A Blueprint for Aboriginal and Islander Health Reform in Queensland

Official Launch October 2011

QAIHC

Queensland Aboriginal and Islander Health Council

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Vision

The Queensland Aboriginal and Islander Health Council's vision is a health care system that achieves high quality access, care and outcomes for all Queenslanders *and* closes the health gap for Aboriginal and Torres Strait Islander people, regardless of where they live and what health services they use.

This Blueprint sets out QAIHC's view of the best way to achieve the second part of this vision in the context of current, nation-wide health system reform. QAIHC seeks the support of the Australian and Queensland governments and other stakeholders in making this view a reality.

In April 2009, the Australian Government formally endorsed the 2007 United Nations Declaration of the Rights of Indigenous Peoples[1]. Article 3 states that "Indigenous peoples have the right to self-determination; and Article 21 states that *"States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions."*

Also in 2009, the Health and Hospitals Reform Commission delivered its report to the Australian Government. The first of its reform goals is "Tackling major access and equity issues that affect health outcomes for people now". In relation to Aboriginal and Torres Strait Islander health, the Commissioners state:

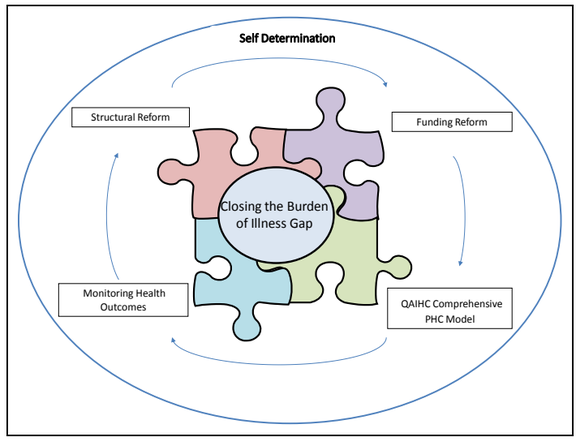
> "Our first priority acknowledges the unacceptable health outcomes of Aboriginal and Torres Strait Islander people. To address this, we are recommending a radical change to how we take responsibility for improving the health of our first Australians." [Health and Hospitals Reform Commission 2009, P3]

In keeping with this Government endorsement of the Rights of Indigenous Peoples and recognition of the need for radical change, QAIHC seeks from the Australian and Queensland governments support for the implementation of a number of reforms.

To guide the reform process, the QAIHC Aboriginal and Islander Health Reform Model has been developed (Figure 1). The goal of reform is to close the gap in Aboriginal and Torres Strait Islander health in Queensland. The model has four pillars – structural reform, funding reform, the QAIHC Comprehensive Primary Health Care Model and monitoring outcomes.

[1] http://www.un.org/esa/socdev/unpfii/en/drip.html

Figure 1. QAIHC Aboriginal and Islander Health Reform Model



Within this Model, QAIHC seeks support to achieve seven significant changes to the way health services for Indigenous people in Queensland are planned, funded, managed and delivered. They are:

1. Implementation of the QAIHC Comprehensive Primary Health Care Model that has both *scope* and *approach* designed by and for Aboriginal and Torres Strait Islander people in Queensland;
2. Establishment of an Aboriginal and Torres Strait Islander specific monitoring function within the National Health Performance Authority;
3. Establishment of three regional Institutes for Indigenous Health in Queensland;
4. Establishment of a Queensland Aboriginal and Islander Health Reform Council;
5. Transfer to community control in remote & regional Queensland;
6. Funding reform; and
7. Enhanced community controlled sector self-regulation.

Before describing these reforms in detail, we consider the current policy context and the rationale for reform.

Policy Context - Health and Hospitals Reform Agreements and Close the Gap

Two critical Council of Australian Governments (COAG) reforms underpin the proposed Indigenous health reform agenda – they are the National Health and Hospitals Network Agreement and Closing the Gap.

National Health and Hospitals Network Agreement

The Australian Government has devised an agenda for national health reform targeted at improving patient care and health outcomes in Australia. The original reform agenda proposed in 2010 has undergone a number of amendments which were accepted and

endorsed at the recent Council of Australian Governments (COAG) meeting on February 13, 2011. Under this agreement, there will be:

- new funding arrangements for public hospitals; an increase in the Australian Government's contribution to public hospitals costs to 45 per cent from 1 July 2014, and 50 per cent from July 2017; governance of public hospital service delivery by Local Hospital Networks (LHNs); a single national funding pool for public hospitals and a national funding body that will administer these funds; and activity-based funding.
- a National Health Performance Authority established to develop and produce reports on the performance of hospitals and health care services, including primary health care services.
- a renewed focus on strengthening the delivery of primary health care in local communities and keeping people out of hospital, including through the establishment of Medicare Locals. These will be new, independent, not-for-profit, member-based organisations with skill based boards. Membership will reflect local primary health care service provision across each region. Medicare Locals will hold budgets for commissioning and/or providing primary health care services and will be empowered over time by way of progressively more flexible funding arrangements to assess and meet local community service needs. The first 15 Medicare Locals will be established by 1 July 2011, the next round by 1 January 2012 and the remainder by 1 July, 2012.

Medicare Locals will be responsible for:

- coordinating primary health care services beyond general practice, encompassing a range of primary health care practitioners in the community;
- undertaking local health planning, identifying gaps in services at the local level, and examining opportunities for better targeting of services;
- supporting the implementation of initiatives that improve the prevention and management of disease in general practice and primary health care;
- driving more efficient use of health resources, including the potential for administering flexible funding pools to target gaps in primary health care service provision;
- improving patients' access to services by improving the coordination and integration of care both within the primary health care sector and across other sectors of the health
- care system (including the coordination of telehealth and after hours primary health care services in the local region), out-of-hospital physician care, linkages with Local Hospital Networks and Lead Clinician Groups, once established;
- identifying local health care needs and having the responsibility and flexibility to address these needs through coordinating and funding services;
- providing patients with increased access to information about services available in the local area; and
- undertaking their obligations in relation to the Government's proposed transparency, performance and accountability arrangements for health reform, including Healthy Communities Reports prepared by the National Health Performance Authority. [Australian Government 2011]

Medicare locals will be important contributors to closing the gap for Aboriginal and Torres Strait Islander people.

Close the Gap

The continuing health disadvantage of Aboriginal and Torres Strait Islander peoples is undisputed. It has attracted widespread condemnation both nationally and internationally, the latter most recently by a United Nations Rapporteur [Grover 2009] on health rights. In this context, the Australian Government has announced the Closing the Gap strategy which is being implemented through the Council of Australian Governments (COAG). COAG has agreed to six ambitious targets for closing the gap between Indigenous and non-Indigenous Australians across urban, rural and remote areas which are:

- to close the gap in life expectancy within a generation;
- to halve the gap in mortality rates for Indigenous children under five within a decade;
- to ensure all Indigenous four years olds in remote communities have access to early childhood education within five years;
- to halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade;
- to halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020; and
- to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

In giving effect to these commitments a number of National Partnerships have been entered into, including the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes ($1.58 billion over 4 years); and the National Partnership on Remote Service Delivery ($291.2 million over 6 years – includes four locations in the Cape York and Gulf regions in Queensland).

An objective of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes is to "significantly expand access to and coordination of comprehensive, culturally secure primary health care, allied health services and related services." Under this objective:

> "the Commonwealth and the States and Territories will work together to improve access to culturally secure primary health care for all Indigenous Australians, with improved access to quality primary health care through better coordination across the care continuum, particularly for people with chronic diseases and /or complex needs; increased uptake of MBS-funded primary health care services by Indigenous people; and increased cultural competence of the primary health care workforce." [COAG 2009]

Rationale for Aboriginal and Torres Strait Islander Health Reform in Queensland

QAIHC welcomes Council of Australian Government (COAG) health system reforms through the National Health and Hospitals Network Agreement and the Close the Gap initiative. QAIHC believes however, that the reform agenda must be structurally enhanced to meet the needs of Aboriginal and Torres Strait Islander people in Queensland, given their higher burden of illness and risk factor prevalence, population and socio-economic characteristics, level of access to services, and workforce issues and the need for better integration of health services, especially for those with chronic complex conditions.

Burden and Patterns of Illness

Indigenous children in Queensland are more likely to die before 5 years of age than non-Indigenous children. In 2007/08 Indigenous children died at a rate of 19.3 for every 10,000 births compared to 11.9 for non-Indigenous children [Queensland Government 2009].

Aboriginal and Torres Strait Islander people suffer a burden of disease that is two-and-a-half times greater than the burden of disease in the total Australian population [Australian Bureau of Statistics 2010]. Non-communicable (i.e. chronic) diseases explained 70% of this health gap including cardiovascular disease (23%), diabetes (12%), mental disorders (12%) and chronic respiratory diseases (9%). Maternal and neo-natal conditions accounted for 6% of the health gap [Vos et al 2003].

In addition, patterns of disease among Indigenous people may be markedly different from those among the non-Indigenous community, in particular with diseases emerging at a much younger age among Indigenous people. For example, the average age of admission to hospital for a 'heart attack' (anterior myocardial infarction) for Indigenous patients in Queensland was 14 years younger than for their non-Indigenous counterparts [Coory and Walsh 2005].

These differentials translate into significant differences in life expectancy - on average Queensland Indigenous males die 10.4 years younger and females 9 years younger than non-Indigenous Australians [Kennedy and McGill 2009].

Risk factors

In 2003, 11 risk factors (tobacco, alcohol, illicit drugs, high body mass, inadequate physical activity, low intake of fruit and vegetables, high blood pressure, high cholesterol, unsafe sex, child sexual abuse and intimate partner violence) taken together accounted for half of the overall Indigenous health gap. On its own, tobacco use accounted for 10% of the excess burden of disease of the Indigenous population [Vos et al 2003]. Forty six percent of the adult Indigenous population are smokers compared with 21% of the non-Indigenous population. Indigenous mothers are three times as likely as non-Indigenous mothers to smoke during pregnancy [Australian Institute for Health and Welfare 2008].

Population Size and Characteristics

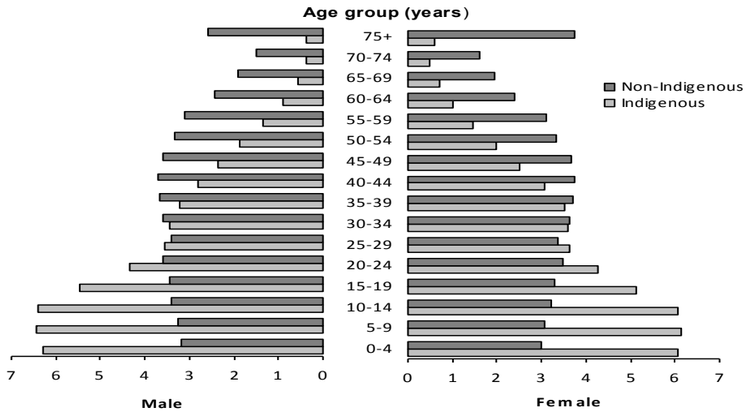
In 2006, Queensland had the second largest number of Aboriginal and Torres Strait Islander people (144,900) after NSW (152,700). However, the Indigenous population of Queensland is projected to be the fastest growing of the states and territories and to overtake NSW by 2021, growing by 48.5% to 215,082 or 29.8% of the total Indigenous population of Australia. This compares with Queensland overall which will grow by 34.9% [Australian Bureau of Statistics 2009a].

As for the country as a whole (see Figure 1), the Queensland Aboriginal and Torres Strait Islander population also has a strikingly different age structure compared to non-Indigenous people. Indigenous people are proportionally much younger, reflecting higher birth rates and shorter life expectancy. In 2006, the median age of Indigenous people in Queensland was 20 years, which is considerably lower than the median age of 36 years for Queensland's non-Indigenous population. 38.9% of Indigenous people were aged less than 15 years, compared with 20.0% of the non-Indigenous population. Only 3.0% of the Indigenous population were aged 65 years and over, compared with 12.5% of the non-Indigenous population [Australian Bureau of Statistics 2009b].

Nationally the non-Indigenous population is projected to age even further, while the Indigenous population "looks set to retain its youthful profile because of large numbers of women moving into child-bearing age, combined with high adult mortality" [Taylor 2006]. While overall the Indigenous population structure will age slightly, the proportion of population below 15 years in 2021 will still be 35.4% [Australian Bureau of Statistics 2009a].

More Aboriginal or Torres Strait Islander mothers have their babies at a younger age compared with non-Indigenous mothers. The average age of Aboriginal or Torres Strait Islander women who gave birth in 2007 was 25.2 years, compared with 30.1 years for non-Indigenous mothers. One in five (19.5%) Aboriginal or Torres Strait Islander mothers were teenagers compared with 3.5% of non-Indigenous mothers. As well as commencing giving birth earlier on average, the average number of births per mother is higher for Indigenous women than for non-Indigenous [Laws and Sullivan 2009].

Figure 2. Age-sex Structure of Indigenous and Non-Indigenous Populations, 2006



Source: Al-Yaman F and Jackson Pulver L., 2010.

Further population differences between Indigenous and non-Indigenous Queenslanders are more subtle but nevertheless of profound significance in terms of the health system. The majority of Queensland is classified as very remote or remote and there are significant differences in the distribution and migration of Indigenous and non-Indigenous people across this vast area. While the largest number of Aboriginal and Torres Strait Islander people live in Brisbane where they constitute a tiny minority, for large tracts of the state they make up a significant proportion of the population (Map 1). There is also considerable Indigenous movement in to as well as out of regional areas. As Taylor argued in 2006:

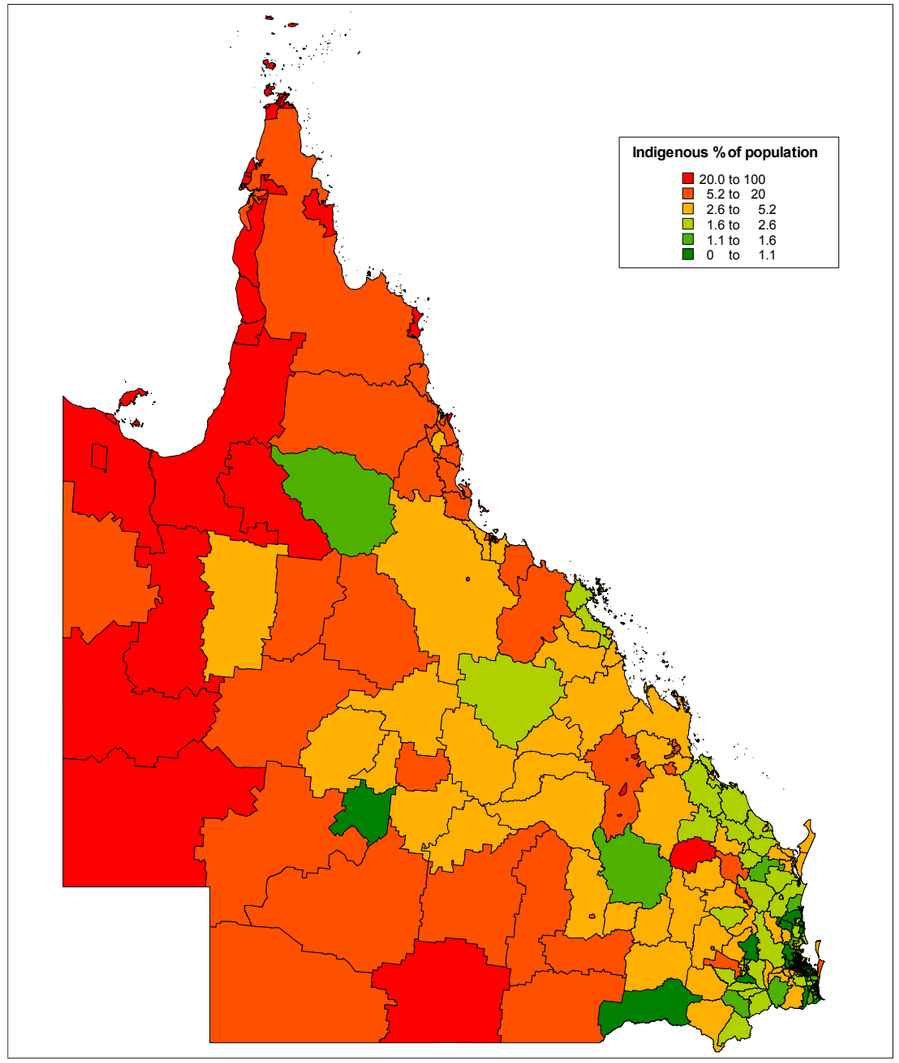
> "While migration from the bush to towns and cities has undoubtedly occurred, the equally telling observation is that many remote settlements have continued to grow in size and complexity with several achieving the status of 'urban centre' within the ASGC. Among those with a population that now exceed 1,000 persons or are very close to it [...] in Queensland [are] Aurukun, Palm Island, Yarrabah, Doomadgee, Mornington Island, Woorabinda, and Cherbourg. The current trajectory for these towns is for continued growth, in contrast to the fortunes of many other more mainstream country towns."

There is also high turnover in resident populations. For example, of those who declared Indigenous status in 1996 in the Moreton region on the outskirts of Brisbane (which encompasses the area from Gold Coast through Toowoomba to Noosa), 75% had changed residence since 1991 and 33 per cent changed residence each year [Taylor 2006].

Socioeconomic characteristics

The capacity to pay for health care affects both the level and the pattern of health care spending. Policy analysts most commonly determine an individual's capacity to pay for health care using mean equivalised gross household income as the statistical measure. This measure plays an important role in assessing Aboriginal and Torres Strait Islander people's capacity to pay for health care.

Map 1. Distribution of Indigenous population in Queensland (percent)



In 2006 the median equivalised gross household income of Aboriginal and Torres Strait Islander people was $460 per week, around 62% of the level earned by non-Indigenous people, which was $740 per week [Australian Bureau of Statistics 2008]. In 2006, 39% of Aboriginal and Torres Strait Islander people were living in low resource households, almost five times the rate of non-Indigenous people—which was 8%. The situation in very remote areas was much worse, with 61% of Aboriginal and Torres Strait Islander people in low resource households, 10 times the proportion of non-Indigenous people—which was 6%.

Furthermore, if you are Indigenous, your level of disadvantage and need for specialised services and support is likely to be higher than the population you live among whether you live in an area of high or low socioeconomic status. For example, of the approximately 126,000 Indigenous people in Queensland, less than 2,000 could be described as middle class or better, even though 35,000 resided in middle class areas [Kennedy and Firman 2004].

Access to Services

Despite the fact the Aboriginal and Torres Strait Islander people suffer a burden of disease that is two-and-a-half times greater than the burden of disease in the total Australian population their access to many services is significantly lower than for the general Australian population.

While Aboriginal and Torres Strait Islander people are high users of public hospital and community health services, they are comparatively low users of medical, pharmaceutical, dental and other health services, which are mostly privately provided (e.g. GPs and specialists). In 2007/08 total Medicare benefits paid per Aboriginal and Torres Strait Islander person was around 58% of the amount spent on non-Indigenous people while total PBS benefits paid per Aboriginal and Torres Strait Islander person was around 60% of the amount spent on non-Indigenous people [Australian Institute of Health and Welfare 2009].

Total *out-of-hospital* Medicare benefits spent per non-Indigenous person was $498 compared to $321 on an Indigenous person (a ratio of 0.64). The differences for some types of services were very large – in 2007/08 expenditure on allied health services for Indigenous people was only 35% of that for non-Indigenous people, and on public dental services only 29% [Australian Institute of Health and Welfare 2009]. Depending on where Indigenous people live in Queensland the differences could be even more stark. In 2007/08 *total* expenditure on out-of-hospital care for Aboriginal and Torres Strait Islander people in Cape York and Yarrabah was only $215 and $663 respectively [Eagar and Gordon 2008].

Bettering the Evaluation And Care of Health (BEACH) data provide further evidence of Aboriginal and Torres Strait Islander under-access of MBS and PBS benefits. While Indigenous people make up 3.5% of the population (2006) only 0.8% of encounters with general practitioners in 2008-09 were with Indigenous clients [Britt et al 2009]. This is likely to be an over-estimate of those seen in private general practice since some of the GPs sampled may have been working in Aboriginal Medical Services [Britt et al 2002]. In 2001-02 more than 70% of GPs did not report a single Indigenous client among 100 consecutive encounters [Britt et al 2002]. While there will be a number of explanations for these figures (including under-identification) they clearly demonstrate limited engagement of private general practice with Indigenous people.

In 2007/08, only 6.3 per cent of Aboriginal and Torres Strait Islander children aged 0-14 years in Queensland received an annual health check (introduced to the MBS in May 2006). Older persons (55 years and over) health checks doubled over the four years 2003/04–2007/08 from an extremely low base of 4.4 per cent in 2003/04 to 12.3 per cent in 2007/08. However, in 2007/08, Aboriginal and Torres Strait Islander older persons were still half as likely to have received an annual health check as older non-Indigenous persons (12.3 per cent compared with 24.4 per cent) [Queensland Government 2009].

A study found that Indigenous people are less likely to receive procedures in public hospitals than non-Indigenous people leading the author to conclude that "in Australian public hospitals there may be systematic differences in the treatment of patients identified as Indigenous" [Cunningham 2002]. Similarly, it has been found that Indigenous patients who have suffered an acute myocardial infarction in Queensland have considerably lower rates (22%) of coronary procedures than non-Indigenous patients. There are a number of factors that could contribute to this, including particularly the higher prevalence of contraindications such as risks factors (e.g. smoking) and comorbidities [Coory and Walsh 2005].

Indigenous Australians are discharged from hospital against medical advice at 6 times the rate of other Australians. The significantly elevated levels of discharge against medical advice suggest that there are significant issues in the responsiveness of hospitals to the needs and perceptions of Aboriginal and Torres Strait Islander peoples [Australian Institute of Health and Welfare 2008]. And after discharge from hospital following a cardiovascular event, Indigenous people are less likely to be involved in cardiac rehabilitation than others [Shepherd et al 2003].

Integration of Care

The Health and Hospitals Reform Commission identified improved connection and integration of health care services as a major challenge for the Australian health care system, especially for those with chronic, complex health conditions. Given their higher burden of chronic, complex conditions this is a particular system challenge for Aboriginal and Torres Strait Islander people. The establishment of Medicare Locals is a key strategy the Commission identified for improving integration. That is about having an entity whose responsibility it is to maximise the quality and safety of patient journeys across space and time at the regional level. Given the particular circumstances outlined above and the recognised need for culturally appropriate approaches, there is clearly a need for an Aboriginal and Torres Strait Islander specific strategy for service integration in Queensland.

Workforce

Workforce disadvantage has two aspects. The first is the relatively small number of Indigenous people in the health workforce and the second is the shortages of workers, particularly health professionals, in Indigenous health. In 2006, while Aboriginal and Torres Strait Islander people made up 3.5% of the population of Queensland, only 1.4% of the

health workforce was Indigenous [Australian Institute of Health and Welfare 2008]. Nationally, only 0.2% of GPs, 0.2% of specialists, 0.4% of midwives, 1.0% of nurses in community health and 0.6% of nurses working in mental health were Indigenous. These figures demonstrate significant gaps in Indigenous participation in the health workforce which is a major problem given national and international recognition of the importance of engagement of communities in their own primary health care if appropriate outcomes are to be achieved.

Shortages of workers in Indigenous health is widely acknowledged. Queensland is the country's most decentralised state and in 2002 it had the lowest number of registered medical practitioners per head of population in Australia, decreasing from 236 per 100,000 in 1997, to 220 in 2002. These will be unevenly distributed across the state in ways that impact on Aboriginal and Torres Strait Islander health services. National data show that the Full Time Employment (FTE) rate of employed primary care practitioners was highest in areas where less than 1% of the population was Indigenous (108 per 100,000 population) and lowest in areas where more than 5-10% of the population was Indigenous (87 per 100,000 population) [Australian Institute of Health and Welfare 2008]. Other professions are also in short supply in Queensland including experienced nurses and allied professionals, especially in rural and remote areas where many Aboriginal and Torres Strait Islander people live [Queensland Government 2005].

Implications for Reform

What does all this mean in terms of a way forward for Aboriginal and Torres Strait Islander health reform in Queensland? No matter what the issue being considered – burden and patterns of disease, risk factors, the size and age structure of the population, geographic distribution and mobility, fertility and future population growth, socio-economic status, or workforce issues – it is abundantly clear that Aboriginal and Torres Strait Islander people have much greater health care needs and are less well served by the health system than other Queenslanders. That this remains the case in 2011 points to primary health care 'market failures' in both the public and private systems. Many factors underpin these market failures and they cannot be addressed piecemeal – instead there needs to be an integrated system-wide response that is dedicated to closing the gap for all Aboriginal and Torres Strait Islander people in Queensland, no matter where they live and what services they use.

Blueprint Focus

This Blueprint focuses on the seven components of reform listed above, namely:

1. Implementation of the QAIHC Comprehensive Primary Health Care Model that has both *scope* and *approach* designed by and for Aboriginal and Torres Strait Islander people in Queensland;
2. Establishment of an Aboriginal and Torres Strait Islander specific monitoring function within the National Health Performance Authority;
3. Establishment of three regional Institutes for Indigenous Health in Queensland;
4. Establishment of a Queensland Aboriginal and Islander Health Reform Council;
5. Transfer to community control in remote & regional Queensland;
6. Funding reform; and
7. Enhanced community controlled sector self-regulation.

Reform Component 1 – QAIHC Comprehensive Primary Health Care Model

Primary health care is "socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health."[2]

The distinguishing characteristic of *comprehensive* primary health care is its broad scope – importantly, it embraces "health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation."[1]

The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013 recognises the internationally accepted importance of comprehensive primary health care to meeting the health needs of Aboriginal and Torres Strait Islander people
[Australian Health Ministers' Conference 2003]

Comprehensive primary health care is the health system's major and essential contribution to closing the health gap for Aboriginal and Torres Strait Islander people and is the cornerstone of the QAIHC health reform model. To this end, QAIHC has developed a Comprehensive Primary Health Care Model/Version 3 (Figure 3) that builds on seminal work done over a number of years by the Apunipima Cape York Health Council.

Under the Model, program planning and service delivery are consistent with two over-arching plans – a Community Health Plan and a Health Services Plan - that are subject to regular review. The Community Health Plan is the key mechanism through which the social and environmental determinants of health are recognised and integrated into service planning and the health service's engagement with broader social programs. The Health Services Plan includes health service performance indicators for monitoring outcomes.

[2] Definition developed by the Australian Primary Health Care Research Institute (APHCRI) and cited in *Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy* (September 2009)

Under best practice systems of clinical governance, multi-disciplinary teams deliver services to ensure delivery of the internationally recognised dimensions of primary health care – namely access, continuity of care, coordination of care and comprehensiveness of care [Kringos et al, 2010]. The services cover a care continuum with six components as follows:

- Primary accident and emergency care
- Routine acute care
- Prevention, detection and early intervention
- Ongoing disease/condition management
- Health promotion and education
- Community development

Across this continuum, *core services*[3] are delivered to meet the *special health needs* of Aboriginal and Torres Strait Islander client populations *across the life course*. These include comprehensive services for mothers and infants; mental health and tobacco, alcohol and other drug services; prevention, early detection and management of chronic diseases including end-stage renal disease; prevention and treatment of communicable diseases including STIs; injury prevention; primary dental care; and disability and aged care.

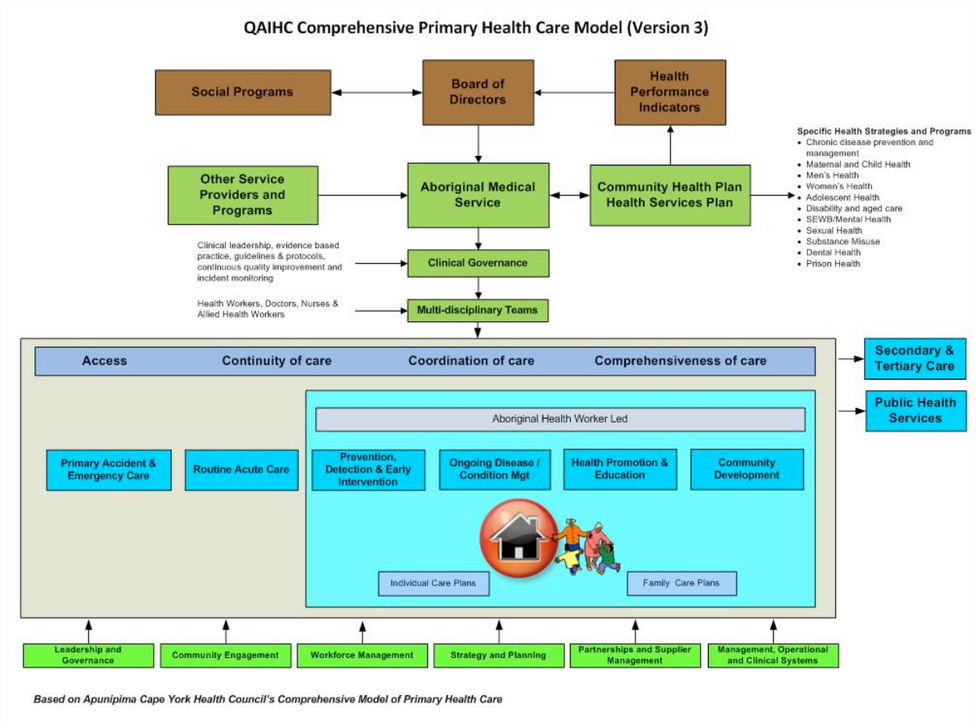
The *approach* to delivering services in the QAIHC Comprehensive Primary Health Care Model is a family-centered one – that is, the family is a principal focus of care and support. Led by Aboriginal Health Workers and taking the household as the unit of interest, health care teams support families and their individual members to engage effectively in primary health care across the care continuum. Key strategies include initiation and maintenance of relationships between the members of households and the health centre, appropriately spaced home visits by Aboriginal Health Workers, the development of family care plans, coordination of health services for households, and individual and household support for self-management.

Underpinning service delivery are six organisational areas derived from the European Framework for Quality Management[4] on which the Australian Business Excellence Framework[5] is based. These are:

- Leadership and governance
- Community engagement
- Workforce management
- Strategy and planning
- Partnerships and supplier management
- Management, operational and clinical systems

[3] Work is underway within the community controlled sector to identify Indigenous Comprehensive Primary Health Care core services.
[4] http://www.efqm.org/en/tabid/132/default.aspx
[5] http://infostore.saiglobal.com/store/Details.aspx?productid=459977

Figure 3



The Model can be readily tailored to meet the requirements of communities across the spectrum of urban, regional, and remote regions. While the components of the model remain constant there will be local and regional variations in implementation. For example, the extent of focus on and the most effective approach to delivering family-centred services may vary from place to place.

QAIHC seeks recognition of and support for the QAIHC Comprehensive Primary Health Care Model in policy, funding and delivery of health services to Indigenous people in Queensland.

Reform Component 2 – Establishment of an Aboriginal and Torres Strait Islander specific monitoring function within the National Health Performance Authority

It is argued that structural reform, funding reform with appropriate long term investment, and adoption of an Indigenous family-centred model of comprehensive primary health will

result in improved health outcomes and contribute to closing the health gap for Indigenous people in Queensland. The setting of appropriate performance indicators and targets and the careful monitoring of health outcomes are central to improving service delivery and assessing performance over time. Appropriate indicators would be a combination of those used in the mainstream and Indigenous-specific, based on the different and higher burden of illness of Indigenous compared to non-Indigenous Queenslanders.

In order to ensure a rigorous, nationally consistent approach to health performance monitoring QAIHC seeks the establishment of an Aboriginal and Torres Strait Islander specific monitoring function within the National Health Performance Authority. Its role would be to:

- Provide transparent, independent national monitoring and evaluation of the range and effectiveness of services provided to Aboriginal and Torres Strait Islander people;
- Advocate on behalf of Aboriginal and Torres Strait Islander people for appropriate health policies and funding priorities at state and federal levels; and
- Be responsible for setting the policy direction through development of a new National Aboriginal Health Policy and Strategic Plan.

Under the auspices of the Aboriginal and Torres Strait Islander specific monitoring function, the regular Medicare Local level *Healthy Communities Reports* that are to be implemented nationwide would include reporting on Aboriginal and Torres Strait Islander health performance, through disaggregation of mainstream indicators and the inclusion of supplementary Indigenous-specific indicators. Led by the Office of Aboriginal and Torres Strait Islander Health work is currently underway to develop an initial set of National Key Performance Indicators for Aboriginal and Torres Strait Islander health. A selection of these indicators would be an initial basis for supplementary monitoring. The initial set of indicators is to be expanded over time.

Consistent with an overall performance framework, data for Indigenous clients would be automatically transferred from service provider clinical systems (and other sources) to a central data repository with web-based access to authorised users to interrogate the data and produce reports. These reports would inform policy and funding decisions at Medicare Local level (through the 'Lead Clinicians Groups') and at state and national levels.

Complementing these national efforts would be a much richer body of data on processes of care and outcomes that is increasingly available and suitable for clinical governance at the local service level. Through the Improvement Foundation QAIHC has already developed a data extraction and reporting system that has strong support within the sector and is being contributed to by both community controlled and mainstream services in several states and territories. It produces a wealth of data for local quality improvement, supported by QAIHC activities at a state level.

Over time, the combination of national and local data/reports will provide a comprehensive picture of changes in Aboriginal and Torres Strait Islander health outcomes and allow assessment of the extent to which the policy goal to close the gap is being achieved.

Reform Component 3 – Establishment of three Institutes for Indigenous Health in Queensland

There is already one Institute for Indigenous Health in Queensland – the Institute for Urban Indigenous Health (IUIH) – that was established in late 2009.[6] Its responsibilities are similar to those now proposed for Medicare Locals. Early achievements of the IUIH are outlined in Annex 2.

Consistent with the overall directions of the IUIH and now also Medicare Locals, QAIHC proposes the establishment of three (3) Institutes for Indigenous Health in Queensland. Major challenges for the Institutes include the health inequalities of Indigenous people in Queensland, planning and delivering services for dispersed populations over large geographic areas, and workforce development and sustainability.

Governance

Institutes for Indigenous Health would be independent, not-for-profit companies limited by guarantee with accountability to the Australian Government and Aboriginal and Torres Strait Islander communities. The Board of Directors should:

- Provide continuity and strategic direction for the organisation
- Appoint, monitor and review a chief executive
- Govern the organisation by broad policies and objectives
- Acquire sufficient resources for the organisation's operations
- Account to the public for the products and services of the organisation and expenditures

Institutes for Indigenous Health would be governed by a skills-based board of directors. These boards would be required to possess a mix of competencies to drive organisational strategy and direction. These competencies would include:

- Business, legal and finance
- Governance and strategy
- Primary health care (clinical governance)
- Human services
- Community and consumer sectors

Given the organisations' focus, Aboriginal and Torres Strait Islander board leadership would be a requirement.

Membership and Partnerships

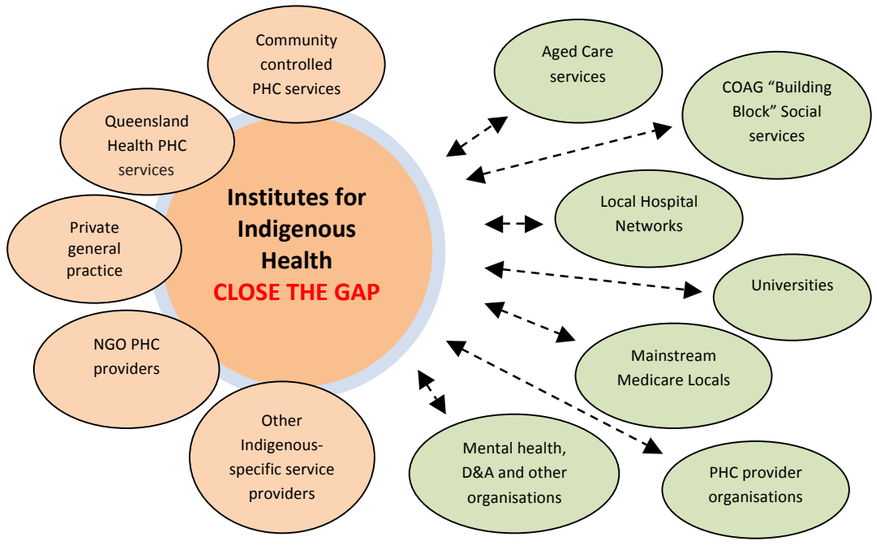
Institutes for Indigenous Health would be member based organisations. Membership would include:

- Aboriginal community-controlled health services,
- Queensland Health primary health care services;
- private general practices;
- NGO primary health care providers; and
- other organisations providing Indigenous specific community-based health and social care.

In addition, partnership arrangements will be critical to ensuring access and integration of health services for Aboriginal and Torres Strait Islander people in Queensland. As shown in Figure 4, essential Institute for Indigenous Health partners would include:

- Mainstream Medicare Locals
- Local Hospital Networks
- Universities
- Aged care services
- Primary health care provider organisations (private and non-profit, including general practice)
- Other key services (mental health, drug and alcohol, youth services)
- Other COAG "Building Block" social services

Figure 4. Institutes for Indigenous Health position in the health and social care system for Aboriginal and Torres Strait Islander people in Queensland



Critical partnerships for the Institutes would be their partnership with Aboriginal and Torres Strait Islander communities. They would need to have effective community engagement strategies in place to ensure Aboriginal and Torres Strait Islander participation in primary health care in Queensland

Roles and Responsibilities

The proposed Institutes for Indigenous Health would address the objectives for mainstream Medicare Locals for all Indigenous people in Queensland, namely:

1. *Identification of the health needs of local areas and development of locally focused and responsive services*
2. *Improving the patient journey through developing integrated and coordinated services*
3. *Provide support to clinicians and service providers to improve patient care*
4. *Facilitation of the implementation and successful performance of primary health care initiatives and programs*
5. *Be efficient and accountable with strong governance and effective management*

In order to achieve their objectives, Institutes will need to take a broad social determinants view of health and health care. They will have to bring together all parties involved in the delivery of primary health and related social care for Aboriginal and Torres Strait Islander people through effective membership and partnership arrangements (see Figure 3). And they will have to have effective partnerships arrangements with Local Hospital Networks to improve patient journeys between hospitals and communities.

In addition to funding reform (considered separately below), improving health care access and integration, expanded scope of primary health care services, innovation in service models, linking and integrating elements of the broader Indigenous reform agenda, and Indigenous health workforce training and development will all be important for Institutes for Indigenous Health.

Access and integration

Access refers both to enhanced use of existing services and provision of services where none exist. In keeping with the directions outlined by the Health and Hospitals Reform Commission, access to prevention and early intervention services would be an important area of focus. Integration refers to both horizontal integration (across community-based care) and vertical integration (between community-based and hospital and other residential care).

Access and integration would be achieved through fulfilment of the responsibilities of Medicare Locals outlined above, with specific focus across the health system on Aboriginal and Torres Strait Islander populations. The Institutes would work closely with and complement the Medicare Locals in their geographic areas (see below). They would also

link with Local Hospital Networks to ensure the safety and quality of transitions into and out of hospitals.

As described above, Indigenous people in Queensland are relatively more mobile and have a much higher burden of chronic disease than the non-Indigenous population, requiring multi-dimensional coordinated care across space and time. Information sharing through high quality information systems is essential for the delivery of safe and effective care. QAIHC is currently piloting the use of a Shared Electronic Health Record (SEHR). Such a record allows all the necessary health care providers to contribute to and monitor a client's care plan, even if the providers are geographically dispersed. As well, through their access the client can be more actively involved in monitoring their ongoing condition. In the coordination of care, the benefit of the SEHR depends on it being actively used as a tool for a key provider to manage and "join up" care for clients. An Institute function would be to sponsor at a business level the provision and management of an SEHR and to establish funding for and manage the care coordination. A fundamental success factor for this role would be the relationship each Institute established with the range of health care providers within its boundaries and with the other Institutes.

Indigenous health workforce training and development

The Health and Hospitals Reform Commission identifies the need to ".... train and recognise an Indigenous health workforce and a workforce for Indigenous health, and up-skill our health workforce to provide culturally appropriate services." Based on state-wide policies and strategies developed by the Queensland Aboriginal and Islander Health Reform Council the Institutes for Indigenous Health would play a key role in Indigenous health workforce training and development. They will be able to expand student and graduate (e.g. GP Registrar) placements, develop new models to build capacity, and enhance career pathways in Indigenous health. The new IUIH has begun to demonstrate what can be achieved. It has negotiated over 100 placements for medical, allied health, nursing and dental students over the next four years. Effective partnerships between Institutes for Indigenous Health and Universities will be central to workforce training and development.

Expanded scope of primary health care services

Three areas of particular significance to Aboriginal and Torres Strait Islander well-being have been excluded from the Commonwealth takeover of primary health care policy and funding – mental health, maternal and child health, and alcohol and drug misuse. It would be essential for the Institutes to have responsibility for planning and commissioning of services to meet Indigenous needs in these areas.

Innovation in service models

Innovation in service models will be key to improving access and integration of health and social services for Aboriginal and Torres Strait Islander people, many of whom are

disengaged from health care. The capacity to develop linkages and hold funds will allow Institutes for Indigenous Health to become leaders in innovation in service models to address this issue. The IUIH is already able to demonstrate how this can work. For example, it has implemented an integrated service delivery model for homeless and vulnerable Aboriginal and Torres Strait Islander people in Brisbane, jointly resourced by the Australian and Queensland governments. This program brings together primary health care, substance misuse, mental health housing and justice services to create an integrated package of care for this population.

Linking and integrating elements of the broader Indigenous reform agenda

There is a broader Indigenous reform agenda – the so-called COAG Building Blocks - that is relevant to health. However, there are currently no regional service delivery structures able to develop the bridges for families and communities between these building blocks and health care. Through their linkages and partnership arrangements Institutes for Indigenous Health will take on this role, thereby ensuring much better value for investment in the overall reform agenda.

Boundaries and Characteristics

Five criteria were used by QAIHC to identify the appropriate number and boundaries for the proposed three Institutes.

1. Each should have a reasonably large Aboriginal and Torres Strait Islander population;
2. The boundaries should make sense in terms of the state's geography and population distribution;
3. The boundaries should make sense in terms of service delivery structures and processes including client journeys to and from major hospitals;
4. The boundaries should align with overall reform boundaries (Local Hospital Networks and Medicare Locals); and
5. There should be a single Institute for Indigenous Health for the regions in which Transfer to Community Control will be the dominant reform over the coming years.

This section describes the boundaries and structures of the proposed three Institutes for Indigenous Health, their current and projected population characteristics and the geographic relationship with a range of health service providers. Additional population information is contained in Annex 1.

Table 1 shows the existing Queensland Health Districts[7] covered by each of the proposed Institutes and the community controlled health services located within in each. Map 2 shows the proposed Institutes and their alignment with Queensland Health Districts and

[7] A small number of these boundaries may change, in which case the Institute boundaries would be realigned to reflect the changes as required.

Statistical Local Area (SLA) boundaries. Each Institute for Indigenous Health would encompass 2-4 mainstream Medicare Locals and a larger number of Local Hospital Networks.

Table 1. Institutes for Indigenous Health alignment with Queensland Health Districts and community controlled health services

Institute for Indigenous Health	Queensland Health Districts	Community Controlled Health Services	ERP[8] 2006	
			Indigenous	Total
Urban	Gold Coast Metro North Metro South (Children's Health Services)	ATSICHS - Brisbane Kalwun Kambu Yulu Burri Ba	35,871	2,209,777
Central – West	Sunshine Coast – Wide Bay Central Queensland Central West West Moreston & Darling Downs South West	Barambah Bidgerdii Carbal Medical Centre Charleville Cunnamulla Galangoor Goolburri Goondir Health Service IWC NCAACH Nhulundu Wooribah	41,313	1,230,921
North Qld	Cape York Torres Strait & NPA Cairns Townsville Mackay Mt Isa	ATSICHS - Mackay Girudala Gurriny Mamu Mudth-Niyleta Mulungu TAIHS Wuchopperen Gidgee Healing	67,694	650,210

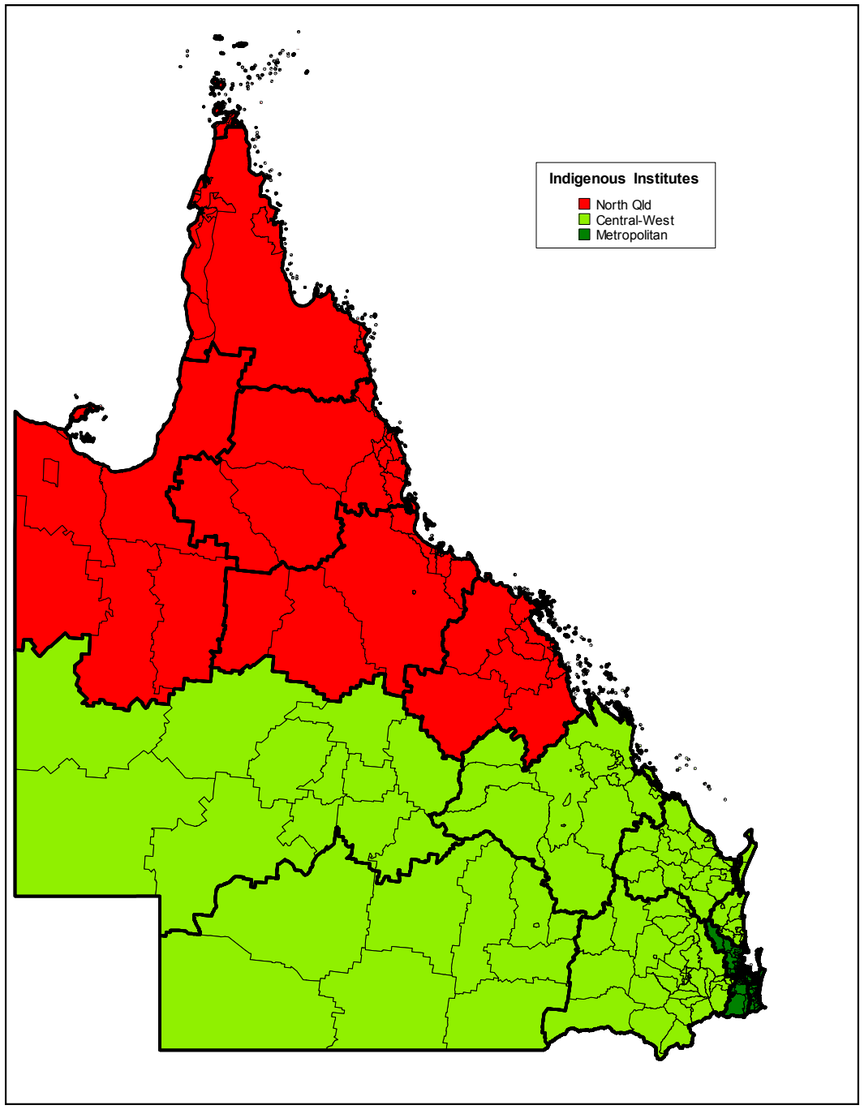
Urban

This is the smallest and most homogenous Institute for Indigenous Health covering an essentially urban Indigenous population of 35,000. It includes both Queensland Health metropolitan districts and the Gold Coast district. There are currently only four community controlled services within this Institute for Indigenous Health boundary as well as the Inala Indigenous Health Service operated by Queensland Health. The bulk of primary health care to the Indigenous population in the region would most likely be delivered by mainstream

[8] Estimated resident population.

services outside of the community controlled sector, though some of these may have an Indigenous focus similar to how the Inala service currently operates.

Map 2. Institute for Indigenous Health boundaries showing alignment with Queensland Health Districts and Statistical Local Areas



Notes: 1.The light lines show the SLA boundaries
2. The dark lines denote the boundaries of Queensland Health Districts

The Institute for Urban Indigenous Health would have a key role in working with the range of mainstream providers to 'broker' affordable and cultural appropriate services and may

have a major role in hosting and managing a Shared Electronic Health Record (SEHR) for at least some of the urban Indigenous population.

It is expected that the Institute for Urban Indigenous Health would align with three mainstream Medicare Locals that would similarly align with anticipated Hospital Network boundaries covering Brisbane, Brisbane South and the Golda Coast area.

Central - West

The Central-West Institute for Indigenous Health would have an Indigenous population of 41,313 making up 3.4% of the population. It would have an extremely diverse make up. It would include:

- the near metropolitan areas of Sunshine Coast and Ipswich, both of which act as dormitory satellites to Brisbane to some extent;
- coastal areas such as Wide Bay and Rockhampton which are undergoing fairly rapid population growth, the first as a 'sea change' destination and the second as a mining service centre;
- a range of small country towns (< 5,000 population) providing services in the central western area; and
- Toowoomba as the major regional centre for the Darling Downs and south west.

Brisbane hospitals provide the major referral hospitals for this region plus a range of other specialist services not available within the region. A major role of the Central – West Institute would be in working with the Institute for Urban Indigenous Health in the coordination and/or transfer of care of a mobile Indigenous population moving between regions both for health related and other reasons.

The area covered by the Central-West Institute for Indigenous Health is where there are a significant variety of options for the mainstream Medicare Local boundaries but it is likely that this Institute would align with 3 to 5 mainstream Medicare Locals.

North Queensland

The North Queensland Institute for Indigenous Health would have an Indigenous population of 67,694 which is just under 50% of the Indigenous population of Queensland. It would cover the areas from Mackay north to the Torres Strait and west to the Northern Territory border and includes the bulk of the discrete Indigenous communities in Queensland as well as major regional centres of Townsville and Cairns. These two centres provide the major hospital referral centres for the region. Currently the region contains nine Community Controlled Health Services and this will increase significantly as many of the primary health facilities currently operated by Queensland Health transition to community control.

Of the three Institutes, the North Queensland one would have the most geographically diverse Indigenous population with significant proportions living in distinct Indigenous communities, in regional and smaller towns such as Mackay and Mt Isa, and in the two major centres of Townsville and Cairns.

Within this region the community controlled sector is likely to be the largest single provider of primary health care to the Indigenous population. A major role of the North Queensland Institute would be to coordinate care from the multiple service providers in the region, including the community controlled services, the Royal Flying Doctor Service, Queensland Health and the mainstream Medicare Locals.

Based on the recommendations of the National Health and Hospitals Report, existing Divisions of General Practice Boundaries and the modelling carried out by the Australian General Practice Network it would be expected that this Institute for Indigenous Health would align with 2 or possibly 3 mainstream Medicare Locals.

Reform Component 4 - Queensland Aboriginal and Islander Health Reform Council

QAIHC proposes the establishment of a Queensland Aboriginal and Torres Strait Islander Health Reform Council (QAIHRC).

The role of the QATSIHRC would be to plan, implement, coordinate and monitor primary health care policy, funding, service delivery and outcomes for Aboriginal and Torres Strait Islander people in Queensland.

QATSIHRC's primary portfolios of responsibility would be the Institutes for Indigenous Health and Transfer to Community Control. It would represent Indigenous interests on the Queensland Health and Hospitals Funding Authority, and work with the National Health Performance Authority to help ensure appropriate monitoring and accountability for Indigenous health outcomes and closing the gap. It would play a major role in state-wide Indigenous health workforce planning and development. Health Reform Council members would be decision makers at the highest levels within the Australian Government, the Queensland Government and QAIHC. The QATSIHRC would be accountable to the Australian and Queensland health ministers.

QAIHC proposes adoption of the same Terms of Engagement for the QATSIHRC as those in Pathways to Community Control in Queensland.

Terms of Engagement

- Aboriginal and Torres Strait Islander self-determination of the local primary health care system is the key to effective, efficient and sustainable comprehensive primary health care;
- There is a shared commitment to Aboriginal and Torres Strait Islander health policy development, implementation, and evaluation;
- There is a shared commitment to an investment model that addresses the higher burden of illness within the Aboriginal and Torres Strait Islander community;
- There is a shared commitment to monitoring and accountability to improve health outcomes for Aboriginal and Torres Strait Islander people; and
- There is a shared commitment to the continuous quality improvement and sustainability of health services for Indigenous people in Queensland.

Reform Component 5 - Transfer to Community Control

QAIHC has developed *Pathways to Community Control* as a blueprint for transfer to community control in remote and regional Queensland. In the first instance these communities are in Cape York, Torres Strait, The Gulf, Palm Island and Yarrabah. These communities all lie within the proposed North Queensland Institute for Indigenous Health.

As part of the proposed reform, QAIHC seeks endorsement of *Pathways* and implementation of transfer to community control over the next few years.

Pathways to Community Control outlines five stages for phasing in transfer. Each stage involves a Readiness Assessment and stakeholder (community controlled sector, Australian Government and Queensland Government) agreement to move to the next stage. They are:

- Stage 1 - Community mandate
- Stage 2 - ICCHO involvement in planning, and coordination of services
- Stage 3 - ICCHO holds funds to address service gaps
- Stage 4 – ICCHO holds funds for core services
- Stage 5 - Local primary health care system community control

The QAIHC Model of Comprehensive Primary Health Care (Version 3) will provide the platform for transfer across communities. The Joint Working Group (or its successor) would oversee transfer under the direction of the QAIHRC. Transfer would be the focus of health system reform in the North Queensland Institute.

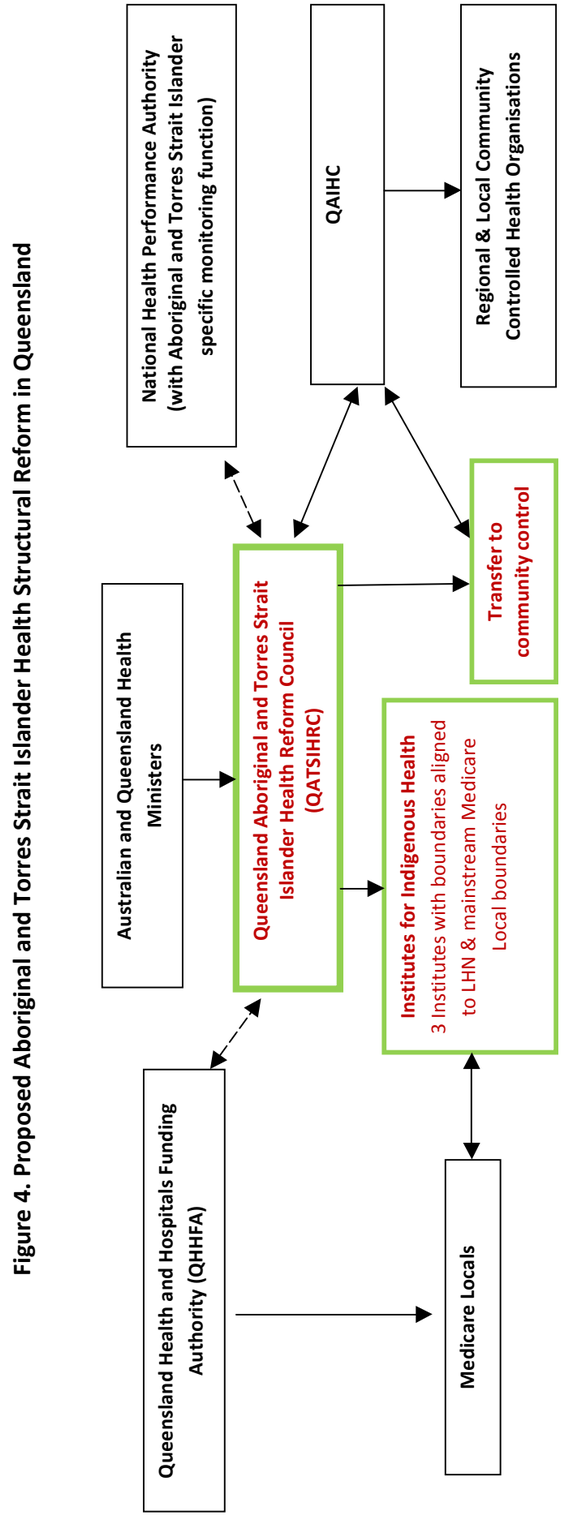


Figure 4. Proposed Aboriginal and Torres Strait Islander Health Structural Reform in Queensland

Reform Component 6 – Funding Reform

Funding reform has two components: reduction in the complexity of funding arrangements for Aboriginal Community Controlled Health Services; and arrangements that allow funds to Institutes for Indigenous Health and Community Controlled Health Services from different sources to be used most efficiently and effectively at health service, regional and state levels.

A study reported in 2009 [Dwyer et al, 2009] looked at the major enablers and impediments to effective service delivery embedded in the current frameworks of funding and accountability for Aboriginal Community Controlled comprehensive primary health care services. For a sub-set of 21 organisations the researchers found that the number of separate funding grants received ranged from 6 to 51, with an average of 22 per service. At the same time, about 80% of total funding to these organisations came from just *one source* – the Australian Government - with about 19% coming from State and Territory governments.

The study findings were subsequently summarised in a Policy Brief as follows[9]:

- *ACCHSs are funded in more complex ways, and from more sources, than most other health care organisations (of equivalent size). These arrangements get in the way of effective health care for two main reasons:*
  i) It is difficult to pull together a comprehensive PHC service from a series of specific purpose grants with separate reporting requirements. PHC needs to be responsive to the whole person or family, regardless of the different kinds of health needs they have. Targeted funding (e.g. for hearing problems) will only work when there is core funding of services to support it.
  ii) The amount of time and effort that goes into preparing and processing reports is out of proportion with the funding levels. Reporting requirements often duplicate each other and are focused on 'counting heads through the door' rather than monitoring people's health outcomes.
- *The complex contractual environments in which ACCHSs work are not monitored or managed in any consistent way. They have emerged from a series of unlinked policy and program decisions, and simply grown over time. Health authority staff are aware of these problems and there is a widespread effort to address them. However, it seems that the implementation of intended reforms is slow and patchy, particularly where cooperation between two levels of government, or different government departments, is required.*
- *Staff on both sides often act as if they are in long-term funding relationships, even though the contracts are generally short-term. This means that the intended advantages for governments of the existing contracts (e.g. retaining the power to cease funding) are not achieved. At the same time, the advantages of relational contracting (such as long-term commitment to programs on the ground, reduced transaction costs and improved staff retention) are not achieved either.*
- *Funding from governments is packaged in ways that do not match the way that services are delivered on the ground, which leads to a high reporting burden on services.*

[9] http://www.crcah.org.au/research/cp203.html

Few would contest these important findings. In order for Institutes for Indigenous Health and Community Controlled Health Services (including those transferred) to have the funding flexibility to deliver comprehensive primary health in the face of the current and future challenges in closing the gap, funding reform is required. In order to create more seamless journeys for clients within and between the health and social sectors, there needs to be a correspondingly more seamless resource base. QAIHC therefore advocates a single source of core funding from the Australian Government for Community Controlled Health Services that better reflects the different burden of illnesses in different geographic locations, and a move to a relational (or alliance) form of funding offering both improved health care delivery and accountability.

Further, funding for Institutes for Indigenous Health should not replicate the funding problems that currently bedevil the community controlled sector. Consistent with the funding complexity described above, funds currently allocated for closing the health gap are in multiple 'buckets' going to different providers in different sectors. Other relevant funds lie in social services sectors (the COAG "Building Blocks"). The establishment of Institutes for Indigenous Health provides an unparalleled opportunity to rationalise much of this funding in a way that maximises flexibility and enables more rational delivery of care, particularly in relation to unmet need.

Initially, funds holding by Institutes for Indigenous Health would be predominantly for closing the health gap monies which would be used to commission services to meet formally identified needs from all primary health and social care service providers – including community controlled, Queensland Government, private general practice and NGO providers. Over time, other funds might be added to Institutes' funds pools.

Structural Reform Component 7 – Enhanced Community Control Sector Self-Regulation

The effectiveness of the Aboriginal and Torres Strait Islander Community Controlled primary health care services sector in providing appropriate and accessible health services to Aboriginal and Torres Strait Islander communities in well documented [National Strategic Framework for Aboriginal and Torres Strait Islander Health, 2003]. The critical role Aboriginal Community Controlled Health Services play in supporting community decision making, participation and engagement in health care is fundamental to effective primary health care and ensures that services are provided to meet community needs in a holistic and culturally appropriate way.

In the context of the proposed health reforms, QAIHC is introducing a number of reforms of its own. These are:

- Regionalisation
- Sustainable corporate governance
- Evidence based model of comprehensive primary health care
- Clinical governance and service delivery models
- Information management
- Workforce development

Regionalisation

QAIHC has embarked on a two-pronged regionalisation process – devolution of QAIHC support to members to regional hubs and the formation of 5 regional community controlled alliances/organisations at the regional level.

QAIHC recognises that to ensure the quality and sustainability of its members' services it must provide support in key strategic areas that is equitable, high quality and responsive to members' needs. The QAIHC Board of Directors has agreed to restructure the organisation with a view to devolution of such support to the regional level.

Devolved support will provide a nexus around which regional organisations will be formed. Each regional organisation will comprise a cluster of the individual community controlled health organisations within its region. These clusters will reflect and support 'client journeys' within regions. Individual health services will be able to increase access to comprehensive primary health care for their communities and have a strong platform to support regional planning, service development and integration, governance, quality improvement, business efficiencies and workforce development.

Regional boundaries are aligned with the boundaries of the proposed Institutes for Indigenous Health – two regions in the North Queensland Institute, two in the Central-West Queensland Institute, and one region that is the same as the Institute for Urban Indigenous Health boundary.

Sustainable corporate governance

One of the key strategic areas for member support is corporate governance. The sector, through QAIHC, is committed to an agenda of sustainable and effective corporate governance. Through the effective corporate governance program, QAIHC is systematically implementing a regular governance development, review, and training program to support the Community Controlled Sector in Queensland. A part of this program is the development of a Self-regulation Framework to guide and support sustainable and good corporate governance practices within the Sector.

Evidence based model of comprehensive primary health care

The QAIHC Comprehensive Primary Health Care Model is described above (see page 12).

Clinical governance and service delivery models

QAIHC has identified three significant programs for the next 3 years. These are:

- Support for participation in quality improvement programs to enhance clinical service, improve outcomes and meet agreed targets;
- Workplace reform to support the 'client journey' through coordinated, multi-disciplinary team work; and
- State-wide implementation of Shared Electronic Health Records (SEHRs), with interoperability between sectors, as the platform for client care plans.

Information Management

This program of work has four major components:

- Implementation of a set of key process and outcome indicators across the sector, enabling assessment of performance and benchmarking, in partnership with the Improvement Foundation Australia (IFA) and General Practice Queensland (GPQ);
- Development of comprehensive regional health profiles to enhance health services planning and delivery;
- Development of analytic maps to show geographic gaps in services that have been pioneered by QAIHC and the IUIH in south east Queensland and will be extended state-wide; and
- Development of Practice Health Atlases™ which are comprehensive service reports used by elected Boards and senior managers to makes decisions about service models and business operations.

Workforce development and sustainability

Community controlled health services have tended to operate independently when it comes to recruitment and retention of GPs, RNs and other professional staff. This is not sustainable in a 'market' of workforce shortages where the sector has not been able to compete on salary and where geographic locations of many of the services in regional, rural and remote communities also puts them at a competitive disadvantage. QAIHC has committed to supporting services to share recruitment and remuneration costs at a regional/sub-regional level and to negotiate income-sharing arrangements with private general practice. It is also looking to pilot other workforce innovations to meet the sector's pressing workforce needs, including employment of physicians assistants.

ANNEX 1 – Additional Population Data for Institutes for Indigenous Health

Tables 2 and 3 show the Estimated Resident Population (numbers and percents rounded to the nearest whole number) of the proposed three Institutes and the state as a whole, broken down by Indigenous and age.

The age breakdowns in the three Institutes are almost identical, with the proportion of population below the age of 15 in the Indigenous population being about twice the proportion in the non-Indigenous population, while the proportion above the age 65 is about 4 times higher in the non-Indigenous population.

Both Tables also show numbers and percents for the state as a whole in 2021 (projected).

Table 2. Estimated Resident Population of proposed Queensland Institutes for Indigenous Health regions (2006) and all Queensland (2021) by Indigenous status and age*

		0-4	5-14	15-44	45-64	65+	Total
Institute for Indigenous Health	**Status**						
Urban	Indigenous	4523	9006	17,232	4,305	805	35,871
	Non-Indigenous	136008	278767	970,668	531,675	256,788	2,173,906
Central-West	Indigenous	5649	11657	17,853	5,056	1,098	41,313
	Non-Indigenous	75489	169883	458,403	314,260	171,573	1,189,608
North Queensland	Indigenous	8803	16752	31,032	8,996	2,111	67,694
	Non-Indigenous	37953	80192	252,656	149,694	62,021	58,2516
All Queensland Indigenous 2006		18975	37415	66,117	18,357	4,014	144,878
All Queensland non-Indigenous 2006		249,450	528,842	1,681,727	995,629	490,382	3,946,030
All Queensland Indigenous 2021		25,174	45,537	98,978	34,678	10,714	215,082
All Queensland non-Indigenous 2021		325,935	670,161	2,118,616	1,327,221	889,445	5,331,377

* Estimates developed by QAIHC based on published and unpublished data

Table 3 : Estimated Resident Population of proposed Queensland Institutes for Indigenous Health (2006) and all Queensland (2021) by Indigenous status and age, percent*

		0-4	5-14	15-44	45-64	65+	Total
Institutes for Indigenous Health	**Status**						
Urban	Indigenous	13%	25%	48%	12%	2%	100%
	Non-Indigenous	6%	13%	45%	24%	12%	100%
Central-West	Indigenous	14%	28%	43%	12%	3%	100%
	Non-Indigenous	6%	14%	39%	26%	14%	100%
North Queensland	Indigenous	13%	25%	46%	13%	3%	100%
	Non-Indigenous	7%	14%	43%	26%	11%	100%
All Queensland Indigenous 2006		13%	26%	46%	13%	3%	100%
All Queensland non-Indigenous 2006		6%	13%	43%	25%	12%	100%
All Queensland Indigenous 2021		11.7%	21.2%	46.0%	16.1%	5.0%	100.0%
All Queensland non-Indigenous 2021		6.1%	12.6%	39.7%	24.9%	16.7%	100.0%

* Estimates developed by QAIHC based on published and unpublished data

ANNEX 2

Early Achivements of the IUIH

The Institute for Urban Indigenous Health (IUIH) was established in July 2009 as a strategic response to the significant growth and geographic dispersion of Aboriginal and Torres Strait Islander peoples within the South East Queensland (Qld) Region and to support the effective implementation of the Council of Australian Government's (COAG) 'Close the Gap' initiatives and other strategic developments in the region and will have a major emphasis on promoting partnerships and integration with other mainstream health services. The latter includes the implementation of the COAG health reform agenda.

The IUIH is a new, independent, not-for-profit, community control member-based organisation with skill based board appointments. Membership reflects local primary health care service provision to the Aboriginal and Torres Strait Islander community of South East Queensland:

- *Aboriginal and Torres Strait Islander Community Health Service (ATSICHS)*
- *Yulu-Burri-Ba Aboriginal Corporation for Community Health (Yulu-Burri-Ba)*
- *Kalwun Health Service (Kalwun)*
- *Kambu Medical Centre (Kambu)*

Based on the discussions to date in relation to the boundaries for the Local Hospital Institutes (LHN), the IUIH will include the Metro North, Metro South, West Moreton and Ipswich LHN's. It is further understood that these boundaries will also align with those of the new Medicare Locals.

There is clear alignment between the objectives of the IUIH and those of the proposed Medicare Locals:

Medicare Locals will hold budgets for commissioning and/or providing primary health care services.

Examples of what the IUIH has achieved in relation to this claim include the following:

- *A mapping of the demographic distribution of the Indigenous population across SEQ, current service provision, current access patterns and related gaps in service provision*
- *The development of a comprehensive business plan that clearly prioritises service provision needs and plans for implementation of enhanced primary health care services*
- *The identification of service access targets as well as projections and models for achieving improved chronic disease management*

- *Funding for the IUIH to co-ordinate expansion of services to meet areas of unmet need and expansion of existing services to meet expected needs based on population and disease prevalence projections*
- *Funding for the IUIH to coordinate the delivery of specialist services for Indigenous communities across SEQ through funds holding arrangements*
- *IUIH has developed a model for chronic disease management that assumes its role as the regional funds holder and provides a basis for decision making and allocation of funds for chronic care needs*
- *Development of collaborative and innovative models for primary health care service delivery, including shared care arrangements, referral pathways between private providers and Aboriginal community controlled health services and co-location of an Aboriginal Medical Service with a mainstream service provider and shared arrangements for some aspects of service provision and clinic management*

Medicare Locals will be responsible for:

Facilitating allied health care and other support for people with chronic conditions, as identified in GP care plans;

- *IUIH has promoted the uptake of health assessments and development of GP Care Plans for people with a chronic disease*
- *IUIH has established links with a range of allied health care providers to contribute to multi-disciplinary team care arrangements for people with a chronic disease. These include podiatry, speech pathology, physiotherapy and oral health. These arrangements have been progressed through a partnership with the University of Queensland to deliver such services through clinical teaching and supervision opportunities, in addition to through the identification of a number of private providers on a visiting or referral basis. Arrangements have been made for the integration of dental care into chronic disease management in the participating Aboriginal community controlled health care services.*

Working with local health care professionals to ensure services co-operate and collaborate with each other so that patients – especially those suffering from chronic disease – can easily and conveniently access the full range of services they need;

- *IUIH has developed a model for chronic disease co-ordination that includes a decision making tool as well as facilitates access to a range of preventive health measures. It also seeks to address the social determinants of health through linking with a range of other sector organisations such as housing, child protection, education and welfare*
- *IUIH is currently working with its member services to ensure more efficient processes and systems to support the needs of chronic care patients – these include, but are not limited to transport, financial costs, cultural competence, and client mobility*

- *IUIH recognises the need to implement shared electronic health record systems and has prioritised its member services in this regard and then a broader network of collaborating services. This will be an essential feature of future co-ordination of services.*
- *IUIH is the regional funds holder for smoking and healthy lifestyle officer positions and is currently funded for 4 such positions with projected increases over the next 2 years. These positions will also contribute significantly to the co-ordination of chronic disease client service needs.*

Identifying groups of people missing out on GP and primary health care, or services that a local area needs, and better target services to respond to these gaps;

- *IUIH is currently leading a project across Indigenous specific and mainstream services to develop a co-ordinated response to the primary health care needs of inner city Aboriginal and Torres Strait Islander peoples. This represents a high needs, marginalised population and also raises issues in relation to homelessness, substance misuse and multi-morbid conditions.*
- *Oral health was identified as a significant priority and current gap in service provision for the Stradbroke Island community. As a result, through a partnership with the University of Queensland, an emergency dental chair has been established on the Island and a regular visiting service provided through the teaching centre arrangements that the IUIH is implementing.*

Working with Local Hospital Networks to assist with patients' transition out of hospital, and where relevant into aged care;

- *Initial work in this regard has been an analysis of the Queensland Health data provided to the IUIH in relation to recent trends in hospital admission across the region, avoidable admissions and maternity hospitals data in relation to pregnancy outcomes.*
- *As a result the IUIH has applied for "New Directions Mothers and Babies" funding to provide support for pregnant women and post discharge follow up and support programs in identified priority areas of SEQ.*
- *IUIH is currently exploring opportunities for supporting a range of service initiatives at the Jimbelunga Aboriginal Aged Care facility.*

Delivering health promotion and preventative health programs targeted to risk factors in communities. " [Prime Minister 2010]

- *The IUIH has employed an anti-smoking co-ordinator and a healthy lifestyle officer to deliver programs across the region. Two additional positions will be filled in the near future. A number of specific initiatives have been implemented in community settings and in collaboration with other sector agencies such as schools and sporting clubs*

Note that these outcomes have been achieved without a full complement of staff and full year budget allocations.

References:

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QAIHC
Queensland Aboriginal and Islander Health Council

QAIHC - WEST END
21 Buchanan St
West End QLD 4101
PO Box 3205
South Brisbane
QLD 4101
P: 07 3328 8500
F: 07 3844 1544

QAIHC - TOWNSVILLE
Level 2, 143 Walker St
Townsville QLD 4810
PO Box 1037
Townsville QLD 4810
P: 07 4721 0744
F: 07 4721 0310

QAIHC - CAIRNS
186 Mccombe St
(c/o Apunipima Cape York
Health Council)
Bungalow QLD 4870
PO Box 12039
Cairns Delivery Centre
QLD 4870
P: 07 4081 5600
F: 07 4051 7940