QAIHC
Queensland Aboriginal and Islander Health Council

QAIHC SUBMISSION TO THE
The Department of Health

SUBMISSION

Mission for Cardiac Health Roadmap

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Mission for Cardiac Health Roadmap

About the 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 28 community-controlled health services and 14 associate 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 Organisation Sector in Queensland at both a state and national level. Its membership comprises of Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) 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.

QAIHC as the peak of ATSICCHOs of Queensland, wish to express the collective views on behalf of our state-wide members, regarding the current approach to service delivery in remote and discrete Aboriginal and Torres Strait Islander communities.

QAIHC would like to thank Medical Research Futures Fund for the opportunity to proposed Cardiac Health Roadmap. The aim of the consultation is to support Australians researchers to work in a culturally safe way to make ground-breaking discoveries, develop a global biotech industry and enable the cultural safety, evidence-based design and implementation of innovative changes in cardiac healthcare.

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1. Background

The Medicare Benefits Schedule Review Taskforce (The Taskforce) was created in 2015 to undertake a review of the Medicare Benefits Schedule (MBS). The Taskforce aim to ensure that health outcomes are improved by ensuring that MBS item numbers align with current best practice. The Taskforce implemented a number of specialist reference groups to provide recommendations on amendments to the schedule. The Aboriginal and Torres Strait Islander Reference Group recommendations are currently out for public consultation. The Queensland Aboriginal and Islander Health Council (QAIHC) has consulted its membership on the acceptability and feasibility of these proposed amendments. The following document details the QAIHC response to the Aboriginal and Torres Strait Islander Reference Group recommendations.

This response has been drafted with respect of the experiences of the ATSICCHO Sector.

QAIHC would like to thank the Queensland Government for the opportunity to respond on the Cardiac Health Roadmap (CHR) issues paper and welcomes review and reform for better outcomes for QAIHC's member services and the Aboriginal and Torres Strait Islander peoples they serve.

QAIHC recommends the following points to make the Cardiac Health Roadmap (CHR) more accessible to ATSICCHOs, and recognises the strengths and value that these ATSICCHO's bring to setting priorities for policy and research design and implementation.

- It is QAIHC's view that this roadmap should explicitly include consultation with Aboriginal and Torres Strait Islander peoples.
- The document would benefit from specific acknowledgement of the Aboriginal and Torres Strait Islander burden of disease related to cardiovascular disease.
- Evidence based research should be used to inform effective design and implementation of health interventions and treatment at all phases of health from preventive or primary health care, in acute care and to rehabilitation and ongoing through the life course.
- Projects specifically related to Aboriginal and Torres Strait Islander research would be a relevant addition to the Investment Section.
- The language in the roadmap needs to be closely considered and re-evaluated. The use of culturally inappropriate and exclusive language highlights the need for Indigenous involvement at all phases of the research process, from conception onwards.

2. Recommendations

Recommendation 1: That consultation with Aboriginal and Torres Strait Islander people is embedded in the project, through specific inclusion in the scope, mission, and vision statements and also the underpinning principles of the CHR.

This connects to the principles of self-determination, and importance of Aboriginal and Torres Strait Islander led initiatives in addressing health disparities, in line with the COAG Health Council's (CHC) Closing the Gap Strategy 2019-2029.

Recommendation 2: Explicit reference to projects related to Aboriginal and Torres Strait Islander research as a standalone item in the 'Investment considerations' section.

QAIHC make this recommendation recognising that Aboriginal and Torres Strait Islander peoples are at high risk of mortality from cardiovascular disease and receive less pro-active treatment. Aboriginal and Torres Strait Islander men are two times more likely to die from heart events as non-Indigenous men, and from as early as the age of 25 (AIHW 2014) and 3 times higher overall (Randall et al. 2014).

Recommendation 3: The language used in the road map document is evaluated and amended

The use of the word 'mission' in the title of the CHR is culturally inappropriate for Aboriginal and Torres Strait Islander peoples, given the historical context of religious missions as places representative of separation of family groups, removal from country, destruction of language and culture, and enforced labour. This word has been rejected by Aboriginal and Torres Strait Islander Organisations in the past. We suggest alternatives: Cardiac Health Roadmap, Roadmap for Cardiovascular Health, Strategy for Cardiovascular Health or Commitment to improve Cardiovascular Health.

While understanding the need for brevity in the CHR, phrases such as 'game-changer' and entrepreneurial jargon such as 'valley of death' demean the gravity of the subject matter. The phrase 'game-changer' could be replaced by words such as 'ground-breaking', 'meaningful' or 'revolutionary'. The 'valley of death' could be replaced by the definition of the phrase.

To avoid exclusionary language, technical terms should be accompanied by a definition, or listed separately in a glossary with definitions to be explained in layman's terms.

Recommendation 4: Evidence Based research should inform Models of Care and Continuity of Care in an ongoing way.

This includes workforce and workplace models that are collaborative and support integrated care to deliver better patient-centred care through multiple settings and stages including preventive care, acute care, rehabilitation care and ongoing care throughout the life course. Such models should prioritise patient-centred value in each setting at each stage of treatment journey, rather than mere volume of services. This focus needs to be incorporated into current services and embedded in future Models of Care. These elements are consistent with the Productivity Commissions 'Shifting the dial' 2017 health reform recommendations.

3. Consultation Questions

Ref #	Question	QAIHC's response
Cultural competency		
1	Does the **scope** address the full range of issues that should be addressed in Cardiac Health Care research? How can it be strengthened?	The scope fails to incorporate the need for best practice care at all phases of health treatment. Incorporate into the scope: the creation and sharing of an evidence base to enable design and implementation of evidence-based health care at all phases of health treatment, from preventive through acute care, recovery, particularly in rehabilitation and beyond.
2	Does the **Vision Statement** address the full range of issues that should be addressed? Can the Vision Statement be strengthened? If so, how?	The vision statement can be strengthened to improve health outcomes for Aboriginal and Torres Strait Islander peoples. After the words: …This strategic investment will significantly lead to an improve step-change associated with the individual and broader community impacts of heart disease, stroke and vascular diseases for all Australians… add the words, "particularly for Aboriginal and Torres Strait Islanders peoples, which evidence shows are particularly at risk."
3	**Mission Statement** Can the Mission Statement be strengthened? If so, how?	The mission statement needs to specifically call for research which can be translated into practice. When the Mission statement mentions an eco- system are they talking about a modified open learning platform, incorporating knowledge sharing within national boundaries? Or would the phrase 'learning platform' be more appropriate? There is a need for clarification around the term eco-system in this context.

4. Key issues and barriers

The Aboriginal and Torres Strait Islander population are at high risk of mortality from cardiovascular disease and receive less access to treatment. There is a need to enable evidence-based models of care and continuity of care for best practice through all phases of treatment including prevention, acute treatment, recovery, rehabilitation and ongoing support through the life course.

Compared with other Australians, Aboriginal and Torres Strait Islander peoples have a similar attendance rate for hypertension and cardiac check-ups but much higher rates of ischaemic heart disease and heart failure [AHMAC 2006]. Aboriginal and Torres Strait Islander men's death rates from heart events are 2 times as high as non-Indigenous men from as early as the age of 25 (AIHW 2014) and 3 times higher overall (Randall et al. 2014).

At the tertiary level, research and implementation of the 'Better Cardiac Care for Aboriginal and Torres Strait Islander People (2017-2019)' aimed to improve access, support and knowledge to provide evidence based culturally safe cardiac care for Aboriginal and Torres Strait Islander people, with reduced readmission and discharge against medical advice for 28 Aboriginal patients at the Princess Alexandria Hospital. This was achieved through a quality improvement approach which involved consultation with Aboriginal and Torres Strait Islander peoples, cultural training for staff members and increased representations of Aboriginal and Torres Strait Islander culture in the hospital environment. Further research in this area may enable pathways to incorporate this level of culturally safe care in mainstream services through to multiple settings at multiple treatment stages.

Co-morbid conditions such as depression and social isolation need to be understood and recognised as contributors to cardiovascular disease and included in the roadmap and prioritised for treatment. These conditions compound the social and economic impacts of cardiovascular disease.

In the medium to longer term, cardiac disease is seen as a risk factor for depression, leading to reduced participation and quality of life and increased risk of suicide (Hippisley-Cox, Fielding & Pringle 1998).Depression itself is a risk factor for ischaemic heart disease in men (Van der Koy et al.2007), so breaking this cycle is significant, and regular moderate exercise (an integral part of cardiac rehab) has been shown to reduce the symptoms of depression (Kvam et al. 2016). According to the National Heart Foundation of Australia, "Social isolation after myocardial infarction (heart attack) is associated with an adverse prognosis" (Jackson et al. 2016) and while evidence remains unclear about the best ways to address this, regular attendance at cardiac rehab sessions would lessen social isolation.

Rehabilitation is a high-risk prevention measure for reducing future mortality for those who have suffered a cardiac event, (Webb & Bain 2011*)* and treatment pathways need to prioritise referral to culturally appropriate cardiac rehabilitation for Aboriginal and Torres Strait Islander patients. Cardiac Rehabilitation has documented health and economic benefits in reducing readmissions.

Despite outcomes of reduced unplanned re-admission rate of between 28-56% (De Gruyter 2016), not all patients who are discharged from hospital with diagnoses of CVD are referred to cardiac rehab (Scott, Lindsay & Harden 2003) and patients are more likely to be referred to rehab in Queensland if they undergo a surgical procedure (31%) or are admitted to a private hospital (52%) versus a public hospital (20%) (Scott, Lindsay & Harden 2003).

Cardiac Rehabilitation has been shown to reduce the risk of further heart attack or death by 25-30%. Ideally, Cardiac Rehabilitation should involve multi- disciplinary teams of health professionals (Jackson AC, Murphy BM, Higgins RO, Beauchamp A, LeGrande M, Rogerson M 2015)

Cardiac Rehabilitation aims to restore individuals to their optimal level of physical psychosocial and emotional wellbeing and is considered an essential part of the contemporary care of heart disease. While WHO and National Heart Foundation recommend that all patients with cardiovascular disease access cardiac rehab, uptake is low in Queensland, with under 33 per cent of cardiac rehabilitation places subscribed and less than 33 per cent of attendees fully completing the cardiac rehabilitation program (Scott, Lindsay & Harden 2003).

5. Conclusion

QAIHC thanks the Department of Health for the opportunity to comment on the current Cardiovascular Health Roadmap and would welcome the opportunity to discuss this further. We extend an invitation to the Department of Health to facilitate a workshop and/or policy development with QAIHC's member services.

For further information please contact QAIHC's Policy Team on phone 3328 8500 or email policyteam@qaihc.com.au

6. References

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