QAIHC

Queensland Aboriginal and Islander Health Council

A response to the Council of Australian Government's discussion paper "Closing the Gap, the Next Phase"

[April 2018]

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QAIHC receives funding support from the Australian and Queensland Governments.

About Queensland Aboriginal and Islander Health Council (QAIHC)

QAIHC was established in 1990 by dedicated and committed Aboriginal and Torres Strait Islander leaders within the Community Controlled Health Sector.

Originally established as QAIHF (Queensland Aboriginal and Islander Health Forum), the organisation provided a voice for the Community Controlled Health Sector in Queensland. This organisation was self-funded until 1996, when the Commonwealth Department of Health commenced funding support. QAIHC has experienced considerable growth in membership and the scope of services provided to those members since its establishment.

In 2004, the organisation was reconstituted under the Australian Investment and Securities Commission (ASIC) and assumed its current form as QAIHC.

Today, QAIHC represents 25 Community Controlled Health Services and 3 Regional Members who share a passion and commitment to addressing the unique health care needs of their communities through specialised, comprehensive and culturally-appropriate primary health care.

QAIHC is the peak body representing the Aboriginal and Torres Strait Islander Community Controlled Health Sector in Queensland at both a state and national level. Its membership comprises of Aboriginal and Torres Strait Islander Community Controlled Health Services (ATSICCHS) located throughout Queensland. Nationally, QAIHC represents the Community Controlled Health Sector through its affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation (NACCHO) and is regarded as an expert in its field.

Overview

The Closing the Gap Refresh is focused on governments reaching out to Aboriginal and Torres Strait Islander people; extracting their views about jobs, economic development, health, quality of life, wellness and participation to inform new ways of progressing advancement in these areas.

In preparing this submission, QAIHC conducted a series of consultations with representatives of QAIHC Member Services. The sessions took place from February to March 2018. This submission is a collaboration of comments, thoughts and recommendations collected during these consultations. QAIHC would like to thank the Members that contributed to the consultations and provided feedback on the submission.

First and foremost, it is our view that the current Closing the Gap health targets should remain. It is important not to forgo the lessons that can be learned, even in failure. The evidence (including data) gathered since the Closing the Gap strategy was launched is crucial to improving service delivery and informing future policy design. The Life Expectancy and Infant Mortality targets stand as important pillars to demonstrate the start and end of life experiences of Aboriginal and

Torres Strait Islander people, but on their own, do not demonstrate the vital health needs throughout the life continuum.

QAIHC and its Members are of the firm view that to achieve long term, sustainable health outcomes, cross-portfolio collaboration is necessary at all levels of government. Health outcomes are symptoms of fractured underlying foundations of life including; education, employment, housing, economic stability and social inclusion. Conversely, it is true that to achieve advancement in any of the other foundations of life, Aboriginal and Torres Strait Islander people must have good health. It follows then that solutions must be designed to address multiple issues and at the very least when funding health outcomes; social determinants should be considered.

QAIHC and its Members consider that 'indicators' and 'measures' used in future Closing the Gap frameworks should have regional relevance rather than simply representing national aspirations. The lifestyle and demographics of Aboriginal and Torres Strait Islander people vary significantly between very remote, remote, rural, regional and urban areas and thus indicators to measure their advancement should be reflective of that.

The issues affecting Aboriginal and Torres Strait Islander people are long understood. The focus should be less about what the 'targets' are and more about ensuring that commitment to progress in any of the areas is funded adequately to support long term change and sustainability.

The Aboriginal and Torres Strait Islander Community Controlled Health Sector (the Sector) cannot alone close the gap in Aboriginal and Torres Strait Islander health as it only receives a small proportion of the funding attribution. Regardless, the Sector continues to achieve significant outcomes. For example; for the 2016-17 period in Queensland, approximately 50% of the Indigenous Health Checks (Medicare Item number 715) were completed by ATSICCHs. In addition to adequately resourcing the Sector; COAG must increase the pressure on the mainstream primary health care sector to work harder for Aboriginal and Torres Strait Islander health advancement.

Lastly, Aboriginal and Torres Strait Islander people need to be empowered through self-determination to articulate their needs. They must be engaged in the design, implementation and evaluation of programmes and policies developed to support their wellbeing.

Recommendations

In preparing a response to the Public Discussion Paper "Closing the Gap, the Next Phase", as part of the Council of Australian Governments (COAG) Closing the Gap refresh; QAIHC and its Members make the following recommendations:

1. That relationships built on **trust** must be developed between governments at all levels and Aboriginal and Torres Strait Islander people
2. That the relationships be **meaningful**, **transparent**, **ongoing** and of mutual value
3. That **measures must be consistently applied** to *all parties* delivering services to Aboriginal and Torres Strait Islander people
4. That outcomes should be measured not only on quantitative but qualitative data, truly **measuring impact**
5. That the notion of **prosperity does not resonate** with Aboriginal and Torres Strait Islander communities and that the focus of the Closing the Gap framework should be Wellbeing
6. That indicators and targets must be **regionally relevant**
7. That any strategy to Closing the Gap must be more than aspirational, it must be sustained by **adequate resourcing**
8. That integrating **Aboriginal and Torres Strat Islander expertise and perspectives** into the design and evaluation of policies and programmes that impact on Aboriginal and Torres Strait Islander people is essential
9. That **Cross-portfolio collaboration** is the key to Closing the Gap
10. That **Institutional racism must be addressed** by making its eradication a new Closing the Gap target

Question: How can governments, Aboriginal and Torres Strait Islander Peoples, and businesses work more effectively together? What is needed to change the relationship between government and community?

RECOMMENDATIONS:

- That relationships built on **trust** must be developed between governments at all levels and Aboriginal and Torres Strait Islander people
- That the relationships be **meaningful**, **transparent**, **ongoing** and of mutual value

Trust is defined by the Oxford Dictionary as "*firm belief in the reliability, truth, or ability of someone or something"*[1].

The Sector in Queensland is reliable, capable and trustworthy. The Sector has been delivering high quality comprehensive health care to their communities for over 40 years and is economically strong. Many of the ATSICCHs in Queensland have sophisticated methods of generating income that is reinvested into the organisation and community to support the delivery of additional services. All QAIHC Member Services have a quality management system measured against either the International Organisation of Standardisation (ISO) or the Quality Improvement Council standards (QIC). Additionally, all eligible QAIHC Member Services are clinically accredited against the Royal Australian Council of General Practitioners (RACGP) standards. All QAIHC Member Services must conform with the financial auditing requirements of either the Australian Charities and Not-for-profit Commission or Office of Registrar of Indigenous Corporations.

Despite this, there seems to be a lack of trust in Aboriginal and Torres Strait Islander organisations, an underlying belief that they are less reliable, less honest and are less likely to have the capability and capacity required to deliver an effective service.

For example, the current funding methodology used to support the Indigenous Australian's Health Programme (IAHP) (predominantly Primary Health Care funding for ATSICCHs) is under review by the Commonwealth Government. A complex model was proposed involving the national Key Performance Indicators (nKPIs) as performance benchmarks, Episodes of Care, Client Count and indexes used to measure remoteness and socio-economic disadvantage.

Conversely, there is currently no funding methodology used by the Commonwealth to calculate the core funding for the Primary Health Networks (PHNs). According to the PHN Grant Guidelines, funding for PHNs takes into account population, rurality and socio-economic factors[2]. There does not appear to be a methodology to determine how each of these factors is 'valued'. The Guidelines also advise that PHNs are provided with flexible funding to 'enable

[1] *https://en.oxforddictionaries.com/definition/trust* (accessed on April 2018)

[2] Department of Health 2016. Department of Health Primary Health Networks Grant Programme Guidelines February 2016 – Version 1.2 p9.

PHNs to respond to identified national priorities as determined by government, and to respond to PHN specific priorities by purchasing/commissioning required services'[3].

An ongoing relationship of mutual value

Positively, governments are dedicating more time to engaging Aboriginal and Torres Strait Islander people in the discussion about services provided to them. There appears to be a genuine interest in 'consulting' with Aboriginal and Torres Strait Islander people when programmes or policies are launched or changed. However, an ongoing relationship where advice and input are regularly welcomed from Aboriginal and Torres Strait Islander people about the progress of services being delivered to their communities is what is required.

Often, governments review the programme's delivery by focusing on the tangible outcomes reported by the provider and very rarely engage the end user in determining the impact or success of that programme. Further, there is little consideration of contextual/on the ground circumstances that may be impacting on outcomes.

A frequent comment at consultations held by QAIHC in developing this submission was that governments, particularly Commonwealth Government departments, are "fly-in, fly-out" only engaging with the community when visiting for media opportunities or when programmes have failed. A relationship that is ongoing and based on a real and genuine interest in the wellbeing of Aboriginal and Torres Strait Islander people is what the communities are crying out for.

[3] Department of Health 2016. Department of Health Primary Health Networks Grant Programme Guidelines February 2016 – Version 1.2 p9.

Question: How could the Closing the Gap targets better measure what is working and what is not?

RECOMMENDATIONS:

- That **measures must be consistently applied** to *all parties* delivering services to Aboriginal and Torres Strait Islander people
- That outcomes should be measured not only on quantitative but qualitative data, truly **measuring impact**

Measures must be consistently applied

Currently, in relation to Aboriginal and Torres Strait Islander health outcomes, progress is measured by the National Key Performance Indicators (nKPIs). The nKPIs are a set of clinical indicators designed to track the health outcomes of Aboriginal and Torres Strait Islander people. The purpose of the nKPIs is to support policy and service planning at the national and state/territory levels, by monitoring progress and highlighting areas for improvement. Reporting against the nKPIs is mandatory for services 'that are providing care to Indigenous Australians'[4].

Pursuant to the funding agreements with the Department of Health, ATSICCHs are required to report against the nKPIs. PHNs are funded (amongst other things) by the Department of Health to support health services to provide culturally sensitive care to Aboriginal and Torres Strait Islander people and to facilitate access to mainstream health services including general practice, allied health and specialists. Unless they are specifically funded for an Aboriginal and Torres Strait Islander activity, PHNs are not required to report against the nKPIs even though they have the capacity to do so. The PHNs in Queensland use clinical extraction software (identical to the software used by QAIHC in supporting its Members to manage their data effectively) which enables them to have access to aggregated, de-identified data of the clinics in their region, including Aboriginal and Torres Strait Islander patient data.

Given that in general only the ATSICCHs are mandated to report against the nKPIs; nKPIs cannot be relied on as a robust source of measurement of population health outcomes. They do not truly paint a 'national' picture as their name suggests. The nKPIs are only representative of the portion of the Aboriginal and Torres Strait Islander people that 'actively' receive services from ATSICCHs. The approximate client count for ATSICCHs in Queensland is 82,636, representing 44% of Queensland's Aboriginal and Torres Strait Islander population[5].

In the interest of measuring the health status of the entire population, it should necessarily follow that the 'measurements' be consistent and transparent. If PHNs are funded to support the

[4] Department of Health 2015. Online Services Report and National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care data framework http://www.health.gov.au/internet/main/publishing.nsf/Content/543206C982A73717CA257EEC00166EA7/$File/OSR_and_nKPI-data-framework.pdf (accessed on March 2018)

[5] Australian Institute of Health and Welfare 2017. Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2015–16. Aboriginal and Torres Strait Islander health services report no. 8. Cat. no. IHW 180. Canberra: AIHW

health advancement of Aboriginal and Torres Strait Islander people, the government should develop an innovative way to encourage PHNs to report in the same way as ATSICCHs to ensure the health population data is robust and meaningful.

Measuring Impact

Governments generally rely on quantitative measures to determine the success of a programme or policy. Very rarely are qualitative measures used in evaluation. QAIHC and its Members understand the importance of 'impact evaluation', particularly when servicing Aboriginal and Torres Strait Islander people. Whilst it is easy to use quantitative measures to determine outcomes e.g. "How many 715 Health Checks were conducted by ATSICCHS in 2017?", measuring qualitative success such as "How have family attitudes towards health changed by delivering x 715 Health Checks in 2017?" can have a wider and more significant impact. Although the delivery of an individual Health Check is a positive result, a greater story of success is gathered by the social impact that person's attitudes or knowledge has had on the family and community. Given the socially integrated nature of Aboriginal and Torres Strait Islander communities, the evaluation of 'impact' is extremely important.

QAIHC is of the strong view that governments should invest resources into researching impact evaluation techniques to determine qualitative factors such as; attitude shift, knowledge development and increased awareness. QAIHC frequently uses live interactive 'Poll' feedback technology when delivering training modules to gather data on whether training delivery was effective and whether the training methodology and content contributed to the participant gaining greater knowledge, confidence and awareness. Factors very rarely captured by reporting on typical outcomes such as '23 participants successfully completed the training'.

A key component of the ATSICCHs' accreditation processes as described earlier in this paper is the use of interviews, observations, case studies and surveys. These are all components of an evaluation process that could be used to measure impact.

Question: What indicators should governments focus on to best support the needs and aspirations of Aboriginal and Torres Strait Islander Peoples? Should governments focus on indicators such as prosperity, wellbeing or other areas?

RECOMMENDATIONS:

- That the notion of **prosperity does not resonate** with Aboriginal and Torres Strait Islander communities and that the focus of the Closing the Gap framework should be wellbeing
- That indicators and targets must be **regionally relevant**
- That any strategy to Closing the Gap must be more than aspirational, it must be sustained by **adequate resourcing**

Prosperity

The definition of prosperity has the connotation of wealth. QAIHC and its Members accept that to be prosperous also means to thrive or live a long life. However, it remains that prosperity refers to a level of affluence. Whilst economic security is a grand aspiration for Aboriginal and Torres Strait Islander people, it is not generally the highest priority. Aboriginal and Torres Strait Islander people prioritise maintaining their cultural connection, family/community safety and wellbeing (body, spirit and mind) over and above 'prosperity'.

Whilst QAIHC and its Members understand that the 'prosperity framework' is not supposed to be taken so literally, our suggestion is that regardless of the government's intention, the terminology will not resonate with the Aboriginal and Torres Strait Islander community and could contribute to them disengaging with the framework altogether.

Regionally Relevant

The indicators used in the Closing the Gap strategy must be regionally relevant. At the very least reporting should reflect the status of Aboriginal and Torres Strait Islander people living in very remote, remote, rural, regional and urban settings. The current method of reporting 'non-Indigenous v Indigenous' does not adequately describe the varied levels of disadvantage experienced by Aboriginal and Torres Strait Islander people because of where they reside.

Solutions should be tailored to support the needs that are associated with the levels of disadvantage experienced within a region. For example; approximately 20% of the population lives remotely or very remotely in Queensland[6] and the disadvantage experienced by individuals is greater due to factors such as isolation, lack of services and lower employment opportunities. Approximately 80% of Aboriginal and Torres Strait Islander people reside in regional or urban areas. This large population represents the greater proportion of 'the gap' and yet communities in these areas have access to vital support services. It must follow that the solutions developed in each of these examples should be different.

A current example of this issue is the Department of Health's use of the nKPIs as 'performance' indicators in the proposed new IAHP funding model discussed earlier in this paper. It is QAIHC's

[6] Queensland Productivity commission 2017. Service delivery in remote and discrete Aboriginal and Torres Strait Islander Communities, p11, https://qpc.blob.core.windows.net/wordpress/2017/10/Complete-draft-report.pdf (accessed on March 2018)

view that although the national targets have significance for the broader population health outcomes, in most cases, they have little relevance to the specific health needs of the communities that the Sector supports. Incentivising these national targets has the potential to divert attention away from the specific health needs of communities. This is of high concern.

Adequate Resourcing

Any strategy to Close the Gap must be more than aspirational, it must be sustained by adequate resourcing.

The *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 (the Plan)*, is a key driver of progress for Aboriginal and Torres Strait Islander advancement in health. It sets aspirations and if realised will have a significant impact on achieving what is required to close the gap in health. To achieve the overall outcomes of the Implementation Plan, each of the Strategies needed to have robust financial support. Unfortunately, the general expectation on signatories was that they would deliver the actions with pre-existing funding and resources.

The Implementation Plan recognises the instrumental role that ATSICCHs play in supporting Aboriginal and Torres Strait Islander Health and commits to strategies to strengthen the Sector. However, QAIHC and its Members are concerned about the lack of commitment to growing and supporting ATSICCHs by the Department of Health, particularly the implementation of a new funding model (described earlier in this paper) that will not address the escalating health needs of the Aboriginal and Torres Strait Islander community.

The proposed IAHP funding methodology restricts the growth of the sector by not supporting the long established, highly successful model of care and imposing a national capped funding amount.

The funding model proposes to use Episodes of Care and Client Counts as proxy measures. The Department of Health's 'Episode of Care' definition only recognises, and therefore funds, one episode per day. In keeping with the principals of 'opportunistic care' it is likely that a typical patient will visit multiple clinicians in a day. The Department's definition does not recognise the cost and effort associated with the provision of 'comprehensive primary health care'. Of highest concern is that in this 'capped model', there seems to be little consideration given to future health needs including escalating health concerns or the development of new ATSICCHs in communities were service gaps exist. Additionally, the capped model will create unnecessary competition in the Sector as ATSICCHs will be vying for the one share of funding.

Question: Should Aboriginal and Torres Strait Islander culture be incorporated in the Closing the Gap framework? How?

RECOMMENDATION:

- That integrating **Aboriginal and Torres Strat Islander expertise and perspectives** into the design and evaluation of policies and programmes that impact on Aboriginal and Torres Strait Islander people is essential

Aboriginal and Torres Strait Islander Expertise and Perspectives

QAIHC and its Members are of the view that it is critical that Aboriginal and Torres Strait Islander people are engaged as core participants in the design, implementation and evaluation of programmes developed for their advancement.

Although there appears to be a genuine commitment from all level of governments to 'consult' with Aboriginal and Torres Strait Islander people, the consultation takes place too late in the development phase. The consultation has become a 'tick and flick' process to seek endorsement of something that has already been developed without any culturally-based expertise or input from the community.

Even at the core of this 'consultation' process for the Closing the Gap refresh, the 'prosperity framework' was announced during public consultations and that the framework was developed by the Department of the Prime Minister and Cabinet. The proposed 'prosperity framework' states that it aims to:

*"provide a complete picture of what it takes to **build a meaningful life** for Indigenous Australians"*

Aboriginal and Torres Strait Islander people know what it takes to build a meaningful life for themselves. What they need is to be empowered and supported through true self-determination to make decisions that are right for their communities. They also hold a wealth of knowledge of what has and has not worked in the past. This information should be invaluable to governments, but over-and-over again, programmes are imposed and co-designed solutions are not readily pursued.

The advantages of co-designing community-led programmes include:

- Cultural values, traditions, language and knowledge are embedded
- It draws on community strengths and expertise
- Increased community participation and ownership
- Building local capacity and community resilience
- Cultivating a relationship of trust and reciprocal accountability

Where possible, governments and other decision-makers should engage with existing community representative groups and not invent their own consultation mechanism. This includes the cultivation of relationships with Aboriginal and Torres Strait Islander representative

organisations such as the regional, state and national peak bodies. An example of where a community has established their own representative body is the Yarrabah Leaders Forum.

The Yarrabah Leaders Forum (YLF) is a group of community organisations that have entered into a shared agreement to improve the status of their people by the year 2020. The YLF have 6 goals for the community. All negotiations with governments that deliver social services or other funding to the Yarrabah community are conducted by the YLF and consequentially, strategic decisions are made to ensure that resources and funding are directed to the agreed community goals. This model ensures that the needs that are of greatest concern for Yarrabah are addressed in a coordinated way and community-based organisations take leadership in decision making.

Question: What do you think are the key targets or commitments that should be measured in a refreshed Closing the Gap agenda?

RECOMMENDATIONS:

- That **Cross-portfolio collaboration** is the key to Closing the Gap
- That **Institutional racism must be addressed** by making its eradication a new Closing the Gap target

QAIHC and its Members agree to the list of priorities identified in the 'Special Gathering Statement' and the priority focus areas under each of the 'prosperity framework' pillars. However, the issues themselves are not new, they are well known and well-documented.

According to the Aboriginal and Torres Strait Islander Health Performance Framework, *"39% of the gap between Indigenous and non-Indigenous Australians health outcomes can be explained by social determinants"*[7]. Specifically, in relation to Queensland Aboriginal and Torres Strait Islander people (based on 2014-15 figures)[8]:

- 20% reported living in overcrowded households; in remote areas the figure is 31%
- 14% reported living in dwellings of an unacceptable standard
- 2.2% reported they did not have access to facilities for washing people; 7.6% did not have access to facilities for washing clothes and bedding; 6.7% did not have access to facilities for preparing food; and 2.3% did not have access to working sewerage facilities
- In 2015 the apparent retention rate from Year 7/8 to Year 12 was 73% but 90% for non-Indigenous students. The apparent retention rate from Year 10 to Year 12 was 72% and 88% for non-Indigenous students
- 50% of the working age population reported they were employed. For non-Indigenous Australians, 74% of the working age population were employed; 53% were working full time and 22% part time
- 34% (aged 18 and over) reported they were living in households in the lowest equivalised weekly household income quintile. This was twice the proportion for non-Indigenous adults (17%)
- On an average day, of those aged 10–17, 218 per 10,000 were under youth justice supervision, compared with 13 per 10,000 for non-Indigenous Australians
- On 30 June 2016 in Queensland, 32% of people in prison custody were Aboriginal and/or Torres Strait Islander
- The rate of children who were the subject of a substantiated child protection notification was 23 per 1,000. This was 6.7 times the rate for non-Indigenous children (3.5 per 1,000)
- Children (aged 0–17) on care and protection orders was 44 per 1,000. This was 9 times the rate for non-Indigenous children (5.1 per 1,000)

[7] Australian Institute of Health and Welfare, Aboriginal and Torres Strait Islander Health Performance Framework 2017, https://www.aihw.gov.au/reports/indigenous-health-welfare/health-performance-framework/contents/tier-one/hpf-tier-1 (accessed on April 2018)

[8] Australian Institute of Health and Welfare, Aboriginal and Torres Strait Islander Health Performance Framework Queensland 2017, https://www.aihw.gov.au/getmedia/0912908c-a8df-4c94-8629-460d5f69784a/aihw-ihw-184-qld.pdf.aspx?inline=true (accessed on April 2018)

The correlation between these social determinants and the health conditions of Aboriginal and Torres Strait Islander people is irrefutable. People are more likely to make sound decisions about their health if they are in good housing, have access to quality education, are employed, have economic security, are culturally safe and have healthy communities and families. To Close the Gap, governments must work collaboratively to support solutions by taking a cross-portfolio approach. Amongst other things, consideration must be given to:

- Innovative approaches to cross-portfolio funding
- Multilateral funding agreements
- Interdepartmental data sharing arrangements
- Interdepartmental collaborative networks including reporting
- Bi-partisan commitment to long-term solutions

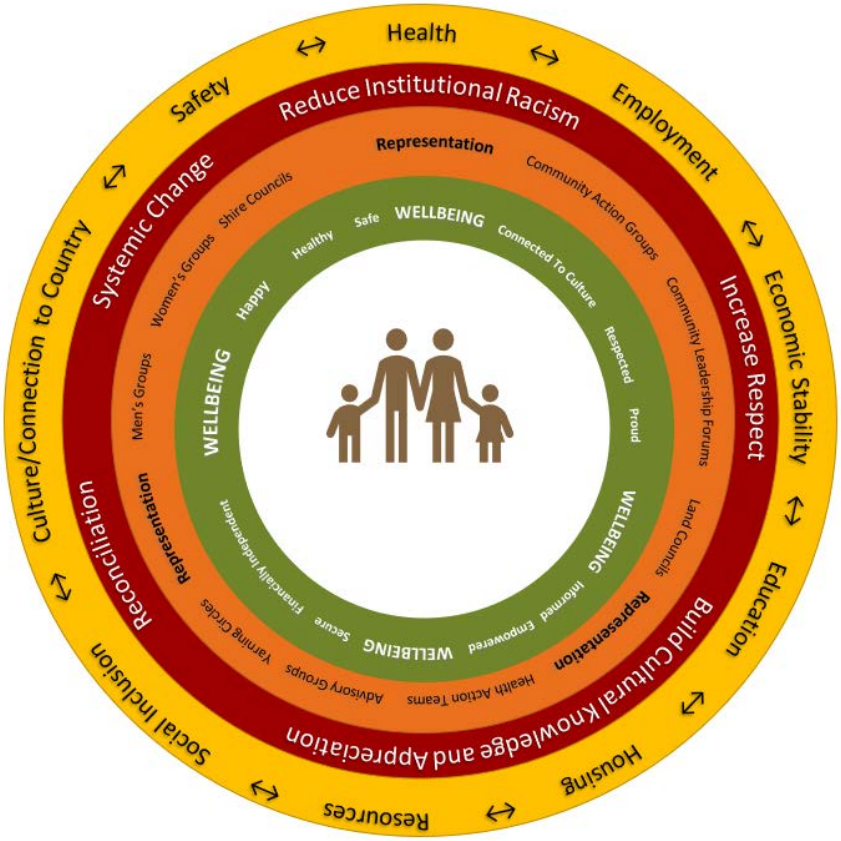
Where success has been achieved in Closing the Gap, namely in Year 12 Attainment, there has been true collaboration between the Education and Employment portfolios. Indeed, the Machinery of Government changes to merge the two Departments (including funding and human resources) must have necessarily contributed to the achievement of the Year 12 attainment target. Nonetheless, innovative programme and policy solutions were developed so that the two major portfolios worked together to support the transition of young people from school to work. These are the kind of solutions that need to be fostered throughout government at all levels to make any progress in the Closing the Gap agenda.

QAIHC and its Members are of the view that any Closing the Gap framework should demonstrate the co-dependent nature of the social determinants and health. It is our strong view that COAG must develop a reporting framework that influences Government Departments to measure how they are working collaboratively to achieve the Closing the Gap targets.

The Wellbeing Framework

QAIHC and its Members are of the view that the Closing the Gap framework should focus on family 'wellbeing' as opposed to prosperity and accordingly propose the following 'Wellbeing Framework'.

- The Yellow outer circle demonstrates the co-dependent nature of the foundations of life. Regardless of where you start in the yellow circle, you must consider how that foundation relies on the other interconnected elements. The Yellow circle also relates to stakeholders and how they must work in collaboration to design effective solutions.
- The Red circle represents where systems change is required to increase cultural knowledge and appreciation to reduce institutional racism.
- The Orange circle represents community advocacy. Community-based solutions should be designed with existing community representatives where possible. Communities should also be resourced and supported to develop their own mechanisms underpinned by good governance.
- The Green circle represents the goal; wellbeing. The smaller font is some of the characteristics that contribute to the wellbeing of Aboriginal and Torres Strait Islander people.
- Lastly but most importantly is the family at the center. Closing the Gap solutions will only be successful if the family unit (as it relates to Aboriginal and Torres Strait Islander people) is the core focus.



Institutional Racism must be addressed

The health of Aboriginal and Torres Strait Islander people relies on supportive and respectful institutions that value cultural education. Significant effort needs to be focused on identifying and eradicating institutional racism in education, employment, health, child protection and justice.

Further, the passive acceptance of such institutionalised discrimination (by failing to address it) contributes to widespread stereotypes. For example, failing to embed Aboriginal and Torres Strait Islander culture and history in the education curriculum leads to a lack of knowledge and therefore understanding. The Medical Journal of Australia, when exploring institutional racism in Australia in 2004 wrote: *"Where societies or social entities have a greater awareness of and concern for mutuality, reciprocity and sharing, trust in institutions will be fostered and racism will diminish"*[9]

Evidence that institutional racism in health services, particularly hospitals was uncovered in 2017 in the QAIHC funded report 'Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander people in Queensland's Public Hospital and Health Services'. The report concluded that 16 Hospital and Health Services throughout Queensland were rated at least with high levels of institutional racism, 10 (62%) were rated with extreme levels[10]. Recognition and acceptance of these results and considered action to improve them is critical to closing the gap. Expansion of this type of review to include hospital services in Australia is necessary to inspire change in addressing Aboriginal and Torres Strait Islander health.

Reducing institutional racism or at the very least improving attitudes and knowledge of the unique perspectives of Aboriginal and Torres Strait Islander cultures, needs to be a core focus of the Closing the Gap framework. The impact it makes on how services are delivered to Aboriginal and Torres Strait Islander people plays an instrumental role in encouraging Aboriginal and Torres Strait Islander people to access vital services and is critical to providing the type of care required.

[9] Barbara R Henry, Shane Houston and Gavin H Mooney. Med J Aust 2004; 180 (10): 517-520.
[10] Marrie A, Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services. March 2017: p16