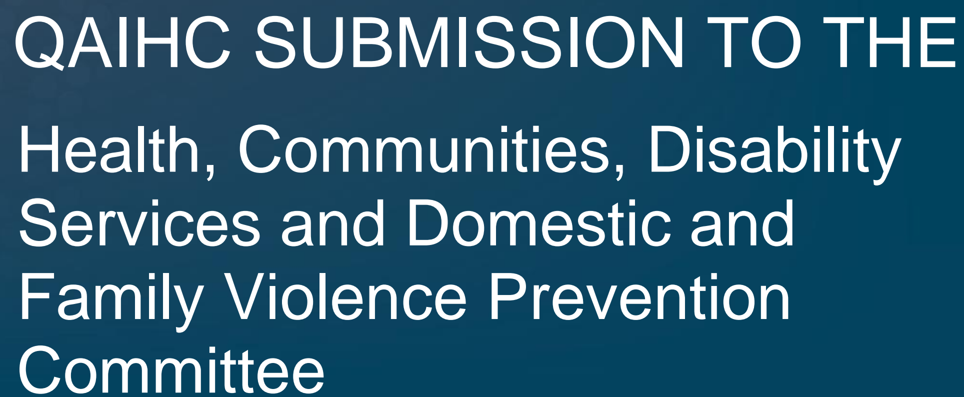
QAIHC

Queensland Aboriginal and Islander Health Council



SUBMISSION

Inquiry into the Queensland Government's Response to COVID-19 in relation to the health response only

July 2020

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QAIHC receives funding support from the Australian and Queensland Governments

SUBMISSION

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About the Queensland Aboriginal and Islander Health Council (QAIHC)

The Queensland Aboriginal and Islander Health Council (QAIHC) was established in 1990 by dedicated and committed Aboriginal and Torres Strait Islander leaders within the community-controlled health Sector (the Sector). From our first meeting 30 years ago, we have grown to become a national leader in Aboriginal and Torres Strait Islander health, and as a voice for our 26 members, the Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) in Queensland, two regional bodies and 14 Affiliate Members.

Like our ATSICCHOs, we embody self-determination; we are governed by an Aboriginal and Torres Strait Islander board that is elected by our Members.

QAIHC Members work tirelessly to provide culturally appropriate, comprehensive, primary health care services to local Aboriginal and Torres Strait Islander communities in Queensland. Collectively they have established more than 60 clinics across the State to service the population. Our two regional bodies – The Institute for Urban Indigenous Health (IUIH) and Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA) also provide support to our Members.

Our Members provide more than just holistic Primary Health Care models, they help the whole community and regional economies by encouraging whole of community wellbeing, thus creating local jobs and ensuring local design of services.

Nationally, we represent ATSICCHOs through our affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation (NACCHO) and are regarded as an expert in our field.

QAIHC, as the peak body for the ATSICCHO's of Queensland, wishes to express the collective views on behalf of our state-wide members on the Government's health response to the COVID-19 pandemic.

The purpose of this submission is to ensure the Inquiry incorporates the unique experiences of the Sector during the health pandemic. QAIHC would like to thank the Queensland Government for the opportunity to comment and would welcome opportunity to present to the Committee.

QAIHC CONTACT REGARDING THIS SUBMISSION:

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1. Opening statement

QAIHC believes that all Aboriginal and Torres Strait Islander peoples should have the same opportunity to be as healthy and as well as other Australians, and deserve equitable access to the health system.

The risk COVID-19 presented to Aboriginal and Torres Strait Islander peoples was identified as far greater than for other population groups due to the systemic disadvantage experienced by Aboriginal and Torres Strait Islander peoples in Queensland. This relative level of heightened risk remains today.

As the National Aboriginal Community Controlled Health Organisation stated in their submission to the Commonwealth Government on COVID-19: *"Generations of systemic and ongoing provision of inadequate housing and infrastructure, overcrowding and social disadvantage, and the high prevalence of comorbidities among Aboriginal and Torres Strait Islander people contribute to higher mortality in Aboriginal and Torres Strait Islander people. Over 50% of all Aboriginal and Torres Strait Islander adults have one or more chronic diseases which places them at high risk of serious COVID-19 infection. During the COVID-19 pandemic, these factors make Aboriginal and Torres Strait Islander people one of the most vulnerable populations to the COVID-19 virus. If COVID-19 gets into Aboriginal and Torres Strait Islander communities, the consequences could be catastrophic."*[1]

NACCHO and QAIHC both played an important role at a national level in setting the expectation of including the Sector in decision making for state governments, as well as QAIHC advocating in the very early stages with the Queensland Government. QAIHC recommends the Committee consider NACCHO's submission when deliberating the Australian Government's health response to COVID-19 and its impacts on the Queensland Government's response as part of this Inquiry. A copy can be found at Annex A.

It is undeniable that the Sector led the way in quickly responding to, and protecting, the vulnerable health needs of their communities whilst maintaining culturally safe, holistic health service delivery throughout the emerging COVID-19 outbreak and eventual pandemic. This is to be acknowledged and celebrated. Without the Sector's commitment, agility, substantial financial investment and expertise, the situation and outcomes would have been drastically different for Aboriginal and Torres Strait Islander peoples in Queensland. QAIHC and the Sector's extensive role included:

- the provision of cultural advice to governments;
- the production and dissemination of culturally safe resources;
- the provision of education to community members on COVID-19, the risks, hygiene and risk minimisation;
- the provision of emergency accommodation;
- maintenance of primary health care services including an agile transition to telemedicine and ensuring staff wellbeing;
- the provision of support for precautionary measures to prevent the spread of COVID-19.

Australia and Queensland acted quickly and decisively, closing international borders, enforcing quarantine, locking down the nation at the point of highest risk, and meticulously contact tracing. Federal and state governments demonstrated ability to work collaboratively, seeking advice from experts and putting health first, whilst maintaining autonomy for the benefit of their people. The situation we see in Australia is exceptionally promising, and the government's actions and leadership in the response should be commended.

Collectively, Australian Governments have demonstrated what can be achieved through a rapid, decisive, prevention-focused, unbureaucratic, evidence-based, consultative and coordinated response.

[1] NACCHO Submission on the Australian Government's Response to the COVID-19 pandemic, 28 May 2020. https://www.naccho.org.au/naccho-submission-the-australian-governments-response-to-the-covid-19-pandemic/

Of vital importance, the response was also funded to support the approach with the Queensland Government releasing $1.2 billion in additional COVID-19 related health funding.[2]

QAIHC recognises that in every disaster, opportunity can be found. The Queensland Government has the opportunity to leverage COVID-19 learnings and launch the Queensland Health system into the future. COVID-19 has taught us what can be achieved through investment in prevention and upstream health to avoid and minimise downstream catastrophe, grief and human suffering. Through applying the principles in the Making Tracks policy[3] and learnings from COVID-19 to date, QAIHC suggests dramatic change can be achieved by transforming health service responses and delivery, thereby ultimately improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples living in Queensland.

QAIHC respectfully make the following recommendations:

Ref	Solutions	Recommendation
1	**Respect the ATSICCHO Sector**	1. Recognise QAIHC and the ATSICCHO Sector's extensive and vital role in the health response to COVID-19, and the valuable contribution the Sector made, and can continue to make, to the state's wellbeing.
2	**Acknowledge shortcomings and reasons behind them**	2. Accept the shortcomings of the Queensland Government's health response, in particular in relation to partnerships and funding, and work with the Sector to prevent them from occurring again (Section 4 – problems)
3	**Capitalise on opportunities to reform health for Queenslanders**	3. Work with QAIHC to ensure short- and longer-term opportunities are realised and actioned, and reform of the relationship between the Sector and HHSs takes place (Section 5 – opportunities). This includes progressing the *Hospital and Health Board Amendment Bill* 2019 and the accompanying Regulation, as well as wider reform and support from across Government for prevention-based treatment and coordinated service delivery.
4	**Recognise the threat of a second wave and / or future health disruptions and prioritise change**	4. Recognise the realistic possibility of a second wave and / or another serious global health crisis, along with the immediate threat that a lack of access to health care presents for Closing the Health Gap, and work with the Sector to prioritise meaningful change.

[2] Funding was for fever clinics, emergency department capacity, acute care services and regional aeromedical services for remote communities. https://www.treasury.qld.gov.au/programs-and-policies/covid19-package/

[3] Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033. Policy and Accountability Framework, page 8 https://www.health.qld.gov.au/__data/assets/pdf_file/0030/159852/making_tracks_pol.pdf

2. Methodology

QAIHC and our Members recognise the important opportunity this Inquiry presents. To ensure the Sector's views are adequately presented to the Committee, QAIHC undertook a virtual SWOT consultation with Members based around the five themes presented in the below table. Consultation was also undertaken with the QAIHC Clinical Leaders Forum (CLF) which comprises of clinical experts from across the Sector who met regularly throughout the response. The feedback in this submission is based on our Member's voices and the Sector's experiences throughout the COVID-19 response.

Systems and policies	Medicare and telehealth / Decisions to postpone elective surgery / Surge workforce / Testing / PBS changes / Fever clinics / Pop-up clinics / Biosecurity zones / Isolation processes / Access to Personal Protective Equipment (PPE) / Homelessness / Food security
Stakeholder collaboration	HHS / Primary Health Network (PHN) / Local Disaster Management Group (LDMG) / Police / Allied Health / CheckUP / Funders / QAIHC
Your organisation	Staffing / Risk management / Contingency planning / Pandemic plans / WFH arrangements / Communication resources for staff / Impact on clients' health / Restrictions to services / Client engagement / Service income / Safeguarding / Transport services
Information	For community / Access to information for clinicians and managers / QAIHC update
Sector support and leadership	NACCHO / QAIHC / Queensland Chief Health Officer / Aboriginal and Torres Strait Islander Chief Health Officer / Media coverage / Clinical Leaders Forum / Policy Network / other networks.

3. Strengths of the response:

There is no single solution for a problem as vast and complex as COVID-19. However, QAIHC notes that the Queensland Government's immediate and current health response has been critical for ensuring equitable access to resources and protection for Aboriginal and Torres Strait Islander peoples. Key strengths include:

a) Self-determination was supported:

Aboriginal and Torres Strait Islander communities requested assistance from the Chief Health Officer (CHO) early on to make decisions for their own communities and ensure their voices were heard. The Premier, Deputy Premier and Chief Health Officer swiftly responded to these requests and community's decisions were respected. Relationships were developed with mutual respect. The CHO's continued communication via weekly teleconference was welcomed by remote communities.

Queensland Health took an important and timely step of working with the Local Disaster Management Groups (LDMGs) and Local Councils across Queensland to implement the Queensland Government's decision to protect remote and discrete First Nations communities under the *Biosecurity Act* 2015 (the Act). This was a substantial action to prevent local community transmission and protect remote and discrete communities.

It should be noted that the Sector pushed strongly for the Act to be enacted well before it was. Communities in the Cape York region were supported by their ATSICCHO to close early, but they did not have the powers necessary to police the closures until after the Act was enacted.

b) Aboriginal and Torres Strait Islander peoples were identified as a priority group:

The Queensland Government committed to the protection of our communities early in the pandemic. The Queensland Government acted quickly upon their established knowledge of the distinct health and social demographics of the Aboriginal and Torres Strait Islander population in Queensland, and our heightened risk of infection and mortality. Queensland Health were engaged on the issues and actions needed to safeguard Aboriginal and Torres Strait Islander peoples within a few weeks such as:

- Queensland Health invested epidemiologist time and resources to model the impact of COVID-19 on Aboriginal and Torres Strait Islander communities, for example highlighting that if the disease were to infiltrate a distinct community of less than 1,000 people, 100 percent of the population would be infected within three days, or 72 hours.
- Recognising, supporting and communicating a different definition of at-risk group if an individual is an Aboriginal and Torres Strait Islander person (aged over 50 with co-morbidities).
- Queensland Health Pathology department have supported the need to prioritise Aboriginal and Torres Strait Islander pathology tests over other HHS departments. This process was assisted by the Queensland Health pathology form already having an identifier on it, which is not the case for most other states.

c) A rapid response to the crisis:

The Queensland Government acted early and activated the State Health Emergency Coordination Centre (SHECC) to respond to the COVID-19 pandemic. Queensland Health, as lead agency, has decisively implemented a number of responses to prevent community transmission and protect the population. These included early isolation and the establishment of biosecurity zones, promotional campaigns (support and education on hygiene practices) and ensuring Fluvax availability for roll out in April (noting supply was low at the start).

d) Partnerships:

Where partnerships existed between HHSs and ATSICCHOs, the community were better prepared.

Case study:

Cairns and Hinterland Hospital and Health Service (CHHHS) established an Aboriginal and Torres Strait Islander Health COVID-19 Planning and Preparation Group led by Joy Savage, Executive Director, Aboriginal and Torres Strait Islander Health. All ATSICCHOs in the region were included as well as the Tropical Health Unit and the PHN. This provided a constructive forum for planning and preparation which built on existing relationships.

Queensland Health Aboriginal and Torres Strait Islander Health Division developed a *'COVID-19 HHS preparedness checklist for Queensland's First Nations people'* that details specific considerations for optimising the preparedness of the health system for a COVID-19 outbreak among Aboriginal and Torres Strait Islander peoples, particularly in remote and discrete communities. This checklist is intended to be used alongside a broader whole-of-population regional preparedness plan. The checklist is comprehensive and seeks broader Sector collaboration. However, the checklist lacks a mandatory requirement for it to be used. This highlights the importance of incorporating accountability requirements into policy.

QAIHC members have shared their experience that some HHSs made significant efforts of sharing workforce and PPE with ATSICCHOs in a way not seen before the pandemic which has led to improved relationships.

Case study:

QAIHC's member service Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health (CWAATSICH) closed three of their outreach clinics to reduce the risk of infection and transmission to staff and ensure that core business could be maintained. The Darling Down HHS has worked closely with CWAATSICH to ensure that vital emergency services are still delivered and available to the communities.

All CWAATSICH staff were trained in contact tracing by the HHS so the ATSICCHO could support the community should an outbreak be identified.

The PHN advised they were willing and able to provide funding to enable primary health care delivery for a community of 1,000 people in Miles. This tripartite relationship and partnership were crucial to the region's success in responding.

e) Public Messaging (Communications):

Aboriginal and Torres Strait Islander communications were dynamic, informative and culturally appropriate. Peak organisations such as QAIHC and the Institute for Urban Indigenous Health (IUIH) quickly developed communications plans and began distributing public health messaging to our communities to provide greater awareness and information. ATSICCHOs across Queensland did the same and very soon social media was flooded with Aboriginal and Torres Strait Islander communications about how to protect the community throughout COVID-19.

Queensland Health eventually supported the ATSICCHO Sector to develop specific and tailored Aboriginal and Torres Strait Islander public health campaigns to raise community awareness. The health literacy resources developed and promoted by the ATSICCHOs helped our community to understand the risks and mitigations for the virus and continue to play an important role in public messaging.

f) Collaboration - Early consultation with the ATSICCHO Sector:

On 5 March 2020, Dr Jeanette Young (CHO) and Haylene Grogan (Aboriginal and Torres Strait Islander Chief Health Officer) visited the QAIHC office in South Brisbane and held an open discussion with QAIHC CEOs and clinical leaders. This meeting was arranged due to the number of cases slowly increasing in Italy and Iran, and in response to an invitation from the Sector. This forum was an opportunity for the Sector to provide early input on Queensland Health's response for Aboriginal and Torres Strait Islander peoples.

QAIHC has had weekly meetings with Haylene Grogan and her team, with a focus being on information sharing. QAIHC was invited to participate in Queensland Health's primary care COVID-19 group which meant QAIHC were able to communicate crucial clinical information back to the Sector regularly and provide real-time situation reports directly from SHECC.

g) Contract management:

In terms of our funding agreements, Queensland Health communicated very early on that pre-COVID-19 funding relationships would be preserved and that Queensland Health would not be adding pressure on performance of contracted milestones throughout the COVID-19 period. This provided great assurance to the Sector and comfort that flexibility and understanding would be applied to funding agreements.

h) Funding:

Some of our Members received funding through the Community Services Funding Branch to support community-led initiatives. Members who were successful in that process commented that the COVID-19 immediate support measures round was an improved funding process compared to others administered by Queensland Health. Information was clear, the process was simple and timely, and the support offered by the Department in responding to queries was helpful.

i) Innovation:

Innovation always arises out of necessity and there were a number of innovative practices, through HHS and ATSICCHO partnership that have been beneficial. For instance, Gurriny Yealamucka Health Service (Gurriny) in Yarrabah has been seeking additional support to increase dialysis on country for over two years. The clinic currently has four dialysis chairs that have historically only been funded for one session per day. This meant that the majority of Yarrabah residents requiring dialysis had to travel into Cairns Base Hospital for dialysis. When the biosecurity measures were introduced and residents were unable to leave community, the HHS supported the increase of the services to all chairs used for two sessions a day, including Saturdays, resulting in very few patients needing to be transferred to Cairns Base Hospital. The dialysis program has been extended for six months.

j) Establishment of fever clinics with good geographical spread:

Queensland Health have effectively established fever clinics in all HHSs across the state over the course of the pandemic. The volume and geographical distribution of the clinics across the state was appropriate to need. In addition, Queensland Health has also supported the establishment of Australian Government funded fever clinic across Queensland. These were particularly successful in major regions and cities and removed early pressure on primary health care for testing which was a very positive outcome.

k) Hub and spoke model of testing:

While the debate around the health risk of Point of Care Testing (PoCT) machines was underway, Queensland Health developed a hub and spoke model for testing which included identifying and building urgent testing capacity of five remote sites through use of helicopters to transport specimens. While the PoCT machines were yet to be approved for use within ATSICCHOs, the hub and spoke model of testing provided intermediate relief for Aboriginal and Torres Strait Islander communities in a situation of great risk.

l) Availability of virtual medicine:

The rapid expansion of virtual medicine has been an unquestionable and positive consequence of COVID-19. In particular, the opportunity for patients to attend specialist appointments as outpatients by virtual means has created a great improvement in care. The barriers to accessing specialist care for many Aboriginal and Torres Strait Islander peoples are generally cost, communication (letters for appointment in the mail), transport, fear, and caring responsibilities. The introduction of specialist telehealth outreach is very encouraging.

The Sector is adapting to this unanticipated opportunity through rapid upgrades of dated systems and software. There are also more sophisticated methods of delivering virtual medicine, such as digital monitoring and mobile health applications. QAIHC has partnered with CSIRO and some of our Members in piloting two mobile health platforms (hypertension and gestational diabetes). The early results demonstrate much higher participation by patients than traditional clinical methods. Goondir Health Services, our member in Dalby/St George, is trialling the use of virtual health monitoring to allow patients to have their symptoms and vital signs monitored in their own home when connected to a mobile application. This includes monitoring pulse and oxygen saturation, temperature, blood glucose, weight and blood pressure.

The rapid shift to virtual medicine, a necessity of the disruption, has created a unique opportunity for developing and implementing successful virtual health solutions within ATSICCHOs.

4. Weaknesses with the response

Queensland Health failed to provide investment and resources to support QAIHC and the ATSICCHOs undertake the required additional response, leaving QAIHC and the ATSICCHOs at a financial deficit for having to cover staffing and unanticipated resourcing costs.

Without QAIHC and the Sector's prompt and significant response, the state of affairs in Queensland would be very different.

The important role of the Sector was recognised by NACCHO, who provided a small grant to QAIHC to support the coordination services. Our Sector's valuable role was also recognised by BHP who donated over $1.3 million to QAIHC to support our member services with an emergency flexible funding pool of $50,000 per service for full members. These funds only go a small way towards covering the costs that the Sector incurred and continue to incur.

During the COVID-19 crisis, QAIHC noted that the Queensland Government failed to acknowledge the role of the ATSICCHO Sector in keeping Aboriginal and Torres Strait Islander peoples in Queensland healthy.[4] Examples of this failure include the following:

a) Partnerships:

Unfortunately, meaningful partnerships between HHSs and ATSICCHOs were rare and relied upon existing relationships established prior to COVID-19.

In partnerships, partners build trust and have an agreed and shared purpose, vision and intent in working together in a supportive and transparent way. Partners design and review outcomes together and problem solve solutions. True partnerships would include co-design, co-development, co-implementation and co-evaluation with Queensland Health, HHSs and the ATSICCHOs, and must be formalised through Agreements.

There were examples of ATSICCHOs who received little to no assistance or communication from their HHS throughout the initial crisis period which could have resulted in dire outcomes for our communities. There were also limited opportunities for ATSICCHOs to participate in leadership decisions and to be involved in local pandemic plans and discussions about biosecurity zones or surge workforce. Partnerships were also missing at a LDMG level where there was a notable lack of public health expertise at the LDMG level where many decisions were made.

Queensland Health established a State Advisory Group to direct and inform government. This group met twice, after which it was not sustained. Thereafter, the Sector experienced uncertainty around where to source accurate policy advice, even though this group had been established to avoid this problem. By contrast, the National Advisory Group has been a permanent group which has credibility with senior Commonwealth Government officials and has visibility to direct and inform government advisory groups. This has been an invaluable mechanism for the Sector to communicate urgent and timely advice on the response and needs of community to the Commonwealth.

QAIHC was not immediately engaged by Queensland Health in issues and actions needed to safeguard Aboriginal and Torres Strait Islander peoples. A process for rapid communication with QAIHC as the primary point of contact on health matters pertaining to the Aboriginal and Torres Strait Islander community would have facilitated better communication with the ATSICCHO Sector. QAIHC has noted that communication with the whole of the Sector could have been improved if such a process had been established and utilised.

QAIHC initiated initial early conversations with Queensland Health regarding the need for a robust communication strategy to provide culturally appropriate, timely and effective information for all Aboriginal and Torres Strait Islander communities through local ATSICCHO engagement. However,

[4] Queensland Government: Our Future State https://www.ourfuture.qld.gov.au/commitments.aspx Keep Queenslanders Healthy

Queensland Health partnered directly with QAIHC Member, IUIH, who are regional body for South East Queensland ATSICCHOs only. Queensland Health's action failed to recognise the important role of QAIHC as the State Peak Body to effectively engage with the whole ATSICCHO Sector across Queensland.

Rather than taking an approach that empowered the community and recognised the extensive health expertise within the Sector, Queensland Health's decision-making process regarding whether PoCT machines could be located in remote and isolated communities of Queensland was one of protectionism. This delay could have been disastrous if the disease had spread.

b) Lack of data:

Aboriginal and Torres Strait Islander infection data was not readily provided to the Sector by the Queensland Government. Surveillance of positive notification data is crucial to ATSICCHO preparation for the 'on the ground' response, particularly in managing outbreaks. Despite many requests for more granular data to support community vigilance, QAIHC were advised that the State Public Health Unit was responsible for data management and it would not disclose that information to QAIHC or the ATSICCHOs. QAIHC, as a representative on the national COVID-19 Advisory Group, were provided with Queensland-level data including Aboriginal and Torres Strait Islander status, but not at a regional level until well into the pandemic response. This could have been catastrophic because without infection data, ATSICCHOs would not have been able to support those families to manage the infections and stop the spread.

The Aboriginal and Torres Strait Islander testing data remains unavailable. The state is unable to determine how many Aboriginal and Torres Strait Islander peoples have been tested for COVID-19. Although it is incredible that only nine Aboriginal and Torres Strait Islander peoples have been infected, we have no visibility of what portion of the community has actually been COVID-19 tested and whether that rate is sufficient to support adequate public health. The implementation of the commonwealth-funded ATSICCHO fever clinics provides some visibility, but they represent a small part of the testing regime. From a Queensland Health perspective, there is no policy mandating that Aboriginal and Torres Strait Islander status be recorded on pathology or notification forms which is a fundamental flaw in our public health response.

c) Inadequate resourcing for ATSICCHOs:

Lack of respect for the ATSICCHO Sector as a core primary health care pillar in the Queensland Health infrastructure:

The current division of health responsibilities between the Commonwealth and State governments creates and sustains a gap between primary health care and tertiary care which was emphasised during this crisis response. This division of powers led to confusion around who was responsible for primary health care funding and support, but also failed to identify the crucial role of the Sector in the Queensland Government's response. The ATSICCHO Sector provides a vital and core role in the health system which needs to be recognised as implicit to the Queensland Health infrastructure; with better partnerships, accountability and funding arrangements in place.

Consultation and the provision of advice, support and clinical leadership:

Whilst a limited amount of meaningful partnerships were developed, the Sector was regularly called upon for advice, support, communications and clinical leadership. These requests for support came, however, without any financial remuneration . For the sake of our communities, our Sector leaders were more than willing to give their time, however time is costly and without funding, this came at the expense of the ATSICCHOs.

By way of example, the Aboriginal and Torres Strait Islander Health Division has worked to develop specific outbreak modelling for remote and discrete communities. This modelling draws upon the national work undertaken by the Doherty and Kirby Institutes to inform the development of a COVID-19 Testing Strategy for Queensland Aboriginal and Torres Strait Islander peoples and communities and Public Health Guideline for COVID-19 Outbreak in First Nations Communities. Queensland

Health has recently consulted with QAIHC on this strategy, involving consultation with 10 lead clinicians (online) that lasted for one hour. A lead clinician can raise approximately $180 per hour in Medicare revenue. The Sector's involvement in this important consultation is likely to cost at least $1,800 from lost Medicare income, not including any QAIHC costs in supporting the consultation. There is a need for the Strategy and the Sector does have value to contribute. However, the Strategy would have been strengthened if it had been developed in partnership with the Sector.

Since March 2020, the Clinical Leaders Forum have met an additional seven times to specifically discuss the COVID-19 response. A key focus has been to provide feedback to Governments regarding the situation on the ground, including: access to PPE; testing; flu vaccines; quarantine and isolation solutions; pandemic response plans; and communication needs.

Public health messaging:

Queensland Health did not have the capacity to develop culturally safe communications about COVID-19, with Minister Miles confirming a few weeks into the pandemic that no suitable resources existed for Aboriginal and Torres Strait Islander populations. By comparison, the Commonwealth Government commissioned Creative 33 (an Indigenous organisation) to produce their entire media campaign and Creative 33 chose to partner with First Nations Media to develop a specific Aboriginal and Torres Strait Islander campaign.

At the Direction of the now Deputy Premier, IUIH and QAIHC were engaged to coordinate and distribute a series public health communications. Given the expediency of the issue and the delay in sourcing Queensland Health funding, both organisations initially provided this assistance to Queensland Health at our own expense. This type of service delivery is not sustainable for community organisations.

The public health directions released by Queensland Health were not always translated into directions suitable for lower socio-economic, more remote settings or relevant to the social determinants of health context that is reality for many Aboriginal and Torres Strait Islander peoples in Queensland. For example, the guidance to "*use the spare bedroom with the ensuite to self-isolate*" is not an option in most remote community households or where overcrowding is present.

Health promotion:

Queensland Health failed to provide investment and resources to support ATSICCHOs to undertake the required additional health promotion response, leaving ATSICCHOs at a deficit for having to cover staffing and unanticipated resourcing costs. ATSICCHOs had limited resources to support running public health campaigns and for modifying the QAIHC culturally appropriate resources to their local community context. This would have been crucial to create infection control and prevention awareness among the wider Aboriginal and Torres Strait Islander communities. An optimal health response required the Sector to quickly mobilise to help the community understand how to prevent the spread of the virus (including how to wash hands effectively and what social distancing means), what to do if someone has symptoms, how to access help, and what isolation and quarantine are.

Case study:

QAIHC's member Mulungu Aboriginal Corporation Primary Care Services (Mulungu) are based in Mareeba on the tablelands of Northern Queensland. They service the communities of Mareeba, Atherton and Kuranda and the surrounding region. When the pandemic struck, Mulungu immediately recognised the need to educate community members on social distancing, good hygiene and what to do should they feel sick. To do this, a team of staff physically visited every patient over a number of days to speak with them about the COVID-19 pandemic and ensure their understanding. This intensive activity required existing health staff to be diverted from their usual duties and was conducted without additional health service funding. Mulungu also reached out to the police and made an informal agreement that if the police spot groups gathering, they will call the health service rather than intervene themselves. This enabled the health service staff to have opportune conversations with community about the need for social distancing to protect their health without necessarily making the issue a police matter.

Maintaining primary health service delivery in biosecurity zones:

The need for staffing flexibility to meet the service delivery needs of the communities in biosecurity zones was greater than for communities outside biosecurity zones. ATSICCHOs across Queensland acted on the needs and requests of the community in several instances at substantial cost. The Queensland Government did not provide any financial aid for this support which put ATSICCHOs at greater risk of service discontinuity.

Case Study:

QAIHC's member Apunipima Cape York Health Council (Apunipima) responded to community requests for more stringent COVID-19 screening and precautionary measures from their health service than provided by the HHS, and subsequently implemented a requirement for clinicians to quarantine in community for 14 days prior to delivering services. Medical staff changed their working patterns, with some remaining in community for over two months (where they usually fly in and fly out weekly). This resulted in an additional cost burden and some communities were over-serviced, particularly in March and April 2020 when clients were not visiting the health clinic as frequently. Apunipima were able to use medical staff time for paper-based health reviews which were helpful, but not income generating.

Supporting people who use Alcohol and Other drugs (AOD) in biosecurity zones:

There was also a failure by the Queensland Government to identify the impact of biosecurity restrictions on people who have a problematic use of AOD, and on communities with Alcohol Management Plans in place. There was a lack of consideration and support available to people who have a problematic use of AOD in the context of travel limitations impacting on service availability and the suspension of some services. There was a lack of medical support available to people with addictions for withdrawal management and detoxification. COVID-19 amplified and exacerbated existing problematic health service issues in an already fragmented system as remote communities did not have community members skilled in being able to provide brief interventions and medical support during lockdown. This gap in service delivery resulted in increased vulnerability for some residents and communities.

Mental health and Social and Emotional Wellbeing support:

The Government has recognised the mental health consequences of isolation, social distancing and unemployment, however, ATSICCHOs were not supported to reach out to communities and respond to mental health and social and emotional wellbeing needs. The consequences of lockdown are reported to include increases in AOD use, increases in levels of family and domestic violence, and increases in levels of poor mental health and social and emotional wellbeing.

ATSICCHOs are the best placed organisations to support their communities through times of crisis, however a lack of recognition by government and support for community-driven responses has left individuals unsupported and communities vulnerable.

Case Study:

Cherbourg Regional Aboriginal and Islander Community Controlled Health Service Ltd (CRAICCHS) identified the most significant and local need highlighted during the COVID-19 pandemic to be youth mental health and suicide prevention. Due to the vulnerabilities of the Cherbourg community, the community was locked down and protected by the *Biosecurity Act* 2015.

A consequence of the lock down was a restriction in the type of services available in community. This deficit contributed to a decrease in preventive mental health support and an increase in risk factors. The community have seen an increase in deaths by suspected suicides relative to pre-COVID-19 occurrences of intentional deaths. In a community the size of Cherbourg, the heightened exposure to suicide has been traumatic and the effects are far-reaching. As of 25 May 2020, the Cherbourg community experienced three youth deaths by suspected and one attempt suicide in a period of just two months.

CRAICCHS have responded by utilising $50,000 from the QAIHC COVID-19 Flexible Funding Pool to establish and build a youth hub in the community. The hub will be open after hours and staffed by local community members. CRAICCHS will provide a safe drop in space for youth. CRAICCHS will be available to support the youth, reduce isolation, and provide safety and wellbeing information in a culturally safe way. The funding used to respond to this community-level crisis is non-recurrent. Therefore, the ongoing sustainability needed to maintain much-needed support is at-risk in the long-term.

The model developed by CRAICCHS and supported by the QAIHC COVID-19 Flexible Funding Pool exemplifies how the Sector can respond to community need. However, it also demonstrates the gap in equitable funding distribution to support culturally appropriate and best-practice suicide prevention. For example, $10.8 million has been committed over four years for Safe Haven Cafés as part of the Queensland Government's $62 million allocated to suicide prevention in the 2019-20 Budget. A Safe Haven Café essentially embodies the model developed at a grass roots initiative in the Cherbourg community. It is important to highlight that the Sector received no funding to participate in Safe Have Café trials currently under development with mainstream organisations, such as Beyond Blue.

d) Queensland health funding for the Sector was delayed:

The vulnerabilities of Aboriginal and Torres Strait Islander peoples were well known very early in the pandemic. However, funding specifically to address community-led responses did not eventuate until eight weeks into the response. Despite the critical nature of ATSICCHOs in supporting the HHSs' response for Aboriginal and Torres Strait Islander communities, there was very limited funding by HHSs to ATSICCHOs for COVID-19 activities. Recently, a $21 million funding announcement was made for a 'First Nations response' to COVID-19 which is encouraging, but the funding was given to the HHSs' with only encouragement to partner with ATSICCHOs.

e) Poor public visibility:

Despite early acknowledgement of the COVID-19 related vulnerabilities of Aboriginal and Torres Strait Islander peoples, mention of Aboriginal and Torres Strait Islander communities was seemingly absent from the media appearances of the Premier, Deputy Premier and CHO. Additionally, Queensland Health's public coverage did not include the Aboriginal and Torres Strait Islander Chief Health Officer.

The Queensland Government's lack of inclusion of Aboriginal and Torres Strait Islander messaging became a very large concern in some communities when the announcement that "Queensland was open again and Queenslanders had earned the right to move around freely" was not qualified in public statements with an explanation that this did not apply to residents of biosecurity zones. Unfortunately, this meant that in some communities, there was violence and tensions directed towards ATSICCHOs who were blamed for 'keeping the residents locked in'.

f) Lack of accountability:

Queensland Health's Aboriginal and Torres Strait Islander Health Division developed some important Aboriginal and Torres Strait Islander guidance material, such as the First Nations Checklist for hospitals. Sector feedback on the documents has been positive.

These guidance documents were undermined, however, from a lack of accountability as they are only for 'guidance'. The guidance was not implemented as policy and therefore is not able to be measured. Information disclosure between HHSs and ATSICCHOs was haphazard during the crisis. Where partnerships existed, information was typically free-flowing. However, in general, the COVID-19 specific processes (such as clinical pathways or isolation/quarantine accommodation procedures) were not readily shared with ATSICCHOs. Additionally, the HHS policies that QAIHC were provided for consideration were not considered to be appropriate. Additionally, ATSICCHOs

were not routinely included in biosecurity discussions despite being a critical service provider and central to the health and self-determination of the remote communities.

g) The HHS processes for accessing isolation and quarantine accommodation were unclear and disjointed:

Queensland Health introduced quarantine/isolation measures including travel and entry restrictions, testing and test results, people experiencing symptoms and self-quarantine requirements to effectively prevent community transmission. Queensland Health, in conjunction with other Queensland Government agencies, funded hotels for peoples who were required to quarantine/isolate. However, Aboriginal and Torres Strait Islander peoples were facing unique challenges. In particular, overcrowded housing where it was not possible to adhere to quarantine or isolation requirements. Queensland Health provided no funding support for ATSICHCO's to manage or support required community accommodation. In rural and remote communities with a need for accommodation, the ATSICCHO was required to liaise with the Public Health Unit for available accommodation. These decisions were based on the Public Health Unit's discretion, which were not always culturally safe. In some instances, ATSICCHOs were advised that the HHS was not in a position to support isolation and quarantine accommodation. This caused considerable frustration as the media was flooded with reports of disgruntled returned overseas travellers in government funded four-star quarantine accommodation. For Queensland's discrete communities, the process for developing isolation or quarantine solutions on country was convoluted and slow, with funding available to support community-led proposals limited. There are only a couple of examples where isolation accommodation on country was supported.

Case Study:

In the remote community of Yarrabah in Northern Queensland, the ATSICCHO Gurriny Yealamucka Health Service (Gurriny Yealamucka) identified an urgent need for isolation facilities. In early April 2020, Gurriny Yealamucka requested funding for demountable units and the repurposing of other accommodation to provide isolation facilities for up to 40 individuals. The request was made to Queensland Health and to the Commonwealth Department of Health through NACCHO. On 1 May 2020, the matter was raised at the Queensland Aboriginal and Torres Strait Islander Health Partnership forum as no response had been received from either government despite the substantial risk. On 1 July 2020 the HHS met with the ATSICCHO to discuss this proposal and verbal agreement has been given. The lack of timely recognition by government for locally designed solutions is not only dangerous if an outbreak were to occur, but it also contributes to community frustration.

h) Unavoidable downscaling of hospital services:

The decision to halt elective surgery was necessary and appropriate. The unavoidable consequence of the downscaling of hospital services is likely to have exacerbated waitlists for much needed elective surgery, dialysis and oral health care. Additionally, a reduction in specialist services is likely to have reduced the number of patients who should be on elective surgery wait lists. This is particularly concerning in remote areas where specialist services have been significantly reduced due to travel restrictions. This is likely to have a sustained and notable negative impact on the ongoing health and wellbeing of Aboriginal and Torres Strait Islander peoples.

5. Opportunities arising from the response:

COVID-19 is currently the top priority for the Australian health care system. There is still uncertainty about how the pandemic will unfold and there are implications that a response will require long-term commitments from the health sector. Government and non-government organisations have put in huge efforts to respond to the crisis. Through the pandemic response, the Sector is now better prepared. However, there are many opportunities to use the experience of dealing with this crisis to continue to reform the Queensland healthcare system.

Recognising this, Queensland Health have established a Reform Planning Group whose purpose is to advise "…*how best to harness the opportunities arising from the pandemic to achieve the best possible health and healthcare for Queenslanders. Reform activities must focus on preventing ill health and delivering better value for our patients, our workforce and our public health system*."

The Sector's view is that Reform must make way for sustainable and effective partnerships between ATSICCHOs and HHSs, and be funded to appropriately achieve a seamless and culturally safe care journey for Aboriginal and Torres Strait Islander peoples.

Sustainable partnerships are about system integration. Systems integration is more than just increasing relationships between HHSs and ATSICCHOs, the funding of time limited projects addressing an emerging health issue, or engaging with ATSICCHOs to increase consumer feedback or provide cultural advice. System integration is about embedding the ATSICCHO Sector as an important and inextricable partner in the Queensland Health health system.

Recurrent, sustainable funding for ATSICCHOs must be built into the HHS funding model to ensure that the Sector is resourced effectively as health system partners. For the foreseeable future, Australia will be challenged economically so it is important that we are highly critical of the allocation of existing HHS funding. System reform does not mean finding new money. This opportunity for change represents a huge shift in health care design. For decades, the Sector has been saying that the objective should be to keep Aboriginal and Torres Strait Islander peoples out of hospitals, yet the resourcing and policy focus has not supported that rhetoric. Redesigning how funding is spent on Aboriginal and Torres Strait Islander health should mean directing it to the delivery of innovative, preventative community controlled services to reduce current service duplication, contribute to the reduction in preventable hospitalisations, and support a continuous care journey for Aboriginal and Torres Strait Islander peoples.

Lastly, but most importantly, the elimination of health disparities is not possible without health equity. Following the Committee's recommendations from the Inquiry into the *Health Legislation Amendment Bill* 2019, QAIHC hopefully anticipate Parliament's decision on the second reading. QAIHC is working with the Aboriginal and Torres Strait Islander Health Division in relation to the *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation* 2020. Achieving Health Equity is everyone's responsibility and Queensland Health must foster a culture committed to the eradication of interpersonal and institutional racism. It needs to be more than an aspiration, it requires greater accountability. Health Equity performance measurements must be built into the HHS funding model. The proposed Health Equity Strategies should be co-designed, co-developed, co-implemented and co-evaluated with the ATSICCHO Sector and, where possible, Aboriginal and Torres Strait Islander consumers. Consultation does not go far enough and genuine partnerships are needed.

The COVID-19 pandemic has highlighted the value that can be realised from co-designing, co-developing, co-implementing and co-evaluating services with the community in control, and supported by the Government. Decision making and resource allocations currently lie entirely within the HHSs with little transparency or requirement for HHSs to demonstrate that their decisions have the support or approval of Aboriginal and Torres Strait Islander peoples, or their representative bodies, even though these matters directly impact Aboriginal Torres Strait Islander peoples.

With this in mind, QAIHC respectfully makes the following recommendations for short-term and longer-term health system reform and would welcome the opportunity to discuss them with the Committee further.

A. Short term opportunities

a) Acknowledge and raise public awareness of institutional racism:

Recognise, and publicly acknowledge, that some Queensland government actions and decisions taken in response to COVID-19, or lack of action and decisions taken, reflect an ongoing lack of awareness of institutional racism across all government systems (not just health) and the need for implicit reform. For example, the lack of public visibility on the reasons why biosecurity zones were so important and acknowledging the intergenerational trauma that has led to Aboriginal and Torres Strait Islander peoples becoming a vulnerable population group.

b) Retain the focus on culturally safe communications:

Communities responded very well to the culturally appropriate, regionally relevant public health material produced by QAIHC, IUIH, their ATSICCHO and the Queensland Government.

Queensland health does not have an Aboriginal and Torres Strait Islander communications team. Accordingly, given the important nature of culturally appropriate, regionally relevant health communications, QAIHC proposes that Queensland Health consider embedding Aboriginal and Torres Strait Islander communications in their organisational structure or entering into a fee-for-services arrangement with the Sector to develop regular Aboriginal and Torres Strait Islander communications material.

c) Reform the elective surgery wait-list process:

The Deputy Premier recently announced an Elective Surgery blitz, funded at $250 million, to support the backlog of patients awaiting elective surgery. The ATSICCHO Sector is willing and able to support the reduction of the waitlists for Aboriginal and Torres Strait Islander peoples through the funding of a Queensland ATSICCHO Surgical Pathways pilot.

Long wait lists pose a significant threat to Aboriginal and Torres Strait Islander peoples' health and, the longer they wait, the less likely they are to continue to pursue preventative treatment. There are a number of barriers for Aboriginal and Torres Strait Islander peoples both presenting to outpatient specialists and eventually participating in elective surgery. Barriers include fear, transport, lack of information, separation from family or support and costs if travel is involved.

Case Study:

The Sector currently has a strong example of an ATSICCHO-led surgical pathway that has achieved excellent results for Aboriginal and Torres Strait Islander peoples receiving vision-saving cataract surgery.

The partnership between IUIH and the Mater Springfield Hospital has resulted in over 300 cataract surgeries being performed in South East Queensland with Surgery Connect funds covering hospital related costs. IUIH has found that with this program, wait list times for cataract surgery in South East Queensland have drastically reduced. Demand is sufficiently addressed with just four batched surgery days per year, generally on weekends.

The cataract surgery pathway is coordinated by IUIH, with a staff coordinator as the connection between the family, the primary care provider, the specialist and the hospital. The IUIH team supports transport to and from the hospital on surgery days, provides support at the hospital throughout the day and then coordinates follow up care and education.

The benefit of this model is coordinated, consistent, culturally safe care and the patient is truly at the centre. This model has demonstrated that barriers to participation for Aboriginal and Torres Strait Islander peoples can be overcome.

The ATSICCHO Sector has the capacity to replicate this model in other regions such as North and Far North Queensland or Central and South West Queensland where relationships between the HHS and ATSICCHO Sector are strong and the need is high across all elective surgery categories. This pilot would utilise the Sector's culturally safe holistic health model of care to provide wrap around support services for patients requiring elective surgery. This would include specialist appointments, surgery and follow up care in the pilot area.

Given the public hospital costs are likely to be covered by Surgery Connect (and surgeons more likely to bulk bill patients if surgeries are batched) the only funding required would be to support transport and accommodation for out of town patients and the establishment of a Surgical Pathway Coordination team in the pilot region.

Other outcomes from this project could include:

a) Provide all patients with regular access to specialist support services, no matter where they live to ensure they are added to surgery waiting lists (e.g. optometrists, dentists, GPs who refer for elective surgeries etc.).

b) Aboriginal and Torres Strait Islander patients on elective surgery waiting lists are advanced and prioritised using the Sector's model which puts patient care at the centre of discussions.

c) The health sector has greater transparency of elective surgery waiting list data and patient prioritisation processes. ATSICCHOs, who are likely to be able to indicate the extent to which the wait lists reflect the population need, can be utilised to identify gaps in wait lists early on.

d) Eradicate institutional racism including the way clients are removed from waiting lists if they do not attend appointments, recognising this is happening because of a lack of understanding, discomfort, social or cultural obligations to leave or stress, and not because of a defiance for the health system. The language used to describe the patients who are unable to attend appointments also needs to change from "failure" to attend.

The pilot gives Queensland Health the opportunity to witness the value of embedding ATSICCHO led surgical pathways in long-term HHS operations.

d) Improve testing and screening data (pathology):

COVID-19 highlighted that there is currently limited visibility to Aboriginal and Torres Strait Islander testing and screening rates. Whilst there is a section on the Pathology Queensland forms to identify Aboriginal and Torres Strait Islander status, it not compulsory to complete it (and therefore it is rarely completed). The Queensland Fever clinics also have the option on their forms, but again it is not compulsory. The notification forms also include a non-compulsory option to identify that the patient is an Aboriginal or Torres Strait Islander person. Only recently, Queensland Health has started the process of linking all COVID-19 pathology tests to Aboriginal and Torres Strait Islander identification information from the Queensland Hospital Admitted Patient Data Collection (QHAPDC). This retrospective evidence-building would not be necessary if the Aboriginal and Torres Strait Islander identification processes were embedded in policy and supported through clinical governance.

Testing and screening protocols are essential to prevent an outbreak of COVID-19. Nationally, the Commonwealth Department of Health and the Australian Health Protection Principal Committee have started to review what is required to increase identification of Aboriginal and Torres Strait Islander peoples in pathology testing. QAIHC recommends that Queensland Health build into policy a requirement that Aboriginal and Torres Strait Islander person status is collected on all pathology, fever clinic and notification forms. This is a chance for the Queensland Government to be ahead of the game.

e) Embed COVID-19 system improvement as business as usual:

A number of system improvements have been made in response to the pandemic and these should be retained and integrated as business as usual. These include: the partnerships developed

between ATSICCHO and HHSs; provision of renal services on country; fever-clinics; regular group meetings and consultation with community; and improvements to virtual and telemedicine.

f) Respect the ATSICCHO Sector:

There is opportunity to better acknowledge and understand the value that QAIHC and the ATSICCHO Sector provide to the health of Queenslanders so that they might be more effectively integrated into the health system. This must include addressing process oversights that fail to list QAIHC as the peak body for ATSICCHOs.

B. Longer term opportunities

The COVID-19 response emphasised existing shortcomings in the health system. In particular, the levels of integration that existed between primary and tertiary health care.

a) Partnerships - an Aboriginal and Torres Strait Islander health voice:

The lack of true partnership between the Sector and Queensland Health led to unnecessary confusion, a lack of self-determination and extraordinary cost incurred by ATSICCHOs in order to provide the protection required for their communities.

The COVID-19 crisis highlighted the need to establish a formal partnership model between the Sector and Queensland Health to ensure effective lines of communication and decision making. This foundation is particularly important in times of crisis, yet will also strengthen service integration during periods of business as usual to support sustainable change.

QAIHC recommend the establishment of a Health Equity Joint Advisory Committee consisting of representatives from QAIHC, the ATSICCHO Sector and Queensland Health. Representatives should include subject matter experts to guide system reform, ensuring overarching state-wide consistency and accountability.

b) Partnerships - Regional Network Funding Agreements

To resolve the regional-level partnership failings, Regional Network Funding Agreements between HHS and ATSICCHOs could be established to support consistent and dynamic systems change in Queensland. The objective of these agreements would be to integrate systems, reduce duplication and shift focus of care on to the patient.

Network Funding Agreements would contribute to achieving health system integration by providing core funding to the ATSICCHO Sector in recognition of the impact community-controlled comprehensive primary health care services have on reducing preventable hospital admissions and other avoidable hospital costs. The agreements would support co-designed Health Equity Strategies, Regional Steering Committees and the implementation of consumer advisory groups.

There are several examples of service duplication between ATSICCHOs and HHSs. For instance:

- the Maternity Services Integration Project, currently being undertaken by QAIHC, has revealed that in almost every location in Queensland, both the hospital and the ATSICCHO deliver Aboriginal and Torres Strait Islander antenatal education and support, generally targeting the same client base.
- QAIHC's Oral Health position statement released earlier this year, demonstrates that in some regions both the HHS and the ATSICCHO provide similar oral care services, on some occasions to the same client base.

- In most regions in Queensland, both the HHS and the ATSICCHO provide immunisation clinics for Aboriginal and Torres Strait Islander peoples and on a number of occasions, QAIHC has received reports that the duplication in services has actually resulted in clients receiving multiple doses of the same immunisation.

Network Funding Agreements could support the sub-contracting of prevention, wellbeing and other activity to ATSICCHOs. This could include dental clinics, dialysis, specialist appointments, coordination of surgical pathways, and maternity services (particularly midwifery). This could also involve the delivery of services on country and closer to home.

The Network Funding Agreements could also give rise to better data management and innovation. Currently, there is a tension about the sharing of data held by both the ATSICCHOs and the HHSs. The lack of coordination and appropriate distribution of information within data sets interrupts the journey of care. Under a Network Funding Agreement, a minimum data set could be co-designed by both Sectors and the Viewer (the tool used to see data) could be utilised more effectively and to its full potential when such a dataset has been agreed.

Additionally, both ATSICCHOs and HHSs expend significant time and resources on research projects. The co-development of research collaboration principles and regional priorities would be of significant benefit to both parties by reducing unnecessary costs. This coordination would also help lessen the impost on community and workforce by avoiding their participation in unnecessary and duplicative research activities, as well as ensuring research funding is invested where it is needed and wanted.

c) Increase efficiency and fix the funding model:

The funding model needs to be re-aligned with Aboriginal and Torres Strait Islander health needs.

ATSICCHOs, through their family centred, holistic Model of Care, create and support a positive patient journey that is culturally safe and focused on improving holistic health outcomes. The unique skills, community-ownership and extensive experience in delivering quality comprehensive primary health care define best practice holistic health services for Aboriginal and Torres Strait Islander peoples. Recognising the ATSICCHO Sector's value would facilitate redesign of the funding model to keep Aboriginal and Torres Strait Islander peoples out of hospitals and shift the focus to culturally safe, innovative and preventative primary care. This will achieve value by reducing duplication and increasing efficiency.

The ATSICCHO Sector currently provide HHS-related services, such as dentistry services[5], maternity services support throughout the maternal journey from antenatal to postnatal support, surgical pathways such as the IUIH's Eye and Ear Surgical Services program, wraparound support services for renal patients, and GP visits upon discharge of chronic disease patients. These programs provide examples of how the ATSICCHO and HHS health systems operate best for the patient when they work together.

HHSs are able to earn incentivised, activity-based funding that is weighted for vulnerable populations (such as Aboriginal and Torres Strait Islander peoples). The 'revenue' that is currently derived from this type of activity is commonly used to make infrastructure upgrades or top-up other areas of the HHS that may be experiencing a shortfall. This design represents an ethically questionable incentive against providing adequate care. Revenue that is garnered for servicing Aboriginal and Torres Strait Islander peoples should be redistributed back into Aboriginal and Torres Strait Islander service delivery. That funding could be used to support meaningful and sustainable partnerships between HHSs and ATSICCHOs.

[5] See QAIHC's Oral Health Care Report 2020 - https://www.qaihc.com.au/media/37576/0069-qaihc-oral-health-care-in-queensland_v10_f.pdf

d) Accountability:

There is limited, and arguably nil, point in implementing health equity measures and systems change if no one is held accountable for achieving them. HHS funding should be designed with equity in mind. Boards should report against equity measures. Chief Executives should have health equity built into their employment contracts and Health Equity Strategies should be reviewed, published and consistently reviewed for quality and effectiveness. Our health system leadership must be transparent and held accountable for health inequity.

e) Apply pandemic-best practice principles to other health crises:

The coordinated focus on rapid response, collaboration and investment that occurred during the COVID-19 crisis demonstrates what can be achieved when significant health threats are prioritised. The potential gains that could be made towards other emerging and chronic health crises, such as communicable diseases (e.g. the sexual health epidemic) and non-communicable but highly preventable diseases (such as rheumatic heart disease, cancer, poor oral health and chronic diseases) would significantly improve lives and communities for many Aboriginal and Torres Strait Islander peoples where health crises are an enduring and unfortunate reality.

f) Improve clinical capability:

The *Hospital and Health Amendment Bill* 2019 and the introduction of Health Equity Strategies will support improvements to clinical capability. Alongside the legislative change Queensland Health needs to support wider workforce reforms. This could involve: increasing Aboriginal and Torres Strait Islander leadership and governance through workforce reforms in HHSs; supporting Aboriginal and Torres Strait Islander Board members to network and meet regularly with each other and with the ATSICCHO Sector; and supporting all Board members to develop a deep understanding of cultural safety and the ATSICCHO sector.

Investment is also needed in developing new workforce rather than moving workforce between sectors – there is a need to be cognisant of the impact an increase in HHS workforce targets will have on the ATSICCHO Sector workforce (as HHSs' higher salaries often attract workforce from the ATSICCHO sector leaving the ATSICCHO sector short staffed). Developing the workforce also includes empowering Aboriginal and Torres Strait Islander Health Workers / Practitioners to perform to their full scope of practice within the HHS system.

g) Provide healthcare closer to home:

Work with the sector to develop how tertiary healthcare could be delivered from the home, for example through providing renal on country or specialist appointments via virtual medicine.

6. Threats remaining for the future:

A threat remains to the health and wellbeing of Aboriginal and Torres Strait Islander peoples, not only from the risk of COVID-19 and low testing rates, but also because of a backlog in access and uptake of health services that occurred during the initial COVID-19 crisis period (first half of 2020). There are potentially long-term health consequences resulting from the pandemic that are yet to be seen and may extend beyond 2020. For example, missed or delayed opportunities for preventive intervention due to lower than average screening and detection of a wide range of health issues. There will also be backlogs in access to elective surgery and likely longer-term impacts through lack of HHS services, such as sexual health contact tracing, specialist visits to community and referrals onto waiting lists.

The Government has recognised the mental health consequences of isolation, social distancing and unemployment. In addition to these, QAIHC anticipate (and has already heard anecdotal evidence of) increases in deaths by suspected suicide, a reduction in access to health care services, reduced screening (e.g. for cancer) and increases in waiting times for surgery and oral health care. The true impact of the pandemic on Aboriginal and Torres Strait Islander health and communities will only be realised over the long term.

A concerted effort is needed to ensure that COVID-19 does not disproportionately impact on the health and wellbeing of Aboriginal and Torres Strait Islander peoples. This is particularly pertinent during the current climate where there is already a substantial underspend on Aboriginal and Torres Strait Islander health. The health need is recognised to be 2.3 times greater than non-Aboriginal and Torres Strait Islander peoples, and government health systems are known to lack cultural safety that is needed to provide health equity.

7. Conclusion

The Queensland Health response to the COVID-19 pandemic emphasised existing health equity failings within the health system relevant to the needs of Aboriginal and Torres Strait Islander peoples. Queensland should, and could, have been better prepared for the pandemic. The occurrence of a pandemic is a predictable public health scenario, and one which Queensland experienced in 2003, with the severe acute respiratory system (SARS) outbreak, and again in 2009 with the swine flu outbreak. Queensland is fortunate that, to date, COVID-19 has not been widespread in Queensland.

There is opportunity to fix the cracks identified in the health system so that Queensland is better prepared to manage COVID-19 into the future, and to protect Queenslanders from future health threats.

The Queensland Government response has highlighted systemic barriers that currently exclude the perspectives of Aboriginal and Torres Strait Islander peoples, a lack of genuine partnerships between Aboriginal and Torres Strait Islander peoples and their organisations and Queensland Health, and an expectation that the Sector is able to work beyond their remit for free.

Many changes to health systems will require legislative levers to effect reform so that the commitment can be sustained and have longevity. The *Hospital and Health Amendment Bill* 2019 and supporting Regulation are important examples of such legislative levers.

Systems change needs to go further than legislation alone, and there are some simple changes that can take place in the short-term which QAIHC recommend. These include building Queensland Health's capacity to produce culturally safe communications, reforming the elective surgery process for Aboriginal and Torres Strait Islander peoples, improving testing and screening identification data, and embedding improvements such as virtual medicine as systems as usual.

In order for the health system to be effective, there needs to be genuine partnerships, funding, and accountability. Partnerships require the sharing of decision making, power, control, responsibility and accountability. They will also support our people to exercise their right of self-determination, as designers of the health services that are there to protect and support their advancement.

A re-distribution of decision-making authority on matters that pertain to Aboriginal and Torres Strait Islander peoples is needed. Decision making and resource allocations currently lie entirely within the HHSs with little transparency or requirement for HHSs to demonstrate that these decisions have the support or approval of Aboriginal and Torres Strait Islander peoples or their representative bodies, despite the matters direct impact on Aboriginal Torres Strait Islander peoples. To truly create change, real partnerships are required, the funding model needs to be fixed, and Queensland Health must be accountable to its decisions.

We agree with the Deputy Premier's statement that the focus needs to be on the health of Queenslanders and not Queensland Health. It is time for Queensland Health to release control and work in true partnership with the ATSICCHO Sector to improve systems, partnerships and funding processes.

QAIHC respectfully recommends that the Committee consider the opportunities highlighted in this submission to help to counter the ongoing threats from COVID-19 to Aboriginal and Torres Strait Islander peoples and would welcome the opportunity to discuss them with the committee further.

Annex A: NACCHO Submission on the Australian Government's response to the COVID-19 pandemic

Overview:

"The COVID-19 virus has exposed the vulnerability of Aboriginal and Torres Strait Islander people to pandemics. Generations of systemic and ongoing provision of inadequate housing and infrastructure, overcrowding, and social disadvantage, and the high prevalence of comorbidities among Aboriginal and Torres Strait Islander people contribute to higher mortality in Aboriginal and Torres Strait Islander people. Over 50% of all Aboriginal and Torres Strait Islander adults have one or more chronic diseases which places them at high risk of serious COVID-19 infection. During the COVID-19 pandemic, these factors make Aboriginal and Torres Strait Islander people one of the most vulnerable populations to the COVID-19 virus. If COVID-19 gets into Aboriginal and Torres Strait Islander communities, the consequences could be catastrophic.

The Australian Government, along with its counterparts in the States and Territories, has recognised Aboriginal and Torres Strait Islander people are highly vulnerable and that it would be catastrophic if the COVID-19 virus was to spread to communities. This same recognition did not occur with the 2009 H1N1 influenza epidemic, during which Aboriginal and Torres Strait Islander peoples suffered a death rate of more than four times higher than non-Indigenous Australians.

The high level of collaboration by the National Cabinet has been instrumental in achieving the low number of COVID-19 cases among Aboriginal and Torres Strait Islander peoples, together with the leadership of Aboriginal and Torres Strait Islander people across our health sector and Ms Pat Turner's leadership on negotiating a new National Agreement on Closing the Gap. In addition, responsiveness by Department of Health (DoH) staff to work in genuine partnership with NACCHO, Affiliates and other Aboriginal and Torres Strait Islander health experts has also contributed significantly to the outcomes to date. There has been extensive support and partnerships with the Royal College of Physicians and General Practitioners, the Australian Medical Association, mining companies and others in the private sector.

It is however, important to note that the support, programs and collaboration is provided as a response to the COVID-19 pandemic and involves the goodwill and leadership by a range of individuals including; the Prime Minister, the Hon Greg Hunt MP, the Hon Ken Wyatt MP and the senior leadership within DoH. Until a vaccine is developed the COVID-19 virus is a significant threat to Aboriginal and Torres Strait Islander people and the response today does not address the social determinants of health. The new National Agreement on Closing the Gap will be a major step in the right direction.

In its response to the COVID-19 virus the Government has recognised its responsibility to the Australian people and effectively, not legally, its fiduciary duty. In Canada the Crown accepted it has a fiduciary duty to its First Nations people, is this a path that could also be explored to enable Aboriginal and Torres Strait Islander people to have certainty that housing needs and other social determinants will be addressed and that there will be adequate funding to be able to respond to any future pandemics?"

Link to the submission:

The full submission can be downloaded at https://www.naccho.org.au/naccho-submission-the-australian-governments-response-to-the-covid-19-pandemic/

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