** No Aboriginal and Torres Strait Islander health service/unit is located on the organisational chart (WMHHS *Annual Report 2014 – 2015*, p. 23). **Score = 0/1.**

**Employment** As at 30 June 2015, WMHHS employed 2,857 full-time equivalent staff (WMHHS *Annual Report 2014 – 2015*. pp. 24 and 36). No data is provided on Aboriginal and Torres Strait employment within that workforce. **Score = 0/1.**

**Workforce planning** No reference is made in the WMHHS *Annual Report 2014 – 2015*. **Score = 0/1.**

**Awards, recognition, etc.** Among the awards, achievements and scholarships recognised on pp. 37-39 of the WMHHS *Annual Report 2014 – 2015*, there are no Aboriginal and/or Torres Strait Islander recipients identified. **Score = 0/1.**

**Aboriginal and Torres Strait Islander Health Plan** A Memorandum of Understanding has been implemented between the WMHHS and Kambu Health establishing the *Numbulli Yalwa* (*All Together Talking*) project (WMHHS *Annual Report 2014 – 2015*. pp 32-33.) The Numbulli Yalwa Project aims to achieve the following:

* Establish a strong partnership with West Moreton [HHS] and Kambu Health to share medical information to assist in the treatment and management of patients.
* Establish Indigenous Patient Navigator (iPN) role that will offer assistance to patients with a number of health conditions.
* Inform and improve planning and coordination of health services for the community and contribute to better long-term health for patients.
* Improve the co-ordination of patient care in order to keep patients well for longer. This is particularly important for the care of patients with a number of health conditions.

(WMHHS and Kambu Aboriginal and Torres Strait Islander Corporation for Health, no date. *Numbulli Yalwa* (*All Together Talking*) *Program,* WMHHS Ipswich Hospital Campus).

Hailed as a first within the Queensland public health system[[406]](#footnote-406), the Patient Navigator currently provides culturally-appropriate care within the healthcare system for up to 40 patients with complex needs. A data-sharing system has been established, based on a shared consent form, that allows each of the services to access relevant clinical information for a shared patient (WMHHS *Annual Report 2014 – 2015*. p. 33). While involving a Memorandum of Understanding, this endeavour, laudable as it is, is described as a project rather than a health plan.

The WMHHS *Strategic Plan 2015-19* (p. 4) also mentions that a partnership protocol is in place between the WMHHS and Kambu Health.

However, given:

1. the failure of the WMHHS to include Closing the Gap in Indigenous Health Outcomes among its strategic priorities in the WMHHS *Strategic Plan 2015-2019* (see Note 5),
2. failure to include in the WMHHS *Annual Report 2014-2015*  data on:

* Closing the Gap KPIs for DAMA and PPH (see Notes 27 and 28) as well as other KPIs listed in the QHMT (Note 23);
* Cultural Competency Training for the non-Indigenous workforce (Notes 23-25); and
* Aboriginal and Torres Strait Islander participation in the WMHHS workforce (Notes 31-34),

1. the absence of a dedicated Aboriginal and Torres Strait Islander community consultative body within the consumer and community engagement framework (see Note 7),
2. almost total absence of Aboriginal and Torres Strait Islander health/Closing the Gap as an agenda item for the 23 WMHHB meetings conducted during 2014 and 2015.[[407]](#footnote-407)

suggests that a WMHHS Aboriginal and Torres Strait Islander Health Plan is needed to complement the *West Moreton Hospital and Health Service: Health Service Plan 2013-26/27.* This assessment, however, credits the existing arrangement between the WMHHS and Kambu Health **Score = 5/10.**

**Cultural competence** 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.[[408]](#footnote-408)

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 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.[[409]](#footnote-409)

**Cultural competency policy/strategy.** The WMHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). A search of the published information and the WMHHS website has failed to reveal the existence of a cultural competency policy or strategy. **Score = 0/3.**

**Capacity to deliver CCT:** No mention is made in the WMHHS *Annual Report 2014 – 2015* regarding cultural competency training of non-Indigenous health workforce staff or the capacity to deliver it. **Score = 0/3.**

**Proportion of non-Indigenous staff to receive CCT** Similarly, no data is reported regarding numbers of non-Indigenous health workers who have received CCT. **Score = 0/4.**

**Indigenous status** Completion of Indigenous status – reporting of ‘not stated’ on admission. This performance indicator has not been reported on.  **Score = 0/2.**

**DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the WMHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

3.35% 2.50% 6.00% 2.20% 4.51% 1.80% 3.72% 1.50%

WMHHS was listed among those HHSs that have “persistently high DAMA rates with little or no change throughout the year” (p. 30). Despite being included in the WMHHS *Service Agreement 2013/14-2015/16* (p. 41), data on DAMA rates were not published for the current assessment period (2014-15) in either the WMHHS *Annual Report 2014 – 2015* (see Performance pp. 27-8) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

**PPH** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the WMHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

16.70% 17.70% 13.30% 17.70% 12.70% 17.70% 16.70% 17.70%

WMHHS exceeded the target for all four quarters. However, despite being included in the WMHHS *Service Agreement 2013/14-2015/16* (p. 40), data on PPH rates were not published for the current assessment period (2014-15) in either the WMHHS *Annual Report 2014 – 2015* (see Performance pp. 27-8) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

**Access to mental health services** measured in terms ofthe 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 that separation. The WMHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 27) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the WMHHS *Annual Report 2014-2015.* **Score = 0/2.**

**Access to drug and alcohol services.** This performance indicator has not been reported on. **Score = 0/2.**

**ATSI workforce development policy/strategy:** A searchof publicly available information, including the WMHHS *Annual Report 2014* – *2015,* and the WMHHS website has not indicated the existence of a comprehensive Aboriginal and Torres Strait Islander workforce policy or strategy. **Score = 0/3.**

**ATSI employment implementation body**: Consistent with Note 31, and due to the absence of publicly available data in the WMHHS *Annual Report 2014 – 2015* (see p. 24 in particular) on Aboriginal and Torres Strait Islander employment, no assessment is possible. **Score = 0/3**

**Employment equity:** As at 30 June 2015, the WMHHS employed 2,857 full-time equivalent staff (WMHHS *Annual Report 2014 – 2015*. p. 8). Aboriginal and Torres Strait Islander people constitute around 3.5% of the total population served by the WMHHS, therefore on a basis of equity the target for participation in the WMHHS workforce is 100. In order to achieve parity with regard to closing the employment gap by 2033, this would mean adding some 6 Aboriginal and Torres Strait Islander staff per year for approximately the next 16 years. No data on Aboriginal and Torres Strait Islander participation in the WMHHS workforce is publicly available on which to base an assessment. **Score = 0/4**.

**ATSI participation in workforce:** Due to the absence of publicly available data in the WMHHS *Annual Report 2014 – 2015* (see p. 24 in particular) on Aboriginal and Torres Strait Islander employment in any of the staff employment categories, no assessment is possible. **Score = 0/10**.

**Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.

**Commonwealth contribution** Neither the financial statements contained in the WMHHS *Annual Report 2014 – 2015* nor the WMHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the WMHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**

**Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the WMHHS has an operating budget of $457.1 million for 2014-15.[[410]](#footnote-410) To support the delivery of the Making Tracks priorities and in accordance with WMHHS *Service Agreement 2013/14-2015/16*, the WMHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

* child and maternal health services
* sexual and reproductive health services
* continuous quality improvement activities
* Indigenous cultural capability services

More details of the WMHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to West Moreton Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (WMHHS *Service Agreement 2013/14-2015/16*, p. 28), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within WMHHS annual reports in the interests of public accountability and transparency**.** The WMHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the WMHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**WMHHS documents consulted**

* WMHHS *Annual Report 2013-2014*,
* WMHHS *Annual Report 2014-2015*,
* WMHHS *Strategic Plan 2014-2018* (revised 2015)
* WMHHS *Consumer and Community Engagement Strategy 2014 – 2018*
* WMHHS *Service Agreement 2013/14 – 2015/16.*
* WMHHB Board meeting summaries for:

1. 2014: 31 January; 28 February; 28 March; 24 April; 30 May; 27 June; 25 July; 29 August; 26 September; 31 October; 28 November; and 19 December.
2. 2015: 30 January; 27 February; 27 March; 24 April; no meeting in May; 26 June; 31 July; 28 August; 25 September; 30 October; and 27 November.

* *WMHHS Health Service Plan 2013-26/27*.

**WMHHS documents not found**

Memo ‘Closing the Gap funding allocations to West Moreton Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: WMHHS *Service Agreement 2013/14-2015/16*, p. 41).

* *Consumer and Community Engagement Strategy 2015-17* (consultation draft) (referred to in WMHHS *Annual Report 2014 – 2015*, p. 34)
* WMHHB Board meeting summary for 18 December 2015.

## Wide Bay Hospital and Health Service

**WIDE BAY HOSPITAL AND HEALTH SERVICE (WBHHS) MATRIX ASSESSMENT 2014-15** (1)

**This assessment is to be read in conjunction with the Queensland Health Matrix Template (QHMT)**

**Key Indicators and Criteria Scoring Score**

* + - 1. **Participation in governance**
* Legal visibility: the *Hospital and Health Boards Act 2011* (Qld) and *Hospital*

*and Health Boards Regulation 2012* (Qld)(2) 20 0.5

* + - * Wide Bay Hospital and Health Board (WBHHB) (3)
* Indigenous representative 10 0
  + - * Executive Management Structure (4)
* Aboriginal and Torres Strait Islander Health Division 5 0
* Aboriginal/Torres Strait Islander Executive Director 5 0

**Total 40 0.5**

* + - 1. **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
  + - * Community engagement
* Aboriginal and Torres Strait Islander consultative body (7) 5 0
* Reconciliation Action Plan (8) 3 0
* ATSI Health Division/Unit community newsletter (9) 2 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 contained in 2013/14 - 2015/16 service agreement (13) 1 0

* Policy references (14)
* (i) Cultural Capability Framework (15) 1.5 0.5
* (ii) Making Tracks (16) 1.5 0
* Organisational structure (ATSI unit placement within) (17) 1 0
* Aboriginal and Torres Strait Islander Employment

1. Data on ATSI employment (18) 1 1
2. Reference to workforce planning, recruitment, etc.(19) 1 1

* Other recognition (e.g., awards, scholarships, etc.)(20) 1 0 **Total 30 6.5**
  + - 1. **Service delivery**
      * Aboriginal and Torres Strait Islander health service plan (21) 10 5
      * Cultural competence (22)
* Cultural competency policy/strategy (23) 3 0
* Capacity to deliver Cultural Competency Training (CCT) (24) 3 1
* Proportion of non-indigenous staff trained (25) 4 1
  + - * Selected Health Service Performance Indicators
* Estimated levels of completion of Indigenous status – specifically the

reporting of ‘not stated’ on admission (26) 2 0

* Discharges against medical advice (DAMA) (27) 2 0
* Potentially preventable hospitalisations (PPH) (28) 2 0
* Access to mental health services (29) 2 0
* Access to drug and alcohol services (30) 2 0

**Total 30 7**

* + - 1. **Recruitment and employment**
      * Aboriginal and Torres Strait Islander health workforce development
* Aboriginal and Torres Strait Islander workforce development policy/strategy (31) 3 1
* Aboriginal and Torres Strait Islander employment implementation body (32) 3 0
* Employment equity (33) 4 1.5
  + - * Aboriginal and Torres Strait Islander participation in health workforce (34)
* Managerial and clerical 1 0
* Medical and other health professionals 2 0
* Nurses 2 0
* Indigenous Health Workers and Liaison Officers 2 0
* Trade and artisans 1 0
* Operational and Support Services 1 0
* Health Practitioners (Professional and Technical) 10

**Total 20 2.5**

* + - 1. **Financial Accountability and Reporting: Closing the Gap funding** (35)
      * Commonwealth contribution (36) 10 0
      * Queensland contribution (37) 10 0  **Total 20 0**

**Score 140 16.5**

**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. **Wide Bay Hospital and Health Service** The Wide Bay Hospital and Health Service (WBHHS) incorporates the North Burnett, Bundaberg and Fraser Coast Local Government Areas and part of Gladstone Regional Council (Miriam Vale – Agnes Waters) covering a geographical area of approximately 37,000 square kilometres. The WBHHS has responsibility for providing public hospital and health services, including Indigenous health services, within its primary region to approximately 210,000 people, 3.6% of whom, or about 7,600 are Aboriginal and Torres Strait Islanders with Hervey Bay, Bundaberg and Maryborough having the highest number of Indigenous residents, while Eidsvold has the highest proportion (25%) (WBHHS *Annual Report 2014-2015,* pp. 8-9; WBHHS *Strategic Plan 2014-2017*, p. 7). Wide Bay ranks as the second most disadvantaged HHS region in Queensland after the Torres Strait-Northern Peninsula region (WBHHS *Strategic Plan 2015-2019*). The WBHHS region has one ATSICCHS, Galangoor Duwalami Primary Health Care Service located on the Fraser Coast, within its region. Galangoor Duwalami operates clinics in Hervey Bay (Torquay) and Maryborough.[[411]](#footnote-411)

2. **Legal visibility** See QHMT Note 4. The single reference in **s.4(c)(vi)** in the HHB Act earns 0.5 point out of 20 for each of the 16 HHSs.

3. **WBHHB** The Wide Bay Hospital and Health Board (WBHHB) comprises 9 members, none of whom, according to their profiles, identify as Aboriginal or Torres Strait Islander or have specific experience in the delivery of health care services to Aboriginal and Torres Strait Islander people (WBHHS *Annual Report 2014-2015,* pp. 15-20 and 32). **Score = 0/10.**

4. **Executive Management Structure** The Executive Management Team (EMT) comprises 12 members. In addition to the Chief Executive, the executive structure comprises directorates for: Finance and Performance; Clinical Governance; Human Resources; Medical Services; Contracts and Contestability; Public Health; Mental Health, Alcohol & Other Drugs Services; Nursing Services; Infrastructure Management; Media and Communications; and the Chief Operating Officer. Aboriginal and Torres Strait Islander Health is not listed specifically among their portfolio responsibilities. None of the EMT, according to their profiles, identifies as Aboriginal or Torres Strait Islander or has specific experience in the delivery of health care services to Aboriginal and Torres Strait Islander people, although one member has served in a public health executive capacity in the Peninsula and Torres Strait, a region with a very high percentage of Aboriginal and Torres Strait Islander people (WBHHS *Annual Report 2014-2015,* pp. 21-24 and 72). **Score = 0/10.**

5. **Closing the Gap health outcomes and the WBHHS Strategic Plan** The WBHHS *Improving health, together - a vision for Wide Bay Hospital & Health service:* *Strategic Plan 2014-2017* (p. 11)is based on the following pledges:

1. Delivering sustainable, patient centred, quality health services

2. Engaging with our communities and partners

3. Developing and empowering our workforce

4. Encouraging innovation and excellence

5. Delivering value for money.

Under the pledge of delivering sustainable, patient centred, quality health services, there are two objectives:

* + - * Improve health outcomes for our Aboriginal and Torres Strait Island communities. The key initiative is to develop “an action plan in partnership with NGOs and Medicare Local to demonstrate our commitment to the National Partnership on Closing the Gap in Indigenous health outcomes” by June 2015. The measure set for the plan is to: “Achieve all the Closing the Gap targets.” WBHHS *Strategic Plan 2015-2019* (p. 2) extends the timeframe to June 2016.
      * Reduce the rate of preventable and avoidable hospital admissions by improving ‘out of hospital’ care (for example hospital in the home, chronic disease programs to manage asthma, chronic heart failure and diabetes) by June 2017. The two measures for this are a “20% reduction in the rate of hospitalisation per 100,000 population”, and “Access to community based chronic disease management programs and primary prevention.” This objective has been dropped from the 2015-2019 Strategic Plan.

Under the second pledge: engaging with our communities and partners, a key initiative is: “Develop a range of strategies for engaging with Aboriginal & Torres Strait Islanders” to be achieved by December 2014 through the establishment of an “appropriate forum”.

The extension of the time-frame and the dropping of one of the objectives in the later plan, seems to indicate a softening in approach to dealing with Closing the Gap targets.

The inclusion of the Galangoor Duwalami Primary Health Care Service by name as one of the NGOs in the development of these objectives would seem appropriate. **Score = 2/5.**

* + - 1. **Closing the Gap KPIs included in the health service agreement** Of the five Closing the Gap KPIs listed in Note 23 of the QHMT, the WBHHS *Service Agreement 2013/14 – 2015/16* for this triennium identifies two: (i) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH) (p. 39); and (ii) Aboriginal and Torres Strait Islander discharges against medical advice (DAMA) (p. 40). **Score = 2/5.**
      2. **Aboriginal and Torres Strait Islander consultative body** The WBHHS *Strategic Plan 2014-2017*, under the pledge:Engaging with our communities and partners, a key initiative is to develop a “range of strategies for engaging with Aboriginal & Torres Strait Islanders” by establishing an appropriate forum by December 2014 (see Note 5). This initiative is not included in the Strategic Plan 2015-2019 (see p. 2). While there is mention of the need to create a more inclusive environment using the WBHHS Community Engagement Strategy, the local Consumer Advisory Network/Consultation Committees and the newly formed Primary Health Networks in the WBHHS *Strategic Plan 2015-2019*, no references are made in the published information of the existence of a stand-alone Aboriginal and Torres Strait Islander consultative body. **Score = 0/5.**
      3. **RAP** 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.[[412]](#footnote-412) Queensland Health co-signed with Reconciliation Australia[[413]](#footnote-413) a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No references are made in the published information available from Reconciliation Australia or the WBHHS concerning the existence of a RAP. **Score = 0/3.**
      4. **ATSI Health Division/Unit community newsletter** The WBHHSpublishes a newsletter *The Wide Bay Wave* which includes some items related to Indigenous health[[414]](#footnote-414), however, a search of the WBHHS website has failed to find any newsletter specifically published for the region’s Aboriginal and Torres Strait Islander community.  **Score = 0/2**
      5. **Annual Report** The sub-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.*
      6. **Traditional Owner acknowledgement** There is no Traditional Owner acknowledgement in the WBHHS *Annual Report 2014-2015.* **Score = 0/1.**
      7. **Closing the Gap section** The WBHHS *Annual Report 2014-2015* does not contain a discrete section devoted to WBHHS Closing the Gap initiatives and achievements. **Score = 0/1.**
      8. **Reporting on KPIs** The WBHHS *Annual Report 2014-2015* contains no data on the Closing the GapKPIs for PPH and DAMA identified in the WBHHS *Service Agreement 2013/14 – 2015/16* (pp. 39-40). **Score = 0/1.**
      9. **Policy references** For the WBHHS, 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.
      10. **Cultural capability framework** No explicit reference is made to the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* in the WBHHS *Annual Report 2014-2015,* although, references and data are included regarding non-Indigenous participation in the WBHH Cultural Practice Program (CCP) (pp. 27-28). However, the cultural capability of a HHS entails more than just delivering CCP training. **Score = 0.5/1.5**.
      11. **Making Tracks** No explicit reference is made in the WBHHS *Annual Report 2014-2015* regarding progress and initiatives undertaken in relation to the *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders* policy. **Score = 0/1.5.**
      12. **Organisational structure** Aboriginal and Torres Strait Islander health is not identified within the organisational structure of the WBHHS (WBHHS *Annual Report 2014-2015,* p. 14). **Score = 0/1.**
      13. **Employment** The WBHHS *Annual Report 2014-2015* (p. 27), under the section on Workforce diversity, indicated that 1.38% of the WBHHS workforce are of Aboriginal and/or Torres Strait Islander origin. **Score = 1/1.**
      14. **Workforce planning** Aboriginal and Torres Strait Islander workforce planning and recruitment is implied in the context of the WBHHS *Aboriginal and Torres Strait Islander Strategic Plan* with three new positions being added since November 2014 (WBHHS *Annual Report 2014-2015,* pp. 11 and 36). **Score = 1/1**.
      15. **Awards, acknowledgements, etc.** The WBHHS *Annual Report 2014-2015* (p. 28) makes a general reference to staff awards and recognition without, with one exception, naming the recipients. No Aboriginal or Torres Strait Islander people were named. **Score = 0/1.**
      16. **Aboriginal and Torres Strait Islander health plan** The WBHHS has developed an Aboriginal and Torres Strait Islander Strategic Plan (WBHHS *Annual Report 2014-2015,* pp. 11 and 35) which, according to the WBHHS *Strategic Plan 2015-2019* has the measurable goal of achieving “all Closing the Gap targets.” The Closing the Gap targets are those contained in the National Partnership [Agreement] on Closing the Gap in Indigenous health outcomes (WBHHS *Annual Report 2014-2015,* p. 35). According to the WBHHS *Annual Report 2014-2015* (p. 11) the Aboriginal and Torres Strait Islander Strategic Plan has been developed and implemented. However, Galangoor Duwalami Primary Health Care Service is not mentioned in either the WBHHS *Strategic Plan* with regard to the action plan, or the *Annual Report* with regard to the strategic plan, so it is unclear as to whether it is a partner in either. A web-search has been unsuccessful in locating the plan.[[415]](#footnote-415) **Score = 5/10.**
      17. 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.[[416]](#footnote-416)

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 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.[[417]](#footnote-417)
  + - 1. **Cultural competency policy/strategy.** The WBHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). In making a statement on workforce diversity, the WBHHS, in the *Annual Report 2014-2015* (p. 27)

… upholds the importance of cultural diversity and inclusiveness particularly recognising the importance of Aboriginal and Torres Strait Islander culture in the community. To further demonstrate the commitment to cultural diversity, the Cultural Practice Program has become part of the mandatory orientation training package.

However, given the poor results for mandatory training compliance for CCT (p. 28) (see Notes 24 and 25), and no evidence of such a policy/strategy on the WBHHS website,[[418]](#footnote-418) suggests that a cultural competency policy/strategy is not in place. **Score 0/3.**

* + - 1. **Capacity to deliver CCT** Ideally all WBHHS staff should undertake cultural competency training at least once every two years. Since there are nearly 3,500 staff (MOHRI headcount) (WBHHS *Annual Report 2014-2015,* p. 26), this roughly translates into CCT for around 1,750 staff per year. CPP is part of the mandatory orientation training package, so, in time, it could be anticipated that a high proportion of the non-Indigenous staff will receive CPP training. Given that 32% of the WBHHS workforce had completed the CCP, this suggests a limited capacity to deliver CCP training. **Score = 1/3.**
      2. **Proportion of non-Indigenous staff to receive CCT** The WBHHS *Annual Report 2014-2015* (p. 28) records that: “The WBHHS is committed to the training and development of staff as a joint individual and organisational responsibility.” At 30 June 2015, the data presented regarding mandatory training compliance for the 3477 staff (MOHRI headcount), only about a third (32%) had completed the CPP. This was by far the worst completion rate of the 11 training programs listed, rates for which ranged from 95% (WBHHS Orientation) and 91% (Queensland Health Orientation, Workplace Induction) to 51% (Performance Appraisal and Development), indicating either a somewhat lax approach to enforcing compliance, or a lack of capacity to deliver. **Score = 1/4.**
      3. **Estimated levels of completion of Indigenous status.** Completion of Indigenous status – reporting of ‘not stated’ on admission. This performance indicator has not been reported on. **Score =0/2**
      4. **DAMA** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the WBHHS:

**DAMA by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

2.60% 2.30% 4.60% 2.00% 2.58% 1.70% 3.65% 1.40%

Thus the WBHHS has failed to meet any of the quarterly targets. Despite being included in the WBHHS *Service Agreement 2013/14-2015/*16 (p. 40), data on DAMA rates were not published for the current assessment period (2014-15) in either the WBHHS *Annual Report 2014 – 2015* (see WBHHS Service Delivery Performance Statement 2014/15 pp. 39-40) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

* + - 1. **PPH** Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the WBHHS:

**PPH by quarterly rates**:

Sep-13 Target Dec-13 Target Mar-14 Target Jun-14 Target

15.40% 17.70% 15.40% 17.70% 14.50% 17.70% 19.20% 17.70%

The WBHHS has bettered the quarterly targets on three occasions.However, despite being included in the WBHHS *Service Agreement 2013/14-2015/*16 (p. 39),data on PPH rates were not published for the current assessment period (2014-15) in either the WBHHS *Annual Report 2014 – 2015* (see pp. 39-40) or the Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

* + - 1. **Access to mental health services** The 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 that separation. The WBHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 26) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the WBHHS *Annual Report 2014-2015.* **Score = 0/2.**
      2. **Access to drug and alcohol services.** This Closing the Gap KPI is not reported in the WBHHS *Annual Report 2014-2015.* **Score 0/2.**
      3. **ATSI workforce development policy/strategy:** Under the pledge: Developing and empowering our workforce, contained in the WBHHS *Strategic Plan 2014-2017*(p. 14), a key initiative is: “Develop the cultural competency of all staff and build capability of the local Indigenous workforce” by June 2015 through the development and implementation of the WBHHS Cultural Capability Plan. This initiative does not occur in the subsequent WBHHS *Strategic Plan 2015-2019* (see p. 3).

While increasing Aboriginal and Torres Strait Islander employment is clearly part of the Aboriginal and Torres Strait Islander Strategic Plan (see also Note 21), no further mention is made in the WBHHS *Annual Report 2014-2015* (see pp. 7 and 26-30) regarding workforce recruitment and training for Aboriginal and Torres Strait Islander people, although the WBHHS has developed an *Education and Training Strategic Plan 2014-2017: Developing and empowering our workforce* (p. 7). Despite multiple references to this plan, best endeavours in searching the WBHHS website have failed to locate this document.[[419]](#footnote-419) In a job ad (reference: H1503WB166558) for the position of Director Education, Training and Research, part of the job description is to coordinate the implementation of the Education and Training Strategic Plan 2014-2017. The accompanying Education, Training and Research Service Organisational Structure locates the position of Cultural Practice Facilitators (1 FTE AO4 Temp 2016).[[420]](#footnote-420) The evidence regarding the existence of Aboriginal and Torres Strait Islander recruitment and employment policy/strategy/plan is somewhat inconsistent and the document has not been sighted.  **Score = 1/3.**

**32. ATSI employment implementation body:** A search of publicly available information and the WBHHS website has failed to find any reference to some form of Aboriginal and Torres Strait Islander workforce implementation body, or a position dedicated to oversee such recruitment, training and employment of Aboriginal and Torres Strait Islander people in the WBHHS workforce. **Score = 0/3.**

1. **Employment equity:** The WBHHS has at June 2015 a MOHRI head count of 3477. 1.38% of the workforce, or about 50 people, identify as Aboriginal and/or Torres Strait Islander. While this participation in the WBHHS workforce is low, with the implementation of the Aboriginal and Torres Strait Islander Strategic Plan, three new Aboriginal and Torres Strait Islander positions have been added to the Aboriginal and Torres Strait Islander health team since November 2014 (WBHHS *Annual Report 2014-2015,* pp. 11 and 36). The Aboriginal and Torres Strait Islander population in the region served by the WBHHS is 3.6% of the total population. To achieve employment equity, there should be around 120 Aboriginal and Torres Strait Islander employees in the WBHHS. Based on the employment equity principle for the region as a whole, this number is below what it should be. In order to achieve parity with regard to closing the employment gap by 2033, based on current figures, this would mean adding some 5 Aboriginal and Torres Strait Islander staff per year for the next 16 years. **Score = 1.5/4.**
2. **Workforce participation:** While obviously employing Aboriginal and Torres Strait Islander people in its workforce, the WBHHS has provided no data regarding their participation across the 6 Queensland Health employment streams (although a gender breakdown of the general workforce is provided)(WBHHS *Annual Report 2014-2015*, p. 26). It is noted that the WBHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous hospital liaison services (see Note 37). An additional stream for Aboriginal and Torres Strait Islander Health Practitioners/Health Workers and Liaison Officers has been included as a new sub-criterion in its own right for future reporting purposes instead of such practitioners/workers being included in the Managerial and clerical stream. **Score = 0/10.**
3. **Financial Accountability and Reporting: Closing the Gap funding** All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.
4. **Commonwealth contribution** Neither the financial statements contained in the WBHHS *Annual Report 2014 – 2015* nor the WBHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the WBHHS’s Closing the Gap programs or their acquittal. **Score = 0/10.**
5. **Queensland contribution** According to the Queensland Government’s service delivery statements for Queensland Health, the WBHHS has an operating budget of $458.3 million for 2014-15.[[421]](#footnote-421) To support the delivery of the Making Tracks priorities and in accordance with WBHHS *Service Agreement 2013/14-2015/16*, the WBHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

* chronic disease management services
* sexual and reproductive health services
* Indigenous hospital liaison services
* Indigenous cultural capability services

More details of the WBHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled ‘Closing the Gap funding allocations to Wide Bay Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013) (WBHHS *Service Agreement 2013/14-2015/16*, p. 27), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within WBHHS annual reports in the interests of public accountability and transparency**.** The WBHHS Financial Statements, as disclosed in its *Annual Report* *2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent.The report contains no information as to how much money was allocated by the WBHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

**WBHHS documents consulted**

* + - * WBHHS *Annual Report 2014-2015*,
      * WBHHS *Strategic Plan 2014-2018* (revised 2015)
      * WBHHS *Consumer and Community Engagement Strategy 2014 – 2018*
      * WBHHS *Service Agreement 2013/14 – 2015/16.*
* WBHHB Board meeting summaries for:

1. 2014: 29 January; 25 February; 25 March; 29 April; 24 June; 28 July; 25 August; 29 September; 27 October; 24 November; and 15 December.
2. 2015: no meeting in January; 25 February; 12 March; 29 April; 27 May; 29 July; 28 August; 30 September (however August and September summaries are the same); 28 October; and 3 December.
   * + - *Improving health, together – a vision for Wide Bay Hospital & Health Service: strategic Plan 2014-2017*

**WBHHS documents not found**

* + - * WBHHS *Aboriginal and Torres Strait Islander Strategic Plan* (referred to in WBHHS *Annual Report 2014-2015,* pp. 11 and 35)
      * *Education and Training Strategic Plan 2014-2017: Developing and empowering our workforce*
      * Memo ‘Closing the Gap funding allocations to Wide Bay Hospital and Health Service for 2013/2014’, file reference PP003447 (10 May 2013)

Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: WBHHS *Service Agreement 2013/14-2015/16*, p. 40).

WBHHB Board meeting summaries for May 2014; and June and August/September, November 2015.

# SUMMARY OF AUDIT RESULTS

This part provides an overall summary of the audit results and highlights examples of HHS best practice encountered. It is again emphasised that the assessment process is based on the publicly available information provided by each HHS, which can vary, and that one of the purposes of the Matrix is to promote transparency in policy implementation and accountability. This means that some HHSs may be doing some of the assessable activities but not reporting them therefore incurring a penalty score.

## Analysis of audit results by criteria

The following sections briefly describe the rationale for each criterion, provide tabulated results of the audits for each criterion and associated sub-criteria for all 16 HHSs, and a commentary on those results.

### The National Health Reform Agreement (NHRA): the structural source of institutional racism in public hospitals and health services

Under the NHRA, States are responsible for establishing the legislative basis and governance arrangements for public hospital services, including the establishment of Local Hospital Networks (LHN) as outlined in Schedule D of the Agreement.[[422]](#footnote-422) In the Queensland context, under the *Hospital and Health Boards Act 2011* (Qld) (HHB Act), LHNs are redefined as HHSs.[[423]](#footnote-423) The Agreement affirms a number of implementation principles which should underpin National Health Reforms, one of which is:

1. governments agree that Australia’s health system should promote social inclusion and reduce disadvantage, especially for Indigenous Australians.[[424]](#footnote-424)

This is the only Indigenous reference in the body of the Agreement[[425]](#footnote-425), which is repeated almost verbatim in **s.4(c)(vi)** of the HHB Act in which **s.4** addresses the principles and objectives of the national health system as detailed in the NHRA. There is also no Indigenous reference in Schedule D of the Agreement which covers, *inter alia*, the establishment of LHNs, their responsibilities, service agreements, governance, and their structure.[[426]](#footnote-426) With regard to governance, paragraph D16 of Schedule D sets out the “appropriate mix of skills and expertise” required among the members of Local Hospital Network Governing Councils.[[427]](#footnote-427) Skill and expertise in the delivery of healthcare to Indigenous Australians is not included in the mix. In paragraph D17, the overall makeup of LHN Governing Councils “will be determined taking into account the need to ensure local community knowledge and understanding”[[428]](#footnote-428) – but again, no reference to include “Indigenous community knowledge and understanding.” Under **s.23(2)** of the HHB Act in relation to membership of HHS boards, the “skills, knowledge and experience required for a Service to perform its functions effectively and efficiently” largely reflect the mix of skills and expertise identified in paragraph D16 of Schedule D on the NHRA. To the extent that the NHRA establishes the framework for the States to follow in drafting their health service legislation, as there are no specific requirements for the inclusion of Indigenous Australians or specific references to Indigenous health in Schedule D, they are, by default, left out of the HHB Act.

The NIRA and NPACGIHO both predate the NHRA, and while the NPACGIHO is centred on five priority areas, one of which is “making Indigenous health everyone’s business”, and contains a package of health reforms that “embeds system reform” and “broader health system changes”[[429]](#footnote-429) these are not reflected in the NHRA. Neither the NIRA nor the NPACGIHO are referred to in the NHRA. The 2012 Regulation to the HHB Act does not refer to either of these agreements when referencing Commonwealth Agreements.[[430]](#footnote-430) It is as though the NHRA and the NIRA and NPACGIHO exist in parallel universes, destined not to meet. Consequently, insofar as the NHRA provides the legislative framework for the HHB Act, Aboriginal and Torres Strait Islander people and their health concerns are “written out” of the legislation. Thus the NHRA provides the structural conditions embodied in the HHB Act which enables institutional racism in Queensland’s HHSs to flourish.

### Criterion: Legal visibility

In the *Aboriginal and Torres Strait Islander Health Performance Framework: 2012 Report*, 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.[[431]](#footnote-431)

The Report then states 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.[[432]](#footnote-432)

In 2015, in the *Australian and New Zealand Journal of Public Health,* Howse and Dwyer noted that

The virtually complete absence of legislated attention to the need to improve Aboriginal health and health care and to allocate systemic responsibility for doing so shows up a stark gap at odds with universal recognition of the importance of reducing Aboriginal health inequity. ... the current public health laws that might create a legislative infrastructure for governance in Aboriginal and Torres Strait Islander health, are almost completely silent and create no legal basis for accountability. … This vacuum in governance persists, and despite reports, commentaries and calls for action for better stewardship and governance, the pace for law reform in this area has been slow.[[433]](#footnote-433)

Using the concept of “legal visibility”, the HHB Act is assessed against a number of sub-criteria that reflect what competent governance entails according to the AHMAC description above. The benchmark by which the HHB Act is compared is the *Nature Conservation Act 1992* (Qld) which provides high legal visibility in its various provisions affecting Aboriginal and Torres Strait Islander stakeholders. Queensland’s HHSs are established by and are subject to the HHB Act and therefore cannot determine or alter its provisions. The purpose of including this criterion and its sub-criteria is to promote public discussion of the HHB Act, particularly among Aboriginal and Torres Strait Islander people and their ATSICCHSs, around the extent to which it provides the necessary legal infrastructure and compliance framework for Closing the Gap in Indigenous Health Outcomes and provides for culturally responsive health service delivery by the state’s HHSs.

An HHB Act that properly incorporates and binds the HHSs to the spirit and intent of the NPACGIHO and the NIRA will provide clear evidence to the Aboriginal and Torres Strait Islander peoples of Queensland that addressing their health status and concerns matters.

While ultimately a matter for the Queensland Health Minister and government, health care/services legislation plays a key part in structuring relations between health services and Aboriginal and Torres Strait Islander peoples and the extent to which they are engaged and participate in the delivery of services to their own people and communities. This engagement requires participation throughout the system with regard to establishing mechanisms for inclusion in governance, administration, community consultation, partnerships with Aboriginal and Torres Strait Islander community controlled health services (ATSICCHSs) and other mainstream health care providers, and the provision of culturally safe and appropriate health care and service delivery.

The national priority in Closing the Gap in Indigenous Health Outcomes in terms of its goals, policies, processes, and performance and accountability frameworks must be reflected in the relevant state health legislation. This is probably the single most cost-effective measure that the government can undertake to Close the Indigenous Health Gap. After-all, it costs relatively little to require, for example: Indigenous representation on governing bodies (such as HHS boards); adequate state and local level Indigenous consultative structures are established; uniform reporting on particular CGKPIs (as per the Aboriginal and Torres Strait Islander Health Performance Framework Performance Measures)[[434]](#footnote-434); proper and consistently applied standards of reporting (on HHS overall Closing the Gap performance); and financial accountability regarding the expenditure of Indigenous health allocations. Making these mandatory requirements in the relevant health service laws will help ensure that Closing the Gap policies will be followed, and create institutional cultures within HHSs that reduce or even eliminate racism making them more comfortable and welcoming for Aboriginal and Torres Strait Islander health workforce employees and clients alike.

Such actions will restore the confidence of Aboriginal and Torres strait Islander peoples that their health and health concerns are being taken seriously and that health care delivery is not just another Indigenous industry whereby non-Indigenous people profit from Indigenous people’s misery.

Whereas all the other criteria employed in the Matrix are scored out of 10, additional weighting has been given to the scoring of this criterion because the HHB Act ultimately determines the structure of relations between HHSs and the Aboriginal and Torres Strait Islander people to whom they provide hospital and healthcare services within their regions. This criterion is scored out of 20.

This criterion addresses both the *Hospital and Health Boards Act 2011* (Qld) and the *Annual Report requirements for Queensland Government agencies.*

#### The Hospital and Health Boards Act 2011 (Qld)

The principal findings regarding the *Hospital and Health Boards Act 2011* (Qld) (HHB Act) are that:

* The HHB Act does not comply with **s.4(3)(j)** of the *Legislative Standards Act 1992* (Qld) in so far as it does not show that it has “sufficient regard to Aboriginal tradition and Island custom” in relation to those traditions and customs that specifically relate to Aboriginal and Torres Strait Islander health and wellbeing.
* Except for a single reference in **s.4 Principles and objectives of the national health system** in sub paragraph **(c)(vi)**,the HHB Act renders Aboriginal and Torres Strait Islander peoples “legally invisible” and creates the structural conditions for institutional racism and health inequity to exist within Queensland Health’s sixteen public hospital and health services by not including:

1. a statement of commitment to Closing the Gap in Aboriginal and Torres Strait Islander health in a Preamble to the Act, reflecting that “Aboriginal and Torres Strait Islander health is everyone’s business”;
2. a provision for the delivery of responsive, capable and culturally competent health care to Aboriginal and Torres Strait Islander people in Queensland as an object of the Act;
3. a requirement that HHS boards have among their members a person (or persons) with expertise and experience in Aboriginal and Torres Strait Islander health care or health service delivery among the skills, knowledge and experience required for a HHS to perform its functions effectively and efficiently under **s.23(2)**;
4. a provision that requires the establishment of Aboriginal and Torres Strait Islander consultative and advisory bodies to provide input into the administration and management of hospital and health services
5. a provision that requires HHSs to establish Aboriginal and Torres Strait Islander health plans;
6. a provision that requires HHSs to report on their progress on closing the Aboriginal and Torres Strait Islander health gap in their annual reports; and
7. a provision that requires HHSs to report the sources and expenditure of funds for Aboriginal and Torres Strait Islander health care and health service delivery in their annual financial statements.

In this regard, the HHB Act compares poorly with the *Nature Conservation Act 1992* (Qld) in terms of compliance with **s.4(3)(j)** of the *Legislative Standards Act 1992* (Qld). The *Nature Conservation Act 1992* (Qld), with regard to “legal visibility”, provides the necessary legal infrastructure that acknowledges and protects the rights, interests and responsibilities of Aboriginal and Torres Strait Islander people in the conservation and management of Queensland’s natural resources and protected areas through, for example, participation in advisory committees and statutory management plans.

In summary, the HHB Act fails to give the necessary legislative force to the COAG national partnership agreements and federal and Queensland policy imperatives to close the Aboriginal and Torres Strait Islander health gap, thus indicating to the Aboriginal and Torres Strait Islander communities that the State is not taking its responsibilities to close the Indigenous Health Gap seriously.

Becausethe HHB Act fails to give the necessary “legal visibility” to the structures and processes required to Close the Gap in Indigenous Health Outcomes, and also fails to comply with **s.4(3)(j)** of the *Legislative Standards Act 1992* (Qld), all HHSs have been penalised 19.5 points out of a maximum score of 20.

#### The Annual Report requirements for Queensland Government agencies

The *Annual Report requirements for Queensland Government agencies*sets out minimum compliance standards, and which do not require HHSs to include a section in their annual reports regarding their performance on Closing the Gap in Indigenous Health outcomes. Consequently, HHS Closing the Gap performances are either not reported at all (in the case of nine HHSs – see Table 8), or very inconsistently (see Table 11). All HHSs should be required to report on, as a minimum, the following selected Tier 3 Health System Performance Measures (HSPM) contained in the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures* endorsed by AHMAC:

1. Aboriginal and Torres Strait Islander participation in the workforce across all streams, including an additional stream for Aboriginal and Torres Strait Islander health workers and liaison officers, and their public service level of employment [HSPM: 3.12];
2. Non-Indigenous Cultural Competency Training completion rates and compared with completion rates for other mandatory training programs [HSPM: 3.08]
3. Selected KPIs such as for DAMA, PPH, access to mental health services and access to drug and alcohol services, and as negotiated with Queensland’s peak Aboriginal and Torres Strait Islander health bodies, such as QAIHC and IUIH [HSPMs: 3.09; 3.07; 3.10; and 3.11]
4. Participation in HHS governance (board representation, executive management, participation in board and executive committees) [HSPM: 3.13];

As well as reporting on:

* Indigenous status [not an HSPM] for both Aboriginal and Torres strait Islander employees and clients;
* Location of Indigenous health units and services within the HHS organisational structure; and
* In a separate financial statement, disclose the sources of funding, their allocation and expenditure for all Closing the Gap programs and services provided by the HHS.

### Criterion - Aboriginal and Torres Strait Islander representation on Hospital and Health Boards (HHB)

As noted in the introduction to Section 5.1.2, competent governance requires, *inter alia*, the “effective participation of Indigenous people on decision-making boards.” As also noted in Section 5.1.2.1, a fundamental flaw of the HHB Act is that **s. 23(2)** does not require Aboriginal and Torres Strait Islander representation on HHS boards. With board member remuneration fees of around $50,000 per annum, having such membership may be the most cost-effective way of creating a HHS culture that provides culturally safe, competent and responsive healthcare services to Aboriginal and Torres Strait Islander clients. In HHS regions which have proportionately high numbers of Torres Strait Islander people (such as TCHHS, CHHHS and THHS), consideration must also be given to their right to be represented on HHS boards. While HHS boards must have a minimum of 5 members, there is no restriction in **s. 23(2)** on the upper limits of membership. Currently board memberships range from 7 to 10 (see Table 3). Consideration might also be given to having both male and female Indigenous representation.

**Table 2: Criterion - Aboriginal and Torres Strait Islander representation on Hospital and Health Boards (HHB)**

**Criterion CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

**Representation**

**on HHBs** 0 0 0 0 0 0 0 0 0 1 0 0 3 1 0 0

**Comments:**

* Only three HHSs had Indigenous representation: the TCHHB with three members, and one each on the NWHHB and on the THHB.
* Of the 131 board members appointed across all HHSs, only 5 were Aboriginal and/or Torres Strait Islander - see Table 3.

HHBs meet monthly – effectively 10 or 11 times a year. Some remote area HHBs, due to difficulty and distance of travel, meet less but tend to have extended meetings over two days. While much of their agendas are taken up addressing routine standing order matters, for example, reports from the Chair, Chief Executive and Chief Finance Officer, and HHB committees (Executive, Finance, Safety and Quality, and Audit and Risk committees), nevertheless, based on an average of 10 agenda items per meeting (the range extends from 5 to 23), the 16 HHBs would have collectively addressed some 3,520 items during 2014 and 2015 – see Table 4. As a possible consequence of the lack of Aboriginal and Torres Strait Islander representation at both board and executive management levels, and allowing for instances where summaries were not sighted (for TCHHB for 2014 and 2015, and for CHQHHB and CWHHB in 2014), during 2014 and 2015 matters relating to Aboriginal and Torres Strait Islander health were addressed an estimated 38 times, accounting for about 1% of HHB business. An analysis of the data reveals that:

* None of the agenda items explicitly included an annual report or review of a HHS’s performance or contribution to closing the Indigenous health gap; and
* For 5 HHSs, Indigenous health was not listed as an agenda item for 2014 and 2015.

It is reasonable to expect that each HHB should review its HHS’s performance in relation to closing the gap in Indigenous health outcomes at least once, if not twice in every year.

**Table 3: Aboriginal and Torres Strait Islander participation in HHS governance: representation on Hospital and Health Boards and Executive Management Teams (as at June 30, 2015 and as per HHS Annual Reports for 2014-15)**

**HHS No. of Board No. of ATSI Size of EMT ATSI Membership**

**Members Board Members of EMT**

CHHHS 7 0 9 0

CHQHHS 10 0 11 0

CQHHS 9 0 12 0

CWHHS 7 0 5 0

DDHHS 9 0 9 0

GCHHS 8 0 8 0

MHHS 8 0 8 0

MNHHS 8 0 23 0

MSHHS 7 0 12 0

NWHHS 8 1 6 0

SWHHS 9 0 9 0

SCHHS 8 0 9 0

TCHHS 7 3 7 0

THHS 10 1 8 0

WBHHS 9 0 12 0

WMHHS 7 0 8 0

**131 5 156 0**

For a full analysis of the data and its sources for Table 3, see Appendix 3.

**Table 4: References to Aboriginal and Torres Strait Islander health matters in Hospital and Health Board (HHB) meeting summaries for 2014 and 2015**

**HHS 2014 ATSI Refs 2015 ATSI Refs Total**

**Mtgs Mtgs**

CHHHS 11 3 11 3 6

CHQHHS n/a n/a 11 0 0

CQHHS 11 0 11 0 0

CWHHS n/a n/a 5 2 2

DDHHS 11 3 10 2 5

GCHHS 10 0 8 0 0

MHHS 12 0 11 0 0

MNHHS 11 1 10 0 1

MSHHS 11 0 11 3 3

NWHHS 2 3 8 1 4

SWHHS 12 2 11 2 4

SCHHS 11 0 9 0 0

TCHHS n/a n/a n/a n/a 0

THHS 12 4 12 2 6

WBHHS 11 6 9 0 6

WMHHS 12 1 11 0 1

**av.176 23 av.176 15 38**

There is at least some evidence of important documents/reports not being tabled or addressed by HHBs. The confidential report *Addressing Allegations of Discrimination against Aboriginal and Torres Strait Islander (ATSI) Employees of the Cairns & Hinterland Hospital and Health Service (CHHHS) and Review of Support Avenues for the ATSI Workforce* (Marrie 2014), presented to the HSCE in February 2014, according to the board meeting summaries, did not appear to have been addressed by the CHHHB in subsequent monthly meetings.

### Criterion - Aboriginal and Torres Strait Islander inclusion in HHS Executive Management Structures

Given the national policy emphasis on the urgency of Closing the Gap, and in particular, the gap in Indigenous health status, and the very considerable financial, human and institutional resources (for tracking and reporting on progress through the AIHW, Productivity Commission and Queensland Health) allocated to achieving this, to ensure that HHSs are playing their part, promoting Aboriginal and Torres Strait Islander health to executive level portfolio responsibility would seem an appropriate measure to properly integrate Aboriginal and Torres Strait Islander healthcare and service delivery within the whole structure of a HHS (see QHMT Note 22). While many HHSs include an Aboriginal and Torres Strait Islander health unit/service at sub-executive level, such units/services could more effectively carry out their responsibilities within an executive level structure overseeing units/services responsible for such activities as:

* oversight of the Closing the Gap and other Aboriginal and Torres Strait Islander health programs and budgets as per the HHS service agreement (see Tables 14 and 15)
* monitoring the quality and safety of health service provision to Aboriginal and Torres Strait Islander clients
* cultural competency training;
* workforce development (recruitment, training and employment);
* patient liaison services;
* monitoring of closing the gap performance;
* supervising Indigenous-specific programs (as detailed in health service agreements – see Tables 14 and 15);
* management of HHS Aboriginal and Torres Strait Islander health budgets;
* intra-HHS interdepartmental liaison; and
* HHS external liaison with ATSICHHSs, Primary Health Networks, and other primary health and Allied Health Service providers.

**Table 5: Criterion - Aboriginal and Torres Strait Islander inclusion in HHS Executive Management Structures**

**Sub-criteria CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

**ATSI Health**

**Division**  2.5/5 0 0 0 0 0 0 2.5/5 0 0 0 0 0 0 0 0

**ATSI Exec.**

**Director**  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

**Comments:**

1. Aboriginal and Torres Strait Islander Health Division

* Only two HHSs (CHHHS and MNHHS) had Aboriginal and Torres Strait Islander Health at divisional status, however, in both instances, Aboriginal and Torres Strait Islander Health was not constituted as a stand-alone division/directorate, but was part of a larger portfolio.

1. Aboriginal and Torres Strait Islander executive director

* Of the 156 executive positions identified among the 16 HHSs, none were occupied by an Aboriginal or Torres Strait Islander person – Aboriginal and/or Torres Strait Islander people were not members of any HHS executive management team or group.

1. Aboriginal and Torres Strait Islander inclusion within the governance structure:

* Within the 16 HHS governance structures, of the 131 board memberships and 156 executive management positions, Aboriginal and Torres Strait Islander people occupied only 5 of the 287 positions.

In terms of HHS governance, the lesson to be learned from this report is that if Aboriginal and Torres Strait Islander health policies are not reinforced in the relevant legislation, then those primarily charged with implementing them, namely the HHS boards and their executive management teams, as this audit well demonstrates, will invariably ignore them. As Romlie Mokak, CEO of the Lowitja Institute, has observed:

Power in the policy world sits with others, not with Aboriginal and Torres Strait Islander peoples. It resides outside of the domain of Aboriginal and Torres Strait Islander people. We must redress the power imbalance. …we are outsiders to the intimate internal discussions about our very own health and wellbeing.[[435]](#footnote-435)

### Criterion - Closing the Gap

Strategic planning is a statutory requirement for all HHSs. This criterion was concerned to determine the extent to which closing the Indigenous health gap was included as a strategic priority within HHS strategic plans, and the extent to which HHS service agreements included six selected Tier 3 Health System Performance Measures (HSPM) drawn from the *National Aboriginal and Torres Strait Islander Health Performance Framework (HPF)* endorsed by AHMAC in 2011 (see QHMT Note 23). Recognising that health system priorities change over time, these six were selected to enable HHSs to give more breadth and scope to their efforts to close the gap and were selected on the basis that 5 of the 6 had already been addressed by some HHSs in previous reporting periods (notably in 2012-2013) and because of their particular priority accorded in various federal and Queensland Indigenous health policy documents.

**Table 6: Criterion - Closing the Gap**

**Sub-criteria CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

**Strategic Priority**

**in HHS Strat. Plan**  0 0 0 0 5/5 0 0 1/5 0 4/5 2/5 1/5 4/5 5/5 0 2/5

**Selected KPIs in**

**HHS Agreement** 2/5 1/5 2/5 2/5 2/5 2/5 2/5 2/5 2/5 2/5 2/5 2/5 2/5 2/5 2/5 2/5

**Comments:**

1. Explicitly identified as a strategic priority in HHS Strategic Plan

* Eight HHSs did not identify closing the Indigenous health gap as a strategic priority
* Of those HHSs that did, only 2 (DDHHS and THHS) included comprehensive strategies, while the remaining six only partially outlined their strategic intent in terms of objectives and actions.

1. Selected Closing the Gap KPIs explicitly referred to in Health Service Agreement:

* Based on KPIs that had been variously included in a number of HHS 2012-13 annual reports (THHS, NWHHS and MHHS) for: (i) Indigenous identification; (ii) cultural competency training; (iii) DAMA; (iv) PPH; and (v) access to mental health services, and with the inclusion of a sixth, access to drug and alcohol services, HHS service agreements were rated for their inclusion of these KPIs.
* However, and in accordance with QH health system priorities, only two KPIs (DAMA and PPH) were included for all HHS 2013/14 – 2015/16 service agreements, except for CHQHHS which only included a KPI for DAMA. In the TCHHS 2014/15-2015/16 service agreement, only PPH is included.
* A KPI for low birthweight babies (LBWB) is also included in the CWHHS, NWHHS and SWHHS agreements, however, as a Tier 1: Health Status and Outcomes KPI, it was not included in the Matrix assessment.

### Criterion - Community engagement

This criterion sought to gauge the level of Aboriginal and Torres Strait Islander community engagement for each HHS in terms of: (i) ability to have a direct say through some form of Aboriginal and Torres Strait Islander consultative/advisory mechanism; (ii) the establishment of a Reconciliation Action Plan (RAP); and (iii) the extent to which each HHS disseminated information directly to the Aboriginal and Torres Strait Islander community through a community newsletter.

**Table 7: Criterion - Community engagement**

**Sub-criteria CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

**ATSI Community**

**Consult. Body**  0 0 0 5/5 0 5/5 0 0 0 0 4/5 0 0 5/5 0 0

**RAP**  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

**ATSI community**

**Newsletter** 0 0 0 0 0 1/2 0 2/2 0 0 0 0 1/2 0 0 0

**Comments:**

1. Aboriginal and Torres Strait Islander community consultative bodies

* Only five HHSs had established Aboriginal and Torres Strait Islander community consultative mechanisms to enable their direct input into and receive feedback about the running of the HHS.

1. Reconciliation Action Plans (RAP):

* Despite the Queensland Government, in its own Reconciliation Action Plan 2009-2012, committing all Queensland Government agencies to establishing their own RAP, no HHS had a current RAP that included the 2014-2015 period.

1. Aboriginal and Torres Strait Islander health community newsletter:

* Only one HHS (MNHHS) was found to have a newsletter specifically dedicated to informing the Aboriginal and Torres Strait Islander community about health matters – a bi-monthly newsletter *Talk-About*. TCHHS also published a bi-monthly newsletter for its whole region (*You-Me-Health*), but, as its title suggests, is very focussed on providing health information to the very predominantly Aboriginal and Torres Strait Islander population. The GCHHS also publishes a bi-monthly newsletter *healthwaves+* which occasionally includes an item on Aboriginal and Torres Strait Islander health matters.
* Instead of publishing newsletters, most HHSs appear to favour regular media releases mostly for publication in the local newspapers within their region. No systematic analysis of these media releases was undertaken, however, during important events on the Indigenous calendar, such as NAIDOC, HHSs frequently devoted media releases covering their activities, presentations of awards, or honouring particular Aboriginal and Torres Strait Islander employees and Elders. (The need to analyse HHS media releases should be considered as a potential criterion/sub-criterion in future revisions of the Matrix).

### Criterion - Public Reporting and Accountability (via HHS 2014-2015 Annual Reports)

The purpose of this criterion is to provide evidence of inclusiveness of Aboriginal and Torres Strait Islander people within the HHS community, a sense that “this is our health service too”, in addition to the role of annual reports in providing transparent and accessible accounts of HHS performance and financial statements. The sub-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.*

**Table 8: Criterion - Public Reporting and Accountability (via HHS 2014-2015 Annual Reports)**

**Sub-criteria CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

**TO acknow -**

**ledgement**  1/1 1/1 0 0 1/1 0 0 0 0 1/1 1/1 0 0 1/1 1/1 0

**Closing the Gap**

1. **Sep. section** 0 1/1 0 1/1 0 0 0.5/1 0 0 0 0 0 1/1 1/1 0.5/1 0
2. **KPIs** 0 0 0 1/1 0 0 1/1 0 0 0 0.5/1 0 1/1 0 0 0

**Policy references**

1. **Cult. Cap. Frwk** 0 1.5/1.5 0 1.5/1.5 1.5/1.5 0 0 0 0 1.5/1.5 0 0.5/1.5 0 1/1.5 0 0.5/1.5
2. **Making Tracks** 0 0 0 1/1.5 1/1.5 0 0 0 0 1.5/1.5 0 0 0.5/1.5 0 1.5/1.5 0

**ATSI unit on org-**

**anisational chart** 1/1 0 0 0 0.5/1 01/1 1/1 0 1/1 0 0 0 1/1 0 0

**ATSI employment**

1. **Empl. data** 0 1/1 0 1/1 0 1/1 0.5/1 0 1/1 0 0 1/1 0 1/1 0 1/1
2. **Ref. wkf. Plan** 1/1 0 0 0.5/1 0 0 0 0 0 0 0 1/1 0 0 0 1/1

**Other recognition** 0 1/1 0 0 0 0 0 0 0 1/1 0 0 0 0 0 0

**Totals out of 10 3 5.5 0 6 4 1 3 1 1 6 1.5 2.5 1.5 5 3 2.5**

**Average score across all 16 HHSs = 2.9**

**Comments:**

The following is a breakdown for each of the sub-criteria:

1. TO acknowledgement:

* In the *Queensland Government Reconciliation Action Plan 2009 – 2012*, reconciliation means, *inter alia*, “acknowledging that Aboriginal and Torres Strait Islander peoples are the first peoples and Traditional Owners of Australia, and have unique cultural relationships to the land, sea and waterways” (p. 5). Only 7 of the 16 HHSs accorded this respect to the Traditional Owners within their HHS region.

1. Closing the Gap:

* Only 6 of the 16 HHSs included a discrete section devoted to initiatives, progress (or lack of), programs, etc., in relation to their efforts to Close the Gap in their 2014-2015 annual report. MHHS was awarded only half a point based on a poor comparison with its previous Close the Gap reporting in its 2012 – 2013 annual report (see MHHS audit, Note 12). While the WMHHS *Annual Report 2014 – 2015* contains no specific section on Closing the Gap, it did provide a summary of Indigenous Health Outcomes (see WMHHS audit, Note 12).
* All HHS service agreements for 2013/14 – 2015/16 required HHSs to address DAMA and PPH, with the exceptions of the CHQHHS which was not required to address PPH (see CHQHHS audit Note 28), and the TCHHS which was not required, in terms of its *Service Agreement 2014/15 - 2015/16* (p. 50) to address DAMA (see TCHHS audit, Notes 13 and 27). Some HHSs were also required to address Low Birthweight Babies (LBWB) – CWHHS, SWHHS and NWHHS. Noting these exceptions, and in spite of being included in their HHS service agreements, only two HHSs (CWHHS, MHHS) reported or commented on DAMA, and only three (CWHHS, MHHS and TCHHS) reported or commented on PPH.[[436]](#footnote-436)

For a more comprehensive analysis of the audit results for each of the seven Tier 3 Health System Performance Measures (HSPM), see the respective Tables in the sections following.

1. Policy references:

* *Cultural Capability Framework*: 7 of the 16 HHSs made reference to this policy – 5 of these were substantive (CHQHHS, CWHHS, DDHHS, NWHHS, THHS) outlining concrete actions being taken to implement elements of the framework.[[437]](#footnote-437)
* *Making Tracks*: 5 of the 16 HHSs made reference to this policy – 4 of these were substantive (CWHHS, DDHHS, NWHHS, WMHHS) outlining concrete actions being taken to close the gap in health outcomes.

1. ATSI Unit placement within organisational structure

* Apart from the focus on the status of Aboriginal and Torres Strait Islander health at executive management level within the overall context of HHS governance, the audit did not set out to ascertain the existence of Aboriginal and Torres Strait Islander health units, or their location, within the overall organisational hierarchy. (This should be considered as a potential criterion/sub-criterion for inclusion in future revisions of the Matrix).
* There is considerable variation among the HHSs in the presentation of their organisational charts. Some detail only their executive management structure (WBHHS, GCHHS and CWHHS), while others provide detailed diagrams of their divisional structures and include their units and services (DDHHS and NWHHS).
* Taking into account the level of variation in presenting organisational structures, 10 HHSs provide no indication where their Aboriginal and Torres Strait Islander units are placed, suggesting that such units are ranked low in HHS hierarchies.

1. Aboriginal and Torres Strait Islander employment:

* All the HHSs employ Aboriginal and Torres Strait Islander people, however, given the very considerable policy emphasis on the need to increase the employment of Aboriginal and Torres Strait Islander people in HHSs, both from the perspective of overall HHS cultural competency, and as one of the 6 NIRA Closing the Gap targets to halve the employment gap (effectively by 2018), this sub-criterion was concerned to identify the overall level of Aboriginal and Torres Strait Islander people employed in HHSs (with simple numbers or percentages sufficing – workforce deployment across the different QH employment streams/categories is dealt with in Table 13), and whether a formal policy, plan or strategy was in place to increase the level of Aboriginal and Torres Strait Islander employment.
* Half of the HHSs provided no data on Aboriginal and Torres Strait Islander employment at all.
* Twelve HHSs provided no evidence of a plan/policy/strategy for recruitment, training and retention of Aboriginal and Torres Strait Islander people in their workforce (see also Table 12).

1. Other recognition (awards, etc).

* Most HHSs devote some space in their annual reports to recognising the significant achievements of their staff, board members, fund-raisers and volunteers, and have award ceremonies on such national occasions as Australia Day and the Queen’s Birthday Holiday. For Aboriginal and Torres Strait Islander people, this usually takes place during NAIDOC week.
* Only two HHSs (CHQHHS and NWHHS) identified Aboriginal and Torres Strait Islander award recipients and achievers in their 2014 - 2015 annual report.

**Concluding comment:**

The overall scores with regard to the sub-criteria used are poor. An average score of less than 3/10 suggests that the *Annual report requirements for Queensland Government agencies* in terms of the compliance check list for HHS reporting should be amended to include a requirement for a Closing the Gap statement - see section 5.1.2.2.

In terms of promoting a sense of inclusiveness in annual reporting, the NWHHS *Annual Report 2014-2015* provided the best example. The annual report provided: (i) a profile of the major rural centres (such as Mt Isa, Karumba, Cloncurry, Dajarra, etc.) and Aboriginal communities (Doomadgee and Mornington Island) which also included an acknowledgement of the Traditional Owners for each area; (ii) provided one of the best examples of where its Aboriginal and Torres Strait Islander health services and facilities were located on the organisational chart; (iii) provided good information regarding initiatives and progress regarding implementation of the *Cultural Capability* and *Making Tracks* frameworks; and (iv) recognised the contribution and achievements of various members of its Aboriginal and Torres Strait Islander staff.

### Criterion - Aboriginal and Torres Strait Islander Health Plan

A health plan is considered the most appropriate vehicle to address major health issues such as disparities in Indigenous access to healthcare, sharing of patient information, 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 and sharing of improved data and evidence to inform clinical practice and service planning. The expectation for this criterion is that the plan be published, and have a time span of 10 years.[[438]](#footnote-438) It is also suggested that such plans be registered with the Chief Executive of Queensland Health as part of executive functions under **s.45(c)** of the HHB Act.

**Table 9: Criterion - Aboriginal and Torres Strait Islander Health Plan**

**Criterion CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

**ATSI Health**

**Plan**  0 0 0 5/10 0 0 0 0 0 0 2/10 5/10 5/10 5/10 5/10 5/10

**Comments:**

The current benchmarks for this criterion are the *Palm Island Health Action Plan 2010 – 2015* and the Northern Sydney Local Health District *Aboriginal Health Services Plan 2013-2016.* Both are published and were developed through consultation with their respective local public health bodies, local community ATSICCHSs (including other services for aged care and drug and alcohol rehabilitation), and their local communities. While both have relatively short time frames, 6 and 4 years respectively, in order to tackle the immense challenge of closing the gap in Indigenous health outcomes a longer view is necessary consistent with the Commonwealth’s *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* and Queensland’s *Making Tracks* and *Cultural Capability* frameworks. Many of the HHSs have established their own health service plans for their whole service area factoring in future growth predictions, demographic changes, etc., for example, the WMHHS *Health Service Plan 2013 – 26/27* and *Cairns and Hinterland Hospital and Health Service Plan 2012-2026.* It is suggested the depth of detail contained in such plans should inform the development by each HHS of its own Aboriginal and Torres Strait Islander health plan (aka Closing the Gap plan).

In terms of analysing the results in Table 9:

* Nine of the HHSs provided no tangible evidence of an Aboriginal and Torres Strait Islander Health Plan.
* While the THHS has the *Palm Island Health Action Plan 2010 – 2015*,no other plan exists incorporating and reflecting the health care needs of the Aboriginal and Torres Strait Islander communities within the wider THHS region.
* While evidence of the existence of a plan is what is required by this criterion, six HHSs have entered into other arrangements, such as agreements, partnerships, MoUs, and protocols with the ATSICHHS(s) within their service region. While these instruments have been mentioned, for example, in HHS 2014-2015 annual reports, and strategic and other plans, they have not been sighted – hence the lesser scores.
* Of these the MoU between the WMHHS and Kambu Health establishing the *Numbulli Yalwa* (*All Together Talking*) project which establishes a strong partnership between WMHHS and Kambu Health to share medical information and to assist in the treatment and management of patients using its newly developed Indigenous Patient Navigator program is particularly worthy of mention.
* Examples of the arrangements entered into include: CWHHS’s Closing the Gap Plan (CWHHS also appears to be unique among the HHSs in that there is no ATSICCHS within its region – see Table 1); partnerships (SWHHS, TCHHS), an MoU establishing partnership arrangements (SCHHS, WMHHS), and an Aboriginal and Torres Strait Islander Strategic Plan (WBHHS).

### Criterion - Cultural Competency Training (CCT)

Cultural Competency Training (CCT) for non-Indigenous staff is one of the mandatory training requirements for all HHSs. However, questions frequently arise as to the effectiveness of CCT, and the best modes of delivery – on-line delivery, on-line supported by sessions with community Elders, training sessions presented by Elders and/or community health workers, placements with an ATSICCHS, for example.[[439]](#footnote-439) The capacity to deliver effective CCT to non-Indigenous staff members can present as a significant challenge for the larger HHSs. The logistics of providing effective mandatory CCT training in a HHS with in excess of 10,000 staff (eg MSHHS, MNHHS) are quite different to that of providing CCT in a HHS which only employs a few hundred staff (eg, CWHHS, NWHHS, SWHHS and TCHHS). The view taken here is that, like the requirement regarding the Code of Conduct for the Queensland Public Service[[440]](#footnote-440), for which employees are required to repeat training every two years, ideally all HHS staff should undertake CCT at least once every two years. Scoring for the capacity to deliver such training is based on a HHS’s capacity to deliver training to at least half of its non-Indigenous staff each year.

**Table 10: Criterion - Cultural competence (CC)**

**Sub-criteria CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

**CC policy/Strat.** 3/3 3/3 1.5/3 3/3 3/3 3/3 0 3/3 0 1/3 0 2/3 0 0 0 0

**Capacity to**

**Deliver CCT** 2/3 3/3 1.5/3 3/3 3/3 1.5/3 0 1/3 0 3/3 0 3/3 00 0 1/3

**Non-Indigenous**

**Staff trained** 0 0 0 4/4 2.5/4 0 0 0 0 0 0 3/4  0 0 0 1/4

**Comments:**

1. Cultural competency policy/strategy/plan, etc.

* Despite all HHSs (with the exception of CQHHS) being funded in their 2013/14 – 2015/16 health service agreements to provide Indigenous cultural capability services (see Table 14), seven of the 16 HHSs provided no evidence of having established a cultural competency policy or strategy.
* Six HHSs have either a framework (CHHHS, CHQHHS), policy (CWHHS), plan (DDHHS - a Cultural Capability Plan) or program (MNHHS – a Cultural Practice eLearning Program; GCHHS – Cultural Practice Program) in operation.
* For the remaining 3 HHSs, either their Cultural Competency policies/frameworks are embedded within larger policy plans and frameworks (SCHHS – within its consumer and community engagement strategy; NWHHS within its *Strategic Plan 2012-2016*), or the existence of a policy is provided in an earlier annual report (CQHHS).
* CHQHHS was mandated in its health service agreement to establish an Aboriginal and Torres Strait Islander Cultural Capability Framework and lead the implementation of the *Queensland Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* within Children’s Health Queensland and statewide.

1. Capacity to deliver Cultural Competency Training (on-line delivery, face-to-face with Elder/Cultural Advisor, or combination)

* Six HHSs provided no evidence of either having a dedicated CCT unit, team, or individual to deliver CCT, or their capacity to deliver CCT.
* Six HHSs (CHHHS, CHQHHS, CWHHS, DDHHS, NWHHS and SCHHS) had dedicated units, teams or individuals (Cultural Advisors) to deliver CCT or have demonstrated their capacity to deliver CCT.
* Four HHSs (CQHHS, GCHHS, MNHHS, WBHHS) while engaged in the delivery of CCT, provide no clear information about responsible body/individual, mode of delivery, effectiveness, etc.

1. Proportion of non-Indigenous staff trained

* In spite of some of the HHSs having CCT policies/strategies in place and the capacity to deliver CCT (CHHHS, CHQHHS, GCHHS), 12 HHSs provided no data on either the number or percentage of their non-Indigenous staff to complete CCT.
* CWHHS, at 90%, achieved perhaps the highest rate of non-Indigenous staff CCT completion of all the HHSs. The SCHHS, with 50% of its target of 70%, also performed well, as did the DDHHS (60% of its non-Indigenous staff).
* In those HHSs that provided comparative completion rates of their mandatory training modules (eg., WBHHS, DDHHS, SCHHS), completion rates for CCT were as little as a third of those for the other training modules.
* While three HHSs (CHHHS, CHQHHS and NWHHS) demonstrated a capacity to deliver CCT, they failed to provide data for their CCT completion rates in their 2014 – 2015 annual reports.

### Criterion - Selected Health Service Performance Measures/Indicators

The two QH avenues for public reporting of the following HSPMs/KPIs are the HHS annual reports for 2014 – 2015, and the QH *Closing the Gap Performance Report 2015* (CTGPR 2015). Scores were based on information provided in either or both of these sources.

**Table 11: Criterion - Selected Health Service Performance Measures/Indicators**

**Sub-criteria CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

**Indigenous**

**Status** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

**DAMA** 0 0 0 2/2 0 0 2/2 0 0 0 0 0 0 0 0 0

**PPH**  0 0 0 0 0 0 2/2 0 0 0 0 0 0.5/2 0 0 0

**Access Mental**

**Health services** 0 0 0 0 0 00 0 0 0 0 0 2/2 0 0 0

**Access to drug**

**& alcohol serv.** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

**Comments:**

1. Estimated levels of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission

* Despite: (i) the existence of QH and AIHW guidelines to improve the identification of Aboriginal and Torres Strait Islander people in health care; (ii) a requirement in the NHRA that ‘Indigenous status’ is a factor to be considered in the Independent Hospital Pricing Authority’s determination of adjustments to the national efficient price[[441]](#footnote-441); and (iii) its incorporation as a KPI in the 2012-2013 annual reports of some HHSs (MHHS, THHS, NWHHS)[[442]](#footnote-442), no HHS incorporated this KPI in their 2014 – 2015 annual report.

1. DAMA

* Despite being a KPI in the 2013/14 – 2015/16 health service agreements for 15 of the 16 HHSs (TCHHS being the exception), only two HHSs (CWHHS and MHHS) reported on this KPI in their 2014 – 2015 annual report. Unlike the previous year, this KPI was not in the QH CTGPR 2015.

1. PPH

* Despite being a KPI in the 2013/14 – 2015/16 health service agreements for 15 of the 16 HHSs (CHQHHS being the exception), only three HHSs (CWHHS, MHHS and TCHHS) reported on this KPI in their 2014 – 2015 annual report. Unlike the previous year, this KPI was also not reported in the QH CTGPR 2015. CWHHS, while it reported on PPH, was given a score of 0/2 because its PPH rate was unacceptably high (see CWHHS audit Note 28).

1. Access to mental health services

* This KPI is measured in terms of:

The 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 that separation.

* All HHSs were funded in their 2013/14 – 2015/16 health service agreements, whether or not as a Closing the Gap funded service, to provide Indigenous Mental Health Services as part of their Community Ambulatory Mental Health Services (see Tables 14 and 15).
* This KPI is included in 2013/14 – 2015/16 HHS service agreements for the general population, but does not include a separate KPI for Aboriginal and Torres Strait Islander consumers of acute mental health services.
* This KPI was reported by only one of the HHSs (TCHHS) in their 2014- 2015 annual report, and not by QH in the CTGPR 2015, however, it was reported by the THHS and MHHS in their 2012-2013 annual reports.
* While not reported as a KPI in the QH CTGPR 2015, nevertheless the performance report (pp. 48-51) provides data concerning specific hospitalisation separation rates for specific mental health conditions, noting that: “Given the high levels of self-reported psycho-social stress and outcomes against risk factors for mental disorders, this suggests a significant untreated burden of anxiety and depression among Indigenous Queenslanders” (p. 48).

1. Access to alcohol and other drug services

* Access to drug and alcohol services is a Tier 3 HSPM, and ATODS is a standard service offered by most HHSs. It was included as the author’s selection based on the very apparent need for many Aboriginal and Torres Strait Islander people to be able to access, not only short term care, but also rehabilitation facilities to overcome their addiction.
* According to their 2013/14 – 2015/16 health service agreements, 11 HHS were funded to provide Indigenous Outreach Services. Of these 11, five (CHHHS, DDHHS, MNHHS, NWHHS and THHS) were also funded to provide Indigenous Youth (12-17 years) Treatment Programs (see Table 15).
* To the author’s knowledge, this has not been used as a KPI before by QH, and so there is no actual wording in existence for framing this KPI.
* No HHSs reported on this KPI in their 2014 – 2015 annual report and it is not addressed in either of the QH CTGPRs for 2014 and 2015.

### Criterion - Aboriginal and Torres Strait Islander health workforce development

For more than a decade great emphasis has been placed on the employment of Aboriginal and Torres Strait Islander people in the health workforce. Following an earlier document in 2002, AHMAC released the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011 – 2015* in 2011, and in 2009 Queensland Health released its revised *Aboriginal and Torres Strait Islander Health Worker Career Structure.* Health workforce employment is also an important element of both *Making Tracks* and the *Cultural Capability* *Framework*. Halving the Indigenous employment gap by 2018 is also one of the 6 objectives of the NIRA. Yet the QH *Closing the Gap Performance report* for 2014 and 2015 contain no data on HHS Indigenous employment.

All HHSs under their 2013/14-2015/16 service agreements are funded to provide placements for clinical education and training for students, interns and trainees in a range of clinical categories. This provides the perfect opportunity to fund placements for Indigenous Health Workers and Indigenous Liaison Officers, as well as those training to become doctors and nurses. This opportunity was not offered in any of the health service agreements.

The expectation for this criterion is that each HHS would have its own published Aboriginal and Torres Strait Islander health workforce employment policy or strategy. The bench mark in terms of setting employment goals and a strategy to achieve them is set by the State Library of Queensland *Aboriginal and Torres Strait Islander Workforce Strategy 2012 – 2016*, which continues the Queensland Government’s *Reconciliation Action Plan 2009-2012* commitment that “all Queensland Government agencies will implement Aboriginal and Torres Strait Islander employment action plans to target employment retention and career advancement for Aboriginal and Torres Strait Islander employees, in particular to middle and senior levels.” In terms of workforce participation it is also important to know the public service level of employment, as the data generally shows Aboriginal and Torres Strait Islander people being predominantly in non-professional, non-frontline positions as managerial and clerical staff and as operational/support workers.

**Table 12: Criterion - Aboriginal and Torres Strait Islander health workforce development**

**Sub-criteria CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

**ATSI Wrk Force**

**Dev. policy/strat.** 2/3 0 1/3 0 0 0 0 2/3 0 1/3 0 1/3 2/3 2/3 0 1/3

**ATSI Wrk Force**

**implemn body** 2/3 0 1.5/3 0 0 0 0 3/3 0 3/3 0 3/3 0 0 0 0

**ATSI employ-**

**ment equity** 0 0.5/4 2/4 4/4 0 3.5/4 0 0 2/4 0 0 4/4 0 1.5/4 0 1.5/4

**Comments:**

1. Aboriginal and Torres Strait Islander workforce development policy/strategy: Evidence of a workforce development plan:

* None of the 16 HHSs has provided evidence of having a published Aboriginal and Torres Strait Islander workforce development policy/strategy/plan.
* Three HHSs have provided evidence of their intention to develop an Aboriginal and Torres Strait Islander workforce policy/strategy/plan (CHHHS, MNHHS, THHS), however, these instruments have not been sighted.
* Four HHSs have indicated their intention to: (i) employ more Aboriginal and Torres Strait Islander people (SCHHS); (ii) build the capability of the local Indigenous workforce (WBHHS); (iii) established an Aboriginal and Torres Strait Islander Workforce Development Unit but has provided no evidence of a policy/strategy/plan (NWHHS); while (iv) CQHHS has provided evidence in its 2012 – 2013 annual report of the implementation of an Aboriginal and Torres Strait Islander career structure, no mention is made of it in the 2014 – 2015 audit period.
* MSHHS, as one of its key reforms for 2014-2015, established a “consistent, integrated and supported structure”, but it is limited to Aboriginal and Torres Strait Islander Hospital Liaison Officers.

1. Aboriginal and Torres Strait Islander workforce implementation body

* Only five HHSs (CHHHS, CQHHS, MNHHS, NWHHS, SCHHS) indicated that they have either established or intend to establish some form of workforce development body or allocate a position to oversee the recruitment, training and employment of Aboriginal and Torres Strait Islander people within their workforces (see also Table 8).
* CHHHS has a designated manager for Aboriginal and Torres Strait Islander Health Worker Services; CQHHS has an Aboriginal and Torres Strait Islander Mentoring Program (*You Pla, Me Pla*), MNHHS has an Indigenous Strategic Development Team, NWHHS has an Aboriginal and Torres Strait Islander Workforce Development Unit, and the SCHHHS has an Aboriginal and Torres Strait Islander Workforce Advisory Group.
* THHS, according to its 2012-2013 annual report, established an Aboriginal and Torres Strait Islander Employment Committee, however, from 2013/14 to 2014/15 the employment rate, in percentage terms, declined slightly.

1. Employment equity

* Rather than adopt the percentage of Aboriginal and Torres Strait Islander people within Queensland’s total population (that is, 3.6% based on the 2011 ABS census figures) as an equity measure, local HHS population percentages are used (see Table 1).
* In using the percentage of the local population as the equity measure, if, for example, Aboriginal and Torres Strait Islander people comprised around one quarter (25%) of the local HHS population, then they should also comprise 25% of the workforce – the equity target. For scoring purposes, the score was based on the proportion of that equity target that was achieved. If the number of Aboriginal and Torres Strait Islander people employed only represented around one quarter (25%) of the equity target, then the score would by 1 out of 4. If the target was reached then a score of 4/4 would result.
* Given that half of the HHSs provided no employment data regarding Aboriginal and Torres Strait Islander people in their workforce (see Table 8), the remaining figures represent levels of employment equity varying from 0 to 4/4.
* CWHHS far exceeds the equity target - 23.8% of the workforce, but only 8.3% of the overall population. SCHHS is just shy of the equity target of 1.7%, but has set an Aboriginal and Torres Strait Islander employment target of 2.13% of its workforce. Two HHSs (GCHHS and MSHHS) are half-way or better in terms of achieving their equity target.
* CWHHS, the smallest HHS (see Table 1), is an HHS anomaly in terms of Aboriginal and Torres Strait Islander employment as it does not appear to have an Aboriginal and Torres Strait Islander employment policy/strategy/plan or an implementation body, yet its employment rate for Aboriginal and Torres Strait Islander people, as noted above, is exemplary.

### Criterion - Aboriginal and Torres Strait Islander participation in the health workforce (by employment stream)

As previously noted, all of Queensland’s HHSs employ Aboriginal and Torres Strait Islander people in their workforce. However, Aboriginal and Torres Strait Islander employment in HHSs is very poorly profiled in terms of:

* the overall number of Indigenous people employed, the employment streams, and public service level of employment;
* the number of identified positions;
* whether they are employed to provide services only to Aboriginal and Torres Strait Islander clients; or
* whether they are employed to provide services to all clients (in the case of Indigenous doctors, nurses, etc.).

This criterion sets out to gauge the distribution of Aboriginal and Torres Strait Islander employees across QH’s six employment streams/categories. As noted in Table 8, half of the HHSs provided no data on overall levels of Aboriginal and Torres Strait Islander employment. Only 3 HHSs (CWHHS, MHHS and SCHHS) have provided data on their distribution/deployment within the workforce. None have provided information on their public service classification, so there is no information available on whether Aboriginal and Torres Strait Islander employees hold positions as unit managers, line managers, medical registrars, etc.

**Table 13: Criterion - Aboriginal and Torres Strait Islander participation in the health workforce (by employment stream)**

**Sub-criteria CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

**Managerial**

**and clerical**  0 0 0 1/1 0 0 0.5/1 0 0 0 0 1/1 0 0 0 0

**Medical including**

**VMOs** 0 0 0 0 0 0 0.5/2 0 0 0 0 2/2 0 0 0 0

**Nurses**  0 0 0 0.5/2 0 0 0.5/2 0 0 0 0 2/2 0 0 0 0

**IHWs and ILOs** 0 0 0 0 0 00 0 0 0 0 0 0 0 0 0

**Trade and**

**Artisans**  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

**Operational and**

**Support services** 0 0 0 1/1 0 0 0.5/1 0 0 0 0 1/1 0 0 0 0

**Health Practition.**

**(Profess. & Tech.)** 0 0 0 0 0 0 0 0 0 0 0 1/1 0 0 0 0

**Comments:**

QH uses 6 employment categories/streams to classify its workforce. A seventh category has been added by the author for Aboriginal and Torres Strait Islander Health Workers (IHWs) and Liaison Officers (ILOs) rather than have them counted generally within the managerial and clerical stream.

* Scores for each stream have been based on the workforce equity targets for each HHS.
* Frontline providers (doctors, nurses and IHWs and ILOs) have been scored out of 2 points, the other streams out of 1.
* As front-line providers, IHWs are generally not deployed in hospitals, but work in Allied Health Services, particularly in relation to home and community care and can perform low-level clinical services. ILOs are more often deployed to work in hospitals. While they are not clinicians, they play an important role in the emotional and social wellbeing of Aboriginal and Torres Strait Islander patients by providing counselling, support (including to family members), and essential liaison with other services.
* Ten of the 16 HHSs have been funded in their 2013/14 – 2015/16 health service agreements to provide Indigenous hospital liaison services – the exceptions are: CWHHS, MSHHS, NWHHS, SWHHS, TCHHS, WMHHS. In the contexts of the provision of hospital services, that both the MSHHS and WMHHS are not funded to provide Indigenous liaison services seems somewhat inexplicable.

1. Managerial and clerical

* Noting that IHWs and ILOS are usually included in the employment data for this stream, this stream usually records the most or largest proportion of Aboriginal and Torres Strait Islander employees.
* Only CWHHS, MHHS and SCHHS provided data on Aboriginal and Torres Strait Islander employees for this stream.

1. Medical (including VMOs)

* Both MHHS and the SCHHS indicated that they employ Indigenous doctors.

1. Nurses

* Only CWHHS, MHHS and SCHHS provided data on Aboriginal and Torres Strait Islander employees for this stream.

1. IHWs and ILOs

* As this stream is being introduced as a suggestion for future categorisation and reporting, no information has therefore been recorded by HHSs.
* However, many HHSs make reference to their IHWs and ILOs in their 2014-2015 annual reports. For example, MNHHS maintains Indigenous Hospital Liaison Services at the Royal Brisbane and Women’s Hospital (RBWH), The Prince Charles Hospital (TPCH) and the Caboolture and Redcliffe hospitals, and also Regional and Remote Indigenous Patient Journey Care Coordinators based at the RBWH and TPCH for patients coming to Brisbane for treatment, and accompanying family or community members.

1. Trade and artisans

* No Aboriginal and Torres Strait Islander people appear to have been employed within this stream as no data was provided by any of the HHSs.

1. Operational and support services

* Where employment data has been provided, most Aboriginal and Torres Strait Islander people are employed, particularly in hospitals, as support workers – as “wardies”, patient transporters, bed washers, cleaners, caterers, ground staff, etc.
* In many instances Aboriginal and Torres Strait Islander support workers act as *de facto* ILOs when the ILOs are off duty (they generally work regular hours). Their presence is often critical in Emergency Departments, and their presence around the wards provides comfort to many Aboriginal and Torres Strait Islander patients.

1. Health practitioners (Professional and Technical)

* Only the SCHHS provided data for this stream.

### Indicator: Financial Accountability and Reporting: Closing the Gap Funding

This indicator is intended to specifically address financial accountability and reporting of dedicated Closing the Gap Indigenous health funding and expenditure in HHSs annual reports. In terms of reporting, the NPACGIHO states that:

The Commonwealth, states and Territories will each provide a detailed report on an annual basis to each other and Aboriginal and Torres Strait Islander organisations against the benchmarks and timelines, as detailed in the Implementation Plan. Reports against the benchmarks and timelines will provide a summary of activity in relation to the agreed outputs to complement national reporting against the performance benchmarks and indicators outlined in clauses 21 and 22 [of this Agreement] to be compiled from national data collections.[[443]](#footnote-443) [emphasis added]

The AIHW points out:

Health funding and health expenditure are distinct but related concepts. Health funding refers to who provides the funds that are used to pay for health expenditure [i.e., money spent on health goods and services]. Health expenditure refers to what is spent, and is reported in terms of who incurs the expenditure, rather than who ultimately provides the funding.[[444]](#footnote-444)

Both federal and Queensland governments allocated funding for various Closing the Health Gap initiatives, therefore it should, in principle, be possible for HHSs to account for both the sources of their funding and its expenditure, and provide summaries in the financial statements included in their annual reports as a matter of financial accountability and transparency. This would honour the then Premier of Queensland’s message in Queensland Health’s *Blueprint for better healthcare in Queensland* that:

A statewide health care 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.[[445]](#footnote-445)

This vision should also apply to Aboriginal and Torres Strait Islander people and their communities in Queensland too (see, also QHMT Note 46). Aboriginal and Torres Strait Islander people have the right to expect of the HHSs the same level of performance and financial accountability as is required by funding bodies of their ATSICCHSs.

However, to provide some background on Aboriginal and Torres Strait Islander health funding and expenditure, the following information is provided by the AIHW.

Nationally in 2010-11, total health expenditure for Indigenous Australians was funded as follows:

* 45% by the Australian Government (similar to the 44% of expenditure for non-Indigenous Australians)
* 47% by state and territory governments (compared with 24% of expenditure for non-Indigenous Australians)
* 8.6% by non-government sources (including out-of-pocket payments by individuals (compared with 32% of expenditure for non-Indigenous Australians)

In terms of average funding per person:

* Australian Government funding for Indigenous Australians was 1.5 times as high as for non-Indigenous Australians ($3,584 compared with $2,418 per person)
* State and territory funding for Indigenous Australians was nearly 3 times as high as for non-Indigenous Australians ($3,722 compared with $1,286 per person).
* Non-government health funding for Indigenous Australians was less than half the funding for non-Indigenous Australians ($689 compared with $1,733 per person).[[446]](#footnote-446)

In terms of health expenditure in 2010-11:

* Health expenditure was estimated to be $4.6 billion for Indigenous people, or 3.7% of Australia’s total recurrent health expenditure (AIHW 2013d)
* Larger proportions of health expenditure for Indigenous Australians were on public hospital and community health services than for non-Indigenous Australians.

On average, health care expenditure was $7,995 per Indigenous person, compared with $5,437 per non-Indigenous person in 2010-11; thus $1.47 was spent on health care per Indigenous person for every $1.00 spent per non-Indigenous person.

In terms of specific areas of health expenditure:

* Publicly-provided services, such as public hospitals and community health services, were the areas of high expenditure for Indigenous people
* Average per person expenditure on public hospital services for Indigenous Australians ($3,631) was more than twice that for non-Indigenous people ($1,683)
* Average per person expenditure on community health services for Indigenous people was more than 8 times that for non-Indigenous people ($1,967 versus $236).[[447]](#footnote-447)

However, it should also be noted that Closing the Health Gap funding is also allocated to:

* Queensland Health itself to run statewide Closing the Gap health programs;
* ATSICHHSs, particularly to run primary health care related programs;
* HHSs (usually for service specified in their health service agreements) (see Tables 17 and 18); and
* Primary Health Networks.

The total cost to all governments of the measures proposed over the four funding periods (2009/10 – 2012/13) under the NPACGIHO was $1.58 billion. Of this, some $805.5 million was proposed as measures funded though Commonwealth Own Purpose Expenses, and $771.5 million from State/Territories Own Purpose Expenses.[[448]](#footnote-448)

**Table 14: HHS Closing the Gap funded services/activities as per 2013/14 – 2015/16 health service agreements**

**HHS CQI Child & Maternal Smoking & Alcohol Sexual & Indig. Cardiac & Indig. Hospital Indig. Cultural Dental Chronic Disease Mental Health**

**Health Services Prevention Services Reprod. HSs Respiratory HSs Liaison Services Capability Ss Services Management Services**

**CH** - - x x x x x x x -

**CHQ** - x - - - x x - - x

**CQ**  - x - x - x - - - -

**CW** x - - x - - x - x x

**DD** - x x x - x x - x x

**GC** - - - - - x x - x -

**M**  - x - x - x x - x -

**MN**  - x x x x x x - - -

**MS**  x x - x - - x - x -

**NW**  - x x x - - x - x -

**SW** x - - x - - x - x x

**SC**  - - - x - x x - - -

**TC\*** x x - x - - x - - -

**T** x x x x - x x - x x

**WM**  x x - x - - x - - -

**WB**  - - - x - x x - x -

**Table 15: Provision of Indigenous-specific non-Closing the Gap health services by HHS according to 2013/2014 – 2015/16 health service agreements** (1)

**HHS ATSI Health**(2) **IBBV & STI Indig. MHS**(4) **Indig. Outreach Indig. Youth ATSI C & Y Indig. Women**

**Outreach**(3) **Services** (5) **Treat. Progs** (6) **Care Coord.** (7) **Cancer SS** (8)

**CH** x - x x x - -

**CHQ** - - - - - x! -

**CQ**  x x x x - - -

**CW**  x - x x - - x

**DD**  x x x x x x@ -

**GC**  x - x x - - -

**M** x x x - - - -

**MN** x x x x x - x

**MS** x x x x - - -

**NW** x x x x x - x

**SW** x - x x - - x

**SC** x - x x - - -

**TC** x x x - - - x?

**T** x x x x x x# x

**WM**  x x x - - - -

**WB** x x x - - - x

(1) The 2013/14 – 2015/16 service agreements have undergone a series of scheduled amendments. This table is based on the original agreements which are, however, classified by QH “for reference only”. (2) One of a wide range of services provided under Primary Health, Community Services and Public Health. (3) Included under Public Health Services providing Sexual Health and Viral Hepatitis Services, to maintain or increase service level of Indigenous Blood Borne Viruses (BBV) and Sexually Transmitted Infections (STI) outreach services. (4) Indigenous Mental Health Services are included as one of the Community Ambulatory Mental Health Services provided under Mental Health and Alcohol and Other Drug Facilities and Services (5) Indigenous Outreach Services are included as one of the Alcohol and Other Drug Services provided under Mental Health and Alcohol and Other Drug Facilities and Services. (6) Indigenous Youth (12-17 years) Treatment Programs are included as one of the Alcohol and Other Drug Services provided under Mental Health and Alcohol and Other Drug Facilities and Services. (7) Aboriginal and Torres Strait Islander Child and Youth Care Coordination (services) are provided as a multi-HHS service by CHQHHS, DDHHS and THHS. (8) In relation to Cancer Screening Services, maintain the existing Health Women’s Initiative in accordance with the *Principles of Practice, Standards and Guidelines for Providers of Cervical Screening Services for Indigenous Women* and national cervical screening policy documents.

! CHQHHS, CQHHS, CWHHS, MNHHS, SCHHS and WBHHS. @ DDHHS, GCHHS, MSHHS, SWHHS, WMHHS and Mater Public Hospitals. # THHS, CHHHS, CYHHS, MHHS, NWHHS ? TS-NPAHHS (CYHHS and TS-NPAHHS amalgamated to become TCHHS 1st July 2014).

The NPACGIHO expired on 30 June 2013.[[449]](#footnote-449) COAG at its December 2013 meeting decided not to renegotiate another agreement[[450]](#footnote-450), however, a further $777 million over 3 years was allocated for the 2013-14, 2014-15 and 2015-16 periods, and $51 million paid to the State and Territories for 2014-15 to support Indigenous health services under the National Partnership on Indigenous Health.[[451]](#footnote-451)

All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program (see Table 14). Other services are funded under other HHS programs in their service agreements (see Table 15). For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs. Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.

### Criterion - Commonwealth funding contribution

As noted above, the Commonwealth allocated $777 million over 3 years for the 2013-14, 2014-15 and 2015-16 periods, and $51 million paid to the State and Territories for 2014-15 to support Indigenous health services under the National Partnership on Indigenous Health.[[452]](#footnote-452) Commonwealth funding allocations for Aboriginal and Torres Strait Islander health for 2014-2015 for Queensland and for individual HHSs have not been sighted.

**Table 16: Criterion - Commonwealth funding contribution**

**CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

**Comments:**

* As indicated in Table 16, no HHS has explicitly reported on Closing the Gap funding received from Commonwealth sources in their annual report financial statements.

### Criterion: Queensland funding contribution

In 2014-2015 the Queensland Government allocated $13.622 billion for Queensland Health’s operating budget. A total of $11.006 billion was allocated through service agreements to provide public healthcare services from HHSs and other organisations including Mater Health Services and St Vincent’s Health Australia.[[453]](#footnote-453) Among the HHSs, MNHHS received the largest allocation (over $2.088 billion), CWHHS the smallest ($57.466 million).[[454]](#footnote-454)

As noted above, the NPACGIHO expired in June 2013. For the last year of the agreement (2012-2013), funding agreed to by Queensland was $54.30 million 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.[[455]](#footnote-455) Presumably a similar amount was allocated at COAG’s December 2013 meeting for 2014-2015.

Both of these Queensland contributions to Aboriginal and Torres Strait Islander health in terms of their allocation to individual HHSs, should have been identified in the HHS 2014- 2015 annual reports.

**Table 17: Criterion: Queensland funding contribution**

**CH CHQ CQ CW DD GC M MN MS NW SW SC TC T WM WB**

0 0 0 0 0 0 0 0 0 0 0 0 ? 0 0 0

**Comments:**

* As indicated in Table 17, no HHS has reported on Closing the Gap funding received from Queensland sources, whether from state-wide programs or through specific funding allocated to the HHS via their service agreement, in their annual report financial statements.

## Institutional racism ratings for QH’s 16 HHSs for 2014-2015

The following Table provides the overall Matrix assessment scores according to the five key indicators. As noted in section 1.6.2, one of the primary purposes of the Matrix audits is to provide a framework for discussion between each HHS and the Aboriginal and Torres Strait Islander community and ATSICCHS(s) within its region. From this perspective, the score is less important than the discussion it generates.

**Table 18 : Institutional racism ratings for QH’s 16 HHSs for 2014-2015**

**5 Key Participation in Policy Service Recruitment & Financial Accountability Total**

**Indic- Governance Implementation Delivery Employment and Reporting**

**ators (40 points) (30 points) (30 points) (20 points) (20 points) (140 points)**

**HHS**

**CH**  3 5 5 4 0 **17**

**CHQ** 0.5 6.5 6 0.5 0 **13.5**

**CQ** 0.5 2 3 4.5 0 **10**

**CW**  0.5 13 17 6.5 0 **37**

**DD** 0.5 11 8.5 0 0 **20**

**GC**  0.5 9 4.5 3.5 0 **17.5**

**M**  0.5 5 4 2 0 **11.5**

**MN**  3 6 4 5 0 **18**

**MS** 0.5 3 0 2 0 **5.5**

**NW**  10.5 12 4 4.5 0  **31**

**SW** 0.5 9.5 2 0 0 **12**

**SC** 0.5 5.5 13 15 0  **34**

**TC** 10.5 8.5 5.5 2 0 **29 .5**

**T**  10.5 17 5 3.5 0  **36**

**WM**  0.5 5 5 0 0 **10.5**

**WB** 0.5 6.5 7 2.5 0 **16.5**

**Hospital and Health Service rating based on the total score across the five key indicators:**

**Score: >110 80-109 60-79 40-59 20-39 <20**

**Institutional Racism**

**Rating: Very Low Low Moderate High Very High Extreme**

The results of the audit indicate that 10 of the 16 HHSs rate within the extreme range of institutional racism, with the remaining 6 rated in the very high range. Thus, all of the 16 HHSs, rated in the very high to extremely high levels of institutional racism. The scores ranged from 5.5 to 37 out of a possible 140 points.

## Examples of best practice

In concluding this report, some examples of HHS best practice should be highlighted. The audit uncovered a number of examples of HHS best practice which could perhaps be emulated by other HHSs. The following is a brief list of these highlights mostly drawn from HHS 2014-2015 annual reports:

* + - * Aboriginal and Torres Strait Islander Health Division/Unit community newsletters: MNHHS Aboriginal and Torres Strait Islander Health Unit’s *Talk-About*.
      * Annual Reports: the NWHHS and CWHHS published annual reports that were particularly inclusive of their local Aboriginal and Torres Strait Islander communities.
      * Cultural competency training (CCT): the CWHHS achieved an outstanding result with 90% of its non-Indigenous staff completing CCT.
      * Inclusion of Mandatory Training Completion Tables in annual reports: three HHSs (WBHHS, DDHHS and SCHHS) provided tables of completion rates for their mandatory staff training programs which enabled comparisons of completion rates for CCT with other modules.
      * Employment equity: the CWHHS has 23.8% of its workforce made up of Aboriginal and Torres Strait Islander people, which is nearly three times the population equity target of 8.3%. SCHHS nearly achieved its equity target for Aboriginal and Torres Strait Islander employment of 1.7%, but has also set an above-equity target of 2.13%.
      * Aboriginal and Torres Strait Islander workforce participation according to QH employment streams: the SCHHS, in its *Annual report 2014-2015*, included a table of the percentage breakdown of Aboriginal and Torres Strait Islander employment in the six employment streams.
      * Reporting of selected Health Service Performance Indicators: the most comprehensive example of Closing the Gap KPI reporting is the MHHS *Annual Report 2012-2013* (pp. 47-8 and 55).
      * System for sharing Indigenous patient medical information: Kambu Health and the WMHHS have developed the Indigenous Patient Navigator system for sharing medical information between the Ipswich Hospital and Kambu Health, the local Aboriginal and Torres Strait Islander community controlled primary health service.
      * Aboriginal and Torres Strait Islander consultative body: in 2016 the CHHHS established an Aboriginal and Torres Strait Islander Health Committee to serve alongside its existing three community consultation committees representing the Trinity, Cassowary and Hinterland hubs.
      * Aboriginal and Torres Strait Islander health plans: the Palm Island Aboriginal Shire Council, in conjunction with the Commonwealth Government and Queensland Health, developed and published the *Palm Island Health Action Plan 2010-2015.*
      * HHS board Indigenous community engagement: a number of HHS boards held meetings during 2014 and 2015 at the premises of local ATSICCHSs, for example, DDHHB at Goondir Health Service (Dalby); and WMHHB at Kambu Health. The THHB held one of its meetings at the Palm Island Aboriginal Shire Council chambers followed by a visit to the Joyce Palmer Health Service; and the NWHHB also held meetings at Mornington Island and Burketown, where there are large Aboriginal communities.

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# APPENDICES

## Appendix 1: Professor Robyn McDermott’s review of the Matrix

Review of Monograph: “A Matrix for identifying, measuring and monitoring institutional racism within public hospitals and health services”. Authors - Adrian Marrie and Henrietta Marrie, June 2014, Gordonvale, Queensland.

Robyn McDermott. September 16, 2015.

Scope of this review, requested by Kevin Cocks AM, Anti-Discrimination Commissioner for Queensland: To comment on the relationship between the objectives and the measures proposed in the instrument, the logic and soundness of the methodology, the relevance of the proposed instrument to the population of north Queensland, and whether the conclusions are supported by the data presented.

Overall summary

I believe this work is important and makes a significant contribution to a better, more robust, transparent and reproducible approach to monitoring the institutional response at the HHS level to persisting health outcome disparities between Aboriginal and Torres Strait Islanders and other Australians.

The stated objective of the Matrix is to measure, score and monitor over time, progress made by Hospital and Health Services in Queensland in addressing perceived and actual institutional racism toward Aboriginal and Torres Strait Islander Australians seeking to access health care in the public sector. This is in response to what is perceived as ongoing failure of implementation of policy at the corporate and serviced delivery end, a failure which can be attributed to the persistence of subliminal institutional racism, at least in part. It contains a thoughtful preamble summarising some of the literature on the impact of institutional racism on health and access to health services, and some of the measures developed to date.

Importantly, it links the proposed measures to policy documents developed and endorsed by successive Commonwealth and State governments, and which have currency. It seeks to link actions by the HHS in the 5 domains of Governance, Policy Implementation, Service Delivery, Workforce recruitment and employment, and Financial Accountability.

Strengths:

The matrix addresses a really important area of policy and practice failure, one which continues to affect access to quality health care for Aboriginal and Torres Strait Islander Australians

It links policy documents and measures to HHS level implementation, derived from annual reports and other information available in the public domain.

The measures are clear, and the sourcing of these from publicly available documents eg annual reports is a robust and repeatable approach

There is an ability to feed back to HHS and others, and to assess progress over time

The authors have populated the Matrix with measures from one HHS to develop a score

The matrix has great potential to be used locally in Queensland, and also applied to other local HHS in other states, especially those with significant Aboriginal and Torres Strait Islander populations.

Suggestions for improvement:

Validation and the weightings attached to each domain: It is not clear how they were derived

Perhaps the name should be changed from “Measuring Institutional Racism…”, to something like “Institutional progress in health service delivery to Aboriginal and Torres Strait Islander people: a proposed instrument”, as the scores do not really measure racism directly (that is a bit tricky) but rather identify important areas where the HHS has failed (or succeeded) in implementing the endorsed policy in these key domains.

Recommendations:

This is a valuable and important development which can improve transparency, accountability and ultimately the performance of HHS in service delivery to Aboriginal and Torres Strait Islanders.

The Matrix should be reviewed by an expert panel in population health and health services to identify areas for improvement in the measures, if any, and make comments on the utility or otherwise of the Matrix in this and other jurisdictions.

Following this, the Matrix should be tested in other settings in Australia, especially where there is a large proportion of Aboriginal and Torres Strait Islander clients, to validate the measures proposed.

Yours sincerely

Robyn McDermott. MBBS, MPH, PhD, FAFPHM Professor of Public Health Medicine, Centre for Chronic Disease Prevention, Australian Institute of Tropical Health and Medicine

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## Appendix 2: Table 1: Qld HHSs’ Indigenous and non-Indigenous population profiles, and location of Aboriginal and Torres Strait Islander Community Controlled Health Services (ATISCCHS) with information sourced.

**HSS Total Pop.[[456]](#footnote-456) A/TSI A/TSI% ATSICCHSs[[457]](#footnote-457)**

**CH** 283,200[[458]](#footnote-458) 25,500[[459]](#footnote-459)9.0[[460]](#footnote-460)4[[461]](#footnote-461)

**CHQ** 1,138,600[[462]](#footnote-462) 94,000[[463]](#footnote-463) 6.5[[464]](#footnote-464) n/a

**CQ** 228,000[[465]](#footnote-465) 12,540[[466]](#footnote-466)5.5[[467]](#footnote-467)2[[468]](#footnote-468)

**CW** 12,400[[469]](#footnote-469) 1,000[[470]](#footnote-470) 8.3[[471]](#footnote-471) 0

**DD** 280,000[[472]](#footnote-472) 11,760[[473]](#footnote-473) 4.2[[474]](#footnote-474) 3[[475]](#footnote-475)

**HSS Total Pop. A/TSI A/TSI% ATSICCHSs**

**GC** 551,000 [[476]](#footnote-476) 6,600[[477]](#footnote-477) 1.2[[478]](#footnote-478)1[[479]](#footnote-479)

**M** 182,000[[480]](#footnote-480) 8,000[[481]](#footnote-481)4.4[[482]](#footnote-482) 3[[483]](#footnote-483)

**MN** 960,000[[484]](#footnote-484) 15,400[[485]](#footnote-485) 1.6[[486]](#footnote-486) 3[[487]](#footnote-487)

**MS** 1,073,400[[488]](#footnote-488)25,450[[489]](#footnote-489)2.0[[490]](#footnote-490)2[[491]](#footnote-491)

**NW** 32,600[[492]](#footnote-492) 7,500[[493]](#footnote-493)23.1[[494]](#footnote-494)2[[495]](#footnote-495)

**SW** 26,000[[496]](#footnote-496) 3,100[[497]](#footnote-497) 12.0[[498]](#footnote-498) 3[[499]](#footnote-499)

**HSS Total Pop. A/TSI A/TSI% ATSICCHSs**

**SC** 390,000[[500]](#footnote-500) 6,600[[501]](#footnote-501) 1.7[[502]](#footnote-502)1[[503]](#footnote-503)

**TC** 25,600[[504]](#footnote-504) 16,400[[505]](#footnote-505)64.0[[506]](#footnote-506)2[[507]](#footnote-507)

**T** 240,000 [[508]](#footnote-508)16,800[[509]](#footnote-509) 7.0[[510]](#footnote-510)1[[511]](#footnote-511)

**WM** 260,000[[512]](#footnote-512) 9,100[[513]](#footnote-513)3.5[[514]](#footnote-514) 1[[515]](#footnote-515)

**WB** 210,000 [[516]](#footnote-516) 7,600[[517]](#footnote-517) 3.6[[518]](#footnote-518) 1[[519]](#footnote-519) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**16 4,754,200 173,310 n/a 28[[520]](#footnote-520)**

## Appendix 3: Table 4: References to Aboriginal and Torres Strait Islander health matters in Hospital and Health Board (HHB) meeting summaries for 2014 and 2015

**HHS 2014 ATSI Refs[[521]](#footnote-521) 2015 ATSI Refs Total**

**Mtgs[[522]](#footnote-522) Mtgs**

CHHHS 11 3[[523]](#footnote-523) 11 3[[524]](#footnote-524) 6

CHQHHS n/a[[525]](#footnote-525) n/a 11 0 0

CQHHS 11 0 11 0 0

CWHHS n/a[[526]](#footnote-526) n/a 5[[527]](#footnote-527) 2[[528]](#footnote-528) 2

DDHHS 11[[529]](#footnote-529) 3[[530]](#footnote-530) 10[[531]](#footnote-531) 2[[532]](#footnote-532) 5

GCHHS 10[[533]](#footnote-533) 0 8[[534]](#footnote-534) 0 0

MHHS 12 0 11 0 0

MNHHS 11 1[[535]](#footnote-535) 10[[536]](#footnote-536) 0[[537]](#footnote-537) 1

MSHHS 11 0 11 3[[538]](#footnote-538) 3

NWHHS 2[[539]](#footnote-539) 3[[540]](#footnote-540) 8[[541]](#footnote-541) 1[[542]](#footnote-542) 4

SWHHS 12 2[[543]](#footnote-543) 11 2[[544]](#footnote-544) 4

SCHHS 11[[545]](#footnote-545) 0 9[[546]](#footnote-546) 0 0

TCHHS n/a[[547]](#footnote-547) n/a n/a n/a 0?

THHS 12 4[[548]](#footnote-548) 12[[549]](#footnote-549) 2[[550]](#footnote-550) 6

WBHHS 11[[551]](#footnote-551) 6[[552]](#footnote-552) 9[[553]](#footnote-553) 0? 6

WMHHS 12 1[[554]](#footnote-554) 11[[555]](#footnote-555) 0? 1

**av.176[[556]](#footnote-556) 23 av.176[[557]](#footnote-557) 15 38[[558]](#footnote-558)**

# Disclaimer:

This report has been produced, in part, to further the validation process in assessing 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 author of this report to ensure the accuracy of the information used, and referred to in conducting the audits. The responsibility for the interpretation and application of government policies both in the development of the matrix and the conduct of the audits is the author’s 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 take no responsibility for the unauthorised use of the Matrix.

The interpretation of evidence and the views expressed in this report are the author’s alone and do not necessarily reflect the views of the Anti-Discrimination Commission Queensland and of its Commissioner, or those of the Queensland Aboriginal and Islander Health Council. All responsibility for this report is borne by its author.

The author acknowledges that he is not a qualified health professional and that he does not work in the health sector either in a private or public capacity, and therefore any advice relating to specific health matters should be sought from an appropriately qualified health professional. The report has been produced in a private capacity concerning a matter of public interest. While the author accepts responsibility for the content of this report, he 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.

# About the author:

**Adrian Marrie** holds a BA with 1st Class Honours from the Elder Conservatorium, Adelaide University, a BA with 1st Class Honours from Flinders University (and a Flinders University Medal), and a Grad. Dip. of Arts from the University of South Australia. He is a director of Bukal Consultancy Services P/L, a company he founded with his wife, Henrietta in 1994, and also serves as company secretary. He has worked privately as a consultant with organisations such as the Foundation for Aboriginal and Islander Research Action (FAIRA) in Brisbane, Bama Wabu Rainforest Aboriginal Corporation in Cairns, and the Yarrabah Aboriginal 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 Consultancy Services, 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. Most recently, as a freelance researcher, he has also been extensively involved with Henrietta in researching the Indigenous charities and non-profit sector, advocating for changes to Australian charity law. He was recently appointed Adjunct Associate Professor, School of Human Health and Social Sciences, Central Queensland University. A keen classical guitarist, he and his wife live in Cairns.

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. [↑](#footnote-ref-1)
2. NSW Government Department of Education and Communities (2013). [↑](#footnote-ref-2)
3. National Aboriginal Health Strategy Working Party (1989), *National Aboriginal Health Strategy*, quoted in the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (Australian Government 2013, p. 9). [↑](#footnote-ref-3)
4. Marrie H (2014). [↑](#footnote-ref-4)
5. Seattle Human Services Coalition (2005). [↑](#footnote-ref-5)
6. Marrie and Marrie (2014). [↑](#footnote-ref-6)
7. See Appendix 1 for the full review. [↑](#footnote-ref-7)
8. AIDA (2016, p. 2) quoting Paradies (2014). [↑](#footnote-ref-8)
9. AIHW (2011, p. 2). [↑](#footnote-ref-9)
10. 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/](http://nacchocommunique.com/2014/02/28/naccho-aboriginal-health-and-%20racism-what-are-the-impacts-of-racism-on-aboriginal-health/) Accessed 19/03/2014. [↑](#footnote-ref-10)
11. *National Aboriginal and Torres Strait Islander Health Plan 2013-2023,* statement of vision guiding the Strategic Framework (Australian Government, 2013, p. 8) [↑](#footnote-ref-11)
12. AHRC (2012) [↑](#footnote-ref-12)
13. 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). [↑](#footnote-ref-13)
14. 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. [↑](#footnote-ref-14)
15. Holland (2014, p. 9). [↑](#footnote-ref-15)
16. Howse (2011:11). [↑](#footnote-ref-16)
17. Many of these federal and state/territory Indigenous healthcare policies relate, for example, to 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). [↑](#footnote-ref-17)
18. Dodson (2016), quoted in CGCSC (2017, p. 6). [↑](#footnote-ref-18)
19. National Aboriginal Community Controlled Health Organisation – the peak body representing the 150 Aboriginal community controlled health organisations around Australia. [↑](#footnote-ref-19)
20. Alford (2014, p. 9). [↑](#footnote-ref-20)
21. Alford (2014, p. 24). Emphases in the original. [↑](#footnote-ref-21)
22. Alford (2014, p. 26). [↑](#footnote-ref-22)
23. CGCSC (2016, pp. 22-23). [↑](#footnote-ref-23)
24. With regard to personal/casual racism against Aboriginal and Torres Strait Islander employees, see for example, Marrie H (2014), *Addressing Allegations of Discrimination Against Aboriginal and Torres Strait Islander (ATSI) Employees of the Cairns & Hinterland Hospital and Health Service (CHHHS) and Review of Support Avenues for the ATSI Workforce* (Report to the CEO, Cairns & Hinterland Hospital and Health Service), Bukal Consultancy Services P/L, Gordonvale Qld; Moreton-Robinson (2007); and AIDA (2016, p. 2) recognises that “systemic racism as well as racist remarks or behaviour, and inadequate reporting and follow-up mechanisms have a detrimental effect on the growth of the Aboriginal and Torres Strait Islander medical workforce.” [↑](#footnote-ref-24)
25. CGCSC (2017, p. 4). [↑](#footnote-ref-25)
26. 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. [↑](#footnote-ref-26)
27. Paradies (2006). [↑](#footnote-ref-27)
28. Paradies *et al* (2008, p. 4). In this assertion, the term “institutional” has been substituted for “systemic” in the original. [↑](#footnote-ref-28)
29. Dudgeon *et al* (2010, p. 36). [↑](#footnote-ref-29)
30. Ibid. [↑](#footnote-ref-30)
31. 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. [↑](#footnote-ref-31)
32. NSW Government Department of Education and Communities (2013). [↑](#footnote-ref-32)
33. 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). [↑](#footnote-ref-33)
34. 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). [↑](#footnote-ref-34)
35. 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). [↑](#footnote-ref-35)
36. Ibid. [↑](#footnote-ref-36)
37. 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). [↑](#footnote-ref-37)
38. Marrie H (2015). [↑](#footnote-ref-38)
39. See, for example, Marrie H (2015). [↑](#footnote-ref-39)
40. 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). [↑](#footnote-ref-40)
41. 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.” [↑](#footnote-ref-41)
42. See, for example, Felton-Busch *et al* (2009, p. 4); AIDA (2016, p. 2). [↑](#footnote-ref-42)
43. Felton-Busch *et al* (2009, p. 4). [↑](#footnote-ref-43)
44. 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 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) [↑](#footnote-ref-44)
45. This column adds up to 29, however, Goondir Health Services operated clinics in both the DDHHS and SWHHS. [↑](#footnote-ref-45)
46. For example, following the lead of the North Sydney Local Health District and the Palm Island Aboriginal Shire Council, it is appropriate that all HHSs 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. [↑](#footnote-ref-46)
47. 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.” (Dunleavy 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” (Dunleavy 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). [↑](#footnote-ref-47)
48. Jones (2003, p. 11). [↑](#footnote-ref-48)
49. CGCSC (2016, p. 23). [↑](#footnote-ref-49)
50. DoH (Department of Health) (2015). [↑](#footnote-ref-50)
51. Ibid., pp. 10 and 12. [↑](#footnote-ref-51)
52. Australian Government (2013). [↑](#footnote-ref-52)
53. The Implementation Plan contains a list of some fifteen strategies either in place, or under development, which are included in the plan (DoH 2015, p. 8). [↑](#footnote-ref-53)
54. For Queensland? – referred to in THHS *Strategic Plan 2014-18* (2015 Update). [↑](#footnote-ref-54)
55. See HHS Service Agreements 2013/14 – 2015/16 – Closing the Gap section. [↑](#footnote-ref-55)
56. Referred to in the CWHHS Health Service Agreement 2013/14 – 2015/16, August 2015 Revision, p. 36. [↑](#footnote-ref-56)
57. For example, SCHHS *Annual Report 2014-2015*, pp. 27 and 36. [↑](#footnote-ref-57)
58. Trenerry and Paradies (2012b). [↑](#footnote-ref-58)
59. See, for example, Marrie H (2014) in relation to the CHHHS, and Moreton-Robinson (2007) regarding the THHS. [↑](#footnote-ref-59)
60. AHMAC (2015, p. 138). [↑](#footnote-ref-60)
61. Ibid., p. 139. [↑](#footnote-ref-61)
62. QH (2015d, 2016 – see relevant sections and tables). [↑](#footnote-ref-62)
63. 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 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) [↑](#footnote-ref-63)
64. *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). [↑](#footnote-ref-64)
65. 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). [↑](#footnote-ref-65)
66. 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), and also more recently in the *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health* (AHMAC 2016, p. 18). [↑](#footnote-ref-66)
67. These terms have also been further refined for use in the new *Cultural Respect Framework 2016 – 2026 for Aboriginal and Torres Strait Islander Health* (AHMAC 2016, p. 18). For a recent discussion of these concepts, see also Bainbridge *et al* (2015, pp. 23-24). [↑](#footnote-ref-67)
68. That is, evidence that can be found in officially sanctioned information made available to the public. [↑](#footnote-ref-68)
69. Policies also include agreements, plans, strategies, frameworks, etc. [↑](#footnote-ref-69)
70. 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. [↑](#footnote-ref-70)
71. 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…”. [↑](#footnote-ref-71)
72. See Came and McCreanor (2015, p. 33) in relation to Lukes’s (Hayward and Lukes 2008) three-dimensional analysis of power examining the cultural and institutional roots of policies:

    The first dimension is the processes and outcomes of overt decision-making. The second dimension is the process of shaping or framing an issue so that certain ides are considered, discussed, and esteemed while others are not. Finally, the third dimension is characterised by the ability to define or determine what is considered to be a relevant issue for discussion through setting agendas and determining priorities. (cited in Came and McCreanor 2015, p. 33).

    This third dimension becomes particularly apparent when considering how many times substantive Aboriginal and Torres Strait Islander health issues are discussed in HHB meetings – see Table 4. [↑](#footnote-ref-72)
73. See, for example, NHFA and AHHA (2010, pp. 10, 12, 14-19). [↑](#footnote-ref-73)
74. As the Close 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). [↑](#footnote-ref-74)
75. Australian Government (2013, pp. 14-15). [↑](#footnote-ref-75)
76. AHMAC (2012, p. 147). Citing de Alcantra 1998; Hawkes 2001; Westbury 2002; Dodson *et al* 2003. [↑](#footnote-ref-76)
77. 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). [↑](#footnote-ref-77)
78. NHFA and AHHA (2010, pp. 14 and 16). [↑](#footnote-ref-78)
79. 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. [↑](#footnote-ref-79)
80. 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. [↑](#footnote-ref-80)
81. Howse (2011, pp. 29-30). See also pp. 33-34. [↑](#footnote-ref-81)
82. NHFA and AHHA (2010, p. 16). [↑](#footnote-ref-82)
83. 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 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. [↑](#footnote-ref-83)
84. DoHA (2007). [↑](#footnote-ref-84)
85. NATSIHC (2008). [↑](#footnote-ref-85)
86. AHMAC (2011, p. 6). [↑](#footnote-ref-86)
87. NHFA and AHHA (2010, pp. 14 and 16). [↑](#footnote-ref-87)
88. Australian Government PHC (2009, p. 19). Quoted by Alford (2014, p. 25). [↑](#footnote-ref-88)
89. Alford (2014, p. 21). Original emphasis. [↑](#footnote-ref-89)
90. 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. [↑](#footnote-ref-90)
91. Queensland Health (2010c, p. 9). [↑](#footnote-ref-91)
92. Queensland Health (2009b, p. 3) [↑](#footnote-ref-92)
93. 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). [↑](#footnote-ref-93)
94. Dudgeon *et al* 2010. Quoted in AHMAC (2012, p. 135). [↑](#footnote-ref-94)
95. AHMAC (2012, p. 135). [↑](#footnote-ref-95)
96. 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. [↑](#footnote-ref-96)
97. DoH (2016). [↑](#footnote-ref-97)
98. Australian Government (2013). [↑](#footnote-ref-98)
99. AHMAC (2012, p. 1). [↑](#footnote-ref-99)
100. Ibid. p. 10. [↑](#footnote-ref-100)
101. AHMAC (2012, Figure 1: Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures). [↑](#footnote-ref-101)
102. PPH = potentially preventable hospitalisations – the acronym generally used for this KPI in HHS annual reports. 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) [↑](#footnote-ref-102)
103. DAMA 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 DAMA 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). [↑](#footnote-ref-103)
104. AHMAC (2011, Foreword). [↑](#footnote-ref-104)
105. Australian Government (2013, pp. 23-4) [↑](#footnote-ref-105)
106. 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). [↑](#footnote-ref-106)
107. NHFA and AHHA (2010, p. 14) citing various authors. [↑](#footnote-ref-107)
108. Australian Government (2014, Phase Two Report, p. ix). [↑](#footnote-ref-108)
109. Ibid, pp. ix-x. [↑](#footnote-ref-109)
110. Alford (2014, p. 14). Original emphasis. [↑](#footnote-ref-110)
111. Queensland Health (2013b, p. 4) [↑](#footnote-ref-111)
112. Ibid, p. 5. [↑](#footnote-ref-112)
113. Ibid, p. 7. [↑](#footnote-ref-113)
114. Ibid, pp. 12-13. [↑](#footnote-ref-114)
115. Quoted in SCHHS *Consumer and Community Engagement Strategy and Implementation Plan 2013-2016*, p. 14. [↑](#footnote-ref-115)
116. Howse (2011, p. 11). [↑](#footnote-ref-116)
117. Apart from a number of references to Indigenous people under Schedule F – Aged Care and Disability Services, the NHRA is virtually silent with regard to the specific healthcare needs and delivery of services for Indigenous Australians. References occur on p. 8 (para. 13.e. re: implementation principles that should underpin National Health Reform *inter alia*, promotion of social inclusion to reduce disadvantage, especially for Indigenous Australians), p.31 (para. B13. c. re: Indigenous status), and p. 50 (para. D35. regarding the establishment of Medicare Locals as independent legal entities with strong links to, *inter alia,* Aboriginal Medical Services). There are no explicit references to, for example, the NIRA or the NPACGIHO. [↑](#footnote-ref-117)
118. These bodies include the Queensland Aboriginal and Islander Health Council (QAIHC), the Institute for Urban Indigenous Health (IUIH), ….., and the Indigenous community controlled health organisations (ICCHO). [↑](#footnote-ref-118)
119. 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 –

     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. [↑](#footnote-ref-119)
120. Queensland Health (2010c, frontis page). [↑](#footnote-ref-120)
121. In July 2015, Queensland Health published the *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Investment Strategy 2015-2018* (Queensland Health, 2015c). [↑](#footnote-ref-121)
122. In the *Nature Conservation Act 1992,* **s.6 Community participation in administration of Act** states:

     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. [↑](#footnote-ref-122)
123. 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. [↑](#footnote-ref-123)
124. **S.132** **Advisory committees**  of the *Nature Conservation Act 1992,* subsection (1) enables the Minister to “establish as many advisory committees as the Minister considers appropriate for the purposes of the administration of this Act, …”. While this section does not include a reference to Indigenous advisory committees, a new section has been added to the Act: **s.132A Committees for protected areas in Cape York Peninsula Region**.Of particular interest is subsection (2) as it requires the Minister to establish a particular Indigenous advisory committee for Cape York. **S.132A** reads as follows:

     (1) The Minister may establish committees to advise the Minister about matters relating to particular protected areas in the Cape York Peninsula Region, including, for example, matters about the preparation of management plans, and matters about implementing the plans, for the areas.

     (2) Also, the Minister must establish a committee of indigenous people who have an interest in a protected area in the Cape York Peninsula Region ( the ***Regional Protected Area Management Committee***) to advise the Minister about matters relating to protected areas in the region, including, for example, matters about –

     (a) employment opportunities for indigenous people in the areas; and

     (b) any management plans for the areas; and

     (c) the provision of resources for the management of the areas.

     (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.

     (4) The Regional Protected Area Management Committee may consist of representatives of –

     (a) the committees established under subsection (1); or

     (b) indigenous regional organisations in the Cape York Peninsula Region. [↑](#footnote-ref-124)
125. Quoted from the Mackay Hospital and Health Service *Annual Report 2012-2013* (p. 62). [↑](#footnote-ref-125)
126. As revised and endorsed by the Australian Health Ministers’ Advisory Council in 2011. Australian Government Department of Health and Ageing, *Aboriginal and Torres Strait Islander Health Performance Framework: 2012 Report.* [↑](#footnote-ref-126)
127. 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). [↑](#footnote-ref-127)
128. Compare CWHHS *Annual Report 2014-2015* (p. 30) and GCHHS *Annual Report 2014-2015* (p. 64) [↑](#footnote-ref-128)
129. For example, the diagram of the organisational structure of the SCHHS includes references to “nursing and midwifery services” or “clinical support services” as executive level services (SCHHS AR 2014-15, p.?) **Check** [↑](#footnote-ref-129)
130. With regard to this proposed list of responsibilities, numbers 4) to 9) are the key focus areas of the CHHHS’s Aboriginal and Torres Strait Islander Health Strategy, Systems Support, Performance and Accountability Unit contained in the job application details for the position of director (identified) of the unit (Job ad reference CA194457, closing date Monday 12 October 2015) (p. 3). [↑](#footnote-ref-130)
131. Queensland Government (2014, pp. 17 and 19-20). [↑](#footnote-ref-131)
132. Queensland Health (2010c, p. 17). [↑](#footnote-ref-132)
133. Queensland Health (2010c). [↑](#footnote-ref-133)
134. Queensland Government (2009b, p.9). [↑](#footnote-ref-134)
135. Ibid., p. 5. [↑](#footnote-ref-135)
136. Ibid. [↑](#footnote-ref-136)
137. Queensland Government (nd, p. 19). [↑](#footnote-ref-137)
138. Then, the Council for Aboriginal Reconciliation. [↑](#footnote-ref-138)
139. Queensland Health. <http://www.health.qld.gov.au/atsihealth/reconciliation.asp> Accessed 22/0/2014. [↑](#footnote-ref-139)
140. Department of the Premier and Cabinet (2015, p. 8), and quoting *Auditor-General’s Report to Parliament No. 4 for 2013-14,* p. 12. [↑](#footnote-ref-140)
141. 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.” [↑](#footnote-ref-141)
142. Under **s.42 Protocol with primary healthcare organisations** of the HHB Act, 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. [↑](#footnote-ref-142)
143. An example of such a protocol is the CQHHSEngagementProtocol (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:

     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). [↑](#footnote-ref-143)
144. Queensland Health (2015c, p. 10). [↑](#footnote-ref-144)
145. See also Queensland Health (2013b, p. 12). [↑](#footnote-ref-145)
146. See NSW Health (2012:12-13). [↑](#footnote-ref-146)
147. Queensland Health (2013b, p. 12). [↑](#footnote-ref-147)
148. Queensland Health (2010c, p. 16). [↑](#footnote-ref-148)
149. Where such data has been reported in HHS annual reports, the indication is, that of the various mandatory training modules, CCT has among the lowest target rates for participation, and among the lowest completion rates (see, for example, SCHHS *Annual Report 2014.2015*, p. 38; DDHHS *Annual Report 2014.2015*, p. 29). [↑](#footnote-ref-149)
150. CHQHHS *Annual Report 2014-2015*, p. 56. See: <http://atsicpp.carbon-media.com.au> [↑](#footnote-ref-150)
151. COAG NHRA, p. 31. [↑](#footnote-ref-151)
152. Steering Committee for the Review of Government Service Provision (2015). [↑](#footnote-ref-152)
153. AIHW (2010). [↑](#footnote-ref-153)
154. See, in particular Schedule F of the NIRA. [↑](#footnote-ref-154)
155. Queensland Health, 2015b. [↑](#footnote-ref-155)
156. For example, NWHHS *2012-13 Annual Report* (p. 36); and THHS *2012-13 Annual Report* (p. 51). [↑](#footnote-ref-156)
157. NPACGIHO , reports “discharge against advice for 25-44 year olds up to 30 times more than for other Australians” (page 4, para.4.(m)) [↑](#footnote-ref-157)
158. See AHMAC 2012, pp. 133-134. [↑](#footnote-ref-158)
159. Ibid., p. 133. [↑](#footnote-ref-159)
160. AHMAC (2012, p. 143). [↑](#footnote-ref-160)
161. This issue was recently highlighted in Cairns, a prime national and international tourist destination. See various articles by Grace Mason in *The Cairns Weekend Post* (29-30 October, 2016, pp. 1 and 6-7) focussing on Aboriginal and Torres Strait Islander “itinerants” mostly from Cape York and Gulf communities. See also Hayes-Jonkers *et al* (2013). [↑](#footnote-ref-161)
162. Queensland Health (2013d, p. 16). [↑](#footnote-ref-162)
163. Queensland Health (2009). [↑](#footnote-ref-163)
164. Queensland Health (2010c, p. 17). [↑](#footnote-ref-164)
165. Ibid. In 2013, the estimated resident population of Aboriginal and Torres Strait Islander population of Queensland was 198,206, representing 4.3 per cent of the Queensland population (Queensland Health, 2016, p. 11). [↑](#footnote-ref-165)
166. See for example, State Library of Queensland, 2012. *Aboriginal and Torres Strait Islander Workforce Strategy 2012-2016*, p. 3. [↑](#footnote-ref-166)
167. Under **s.25** and **s.105** of the *Anti-Discrimination Act 1991* (Qld). [↑](#footnote-ref-167)
168. West *et al* (2010). [↑](#footnote-ref-168)
169. Shaw (2016, p. 16 and p. 5). [↑](#footnote-ref-169)
170. Queensland Health (2013d, p. 6); AHPRA (2013, pp. 24-27) [↑](#footnote-ref-170)
171. Queensland Health, Ibid., p.9. [↑](#footnote-ref-171)
172. Ibid. [↑](#footnote-ref-172)
173. AHPRA (2015, p. 13). [↑](#footnote-ref-173)
174. Queensland Health (2009a, p. 5). [↑](#footnote-ref-174)
175. Ibid., p. 8. [↑](#footnote-ref-175)
176. Queensland Health (2015c, p. 10). [↑](#footnote-ref-176)
177. For an overview of the roles of IHWs and ILOS and the critical services they provide, see Shaw (2016, pp. 10-11). [↑](#footnote-ref-177)
178. 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 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, together with other Aboriginal and Torres Strait Islander health workforce staff, share with each other, their communities, and their patients, in the words of Gungulu member, Dr Shane Houston, a “communitarian solidarity” (Henry BR *et al* 20014, p. 518). [↑](#footnote-ref-178)
179. Queensland Health (2013c, p. 1), citing Council of Australian Governments, 2012. *National Healthcare Agreement 2012.* Australian Government, Canberra. [↑](#footnote-ref-179)
180. [www.health.queensland.gov.au/performance](http://www.health.queensland.gov.au/performance) [↑](#footnote-ref-180)
181. COAG NPACGIHO (2008, p. 13). [↑](#footnote-ref-181)
182. See also Queensland Health (2010a, p. 54). [↑](#footnote-ref-182)
183. COAG NPACGIHO (2008, p. 13). The benchmarks and indicators referred to in the clause 21 and 22 tables are generally further identified in the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures*  (AHMAC, 2012: Figure 1). [↑](#footnote-ref-183)
184. All information and amounts – Queensland Health (2010a, p. 53). [↑](#footnote-ref-184)
185. All information and amounts – Queensland Health (2010a, p. 54). [↑](#footnote-ref-185)
186. An implementation plan for the second triennium (2012-13 to 2014-15) does not appear to be available at present. [↑](#footnote-ref-186)
187. Queensland Health (2015c, p. 8). [↑](#footnote-ref-187)
188. Queensland Government (2014, pp. 79 and 241). [↑](#footnote-ref-188)
189. Dudgeon *et al* (2010, p. 37) also citing Dudgeon *et al* (2000). [↑](#footnote-ref-189)
190. RCADIC (1991), cited in SCRGSP (2016, section 1.11, p. 39). [↑](#footnote-ref-190)
191. SCRGSP (2009). [↑](#footnote-ref-191)
192. Purdie *et al* (2010, pp. 35-38) [↑](#footnote-ref-192)
193. AHRC (2012, p. 3) [↑](#footnote-ref-193)
194. Australian Government (2013, pp. 23-24) [↑](#footnote-ref-194)
195. DoH (2015, pp.11 and 12) [↑](#footnote-ref-195)
196. Reconciliation Australia (2016a, 2016b). [↑](#footnote-ref-196)
197. SCRGSP (2016, pp. 1243-4 and accompanying tables). [↑](#footnote-ref-197)
198. Siebert (2014). The second of Krystian Siebert’s three reasons has been slightly adapted from his original wording directed at the Not-for-Profit sector. [↑](#footnote-ref-198)
199. CGCSC (2016, pp. 3 and 22-23). [↑](#footnote-ref-199)
200. CGCSC (2017, p. 4). [↑](#footnote-ref-200)
201. Paradies *et al* (2008). [↑](#footnote-ref-201)
202. Ibid., p. 12. [↑](#footnote-ref-202)
203. Ibid, p. 15. [↑](#footnote-ref-203)
204. 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) [↑](#footnote-ref-204)
205. Australian Government (2013, p. 23-4). [↑](#footnote-ref-205)
206. Alfred Deakin Institute for Citizenship and Globalisation (2016), citing Elias (2015). See also AHMAC (2016, p. 8). The study takes into account microeconomic factors, such as indirect costs related to the labour market, and macroeconomic factors such as the economic costs of discrimination in relation to physical and mental health. [↑](#footnote-ref-206)
207. Katzenellenbogen *et* al (2013), Wright (2009a, 2009b) cited in Shaw (2016, p. 6). [↑](#footnote-ref-207)
208. Henry *et al* (2007), cited in Shaw (2016, p. 8). [↑](#footnote-ref-208)
209. Shaw (2016, p. 10). [↑](#footnote-ref-209)
210. For a more detailed analysis of how these savings might be achieved, see Elias (2015, particularly pp. 130-176). [↑](#footnote-ref-210)
211. Department of Health (DoH) (2015, pp. 10 and 12, 1) [↑](#footnote-ref-211)
212. AHMAC (2012, 2015, Figure 1). [↑](#footnote-ref-212)
213. The *Aboriginal and Torres Strait Islander Health Performance Framework* reports. [↑](#footnote-ref-213)
214. *The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples* overview reports. [↑](#footnote-ref-214)
215. *Overcoming Indigenous Disadvantage* reports. See also SCRGSP (2016, Box 1.2.1: National reports on Aboriginal and Torres Strait Islander Australians, p. 31). [↑](#footnote-ref-215)
216. CGCSC (2017, p. 29). [↑](#footnote-ref-216)
217. DoH (2015, p. 7). [↑](#footnote-ref-217)
218. CGSC (2017, pp. 29 and 30). [↑](#footnote-ref-218)
219. DoH (2015, p. 12). [↑](#footnote-ref-219)
220. This estimate does not take into account HHS future estimates of population change for both the general and Aboriginal and Torres Strait Islander populations. [↑](#footnote-ref-220)
221. Willis *et al* (2010b, p. 17). [↑](#footnote-ref-221)
222. Willis *et al* (2010a, p. 10). [↑](#footnote-ref-222)
223. Ibid. [↑](#footnote-ref-223)
224. NHPA (2015, p. 9). [↑](#footnote-ref-224)
225. AHMAC (2015, p. 4). [↑](#footnote-ref-225)
226. Ibid., p. 51. The impacts of discrimination and racism on health of Aboriginal and Torres Strait Islander people are discussed on p. 77. [↑](#footnote-ref-226)
227. AHMAC (2016, p. 10) [↑](#footnote-ref-227)
228. AHMAC (2016, p. 12). [↑](#footnote-ref-228)
229. CGCSC (2017, p. 33), citing Australian Healthcare and Hospital Association (AHHA) PHN discussion paper (2015). [↑](#footnote-ref-229)
230. Ibid., citing NACCHO (2016). [↑](#footnote-ref-230)
231. DoH (2016, p. 3). [↑](#footnote-ref-231)
232. Ibid., pp. 4-8. [↑](#footnote-ref-232)
233. Brisbane North (corresponding to MNHHS); Brisbane South (corresponding to MSHHS); Gold Coast (corresponding to GCHHS); Darling Downs and West Moreton (DDHHS and WMHHS); Western Queensland (NWHHS, CWHHS and SWHHS); Central Queensland, Wide Bay and Sunshine Coast (CQHHS, WBHHS and SCHHS); and Northern Queensland (MHHS, THHS, CHHHS and TCHHS). [↑](#footnote-ref-233)
234. [↑](#footnote-ref-234)
235. Reconciliation Australia (2016a). [↑](#footnote-ref-235)
236. Reconciliation Australia (2016b). [↑](#footnote-ref-236)
237. *Koori Mail* (2017, p. 8). [↑](#footnote-ref-237)
238. Peter Harris AO, in SCRGSP (2016, p. iii). [↑](#footnote-ref-238)
239. SCRGSP (2016, Part 8, pp. 2183 – 2600) covering the following indicators: access to primary health care, potentially preventable hospitalisations, potentially avoidable deaths, tobacco consumption and harm, obesity and nutrition, oral health, mental health, and suicide and self-harm. [↑](#footnote-ref-239)
240. SCRGSP (2016, section 8.7 Mental health, p. 2218) citing Dudgeon, Milroy and Walker 2014). [↑](#footnote-ref-240)
241. Australian Government (2013, pp. 14-15) [↑](#footnote-ref-241)
242. Australian Government (2013, p. 8) [↑](#footnote-ref-242)
243. SCRGSP (2016, pp. 1243-4 and accompanying tables). [↑](#footnote-ref-243)
244. SCTGSP (2016, p. 1272). [↑](#footnote-ref-244)
245. SCRGSP (2016, Section 5.13, p. 1250). [↑](#footnote-ref-245)
246. SCRGSP (2016, Section 5.17, p. 1254). [↑](#footnote-ref-246)
247. Ibid, Phase One Report, p. iii. [↑](#footnote-ref-247)
248. Ibid, Vol. 1 Appendix, p. 45. [↑](#footnote-ref-248)
249. Ibid, Vol. 1 Appendix, p. 51. [↑](#footnote-ref-249)
250. Jones CP (2003). [↑](#footnote-ref-250)
251. In January 2017, in an allegation of systemic racism against the Australian College of Emergency Medicine, “more than 30 non-white students… have revealed their white colleagues are 13 times more likely to be admitted as specialist emergency doctors”, with the students lodging a 34-page complaint with the college. As reported by Klan (2017a). See also Klan (2017b, 2017c). Also, as pointed out in this report on p. 76, racial discrimination has been estimated to cost the Australian economy $44.9 billion, or 3.6 per cent of GDP each year in the decade from 2001 to 2011 (AHMAC, 2016, p. 8 citing Elias 2015, and Alfred Deakin Institute for Citizenship and Globalisation, 2016). [↑](#footnote-ref-251)
252. 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 [CHHH]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 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. [↑](#footnote-ref-252)
253. 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. [↑](#footnote-ref-253)
254. CHHHS *2012-2013 Annual Report*, p. 9. [↑](#footnote-ref-254)
255. 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). [↑](#footnote-ref-255)
256. See, for example, Hayes-Jonkers *et al* (2013). [↑](#footnote-ref-256)
257. [www.health.qld.gov.au/cairns\_hinterland](http://www.health.qld.gov.au/cairns_hinterland)/ Accessed 28/11/2016. [↑](#footnote-ref-257)
258. Bateman D, 2016. Change of guard at health service board. *The Cairns Post,* May 23, p. 4. [↑](#footnote-ref-258)
259. 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). [↑](#footnote-ref-259)
260. 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. [↑](#footnote-ref-260)
261. See also Queensland Government (2014, pp. 57-8). [↑](#footnote-ref-261)
262. Queensland Government (nd, p. 19). [↑](#footnote-ref-262)
263. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-263)
264. CHHHS website: [www.health.qld.gov.au/cairns\_hinterland](http://www.health.qld.gov.au/cairns_hinterland)/ Accessed 28/11/2016. [↑](#footnote-ref-264)
265. Queensland Government (2012). [↑](#footnote-ref-265)
266. Ibid, pp. 65-70. [↑](#footnote-ref-266)
267. Queensland Health (2013b, p. 12). [↑](#footnote-ref-267)
268. Queensland Health (2010c, p. 16). [↑](#footnote-ref-268)
269. The issue of Indigenous status can also extend to employment. 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. [↑](#footnote-ref-269)
270. Queensland Health (2016). [↑](#footnote-ref-270)
271. 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> [↑](#footnote-ref-271)
272. 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). [↑](#footnote-ref-272)
273. Queensland Government (2014, p. 58). [↑](#footnote-ref-273)
274. Queensland Health, 2013. *Cairns and Hinterland Hospital and Health Service* *Service Agreement 2013/14-2015/16* (November 2013 Revision), p. 27. [↑](#footnote-ref-274)
275. CHHHS *Service Agreement 2013/14-2015/16* (November 2013 Revision), p. 27. [↑](#footnote-ref-275)
276. There is evidence of at least one important report not being tabled/addressed by the CHHHB. The confidential report prepared by Marrie (2014), Addressing Allegations of Discrimination against Aboriginal and Torres Strait Islander (ATSI) Employees of the Cairns & Hinterland Hospital and Health Service (CHHHS) and Review of Support Avenues for the ATSI Workforce, presented to the HSCE in February 2014 did not appear to have been addressed by the CHHHB in subsequent monthly meetings. [↑](#footnote-ref-276)
277. Ostrowski *et al* (2017, Conclusions p. 1). [↑](#footnote-ref-277)
278. CHQHHS web address: <http://www.childrens.health.qld.gov.au/about-us/our-executive/> [↑](#footnote-ref-278)
279. Website: <http://www.childrens.health.qld.gov.au/wp-content/uploads/2016/09/fac-rd.pdf> Accessed 30/11/2016. [↑](#footnote-ref-279)
280. Queensland Government (nd, p. 19). [↑](#footnote-ref-280)
281. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-281)
282. CHQHHS website: <http://childrens.health.qld.gov.au/> Accessed 30/11/2016. [↑](#footnote-ref-282)
283. Queensland Health (2013b, p. 12). [↑](#footnote-ref-283)
284. Queensland Health (2010c, p. 16). [↑](#footnote-ref-284)
285. Queensland Government (2014, p. 87). [↑](#footnote-ref-285)
286. In the CQHHS *Service Agreement 2013/14 – 2015/16,* the percentage is given as 2.5% (p. 20) [↑](#footnote-ref-286)
287. Central Queensland Hospital and Health Service and Central Queensland Medicare Local (2014, p. 18). [↑](#footnote-ref-287)
288. A search of the CQHHS website failed to find any reference to such a unit or service: <http://www.health.qld.gov.au/cq/> Accessed 1/12/2016. [↑](#footnote-ref-288)
289. Approved by the Central Queensland Hospital and Health Board Chair, Version 2.6. May 2015 P0354. [↑](#footnote-ref-289)
290. CQHHS website: <http://www.health.qld.gov.au/cq/> Accessed 1/12/2016. [↑](#footnote-ref-290)
291. Queensland Government (nd, p. 19). [↑](#footnote-ref-291)
292. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-292)
293. CQHHS website: <http://www.health.qld.gov.au/cq/> Accessed 1/12/2016. [↑](#footnote-ref-293)
294. Queensland Health (2013b, p. 12). [↑](#footnote-ref-294)
295. Queensland Health (2010c, p. 16). [↑](#footnote-ref-295)
296. Queensland Government (2014, p. 67). [↑](#footnote-ref-296)
297. See also Queensland Government (2014, p. 79). [↑](#footnote-ref-297)
298. However, it does raise the issue about what KPIs should/should not be included in the Matrix, and will form a key part of the validation process. [↑](#footnote-ref-298)
299. Queensland Government (nd, p. 19). [↑](#footnote-ref-299)
300. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott, as the Chairperson and co-signatory. [↑](#footnote-ref-300)
301. Queensland Health (2013b, p. 12). [↑](#footnote-ref-301)
302. Queensland Health (2010c, p. 16). [↑](#footnote-ref-302)
303. Queensland Health (2016). [↑](#footnote-ref-303)
304. Queensland Government (2014, p. 79). [↑](#footnote-ref-304)
305. Queensland Government (nd, p. 19). [↑](#footnote-ref-305)
306. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-306)
307. Queensland Health (2013b, p. 12). [↑](#footnote-ref-307)
308. Queensland Health (2010c, p. 16). [↑](#footnote-ref-308)
309. Queensland Government (2014, p. 99). [↑](#footnote-ref-309)
310. For information about Kalwun Health Service see: <http://karulbo.com.au/about/> Accessed 23/11/2016. [↑](#footnote-ref-310)
311. Queensland Government (2014, p. 110). [↑](#footnote-ref-311)
312. Information provided at: <http://karulbo.com.au/about/> Accessed 23/11/2016. [↑](#footnote-ref-312)
313. See <https://www.health.qld.gov.au/goldcoasthealth/html/about/board.asp> (last updated and reviewed 27 May 2015). Accessed 23/11/2016. The posting reflects a change to board membership, expanded from 7 to 9, with two of the board members identified in the GCHHS *Annual Report 2014-2015*  (photograph, p. 35) no longer serving. [↑](#footnote-ref-313)
314. Ibid., p. 109. [↑](#footnote-ref-314)
315. Gold Coast Health *Community and Consumer Engagement: 2013-15 summary of highlights* (p. 2). [↑](#footnote-ref-315)
316. About Karulbo: <http://karulbo.com.au/about/> Accessed 23/11/2016. [↑](#footnote-ref-316)
317. Queensland Government (nd, p. 19). [↑](#footnote-ref-317)
318. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-318)
319. *healthwaves+* issues: December 2014/January 2015; February/March 2015; April/May 2015; June/July 2015; August/September 2015; and October/November 2015. [↑](#footnote-ref-319)
320. *healthwaves+* June/July 2015, p. 4 (Indigenous benefit from free vaccine) and reference to Nursing & Midwifery Symposium which includes an Indigenous speaker (p. 5); August/September 2015, p. 5 (essentially same reference to Nursing & Midwifery Symposium). [↑](#footnote-ref-320)
321. GCML now no longer exists and has been replaced by a larger regional entity, the Gold Coast Primary Health Network. [↑](#footnote-ref-321)
322. GCHHS, 2013. *Gold Coast Primary Health Care Protocol.* [↑](#footnote-ref-322)
323. Queensland Health (2013b, p. 12). [↑](#footnote-ref-323)
324. Queensland Health (2010c, p. 16). [↑](#footnote-ref-324)
325. Queensland Health (2016). [↑](#footnote-ref-325)
326. Ibid. [↑](#footnote-ref-326)
327. Queensland Government (2014, p. 109). [↑](#footnote-ref-327)
328. Information provided at <http://www.mackay.health.qld.gov.au/your-hospitals/mackay-base-hospital/atsi-aboriginal-and-torres-strait-islander/> Accessed 25/11/2016. [↑](#footnote-ref-328)
329. In the MHHB Organisational Map presented in the MHHS *Annual Report 2012 – 2013* (p. 22), listed among the directorates is a “quasi directorate” for Regional Indigenous Health, however, its head is not listed as a member of the 8-member Executive Committee and is not profiled with the Executive Directors (pp. 24-25). The Executive Director: People and Culture is also responsible for, *inter alia*, “Indigenous training and development, and cultural awareness programmes for the Health Service” (Financial Statements, p. 6-37). [↑](#footnote-ref-329)
330. Queensland Government (nd, p. 19). [↑](#footnote-ref-330)
331. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-331)
332. Web address: [www.mackay.health.qld.gov.au](http://www.mackay.health.qld.gov.au) Accessed 24/11/2016. [↑](#footnote-ref-332)
333. Queensland Health (2013b, p. 12). [↑](#footnote-ref-333)
334. Queensland Health (2010c, p. 16). [↑](#footnote-ref-334)
335. Data for both DAMA and PPH were not provided in the 2015 Closing the Gap performance report (Queensland Health, 2016). [↑](#footnote-ref-335)
336. Queensland Government (2014, p. 119). [↑](#footnote-ref-336)
337. MNHHS website: <https://www.health.qld.gov.au/metronorth/atsi/coming-to-brisbane/default.asp> Last up-dated 18 February 2016. Accessed 3/12/2016. [↑](#footnote-ref-337)
338. MNHHS website: <https://www.health.qld.gov.au/metronorth/about/executive/default.asp> Last up-dated 15 January 2016. Accessed 3/12/2016. [↑](#footnote-ref-338)
339. Queensland Government (nd, p. 19). [↑](#footnote-ref-339)
340. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-340)
341. MNHHS website:<https://www.health.qld.gov.au/metronorth/publiccations/default.asp> Last up-dated 13 January 2016. Accessed 3/12/2016. [↑](#footnote-ref-341)
342. Queensland Health (2013b, p. 12). [↑](#footnote-ref-342)
343. Queensland Health (2010c, p. 16). [↑](#footnote-ref-343)
344. MNHHS website. “5,000 complete cultural awareness training.” <https://www.health.qld.gov.au/metronorth/news/2015/09/23/default.asp> Accessed 3/12/2016. [↑](#footnote-ref-344)
345. Indigenous patient identification still remains a priority issue. During the 2016 NAIDOC Week (3-10 July), MNHHS launched a campaign to highlight the importance of Aboriginal and Torres strait Islander patients identifying when accessing their facilities. “Identification: It’s your right to a healthier life.” <https://www.health.qld.gov.au/metronorth/news/2016/07/naidoc-identification/default.asp> Accessed 3/12/2016. [↑](#footnote-ref-345)
346. Queensland Government (2014, p. 132). [↑](#footnote-ref-346)
347. Website: <http://www.health.qld.gov.au/iihs/> Accessed 18/04/2016. [↑](#footnote-ref-347)
348. MSHHS website: <https://metrosouth.health.qld.gov.au/health-equity-and-access/aboriginal-and-torres-strait-islander-people> Last up-dated 5 May 2016/Reviewed 21 October 2016. Accessed 3/12/2016. [↑](#footnote-ref-348)
349. Queensland Government (nd, p. 19). [↑](#footnote-ref-349)
350. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-350)
351. Queensland Health (2013b, p. 12). [↑](#footnote-ref-351)
352. Queensland Health (2010c, p. 16). [↑](#footnote-ref-352)
353. Queensland Health (2015d), *Closing the Gap performance report 2014*, p. 30. [↑](#footnote-ref-353)
354. DAMA is a Tier 2 KPI. [↑](#footnote-ref-354)
355. PPH is a Tier 2 KPI. [↑](#footnote-ref-355)
356. Queensland Government (2014, p. 143). [↑](#footnote-ref-356)
357. Queensland Government (2014, p. 155). [↑](#footnote-ref-357)
358. Queensland Health, 2014. *The health of Queenslanders 2014 - Fifth report of the Chief Health Officer Queensland: North West HHS.* p. 5. [↑](#footnote-ref-358)
359. Gidgee Healing website: <http://www.gidgeehealing.com/> Accessed 5/12/2016. [↑](#footnote-ref-359)
360. Queensland Government (nd, p. 19). [↑](#footnote-ref-360)
361. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-361)
362. Website: <https://www.health.qld.gov.au/services/northwest/> Last update: 12 September 2014. Accessed 5/12/2016. [↑](#footnote-ref-362)
363. Queensland Health (2013b, p. 12). [↑](#footnote-ref-363)
364. Queensland Health (2010c, p. 16). [↑](#footnote-ref-364)
365. See also NWHHS website: <https://www.health.qld.gov.au/services/northwest/> Last update: 12 September 2014. Accessed 5/12/2016. [↑](#footnote-ref-365)
366. Queensland Government (2014, p. 155). [↑](#footnote-ref-366)
367. CWAATSICH website: <http://www.cwaatsich.org.au/> Accessed 6/12/2016. [↑](#footnote-ref-367)
368. CACH website: <http://www.cach.org.au/> Accessed 6/12/2016. [↑](#footnote-ref-368)
369. SWHHS *Community and Consumer Engagement Strategy: Annual Evaluation June 2016*, p. 1. [↑](#footnote-ref-369)
370. Queensland Government (nd, p. 19). [↑](#footnote-ref-370)
371. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-371)
372. Queensland Health (2013b, p. 12). [↑](#footnote-ref-372)
373. Queensland Health (2010c, p. 16). [↑](#footnote-ref-373)
374. The standard format for reporting on HSS performance as per Service Agreement has not been used. [↑](#footnote-ref-374)
375. SWHHS website: <https://health.qld.gov.au/southwest/> Accessed 6/12/2016. [↑](#footnote-ref-375)
376. Queensland Government (2014, p. 166). [↑](#footnote-ref-376)
377. See *NCACCH News,* a quarterly publication which can be viewed at : [www.ncacch.org.au](http://www.ncacch.org.au) Accessed 7/12/2016. [↑](#footnote-ref-377)
378. Queensland Government (nd, p. 19). [↑](#footnote-ref-378)
379. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-379)
380. SCHHS website: <https://www.health.qld.gov.au/sunshinecoast/html/publications.asp> Accessed 7/12/2016. [↑](#footnote-ref-380)
381. SCHHS website: <https://www.health.qld.gov.au/sunshinecoast/html/partners.asp> Accessed 7/12/2016. [↑](#footnote-ref-381)
382. Queensland Health (2013b, p. 12). [↑](#footnote-ref-382)
383. Queensland Health (2010c, p. 16). [↑](#footnote-ref-383)
384. Queensland Government (2014, p. 173). [↑](#footnote-ref-384)
385. Queensland Government (2014, p. 183). [↑](#footnote-ref-385)
386. Queensland Government (nd, p. 19). [↑](#footnote-ref-386)
387. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-387)
388. Queensland Health (2013b, p. 12). [↑](#footnote-ref-388)
389. Queensland Health (2010c, p. 16). [↑](#footnote-ref-389)
390. Queensland Government (2014, p. 183). [↑](#footnote-ref-390)
391. Palm Island Aboriginal Council website: [www.piac.gov.au](http://www.piac.gov.au) Accessed 9/12/2016. [↑](#footnote-ref-391)
392. See also THHS *2012-2016 Strategic Plan* (2013 update) (p. 1) [↑](#footnote-ref-392)
393. THHS website: <https://www.health.qld.gov.au/townsville/publications.asp> Accessed 9/12/2016. [↑](#footnote-ref-393)
394. Queensland Government (nd, p. 19). [↑](#footnote-ref-394)
395. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-395)
396. THHS website: <https://health.qld.gov.au/townsville/publications.asp> Accessed 9/12/2016. [↑](#footnote-ref-396)
397. THHS *Townsville Hospital and Health Service Health Service Plan 2012-2027* (p. 12). [↑](#footnote-ref-397)
398. Queensland Health (2013b, p. 12). [↑](#footnote-ref-398)
399. Queensland Health (2010c, p. 16). [↑](#footnote-ref-399)
400. AHMAC (2011). [↑](#footnote-ref-400)
401. Queensland Government (2014, p. 201). [↑](#footnote-ref-401)
402. See WMHHS *Annual Report 2014-2015* (p. 23) and a search of the WMHHS website failed to identify such a unit/service. <http://www.westmoreton.health.qld.gov.au/about-us/> Accessed 30/11/2016. [↑](#footnote-ref-402)
403. Ibid., website. [↑](#footnote-ref-403)
404. Queensland Government (nd, p. 19). [↑](#footnote-ref-404)
405. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-405)
406. WMHHS, media statement 19 August 2015: Indigenous health partnership launches a statewide first. [↑](#footnote-ref-406)
407. The single reference occurs in the WMHHB *Board Meeting Summary,* 25 July 2014, held at Kambu Medical Centre. [↑](#footnote-ref-407)
408. Queensland Health (2013b, p. 12). [↑](#footnote-ref-408)
409. Queensland Health (2010c, p. 16). [↑](#footnote-ref-409)
410. Queensland Government (2014, p. 211). [↑](#footnote-ref-410)
411. For further information visit: <http://www.galangoorduwalami.com.au/> Accessed 29/11/2016. [↑](#footnote-ref-411)
412. Queensland Government (nd, p. 19). [↑](#footnote-ref-412)
413. Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory. [↑](#footnote-ref-413)
414. For example, the January 2014 issue contained an article regarding research by a WBHHS staff member on the effects of native tobacco (‘pituri’) chewing during pregnancy in central Australia (p. 6), and the June/July/August 2014 issue an item regarding increasing influenza vaccinations in the Aboriginal and Torres Strait Islander community (p. 12). [↑](#footnote-ref-414)
415. WBBHHS website: <http://www.health.qld.gov.au/widebay/> Accessed 29/11/2016. [↑](#footnote-ref-415)
416. Queensland Health (2013b, p. 12). [↑](#footnote-ref-416)
417. Queensland Health (2010c, p. 16). [↑](#footnote-ref-417)
418. See: <http://www.health.qld.gov.au/widebay/> Accessed 29/11/2016. [↑](#footnote-ref-418)
419. See: <http://www.health/qld/gov/au/widebay/> Accessed 29/11/2016. [↑](#footnote-ref-419)
420. Ibid. [↑](#footnote-ref-420)
421. Queensland Government (2014, p. 221). [↑](#footnote-ref-421)
422. NHRA (2011, pp. 6 and 8). [↑](#footnote-ref-422)
423. See HHB Act **s.15 Meaning of *health service****.*  [↑](#footnote-ref-423)
424. Ibid., p. 8. [↑](#footnote-ref-424)
425. The NHRA does contain a number of Indigenous references in the schedules, for example, in Schedule B, in relation to the Principles for Determining the National Efficient Price, in determining adjustments to the national efficient price, the Independent Hospital Pricing Authority must have regard to inputs which affect the costs of service delivery including “patient complexity, including Indigenous status.” (p. 31, para. B13.c.). Schedule F contains numerous references to “Indigenous Australians” in the context of the Commonwealth’s responsibility for funding, policy, management and delivery for aged care to be available for people aged 65 years and over, but in the case of Indigenous Australians, eligibility starts at age 50 years (pp. 53-55). [↑](#footnote-ref-425)
426. Reference is also made in Schedule D, in relation to the establishment of Medicare Locals (now reconfigured as regional Primary Health Networks each of which in Queensland include a number of HHSs – see Section 3.2.8 of this report), as independent legal entities with strong links to a range of service providers which include “Aboriginal Medical Services” (p. 50, para D35). Medicare Locals are not a responsibility of Queensland under the HHB Act. [↑](#footnote-ref-426)
427. NHRA, p. 48. [↑](#footnote-ref-427)
428. Ibid. [↑](#footnote-ref-428)
429. NPACGIHO, p. 4, paras 5 and 6. [↑](#footnote-ref-429)
430. See **Part 1** of **Schedule 3 Agreements** of the *Hospital and Health Boards Regulation 2012* (Qld) in relation to **Agreements with Commonwealth, State or entity**. [↑](#footnote-ref-430)
431. AHMAC (2012, p. 147). Citing de Alcantra 1998; Hawkes 2001; Westbury 2002; Dodson *et al* 2003. [↑](#footnote-ref-431)
432. 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). [↑](#footnote-ref-432)
433. Howse and Dwyer (2015, p. 4). [↑](#footnote-ref-433)
434. For example, inconsistencies in the application of HPF measures in relation to Tier 3: Health System Performance Indicators exist in the reporting on HPF KPIs between different Hospital and Health Services operating in North Queensland. The Townsville Hospital and Health Service *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 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
     * 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 Mackay Hospital and Health Service also reported on these KPIs (MHHS 2013, p. 55), while the North West HHS (2013, p. 36) reported on each of the above except the percentage of inscope 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. In their 2014-15 annual reports, reporting on these and other KPIs was largely ignored (see Table 11). [↑](#footnote-ref-434)
435. CGCSC (2017, p. 1), quoting Romlie Mokak (2016). [↑](#footnote-ref-435)
436. While the CWHHS reported on PPH, it was given 0/2 in Table 11 on the basis of the poor result achieved for this KPI. [↑](#footnote-ref-436)
437. This criterion and its sub-criteria only deal with information as reported in the 2014-2015 annual reports. The scoring discrepancies between Table 8 and Table 10 occur because, for the latter, a wider range of documents were searched in order to provide a score. [↑](#footnote-ref-437)
438. That is, similar in duration to the *National Aboriginal and Torres strait Islander Health Plan 2013-2023* (Australian Government 2013), the *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health* (AHMAC 2016). [↑](#footnote-ref-438)
439. See Bainbridge *et al* (2015) for a recent review of approaches to CCT and their effectiveness. [↑](#footnote-ref-439)
440. As noted in the CQHHS *Annual Report 2014 – 2015*, p. 48. [↑](#footnote-ref-440)
441. NHRA Schedule B. In relation to the Principles for Determining the National Efficient Price, in determining adjustments to the national efficient price, the Independent Hospital Pricing Authority must have regard to inputs which affect the costs of service delivery including “patient complexity, including Indigenous status.” (p. 31, para. B13.c.). [↑](#footnote-ref-441)
442. Not all HHS 2012-2013 annual reports were considered in the course of this audit - only those in North Queensland for the purpose of the 2014 Matrix case study of the CHHHS (see Marrie and Marrie, 2014) . [↑](#footnote-ref-442)
443. COAG NPACGIHO (2008, p. 13). The benchmarks and indicators referred to in the clause 21 and 22 tables are generally further identified in the *Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures*  (AHMAC, 2012: Figure 1). [↑](#footnote-ref-443)
444. AIHW (2015, pp. 152 and 157). The health expenditure estimates include recurrent health expenditure, consisting mainly of expenditure on wages, salaries and supplements, purchases of goods and services, and consumption of fixed capital. They do not include expenditure that results in the creation or acquisition of fixed assets (p. 170). [↑](#footnote-ref-444)
445. Queensland Health (2013a, p. 4). [↑](#footnote-ref-445)
446. AIHW (2015, p. 157). [↑](#footnote-ref-446)
447. AIHW (2015, pp. 152-3). [↑](#footnote-ref-447)
448. COAG NPACGIHO (2008, p. 13). [↑](#footnote-ref-448)
449. COAG NPACGIHO (2008, p. 4). [↑](#footnote-ref-449)
450. See for example, comments by Russell (2014). [↑](#footnote-ref-450)
451. Russell (2014, p. 10. Citing information from the 2013-14 Budget Paper No. 3). [↑](#footnote-ref-451)
452. Russell (2014, p. 10. Citing information from the 2013-14 Budget Paper No. 3). [↑](#footnote-ref-452)
453. Queensland Government (2014, p. 5). [↑](#footnote-ref-453)
454. Ibid., Health Portfolio: Summary of portfolio budgets. [↑](#footnote-ref-454)
455. See also Queensland Health (2010a, p. 54). [↑](#footnote-ref-455)
456. Populations rounded to the nearest 100. [↑](#footnote-ref-456)
457. Refers to primarily primary healthcare services. Some HHS regions also have Aboriginal and Torres Strait Islander community controlled facilities for aged care and drug and alcohol rehabilitation, for example. These are not included. [↑](#footnote-ref-457)
458. CHHHS *Annual Report 2014-2015*, p. 11. [↑](#footnote-ref-458)
459. Ibid., calculated at 9.0% of total population of 283,200. [↑](#footnote-ref-459)
460. Ibid., p. 11. [↑](#footnote-ref-460)
461. Wuchopperen Health Service (Cairns, with clinics in Edmonton and Atherton); Gurriny Yealamucka Health Service Aboriginal Corporation (Yarrabah); Mulungu Aboriginal Corporation Primary Health Care Service (Mareeba); Mamu Health Service Ltd (Innisfail and Ravenshoe). Apunipima Cape York Health Council services the Cape York region, but has its administrative HQ in Cairns. The Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA) was established by QAIHC members in Far North Queensland as a strategic response to health reform challenges for communities and organisations across the FNQ region. [↑](#footnote-ref-461)
462. CHQHHS is a specialist statewide HHS dedicated to caring for children and young people (from birth to 18 years) from across Queensland and northern NSW. Queensland’s children comprise 25% of the state’s total population, and approximately 6 – 7% are of Aboriginal and/or Torres Strait Islander origin (CHQHHS *Annual Report 2014-2015,* pp. 6 and 9; CHQHHS *Service Agreement 2013/14 – 2015/16*, p. 20).  The figures here are based on Queensland’s estimated resident population in 2013 but include 19 year-olds. The total number of children (age group 0-19) was 1,232,700 accounting for 26.5% of the total Queensland population of 4,656,800. Of the child population, there were 94,000 Aboriginal and Torres Strait Islander children. The age distribution of Queensland’s Aboriginal and Torres Strait Islander population is significantly younger than the non-Indigenous population. In 2013, Aboriginal and Torres Strait Islander Queenslanders aged 0-19 made up 47.5% of the Indigenous population in Queensland, while the same age group made up 25.5% of the non-Indigenous population in Queensland (Queensland Health, 2016. p. 11). [↑](#footnote-ref-462)
463. Ibid. [↑](#footnote-ref-463)
464. Ibid. [↑](#footnote-ref-464)
465. CQHHS *Annual Report 2014 – 2015,* p. 3. [↑](#footnote-ref-465)
466. Ibid., calculated at 5.5% of total population of 228,000. [↑](#footnote-ref-466)
467. Ibid. [↑](#footnote-ref-467)
468. Bidgerdii Aboriginal and Torres Strait Islander Corporation Community Health Service Central Queensland Region (Bidgerdii) (Rockhampton); Nhulundu Wooribah Indigenous Health Organisation Incorporated (Nhulundu Wooribah) (Gladstone, Boyne Island, Tannum Sands and Calliope). The Central Queensland Regional Aboriginal and Torres Strait Islander Community Controlled Health Organisation (CQ RAICCHO) was established by QAIHC members in the CQ region as a strategic response to health reform challenges for communities and organisations in Central Queensland. [↑](#footnote-ref-468)
469. CWHHS *Annual Report 2014 – 2015,* p. 6. [↑](#footnote-ref-469)
470. Ibid., calculated t 8.3% of total population of 12,400. [↑](#footnote-ref-470)
471. Ibid. [↑](#footnote-ref-471)
472. DDHHS *Annual Report 2014 – 2015,* p. 9. [↑](#footnote-ref-472)
473. Ibid., calculated at 4.2% of total population of 280,000. [↑](#footnote-ref-473)
474. Ibid. [↑](#footnote-ref-474)
475. Cherbourg Regional Aboriginal and Islander Community Controlled Health Service /Barambah Regional Medical Service (Aboriginal Corporation) (Cherbourg and surrounding communities in the South Burnett region); Goolburri Aboriginal Health Advancement Company Ltd (Toowoomba); Carbal Medical Centre (an Aboriginal and Torres Strait Islander Community Controlled Medical Service managed by Darling Downs Shared Care Association Incorporated) (Toowoomba and opened in Warwick in February 2016); and Goondir Aboriginal and Torres Strait Islanders Corporations for Health Services (Goondir Health Services) (Dalby and Oakey – also has a clinic in St George in the SWHHS region). [↑](#footnote-ref-475)
476. GCHHS *Annual Report 2014 – 2015,* p. 9. [↑](#footnote-ref-476)
477. No estimate of Aboriginal and Torres Strait Islander population found in annual report. Calculated at 1.2% of total population of 551,000 (GCHHS *Service Agreement 2013/14 – 2015/16*, p. 20). [↑](#footnote-ref-477)
478. Ibid. [↑](#footnote-ref-478)
479. Kalwun Health Service (Gold Coast). [↑](#footnote-ref-479)
480. MHHS *Annual Report 2014 – 2015,* p. 9. [↑](#footnote-ref-480)
481. Ibid., calculated at 4.4% of total population of 182,000. [↑](#footnote-ref-481)
482. Ibid. [↑](#footnote-ref-482)
483. Girudala Community Cooperative Society Ltd (Bowen, Collinsville and Proserpine); Aboriginal and Torres Strait Islander Community Health Service (Mackay Ltd) (Mackay); Mudth-Niyleta Aboriginal and Torres Strait Islander Corporation (Sarina). [↑](#footnote-ref-483)
484. MNHHS *Service Agreement 2013/14 – 2015/16*, p. 20 (actual figure is given as 958,455). [↑](#footnote-ref-484)
485. Ibid., calculated at 1.6% of total population of 960,000. [↑](#footnote-ref-485)
486. Ibid. [↑](#footnote-ref-486)
487. Moreton Aboriginal and Torres Strait Islander Community Health Service (MATSICHS) (Caboolture, and also operates clinics at Morayfield, Strathpine and Deception Bay); the Institute for Urban Indigenous Health (IUIH) (Bowen Hills); and the Aboriginal and Torres Strait Islander Community Health Service Brisbane Northgate Clinic. IUIH integrates four ATSICCHSs in South East Queensland: Moreton Aboriginal and Torres Strait Islander Community Health Service (Caboolture); Aboriginal and Torres Strait Islander Community Health Service Brisbane Ltd (Wooloongabba); Kambu (Ipswich); Kalwun Health Service (Gold Coast); and Yulu-Burri-Ba (Stradbroke Island and Capalaba). [↑](#footnote-ref-487)
488. MSHHS *Annual Report 2014 – 2015,* p. 13. [↑](#footnote-ref-488)
489. Ibid., 2013 estimate. [↑](#footnote-ref-489)
490. Ibid. [↑](#footnote-ref-490)
491. Aboriginal and Torres Strait Islander Community Health Service Brisbane Ltd (ATSICHS Brisbane) and Yulu Burri-Ba Aboriginal Corporation for Community Health (based at Dunwich, North Stradbroke Island, also services the Indigenous communities in Capalaba and Wynnum). ATSICHS Brisbane has clinics in Wooloongabba, Acacia Ridge, Browns Plains, Logan Woodridge Mums & Bubs and Northgate (in the MNHHS area). [↑](#footnote-ref-491)
492. NWHHS *Annual Report 2014 – 2015,* p. 13. [↑](#footnote-ref-492)
493. Ibid., calculated at 23.1% of total population of 32,600. [↑](#footnote-ref-493)
494. Ibid. [↑](#footnote-ref-494)
495. Mt Isa Aboriginal Community Controlled Health Service (trading as Gidgee Healing) which also operates a Mobile Health Clinic in Normanton, and the Injilinji Aboriginal and Torres Strait Islander Corporation for Children and Youth Services (Mt Isa). [↑](#footnote-ref-495)
496. SWHHS *Annual Report 2014 – 2015,* p. 6. [↑](#footnote-ref-496)
497. SWHHS *Service Agreement 2013/14 – 2015/16,* p. 20. Calculated at 12% of total population of 26,000. [↑](#footnote-ref-497)
498. Ibid. [↑](#footnote-ref-498)
499. Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health (CWAATSICH) which has clinics in Charleville, Roma, Mitchell and Quilpie, the Cunnamulla Aboriginal Corporation for Health (CACH) and the Goondir Aboriginal and Torres Strait Islander Corporation for Health Services (Goondir Health Services). Goondir Health Services is based in Dalby in the DDHHS area, but maintains a clinic in St George. [↑](#footnote-ref-499)
500. SCHHS *Annual Report 2014 – 2015,* p. 11. [↑](#footnote-ref-500)
501. Ibid., calculated at 1.7% of the total population of 390,000. [↑](#footnote-ref-501)
502. Ibid. [↑](#footnote-ref-502)
503. North Coast Aboriginal Corporation for Community Health (NCACCH) (Sunshine Coast and Gympie). [↑](#footnote-ref-503)
504. TCHHS *Annual Report 2014 – 2015,* p. 7. [↑](#footnote-ref-504)
505. Ibid., calculated at 64.0% of the total population of 25,600. [↑](#footnote-ref-505)
506. Ibid. [↑](#footnote-ref-506)
507. Apunipima Cape York Health Council services the Cape York region but has its administrative HQ in Cairns, and the Northern Peninsula Area Family and Community Services Aboriginal and Torres Strait Islander Corporation. [↑](#footnote-ref-507)
508. THHS *Annual Report 2014 – 2015,* p. 27. [↑](#footnote-ref-508)
509. Ibid., p. 28, calculated at 7.0% of totl population of 240,000. [↑](#footnote-ref-509)
510. Ibid. [↑](#footnote-ref-510)
511. Townsville Aboriginal & Torres Strait Islander Corporation for Health Services (Townsville). [↑](#footnote-ref-511)
512. WMHHS *Annual Report 2014 – 2015,* p. 8. [↑](#footnote-ref-512)
513. No estimate of Aboriginal and Torres Strait Islander population found in annual report. Calculated at 3.5% of total population of 260,000 (WMHHS *Strategic Plan 2015-19: Path to Excellence* (Version 1 – OP140305), p. 4. [↑](#footnote-ref-513)
514. Ibid. [↑](#footnote-ref-514)
515. Kambu Aboriginal and Torres strait Islander Corporation for Health (Kambu Health) (Ipswich). [↑](#footnote-ref-515)
516. WBHHS *Annual Report 2014 – 2015,* p. 9. [↑](#footnote-ref-516)
517. Ibid., calculated at 3.6% of total population of 210,000. [↑](#footnote-ref-517)
518. Ibid. [↑](#footnote-ref-518)
519. Galangoor Duwalami Primary Health Care Service located on the Fraser Coast and operating clinics in Hervey Bay (Torquay) and Maryborough. [↑](#footnote-ref-519)
520. This column adds up to 29, however, Goondir Health Services operated clinics in both the DDHHS and SWHHS – see footnotes 20 and 44. [↑](#footnote-ref-520)
521. Substantive Indigenous health agenda items are identified as opposed to those that are more in the nature of passing references. It is also assumed that some of the Queensland Aboriginal and Torres Strait Islander health KPIs, such as those for PPH and DAMA, would be routinely raised in the board meetings along with a host of other KPIs (as per their health service agreements) as part of, for example, Chief Executive or Clinician’s reports on HHS performance (for a list of those KPIs see Queensland Health, 2015, *Closing the Gap Performance Report 2014*, pp. 6-7) without being specifically identified as an agenda item. [↑](#footnote-ref-521)
522. HHS boards generally meet monthly. Board Summaries - also referred to as “Board communiques” (CWHHB), “Board updates”(SWHHB) and “Board meeting resolutions”(CQHHB) - are, for the most part, one page summaries of key issues discussed and decisions made, but do not form or represent any part of the minutes of the board meetings. Allowance has been made for different formatting of summaries, and even changes in format by the one board over the two year period (for example, the THHS board introduced a new format for reporting of their 23 June 2014 meeting and subsequent board summaries). [↑](#footnote-ref-522)
523. (i) 26 March, board received a presentation from the Clinical Director Renal Medicine on Assisted Care Dialysis in Yarrabah; (ii) 30 April, board approved renaming 8 Remote Hospitals to Primary Health Centres to enable compliance with eligibility requirements of the s100 Indigenous Access Program; and (iii) 25 June, board endorsed recommendations to rename the Cairns Mental Health Unit ‘Mundu Gurri’ – My spirit is good [the name given by the Gimuy Walubara Yidinji Elders, the Traditional Owners of the Cairns Hospital site]. [↑](#footnote-ref-523)
524. (i) 28 January, board considered the demographic reports prepared by Executive Director Strategy, Planning, Performance and Aboriginal and Torres Strait Islander Health – presumably this included information/data on Indigenous demographics; (ii) 21 October, board briefed on contractual arrangements for service delivery at Yarrabah, with Chief Executive CHHHS to sign a sublease with Gurriny Yealamucka Health Service; (iii) 18 November, board resolved that CHHHS continue with the formation of the Aboriginal and Torres Strait Islander Community Consultation Committee. [↑](#footnote-ref-524)
525. No board summaries had been posted on the CHQHHS website for 2014. See <http://www.centralwest.health.qld.gov.au/> Accessed 14/12/2016. [↑](#footnote-ref-525)
526. No board summaries/communiques had been posted on the CWHHS website for 2014. See <http://www.centralwest.health.qld.gov.au/> Accessed 14/12/2016. [↑](#footnote-ref-526)
527. Only summaries available on the CWHHS website were for 28 August, 24 September, 22 October, 26 November and 17 December. [↑](#footnote-ref-527)
528. (i) 28 August, in other business the board received a summary of the recommendations of the Indigenous health program review; and (ii) 17 December, in completing a review of its strategic plan, the board noted that more focus was also needed to improve Indigenous health. [↑](#footnote-ref-528)
529. No board meeting held in November 2014. [↑](#footnote-ref-529)
530. (i) 29 January, at this meeting the Board took the opportunity to meet with representatives of Carbal Medical Service, Goondir Medical Service and DDHHS Aboriginal and Torres Strait Islander Health Workers and their managers to learn more about the service they provide; (ii) 26 August, the Board attended a breakfast meeting with Goondir Health Services, who provided an overview of their services and activities; (iii) 9 December, The Board reviews progress of Capital Infrastructure Planning studies underway for Cherbourg, as well as in other rural centres. [↑](#footnote-ref-530)
531. No board summary found for October, no meeting held in November. [↑](#footnote-ref-531)
532. (i) 24 February, Board meeting held at the Ration Shed, Cherbourg, with Board Chair officially opening the refurbished Place of Healing Building which will house the new Women’s and Children’s Service, and the Board also toured the Cherbourg Health Service; (ii) 7 December, the Executive Director Allied Health and the Cultural Practice Coordinator attended the Board meeting and provided an update on current actions and strategies being undertaken across the DDHHS towards closing the gap in Aboriginal and Torres Strait Islander health outcomes. [↑](#footnote-ref-532)
533. No December board summary found. website [↑](#footnote-ref-533)
534. No board summaries found for January, October, November and December. [↑](#footnote-ref-534)
535. 5 August, the board considered a paper on the Aboriginal and Torres Strait Islander Unit providing an update on the service. [↑](#footnote-ref-535)
536. No board summaries located for January and November. [↑](#footnote-ref-536)
537. 6 October, the Executive Director Community, Indigenous and Subacute Services showed the board members the great work occurring at the Brighton Health Campus – primarily focussed on stroke rehabilitation. While no doubt Aboriginal and Torres Strait Islander patients would benefit, however, there is no specific reference to them. [↑](#footnote-ref-537)
538. (i) 28 April, the Board noted the paper provided in relation to Inala Indigenous Health Centre; (ii) 28 July, the Board approved the paper provided in relation to the Indigenous Health Centre; and (iii) 25 August, the Board approved the paper provided in relation to the Indigenous Australian’s Health Program Head Agreement. [↑](#footnote-ref-538)
539. Only two board summaries located – 29 January and 28 February [↑](#footnote-ref-539)
540. (i) 29 January, matters dealt with included the Mornington Island Collaborative Project; (ii) 28 February, matters dealt with included the Mornington Island Collaborative Project; and (iii) Doomadgee Land Tenure. [↑](#footnote-ref-540)
541. The summary given for 20 March is identical to that for 6 February. 2-day meetings were held in July (22-23) and November (5-6). Meetings do not appear to have been held in September and October (no summaries located) and no meeting was scheduled for December. [↑](#footnote-ref-541)
542. 30 June, matters relating to the employment of local health workers in Indigenous communities. 5-6 November, the Board approved the purchase of a plaque for the “Old Doomadgee Hospital”- not considered a substantive matter. [↑](#footnote-ref-542)
543. (i) 26 May, March Dashboard Report noted with recognition of the significant improvement in Closing the Gap key performance indicators for the SWHHS; and (ii) 25-26 August, a representative of the Department of Health, made a presentation to the Board on Aboriginal and Torres Strait Islander Health Indicators. [↑](#footnote-ref-543)
544. (i) 23-24 February, presentation to the Board by a Program Manager, Child Safety Services, on collaborative partnerships with Aboriginal Medical Services and (ii) an Indigenous Health Worker addressed the Board on Aboriginal and Torres Strait Islander Cultural Capability. [↑](#footnote-ref-544)
545. In addition to the 11 monthly meetings an extraordinary board meeting was held 19 August. [↑](#footnote-ref-545)
546. No board summaries were located for January, September and December. [↑](#footnote-ref-546)
547. A search of the TCHHS website revealed no board summaries for either 2014 or 2015. Website: <https://www.health.qld.gov.au/torres-cape/html/publication-scheme#decisions> Accessed 15/12/2016. [↑](#footnote-ref-547)
548. (i) 26 May Board meeting held at the Palm Island Aboriginal Shire Council Chambers, and the Board toured the Joyce Palmer Health Service. The Board noted a Progress Report from the Professor of Indigenous Health and Workforce Development, a joint initiative between Griffith University and THHS; (ii) 28 July,[ in reference to an August 2013 decision regarding due diligence obligations, which includes visits to regional THHS facilities involving a tour of the facility, presentation from and discussion with local staff, as well as a formal Board meeting, it was noted that the Joyce Palmer Health Service on Palm Island was among those THHS facilities already visited – considered as a passing reference and therefore not a substantive matter], also Board made reference to the construction of New Staff Accommodation on Palm Island; and (iii) 15 December, Board received an up-date on, *inter alia*, the opening of the Community Care Centre on Palm Island, and also received updates on, *inter alia*, (iv) Mandatory Training and Cultural Practice Program [it is assumed here that the Cultural Practice Program refers to training in relation to Aboriginal and Torres Strait Islander cultural awareness]. [↑](#footnote-ref-548)
549. Board summary for 21 December not sighted. [↑](#footnote-ref-549)
550. (i) 25 May, the Board noted a number of reports including the Palm Island Health Action Plan; (ii) 23 November, the Board welcomed a second Indigenous member to their first meeting of the THHB. [↑](#footnote-ref-550)
551. No Board meeting summary was posted for May. Website: <http://widebay.health.qld.gov.au/> Accessed 15/12/2016. [↑](#footnote-ref-551)
552. (i) 29 April, reference to Indigenous Health Plan; (ii) June 24, reference to Aboriginal & Torres Strait Islander Health draft strategic planning process; (iii) 25 August, reference to Indigenous Health; (iv) 29 September, reference to Indigenous Health Plan; (v) 27 October, reference to Indigenous Health; and (vi) 15 December, reference to devolution of Mental Health and Indigenous Health funding. [↑](#footnote-ref-552)
553. Although at least 9 meetings took place, the Board meeting summary posted on the website for 28 August is the same as that for the 30 September meeting. No board meeting summaries were posted for June and November. No meeting was held in January. [↑](#footnote-ref-553)
554. 25 July, board meeting was held at Kambu Medical Centre, board toured the centre, and heard from the CEO of the Institute of Urban Indigenous Health regarding its work, including its primary health clinics, model of care and the successful Deadly Choices program. [↑](#footnote-ref-554)
555. No board meeting scheduled for May; meeting scheduled for 18 December but board summary not sighted. [↑](#footnote-ref-555)
556. Taking into account that no board meeting summaries were found for CHQHHS, CWHHS and TCHHS, this figure is based on an average of each board meeting 11 times per year for 2014. [↑](#footnote-ref-556)
557. Taking into account that no board meeting summaries were found for TCHHS, this figure is based on an average of each board meeting 11 times per year for 2015. [↑](#footnote-ref-557)
558. While much of their agendas are taken up addressing routine standing order matters, for example, reports from the Chair, Chief Executive and Chief Finance Officer, and HHB committees (Executive, Finance, Safety and Quality, and Audit and Risk committees), nevertheless, on a basis of an average of 10 agenda items per meeting (the range extends from 5 to 23), the 16 HHBs would have collectively addressed some 3,520 items during 2014 and 2015. Allowing for instances where summaries were not sighted (for TCHHB for 2014 and 2015, and for CHQHHB and CWHHB in 2014), during that period matters relating to Aboriginal and Torres Strait Islander health were addressed an estimated 40 times, ie, Aboriginal and Torres Strait Islander health matters only accounted for about 1% of HHB business, and for at least 5 of the HHBs (and excluding TCHHS), not at all. [↑](#footnote-ref-558)