20 February 2015

Indigenous Early Childhood Section
The Department of Health
GPO Box 9848
CANBERRA ACT 2601

mothersandbabies@health.gov.au

To whom it may concern

Draft National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families

Attached please find our submission to the Department of Health regarding the *Draft National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families*. The five nursing and midwifery organisations whose logos are included in this letter contributed to this submission and endorse its content. I am signing this letter on behalf of these nursing and midwifery organisations.

Please direct any future correspondence with the contributing nursing and midwifery organisations through me:

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Please do not hesitate to contact the participating nursing or midwifery organisations for any further discussion relating to this submission through this office. We look forward to the publication of the *National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families*.

Yours sincerely

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Chief Executive Officer
Australian College of Nursing

Australian College of Midwives
ACN
CATSINaM
CRANAplus improving remote health
MATERNAL, CHILD AND FAMILY HEALTH NURSES AUSTRALIA

Submission to the Department of Health on the *Draft National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families*

This submission to the Department of Health's consultation on the *Draft National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families* was jointly prepared by the Australian College of Nursing (ACN), the Australian College of Midwives (ACM), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), the Maternal, Child and Family Health Nurses Australia (MCaFHNA) and CRANA*plus*.

The following signatures represent the formal endorsements from each organisation.

Debra Thoms, CEO,
Australian College of Nursing

Janine Mohamed, CEO,
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

Julian Grant, CEO,
Maternity, Child and Family Health Nurses Australia

Ann Kinnear, CEO,
Australian College of Midwives

Christopher Cliffe, CEO,
CRANAplus

Our organisations

Australian College of Nursing (ACN)

ACN is the national professional organisation for all nurse leaders. ACN is an advocate for the nursing profession, advancing the skills and expertise of nurses to provide leadership in their contribution to the policy, practice and delivery of health care. ACN is a membership organisation with members in all states and territories, health care settings and nursing specialties. ACN's membership includes many nurses in roles of influence, including senior nurses, organisational leaders, academics and researchers. ACN is also the Australian member of the International Council of Nurses headquartered in Geneva.

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives is the national peak body that represents, advocates for and supports Aboriginal and Torres Strait Islander nurses and midwives. CATSINaM is a not-for-profit membership-based organisation, governed by a nationally elected Aboriginal and Torres Strait Islander Board.

CATSINaM's purpose is to:

> *honour an holistic and culturally safe approach to achieving optimal health and wellbeing for Aboriginal and Torres Strait Islander peoples and communities. We develop and promote strategies to ensure that this holistic and culturally safe approach is understood and applied by nurses and midwives working in Australia.*

A key component of our work is to promote health services to become culturally safe working environments for Aboriginal and Torres Strait Islander nurses and midwives; and the promotion of Indigenous health through the improvement of health service delivery for Aboriginal and Torres Strait Islander peoples.

CRANA*plus*

As the peak professional body for remote health, CRANA*plus* is able to provide comments that reflect the unique context of remote health with specific reference to access to health services, and workforce effectiveness, impacting on health services for Aboriginal and Torres Strait Islander children and families.

The core business of CRANA*plus* is to educate, support and represent all health professionals working in the remote sector of Australia. We are the only member based, national health organisation that has remote health as its sole focus, making us the remote health experts.

CRANA*plus* through its reach and internal resources provides input into relevant Government inquiries and other public and targeted consultations, ensuring that the mechanisms of government have broad grass roots input into policy decisions that impact on the health and welfare of remote Australians.

This specialisation allows us to provide unique education and support services vital for clinicians to be suitably prepared to remain within the remote health workforce.

Australian College of Midwives (ACM)

The Australian College of Midwives (ACM) is a national, not-for-profit organisation that serves as the peak professional body for midwives in Australia. The ACM is committed to being the leading organisation shaping Australian maternity care, to ensure the best possible maternity outcomes for all Australian women. ACM is guided by research evidence that pregnant women and mothers benefit from having access to midwifery care throughout their childbearing experience.

Maternal, Child and Family Health Nurses Australia (MCaFHNA)

MCaFHNA is the peak professional body in Australia for nurses working with parents of children from birth to five years of age. MCaFHNA promotes the clinical specialty of maternal, child and family health nursing based on working in partnership with parents through a primary health care model. MCaFHNA is a key consultative body on matters relating to maternal, child and family health nursing in Australia and provides a forum at the national level for members to promote their specialty.

Introduction

Overall our organisations are in support of the proposed vision, principles and key elements of the *Draft Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families* (the draft Framework). While the draft Framework provides well considered and comprehensive advice to guide health service planning and delivery for Aboriginal and Torres Strait Islander children and families, this submission identifies a range of issues we believe require further consideration in the development of the final Framework. Of key importance is the need to persuasively highlight the linkages between enabling the nurse and midwifery workforces to work to their full scope of practice and the broadening of health service availability to Aboriginal and Torres Strait Islander children and families. Additionally, while the Framework promotes flexible service models, the imperative of supporting health service innovation to ensure the needs of all Aboriginal and Torres Strait Islander children and families are met should be emphasised. Finally, of overarching importance, the draft Framework should outline an implementation plan to engage and secure government and sector commitment to its principles and vision to ensure the document has a practical not just an aspirational impact. Our general comments and specific responses to the consultation questions on the draft Framework are detailed below.

General Comments

We offer the following general comments in relation to the draft Framework.

Key strengths of the draft Framework

Our organisations are pleased that the draft Framework specifically states that the health needs of all Aboriginal and Torres Strait Islander people are not currently met by existing child and family health service systems and that it seeks to provide guidance to address this. We are also encouraged by the acknowledgement that early childhood experiences starting in pregnancy have an enduring effect throughout the lifespan and that the draft Framework focuses on the benefits of prevention and early intervention programs for improving health and development outcomes for children and their families.

Additionally, we offer strong support for the focus on; the need for an appropriately skilled workforce and accessible health services and providers, comprehensive assessment incorporating holistic and collaborative approaches aimed at fostering relationships and promoting opportunistic and flexible models of care. Furthermore, the draft Framework appropriately highlights the importance of cross-sectoral collaboration, recognises the importance of the organisation of services within the broad service system as well as the need for local or regionally based health care system development.

The emphasis on using and building the evidence-base for program and practice development is strongly supported. It is essential that health policy and service delivery be informed by the best available evidence and experience. Our organisations do however stress that evidence should be inclusive of that generated from Aboriginal and Torres Strait Islander ways of knowing and being. The draft Framework appropriately raises some of the challenges of applying different evidence in the "real world" and there may be value in providing more detailed guidance including examples or brief case studies demonstrating how organisations can apply evidence.

We are also pleased to see the Framework incorporates a clear discussion distinguishing the concepts of primary care and primary health care. The essential differences between these terms are rarely addressed in governmental health policy documents. Providing an explanation within the context of the draft Framework is an important starting position for formulating and implementing plans to address the health needs of Aboriginal and Torres Strait Islander children and families.

Nurses and midwives are extremely well-placed within communities to deliver primary health care. There is a range of nursing and midwifery services that focus on maternal, child, adolescent and family health that are provided through schools, community health services, outreach services, and general practices. Access to and the integration of these services is, however, extremely variable. The Framework could promote the development and integration of services by (1) identifying how these services fit into the Framework (2) how they contribute to the health care of Aboriginal and Torres Strait Islander children and families (3) how they improve access to care for these individuals and families.

Identified gaps and concerns within the draft Framework

The sections below discuss a number of gaps and concerns our organisations draw to your attention.

While offering support for the draft Framework, our organisations consider the document does not adequately stress the importance of self-management and self-determination. It is generally accepted that people are more inclined to participate in the promotion of their health care and engage with health professionals if the agenda is inclusive.

We provide specific feedback on workforce issues relevant to the Framework below however, as an overarching point we note it should mention that within remote health services nurses, midwives and Aboriginal Health Workers are often the predominantly available health professionals to provide consistency in health care delivery. This workforce must be well supported to enable the provision of services as envisioned by the Framework. Such support depends on:

- Increased availability of Aboriginal and Torres Strait Islander health professionals.
- Innovative models of care that effectively leverage skills and experience of health professionals within their specific scopes of practice.
- Access to education for health care professionals to upskill in the essentials of child and family health assessment and management. This upskilling would also support the remote generalist workforce to work to their full scope of practice.
- The availability of Medicare Benefits Schedule (MBS) items to support and enable nurses and midwives to provide initial health assessments to consumers. Appropriate MBS funding for health assessments undertaken by nurses and midwives is particularly critical in remote and isolated areas because they are often the most widely distributed and accessible health care professionals in these communities.
- Well established networks of 'specialist' expertise and support services through expanded telehealth services and visiting /outreach services.

These workforce imperatives for rural health service delivery are also generally applicable across health settings.

It is also recommended that the document place greater emphasis on consumer health literacy by embedding this principle in all aspects of health care design and delivery. Supporting health literacy requires a commitment to ongoing, two-way communication between consumers and health care providers, within the context of a therapeutic relationship. It should not be assumed that health literacy could be adequately addressed by increasing the amount of information provided to consumers, or by diversifying the mediums and languages in which information is provided. To ensure safe and quality health care it is imperative that health services have the flexibility to be responsive to the varying levels of health literacy within the Aboriginal and Torres Strait Islander communities. The draft Framework does not adequately incorporate recognition of health literacy in its *Approaches to Care* and *Service Elements* and should emphasise the importance of its promotion through appropriate communication, education and information provision. Furthermore,

opportunities to promote health literacy through health and educational sector collaboration should be sought. There may be value in referencing the *National Statement on Health Literacy: Taking Action to Improve Safety and Quality* within the Framework.[1]

We also stress the need for the Framework to include a glossary of terms to avoid any concept ambiguity. For example, references to cultural competence should be supported by a definition in a glossary to avoid misinterpretation of its meaning. The term is mentioned several times within the draft Framework prior to its aspects being defined in detail in section 4.6. Before this point, it could be assumed that cultural competence is an attainable skill rather than an ongoing development process. Additionally, consideration should also be given to including a high-level introductory diagram to demonstrate the Framework's concepts and components and how they will be applied. While the draft document is comprehensive it is not well formatted for quick reference. Finally, the influence of the Framework will be dependent on multilateral government commitment as well as multi-stakeholder adoption to ensure its elements can be put into effect. The Framework should be supported by inter-jurisdictional arrangements to steer its implementation and evaluation.

Questions 1 and 2

Do the proposed Vision and Principles reflect the core elements of a national framework for health services for Aboriginal and Torres Strait Islander children and families? If not, what else should be included in the Vision and Principles?

The Vision and Principles are supported, particularly the coverage of antenatal care and preconception, which are not covered in the *National Framework for Universal Child and Family Health Services.* However, the title of the draft Framework should be amended to reflect the intended scope of the document.

There are additional issues requiring consideration, these include:

- The Vision statement says that children and families should have access to high quality health services however a conceptual statement or definition of high quality care is not mentioned in the draft Framework's guiding principles.
- Regarding Principle 1 *Access,* this principle should include the universal access to free appropriate services to reflect section 3.5 Principles of the *National Framework for Universal Child and Family Health Services*. Additionally, it is recommended that the term 'holistic approach' be defined within a glossary of terms in order that it is well understood that health needs include social, emotional, psychological, spiritual and cultural needs. This definition should take account of the communitarian outlook that tends to characterise Aboriginal and Torres Strait Islander cultures as well as the concepts of autonomy. Taking account of these two diverse views of how people make decisions will help ensure that Aboriginal and Torres Strait Islander women and families are supported to make well informed decisions about their care with the level of family support they desire.
- It is recommended that Principle 3 *Working in partnership* be reworded to specifically indicate the need for Aboriginal and Torres Strait Islander organisations and people to be involved at all levels of health service planning and delivery. The current wording places emphasis on local level planning that does not take place in isolation

1 Australian Commission on Safety and Quality in Health Care (2014), *National Statement on Health Literacy*: *Taking action to improve safety and quality*, <http://www.safetyandquality.gov.au/publications/health-literacy-national-statement>, accessed 3 February 2015.

of other levels of health planning. It is also noted that the use of the term 'involved' should be clarified to stress that the community should be defining their needs and preferences in genuine and equal partnership with the planners of health services.

- Regarding Principle 4 *Collaboration and continuity,* it is proposed that the justice and employment sectors be specifically mentioned. Further, the statement should reflect that health service planning and delivery requires a bottom up as well as top down approach with the community co-leading planning and delivery.

- Principle 5 *Evidence-based*: It is recommended that the phrase 'best available evidence' be clarified to ensure that the fullest possible range of high quality evidence is considered in the design and implementation of child and family health services for Aboriginal and Torres Strait Islander people. Policy makers and service providers should actively seek out and incorporate evidence generated from Aboriginal and Torres Strait Islander ways of knowing and being, as well as evidence from the lived experience of people receiving services, rather than relying solely on mainstream Western evidence. To ensure that research will translate into practice, priority should be given to interventions with proven effectiveness. In the main research findings used should not have been derived from short-term pilot projects but rather from long-term research which is more likely to deliver valid results.

  Also regarding, Principle 5. *Evidence Based*: The Framework should recognise that some positive practices that occur within the health system may not have an extensive evidence-base. It is important that innovation in the sector is not unnecessarily stifled in the absence of evidence.

- The wording of Principle 8 *Workforce development* is open to interpretation. The reference to a strong workforce should more specifically state its intent including the need to increase the size of the Aboriginal and Torres Strait Islander health workforce.

- The principle of family-centred care is not adequately emphasised within the draft Framework. While the concept of "family-centred" care is featured in *Approaches to Care*, consideration should be given to strengthening its general importance throughout the Framework.

Questions 3 and 4

Do you agree with the scope of the Framework? If not, what else should be included in the scope of the Framework?

Our organisations generally agree with the scope of the Framework particularly its focus on the intersection between health, education and social services and the need for a holistic approach to supporting Aboriginal and Torres Strait Islander children and families. While in support of the overall scope, our organisations offer the following comments:

- We have concerns about the coverage of maternity care. Section 4.11 notes that the draft Framework refers to the National Maternity Services Plan, however this plan is due to expire in 2015. It is our understanding that there has been no indication from the Australian Government as to whether this plan will be extended and/or updated. Excluding antenatal/birthing/postnatal and broader maternity services from a primary health care framework is a missed opportunity. The Framework does not adequately address the influence that the location of birthing services can have on the health outcomes of mother and baby. Not accounting for the importance of having access to quality antenatal care from a midwife and birthing services on or close to country and community highlights a lack of genuine understanding and acceptance of the role of culture and identity on the health of Aboriginal and Torres Strait Islander mothers, babies, families, and community. Birthing services should be part of primary health care services as a matter of course and should only be provided at the tertiary level when birthing is deemed a medical matter.

- As the scope of the draft Framework includes antenatal and pre-conception periods, birthing on country (BOC) is an important maternity services consideration that should be acknowledged within the Framework (please see 'Additional general comments' on p. 19 of this document for an explanation of BOC). BOC can include supporting women and families to birth on country or to make their place of birth (when it is away from country) feel like they are birthing on country. Birth and how women give birth are fundamental to ongoing good health, relationships, parenting.

- In our view, it is not sufficient to state that continuity should be provided "wherever possible" as included on page 36. There should be an expectation that continuity of care will occur as part of standard practice. The scope of the Framework should specifically promote the need to embed the principle of continuity of midwifery care in service delivery models, which facilitates informed choice and improves birth outcomes. This includes women having named midwives who work with them throughout pregnancy and birth, even at times of transfer to tertiary hospitals. Supporting Aboriginal and Torres Strait Islander midwives to attend Aboriginal and Torres Strait Islander women when preferred is a key consideration. Continuity is also essential to support the transition to child and family health services after the baby is born.

- Under section *4.4 Overview* (page 14) it is important that children are included in the following statement outlining the scope of the Framework to recognise that not all Aboriginal and Torres Strait Islander children will be in the care of their families: '*…the framework encompasses universal health services across the continuum from pregnancy to youth/pre-conception as well as highlighting the intersection between health, education and social service and the need for a holistic approach to supporting Aboriginal and Torres Strait Islander families* and children *to maximise their health*".

- The draft Framework does not clearly state when pre-pregnancy begins rather it refers to young people and adolescence. There would be benefit in defining this age group to provide clear guidance to organisations and health workers.

- The draft Framework does not clearly address the needs of 8-10 year olds. It is important to consider the health service needs of these age groups who are likely to share similar health, family, social and emotional issues as they did when they were 7 years old.

- The scope of the Framework should more specifically include the intersections with justice health and the justice system more broadly. This sector has a significant bearing on some Aboriginal and Torres Strait Islander communities and there is potential to better integrate services to improve supports provided to children and their families.

- What is meant by 'The key elements of the Framework' on page 15 should be briefly explained. It is not immediately clear how 'the key elements' are addressed within the document. The draft Framework describes its 'underpinnings' but the incorporation of the 'key elements' is not demonstrated by Figure 2: *Framework Overview* or within the guidance provided by the *Underpinning Components, Approaches to Care* or *Services Elements* sections.

- It is recommended that communication be emphasised in the Framework's underpinnings. Including *communication* and *collaboration* in dot point 3 on page 15 would support this emphasis: "Information sharing and communication to enable seamless movement of the child and family through the service system and access to care". Furthermore, it is recommended that this point avoid using the term "seamless" which tends to set unrealistic expectations, alternatives such as *planned movement* or *integrated transition* should be considered.

- It is noted that Figure 2: *Framework Overview* would benefit from a more comprehensive introduction. The figures do not clearly demonstrate the overview discussion that precedes them in the document. It may be more effective to present these figures after section 4.

Questions 5 and 6

Do you agree with the Underpinning Components listed above? If not, what other Underpinning Components must be included?

Our organisations agree with the Underpinning Components, however, it would be preferable to have the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 more firmly embedded in the Framework as it covers the life course approach with an emphasis on primary health care. The Plan aligns with the Framework particularly in areas of maternal health, parenting and childhood health and development and complements the *National Framework for Universal Child and Family Health Services.*

The National Aboriginal and Torres Strait Islander Health Plan envisions a health system that is free of racism and inequality, and which enables all Aboriginal and Torres Strait Islander people to gain access to health services that are effective, high-quality, culturally-safe and affordable. To achieve this vision, it is imperative that *all* health professionals understand the impact that past governmental policies and cultural practices have had on Australia's First Nations People. It is equally important that policy makers and health professionals realise that Australia's health system is not structured in a way that is conducive to comprehensive Aboriginal and Torres Strait Islander wellbeing. It is an individualised, medical-centric model, which poorly services the social and emotional wellbeing vital to the Aboriginal and Torres Strait Islander people's communitarian, holistic health centred culture. Appropriate cultural safety education and ongoing continuing professional development is a key element to achieving the vision set out in the National Aboriginal and Torres Strait Islander Health Plan. It is also important that the National Aboriginal and Torres Strait Islander Health Plan is embedded in this Framework.

Our organisations have a range of other comments that should be considered for inclusion:

- In our view Figure 2 could be improved by the inclusion of a column on the left that explains the content in each row. This would assist readers to picture how the various components connect to form a framework.
- School and justice health programs should feature more specifically within the scope of the Framework. These services are important primary health care entry points for some children and families and should be appropriately linked-in with integrated place-based systems.
- It is recommended that "*Integrated place-based systems"* aim for inclusive as well as '*collaborative'* governance models.
- In addition to '*clinical and organisation governance within and between organisations*', our organisations firmly believe *Integrated place-based systems* should aim for multi-disciplinary clinical governance arrangements. Multi-disciplinary involvement in clinical governance is necessary to ensure health professionals with the appropriate professional expertise and experience direct and oversee particular primary health care services.
- It is recommended that section 4.4 on page 15 better articulate with the discussion in section *4.5 Underpinning Components*. The use of 'Underpinnings' or 'underpinned' in titles and subtitles must be consistently applied to the same content matter throughout the document to avoid misperception. The content on page 15 that falls under the two separate headings of "*The Key Elements of the Framework Are*" and "*The Framework is*

Underpinned By" together form the basis of the content that is discussed under the section *4.5 "Underpinning Components*". Referring to some of this content as "Elements" in one section and then "Underpinning Components" in another, could potentially confuse readers.

- Strong support is offered for the inclusion of the Principles of Primary Health Care in section 4.5.1 however the following observations are made:
  - Under *Universal access to care and coverage on the basis of need*, it would be beneficial to include a brief definition of universal access. Furthermore, there is no specific mention within the paragraph of coverage on the basis of need. This concept should be specifically referred to and explained within the paragraph to clarify that 'access on the basis of need' is intended to ensure that consumers with all types of levels of need have a right to appropriate and accessible health care.
  - Regarding *Commitment to health equity as part of development oriented to social justice*, consideration should be given to the role of consumer health literacy in promoting health equity between Aboriginal and Torres Strait Islander people and other Australians. Systems change must incorporate strategic investments and goals to address poor health literacy as part of development oriented to social justice.
  - While the statements under *Inter-sectoral approaches to health* are sound there should be emphasis on embedding systemic inter-sectoral responses to care delivery and to prioritise the development of these systems where they don't exist.
  - Consideration should be given to embedding the principles *informed choice and respect of individual autonomy* within a communitarian cultural context in the Principles of Primary Health Care.
- The following comments relate to page 19 section 4.5.2 *Workforce*,
  - Midwives are not mentioned in the section; their central role in the delivery of health services to young, indigenous families must be acknowledged.
  - Nurse practitioners (NPs) should be specifically mentioned in the first paragraph. The NP workforce is rapidly expanding and their impact in primary health care will be significant into the future.
  - Dot point 2 '*Understanding of social determinants of health, and broader outcomes for children and families, including risk factors such as domestic violence and drug and alcohol'* should be revised for clarity. For example is 'drug and alcohol' a risk factor or is exposure to or use of drugs, alcohol and other substances more appropriate?
  - Dot point 3 '*Skills in assessment, monitoring and observation*' is too broad and should be revised to clarify what specific skill set is being referred to.
  - While workforce strategies are outside the scope of the Framework, it should emphasise the importance of developing strategies to recruit to and support the growth of the Aboriginal and Torres Strait Islander nurse and midwife workforces. The Framework could advise that these strategies should not prescribe where and in what capacity Aboriginal and Torres Strait Islander nurses and midwives pursue their careers nor limit the growth in Aboriginal and Torres Strait Islander representation within the profession.
  - Strategies for addressing the issue of racism within the Australian health system and within the health workforce should be more explicitly discussed within the draft Framework. As mentioned above, the promotion of cultural safety and cultural respect, including anti-racism strategies, will be a necessary and critical factor for improving health services to Aboriginal and Torres Strait Islander children and families.

- Furthermore, an affirmative action approach should be adopted to increase the recruitment and retention of the Aboriginal and Torres Strait Islander health workforce, particularly nurses and midwives, to achieve the vision and goal of this Framework. The employment gap is somewhat explained through barriers such as institutional racism within the service system which has impacted on the recruitment and retention of staff as well as the health outcomes of Aboriginal and Torres Strait Island peoples. An overall focus should be on the recruitment of health professionals into our primary health care system rather than the hospital system and this requires better workforce planning and development than has been suggested in the Framework.

- The Framework should explicitly state that where maternal and child health services are required in remote areas, funding must be allocated to resource professional positions, professional skills development and support for the workforce who often work in isolated and challenging situations.

- In rural and remote areas, it is generally expected that health professionals practice at an advanced and extended scope to meet the needs of their communities. However the supports for these health care professionals, in terms of enablers in current legislation and access to ongoing professional development, to practice at this level may be missing or may be inadequate. The Framework should highlight that workforce strategies must recognise the requirements to support practice at this level in remote and isolated areas.

  The Framework should also recognise that health care in rural and remote areas should be delivered by clinicians with equivalent levels of knowledge, skill and experience to clinicians working in metropolitan areas. However, the constraints of delivering health care in rural and remote areas often mean that different and innovative approaches to service delivery are needed. Therefore, in rural and remote areas Aboriginal Health Workers, nurses and midwives who work in maternal and child health must be enabled to deliver these essential services with appropriate infrastructure and support. It should also be acknowledged that some services can only be safely delivered by specialist providers. Where this is the case, specialist positions and/or services should be funded. This may require the development of new models of service delivery and/or employment.

  While the scope of practice of the generalist workforce in remote and isolated areas needs to support different service delivery models than those typically applied in more urban and regional areas, remote health practitioners do not practice in isolation. They work collaboratively through well-established collegial networks, including specialist teams, to provide services. It is imperative that effective telehealth systems, inclusive of broadband infrastructure, are available to support the delivery of local services, including access to specialists, networks and peer support.

- It is queried whether dot point 4 under section 4.5.6 *Systems*, should include data analysis and reporting in addition to '*Data collection'*.

- Regarding section 4.5.7 *Governance and Leadership*, it is noted that change is required not only in the way health services are '*planned and delivered'* but also how they are developed.

- Regarding section 4.5.8 Table 2 *Roles and responsibilities – underpinnings,* consideration should be given to:

  - Under *Infrastructure – Government/Policy*, the inclusion of the concept of sustainability is recommended to promote longer term commitment to and sustainability of health programs. We suggest the following wording '*Policy and programs that provide adequate and* sustainable *resources for:…*'

  - Including communication as a *Systems* responsibility of practitioners. It is incumbent upon health practitioners to effectively communicate and share information appropriately to ensure safe continuity of care.

- It is recommended that dot point 3 of the Practitioner role under Evidence should stress '*Commitment to* quality *data collection, monitoring and review*'.
- It is queried why there are no identified roles under *Government/Policy* or *Practitioners* within the *Leadership and governance* section. Providing policy direction and advice is a key role of government and governments are often best placed to coordinate and roll-out broad system initiatives. Furthermore, the leadership roles of practitioners are vital to the success of service organisation leadership and governance initiatives. Effective clinical leadership and governance is dependent on the active engagement and participation of practitioners and is particularly important in processes of change management.

Questions 7 and 8

Do you agree with the proposed approaches to care? If not, what else should be included?

Overall, our organisations agree with the outlined approaches to care and offer the following comments on this section of the draft Framework:

- With regards to the "culturally competent approach", as mentioned above, whilst an explanation of cultural competence is provided that acknowledges an ongoing learning process, 'competency' conjures up a checklist approach to professional development and staff training. For the reasons given below health care professionals are more likely to understand and accept the term *culturally respectful practice* and guide their practice by this term.

  Health professionals will find it difficult to be 'culturally competent' to Aboriginal and Torres Strait Islander Australians if they are not Aboriginal and Torres Strait Islander themselves. They cannot be competent or responsive from a cultural position that they do not share. Even then, due to the significant cultural diversity among Aboriginal and Torres Strait Islander nations (due to there being over 200 Aboriginal and Torres Strait Islander nations) competency is also difficult and not straightforward for Aboriginal and Torres Strait Islander health professionals. However, non-Aboriginal health professionals such as nurses and midwives can demonstrate culturally respectful practice towards Aboriginal and Torres Strait Islander Australians, and provide care that Aboriginal and Torres Strait Islander Australians experience as culturally safe. For example, an organisation through its staff provides a service that is free from any form of racism and where needs and cultural preferences are recognised or inquired about, but not cross-examined, and responded to in a supportive and respectful manner.

- The Framework should further emphasise the need for health services to support midwives to provide continuity of care to pregnant women and during birth. Focus must also be placed on ensuring midwifery continuity programs are just as accessible in rural and remote areas, as they are in urban areas.

- We offer strong support for the emphasis on multi-disciplinary care within this section. An additional enabler of multi-disciplinary care is the promotion of multi-disciplinary education including continuing professional development training. Shared and professionally balanced educational experiences provide opportunities for different professional groups to exchange knowledge and learn more about the scope of each others' roles. It is recommended participation in inter-professional education and training be added to the list of '*Enablers of multi-disciplinary care*' on page 25.

- In the Approaches to Care box at the top of page 23, it is recommended that 'person' be added to '*person and family-centred'*. In midwifery care, woman-centred care is a fundamental requirement in the care of pregnant women. We suggest the inclusion of the words 'woman-centred midwifery care' in the Approaches to Care box.

- As mentioned above, consumer health literacy should be taken into account in the Framework's Approaches to Care. Health literacy involves enabling consumers to take a driving role in managing their own health and should be a strategic consideration for health service design and delivery.
- Regarding section 4.6.1 Table 3 *Roles and responsibilities – approaches to care,* consideration should be given to:
  - Roles and responsibilities relating to the promotion of multi-disciplinary care should be included in the table.
  - The role of *Government/Policy* in the last row of roles and responsibilities needs to be included. Governments should provide a degree of strategic policy guidance to service organisations or set requirements to support and prioritise system-wide changes via performance indicators or other measures. Without government influence, there is a risk that organisations will place varying priority on developing the suggested service models to build strong professional relationships with children and families.

Question 9

What are the enablers and barriers to implementing the Framework?

- The lack of an explicit implementation plan for the Framework may represent a barrier. Our organisations recommend the development of an implementation plan to complement the Framework and ensure that it has a practical not just aspirational impact. The implementation plan should outline strategies to secure broad support for the Framework and give consideration to the actions needed to ensure that the Framework's principles and vision are realised in the delivery of health services for Aboriginal and Torres Strait Islander Children and Families.
- If communities receive services from organisations with an overlapping remit they can experience problems with service continuity and clear communication with service providers. In the case of service overlap communities may also encounter issues with the accountability and governance of the organisations involved.

  Inter-sectoral engagement and collaborative commitment to implementing the Framework will be an essential enabler to minimise the impact of fragmented service delivery arrangements.

  At an individual level in the community, health professionals and workers generally seek to work together to achieve outcomes for children and families. However they can face organizational and service provider barriers through an often arbitrary demarcation of service roles and scope, governance and accountability parameters.
- Improving systems' capability to demonstrate the service effectiveness of programs that work well would support the implementation of the Framework.
- Funding constraints resulting in time limited health services research are barriers to the implementation of the Framework. Quality health service research requires considerable time investment to develop relationships with communities, to introduce and trial programs, to embed programs into existing service delivery in collaboration with community members and current services, and to establish effective evaluation strategies that will provide good quality data to determine program effectiveness over time.
- Research and evaluation methods that are built into service delivery models would support the realisation of the draft Framework's vision. Furthermore, promoting the incorporation of evaluation methods and data that respect Aboriginal and Torres Strait Islander ways of knowing and being would enhance the impact of the Framework.

- A further barrier is the medical-model approach to health care, which prioritises the implementation of generic programs that were originally developed for use in other settings, over programs designed to address the needs of Aboriginal and Torres Strait Islander communities in a holistic way. It is important to recognise that Aboriginal and Torres Strait Islander children and families have specific needs, and that programs and interventions may need to be tailored for use in these communities, or developed specifically for Aboriginal and Torres Strait Islander communities. There is a persistent danger that generic models of health care based on the medical model approach will divert funding from programs based on engagement with Aboriginal and Torres Strait Islander communities and ways of knowing.
- A lack of awareness and understanding of the birthing on country (BOC) concept would be a barrier to implementing some of the vision and principles outlined in the draft Framework. Women are routinely moved out of their community to birth, because of perceived medical risks, into large urban hospitals where they may not have any support and they lose connection with their land. This can have devastating effects for both themselves, and their babies.

  Professional good-will and commitment to the vision of BOC will be a critical enabler at local level for the delivery of programs. Programs relating to BOC which include continuity of care midwifery models of care have been demonstrated to have positive benefits for women and babies. However, there is no long-term research exploring the impact of BOC on health outcomes. Maternity care programs are often set up as pilots and are not funded to facilitate effective research.

Question 10

Please provide any other comments on the Draft Framework.

A. Section 4.7: Service elements

As outlined in section 4.7, our organisations agree with the key elements of service delivery that need to be in place to enhance the scope and quality of services for Aboriginal and Torres Strait Islander children and families and offer the following comment for consideration:

- It is suggested that paragraph 5 of section 4.7.1 *Comprehensive assessment needs to incorporate* include the person/family's ability to access services.
- Regarding Table 4 *Roles and Responsibilities – elements of care,* within the first row *Engagement and Assessment* the Government/Policy responsibilities should include providing adequate funding for engagement as well as assessment. Engagement can involve lengthy and complex processes, particularly services provided by Aboriginal Health Workers, nurses and midwives who are the professional groups most likely to make home and community visits and to initiate initial engagement with children and families.
- The last row of Table 4 Transitions should include a Government/Policy responsibility to provide system-wide guidance or set requirements via performance indicators or other measures to support/encourage service organisations to build referral networks.

B. Section 4.8: Universal Services for Aboriginal and Torres Strait Islander children and families

- It would be useful to include a brief explanation to accompany the table under section 4.8.

- Our organisations support the draft Framework's assessment that there are gaps in universal programs for young people and that there is a need for greater attention to be directed towards youth health and pre-pregnancy. There is significant potential for addressing these gaps through investing in the development of the school nurse workforce and child and family care networks. This strategy to address gaps could take a similar approach to the National Maternity Services Plan and our organisations recommend that dedicated funding be made available for such a plan.

C. Section 4.11.2: Maternity: Implications for service delivery

- Regarding dot point 3 on page 36 that states '*Postnatal care plans should be developed with the woman during the antenatal period'*, it is recommended that birthing plans should also be considered during the antenatal period and on an ongoing basis.

D. Section 4.15: Youth and pre-pregnancy

- As noted above, investment in the school nurse workforce and in school nurse programs would significantly increase access to services to support the social and physical and mental health needs of some adolescents.

E. Additional general comments

Context of remote health

Whilst only 22% of the Australian Aboriginal and Torres Strait Islander population live outside of cities and regional centres,[2] 16% of people in remote areas and 45% of people in very remote areas are Aboriginal and Torres Strait Islander.[3] It is widely acknowledged that the Aboriginal and Torres Strait Islander populations of Australia have a higher burden of diseases and subsequent reduced life expectancy, yet have poorer access to equitable health services compared to the rest of the Australian population.

Models of care should be designed to support the provision of equitable services to Aboriginal and Torres Strait Islander people living in rural and remote areas. Remote areas need different models of care that support the delivery of health care by the entire range of health professionals on the ground, not just through medical officers. Models of care need to enable nurses, midwives, ATSI health workers to provide quality health services to Aboriginal and Torres Strait Islander people.

Remote health services

Health services in remote contexts are provided by a range of organisations. These include Aboriginal Community Controlled Health Organisations (ACCHO), government services, private and other non–government organisations or a combination of different groups providing services to the same locations, which may lead to fragmentation of services.

Health service models in remote contexts differ from urban and regional "mainstream" service models essentially due to workforce issues and available service infrastructures. As a result of the maldistribution of general practitioners, medical specialists and allied health professionals, Aboriginal and Torres Strait Islander Health Workers (ATSIHW) and Remote Area Nurses/Midwives (RAN/Ms) are the primary providers of care to most people in the remote and isolated context and the complexities of their practice continues to expand.

2 AIHW (2014), *Australia's health 2014*, Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW, <http://www.aihw.gov.au/publication-detail/?id=60129547205>, accessed online 3 February 2015, p. 297.

3 AIHW 2014, p. 14.

Primary health care services, whilst they may be multi-disciplinary in nature, are increasingly provided on a Fly In Fly Out basis particularly those providing access to medical officers, specialists and allied health professionals. ATSIHWs and RAN/Ms are predominately based in the community on a more permanent basis. Therefore ATSIHWS, RAN/Ms have continuous access to the Indigenous communities they serve and thus have capacity for relationship building.

Birthing on Country

"Birthing on country" is defined as, "…maternity services designed and delivered for Indigenous women that encompass some or all of the following elements: are community based and governed; allow for incorporation of traditional practice; involve a connection with land and country; incorporate a holistic definition of health; value Indigenous and non-Indigenous ways of knowing and learning; risk assessment and service delivery; are culturally competent; and developed by, or with, Indigenous people." [4]

The term BOC should be understood "as a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families, an appropriate transition to motherhood and parenting for women, and an integrated, holistic and culturally appropriate model of care for all." [5]

Comments relating to the draft Background Paper

- Issues relating to racism, discrimination, child protection and contact with the justice system are reasonably well-covered in the draft Background Paper however should be given greater emphasis in the draft Framework.
- Paragraph two on page 20 of the draft Background paper includes an incomplete sentence resulting in unclear content.
- When the draft Background paper refers to Waves 3 and 4 of the *Footprints in Time* report more detail is required to provide an explanation of what the Waves represent. The content currently lacks context and meaning.
- Dot point 9 on page 20 of the draft Background paper needs revision for clarity and sense: *children in families experiencing housing problems or overcrowded or where they had moved in the last year, experienced in three or four years*;
- The Background paper does not focus on birthing services yet highlights a number of key issues that impact on the pre to post natal environment. The paper addresses many relevant issues that impact on the health of Aboriginal and Torres Strait Islander children and families, but does not adequately highlight the essential linkage to culture and the need for health and other services to be located within or close to community. A primary health care approach needs to take a holistic approach if it is to provide genuine primary health care that delivers effective health promotion, illness prevention and treatment of illness.

4 Kildea S and Van Wagner V (2012), '*Birthing on Country', Maternity Service Delivery Models: A review of the literature,* An Evidence Check rapid review brokered by the Sax Institute on behalf of the Maternity Services Inter-Jurisdictional Committee for the Australian Health Minister's Advisory Council: Sydney, <http://www.qcmb.org.au/media/pdf/Final%20BoC%20Lit%20review.pdf>, accessed 3 February 2015, p. 4.

5 Kildea S, Magick Dennis F, Stapleton H (2013), *Birthing on Country Workshop Report, Alice Springs, 4 July 2012,* Australian Catholic University and Mater Medical Research Unit on behalf of the Maternity Services Inter-Jurisdictional Committee for the Australian Health Minister's Advisory Council: Brisbane, <http://www.qcmb.org.au/media/pdf/Birth%20On%20Country%20Report.pdf>, accessed online 3 February 2015, p. 3.