

# **Responses to the development of a National Aboriginal and Torres Strait Islander Health Plan**

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*Q1. How can the Health Plan harness the strengths and culture of Aboriginal and Torres Strait Islander peoples to improve the health of Aboriginal and Torres Strait Islander peoples?*

The Commonwealth Department of Health and Ageing National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) clearly states that “the capacity to recruit and retain appropriate staff is essential to sustaining PHC services for ATSI people...” (p22) and “Building Aboriginal and Torres Strait Islander health workforce capacity across all levels of health is fundamental...” (p22) For these visions to be fully realised, the Commonwealth needs to recognise the opportunity the NATSIHP provides for ‘building the capacity of the system to prepare, supports and sustain all the health and social care workforce (not just Aboriginal and Torres Strait Islander) required to address the needs, wants, and expectations of ATSI people, particularly Aboriginal and Torres Strait Islander with complex chronic conditions.

*Q2. What are the key things that would make a difference to Aboriginal and Torres Strait Islander peoples health outcomes?*

The NATSIHP needs to further recognise that a lack of coordinated care exists for Aboriginal and Torres Strait Islander peoples. The Commonwealth funded Care Coordination and Supplementary Services Program which funds a Care Coordinator workforce is a start. For this program outcomes to be realised the NATSIHP needs to invest in building the ATSI workforce capability which requires evidence about:

- What clinical governance frameworks can optimise Workforce Models of Care and workforce functions?
- What authorising environments are required to support Workforce Models of Care and workforce functions? and
- What workforce capability frameworks can prepare, support & sustain Workforce Models of Care and workforce functions?

*Q3. What do governments need to do to:*

*Q3.1. Build on the strengths of Aboriginal and Torres Strait Islander peoples to improve their health?*

NATSIHP can provide a platform for investing in a multi-level support system for Care Coordinators including: community outreach strategy; multidisciplinary collaborative team approaches to span boundaries of services, organisations and systems; and clinical support to professional development opportunities

*Q3.2. Support Aboriginal and Torres Strait Islander Peoples to proactively manage their health and to Achieve and maintain social, emotional and cultural wellbeing*

NATSIHP can recognise the differing settings within which Indigenous, non-indigenous health and social care workforce works (e.g., General Practice Clinics, Aboriginal Health Services, Community Health Services, Medicare Locals) as these will have governance (clinical and organisational) and authorising environment implications.

*Q3.3. Address the social determinants of health?*

NATSIHP can provide a vehicle to a whole system of care approach to support models of complex care coordination across the primary and acute health care interface via team-based models (aligned to the needs of Aboriginal and Torres Strait Islander people to ultimately enable greater continuity of care and optimal health client outcomes.

*Q4. How could the health system work better for Aboriginal and Torres Strait Islander peoples? This may include: health promotion activities, comprehensive primary health care, allied health and specialist services, mental health services, hospitals and aged care?*

For the health system to work better for Aboriginal and Torres Strait Islander peoples, the NATSIHP needs to:

- provide a vehicle to a whole system of care approach to support models of complex care coordination across the primary and acute health care interface via team-based models (aligned to the needs of Aboriginal and Torres Strait Islander people to ultimately enable greater continuity of care and optimal health client outcomes.
- provide a platform for investing in a multi-level support system for Care Coordinators including: community outreach strategy; multidisciplinary collaborative team approaches to span boundaries of services, organisations and systems; and clinical support to professional development opportunities.
- recognise the differing settings within which Indigenous, non-indigenous health and social care workforce works (e.g., General Practice Clinics, Aboriginal Health Services, Community Health Services, Medicare Locals) as these will have governance (clinical and organisational) and authorising environment implications.
- recognise the opportunity and challenges that the funded network of Medicare Locals offers Indigenous people, particularly with regard to coordination, for people with complex care needs
- provide a platform to support and strengthen the Care Coordinator workforce, by the Commonwealth Department of Health and Ageing developing a Workforce Plan, of which a Care Coordination Workforce Capability Framework would support the preparation, implementation and sustainability of the Care Coordinators workforce

*Q5. What more could be done to facilitate the growth, support and retention of Aboriginal and Torres Strait Islander health professionals?*

Health workforce: Workforce capability – The NATSIHP recognises that “Building ATSI health workforce capacity across all levels of health is fundamental..”(p22). An Evaluation of Models of Care Coordination by The Australian Health Workforce Institute confirmed the need to build workforce capacity. However, our evaluation

further reveals that the roles/functions of the workforce needs to be clearly articulated, to ensure capacity building strategies are aligned to preparing, supporting and sustaining the workforce. The Care Coordinator workforce was found to perform multiple clinical and patient support functions, thus require a wide spectrum of skills and competencies, which require appropriate clinical governance and authorising environments.

*Q6. What more could be done to develop, support and retain mainstream health professionals to provide comprehensive and culturally appropriate health care services to Aboriginal peoples?*

An Evaluation of Models of Care Coordination by The Australian Health Workforce Institute, revealed that - in line with recent shifts in workforce planning approaches – i.e. patient and community informed workforce planning – the Care Coordination and Supplementary Services Program has funded a Care Coordinator workforce. The Evaluation Models of Care Coordination revealed that multiple models are being developed in response to local patient and system context in 3 main settings: General Practice Clinics, Aboriginal Health Services and Medicare Locals. An Indigenous engagement and outreach strategy was found to be key to all settings. Furthermore, CC were performing multiple clinical care (care coordination), and patient support (service coordination) functions. Five key interdependent mechanisms are essential for models of Care Coordination to work: 1) connections with Aboriginal and Torres Strait Islander communities; 2) workforce role clarity and capability; 3) know-how of service systems of care; 4) appropriate clinical governance and 5) a supportive authorising environment.

*Q7. How could the integration and coordination of comprehensive health care for Aboriginal and Torres Strait Islander patients be improved? Examples include: support for patients after they have been discharged from hospital and the interaction between mental health and drug and alcohol services?*

The NATSIHP could provide a vehicle for a whole system of care approach to support models of complex care coordination across the primary and acute health care interface via team-based models (aligned to the needs of Aboriginal and Torres Strait Islander people to ultimately enable greater continuity of care and optimal health client outcomes.

*Q8. How can comprehensive health care services be made more accessible for Aboriginal and Torres Strait Islander peoples, including in urban, regional and remote areas?*

The NATSIHP needs to:

- recognise the differing settings within which Indigenous, non-indigenous health and social care workforce works (e.g., General Practice Clinics, Aboriginal Health Services, Community Health Services, Medicare Locals) as these will have governance (clinical and organisational) and authorising environment implications.
- recognise the opportunity and challenges that the funded network of Medicare Locals offers Indigenous people, particularly with regard to coordination, for people with complex care needs

*Q9. How can services be made more culturally competent and appropriate for Aboriginal and Torres Strait Islander peoples?*

The NATSIHP needs to:

- provide a platform to support and strengthen the Care Coordinator workforce, by the Commonwealth Department of Health and Ageing developing a Workforce Plan, of which a Care Coordination Workforce Capability Framework would support the preparation, implementation and sustainability of the Care Coordinators workforce

*Q10. What do you think should be the guiding principles of the Health Plan?*

The NATSIHP need to provide the platform for 'building the capacity of the system to prepare, supports and sustain all the health and social care workforce (not just Aboriginal and Torres Strait Islander) required to address the needs, wants, and expectations of ATSI people, particularly Aboriginal and Torres Strait Islander people with complex chronic conditions.

*Q11. What do you think should be the priorities for the Health Plan?*

The NATSIHP priorities include: investing in building the ATSI workforce capability, by investing in research that explores:

- What clinical governance frameworks can optimise Workforce Models of Care and workforce functions?
- What authorising environments are required to support Workforce Models of Care and workforce functions? and
- What workforce capability frameworks can prepare, support & sustain Workforce Models of Care and workforce functions?

*Is there anything else you would like to tell us that would help the development of the Health Plan?*

The Health Plan needs to recognise that Workforce Capability to provide Complex Care Coordination is essential to improve the outcomes of Aboriginal and Torres Strait Islander people with complex chronic conditions.