National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan

Jurisdiction: Queensland

TABLE OF CONTENTS

1 BACKGROUND AND CONTEXT 2

2 NATIONAL REFORMS 4

2.1 National minimum service standards 4

2.2 Improved quality of Aboriginal and Torres Strait Islander identification in key datasets 4

2.3 Infrastructures to support linked records between primary, in-patient and specialist services 4

2.4 Workforce. 4

2.5 Cultural Security. 5

3 IMPLEMENTATION PLAN 6

3.1 Priority Area: Tackle Smoking 7

3.2 Priority Area: Primary Health Care Services That Can Deliver 12

3.3 Priority Area: Fixing the Gaps and Improving the Patient Journey 18

3.4 Priority Area: Healthy Transition to Adulthood 23

3.5 Priority Area: Making Indigenous Health Everyone's Business 25

4 RISK MANAGEMENT 27

5 REVIEW AND EVALUATION 27

6 APPENDIX A: NATIONAL INDIGENOUS REFORM AGREEMENT'S SERVICE DELIVERY PRINCIPLES FOR INDIGENOUS AUSTRALIANS: 28

6.1 Priority Principle: 28

6.2 Indigenous engagement: 28

6.3 Sustainability: 28

6.4 Access: 28

6.5 Integration: 29

6.6 Accountability: 29

7 APPENDIX B: NATIONAL PRINCIPLES FOR INVESTMENTS IN REMOTE LOCATIONS 30

8 APPENDIX C: QUEENSLAND'S GUIDING PRINCIPLES FOR IMPLEMENTATION 31

9 APPENDIX D: ACRONYMS AND REFERENCES 32

1 BACKGROUND AND CONTEXT

On the 16th February 2009, the Queensland Premier signed the National Partnership Agreement (NPA) on *Closing the Gap on Indigenous Health Outcomes*. This Agreement is critical to, but not the totality of effort required, meeting the Council of Australian Governments (COAG) targets of:

- Closing the life expectancy gap within a generation (by 2030); and
- Halving the gap in mortality rates of Indigenous children under five within a decade (by 2018).

The estimated resident Aboriginal and Torres Strait Islander population of Queenslanders is 146,400 with 46% living in major cities and regional centers and 54% living in outer regional, remote and very remote areas[i]. Aboriginal and Torres Strait Islander Queenslanders comprise 28.3% of the total Aboriginal and Torres Strait Islander Australian population and 3.6% of the total Queensland population. Torres Strait Islander people make up around 10% of all Aboriginal and Torres Strait Islander Australians and 23% of Aboriginal and Torres Strait Islander Queenslanders.

The gap between Queensland Aboriginal and Torres Strait Islander males and females and the Australian non-Indigenous population is now estimated to be 10.4 and 9 years respectively[ii]. To close the gap within a generation (25 years), based on a straight line trajectory, Aboriginal and Torres Strait Islander Queenslanders would need to gain 16 years in life expectancy by 2033; this is gain of approximately 8 months per year over 25 years. In Queensland, the infant mortality rate for Aboriginal and Torres Strait Islander infants is 2.1 times that of all Queensland infants (11.1 compared with 5.2). To halve the gap within a decade, Aboriginal and Torres Strait Islander infant mortality rates in Queensland would need to decline to 8.2 per 1000 live births (1.6 times).

Of the ten leading causes of disease and injury burden affecting Aboriginal and Torres Strait Islander Queenslanders, the main contributors to the health gap are:

- Cardiovascular disease – an estimated 28% of the health gap;
- Diabetes – an estimated 16% of the health gap;
- Chronic respiratory disease – an estimated 11% of the health gap;
- Cancers – an estimated 9% of the health gap; and
- Mental disorders – an estimated 8% of the health gap[iii].

Cardiovascular disease, diabetes and chronic respiratory disease are the three leading contributors regardless of where a person lives. In major cities and regional centers, these are followed by cancers and mental disorders. In remote areas, these are followed by injuries and infectious diseases.

Eleven risk factors explain 37.4% of the total burden of disease including: smoking, alcohol and other drugs, obesity, low rates of physical activity and poor nutrition, high blood pressure and high cholesterol, unsafe sex; and child sexual abuse and intimate partner violence. Of these, smoking contributes 12.1% to the total Aboriginal and Torres Strait Islander burden of disease and one fifth of all deaths[iv].

The Queensland Government, through Queensland Health (QH), is a funder and provider of health care. QH delivers hospital services, primary health care services (through primary health care clinics and community health centers), rehabilitation services, patient transport schemes, and population/public health programs. These are mainstream public services but some deliver targeted Aboriginal and Torres Strait Islander services. In remote areas, QH is often the only or main provider of primary and secondary care.

Non-Government organisations, such as the Royal Flying Doctor Service (RFDS), General Practice (GPs) and Divisions of General Practice also provide mainstream primary health care services and some deliver Aboriginal and Torres Strait Islander programs. There are also currently approximately 30 Aboriginal and Torres Strait Islander Community Controlled Health organisations (A&TSICCHOs) in Queensland who provide comprehensive primary health care or substance use services.

In Queensland there are two longstanding Aboriginal and Torres Strait Islander health partnerships, underpinned by Agreements, signed at a Ministerial level:

- The Torres Strait Health Partnership (TSHP), involving QH, the Commonwealth Department of Health and Ageing (DoHA), and the Torres Strait Regional Authority (TSRA); and
- The Queensland Aboriginal and Torres Strait Islander Health Partnership (QATSIHP) involving QH, DoHA and the Queensland Aboriginal and Islander Health Council (QAIHC). QATSIHP is underpinned by regional health forums (RHFs) of local service providers to inform health service planning, implementation and coordination.

These partnerships provide forums for collective strategic discussion and priority setting for Aboriginal and Torres Strait Islander Health in Queensland.

On 29 April 2008, the Queensland Government signed a *Statement of Intent* with Aboriginal and Torres Strait Islander Queenslanders, represented by QAIHC. The Statement commits the signatories to several actions including:

- developing a long term plan of action that is targeted to need and evidence-based, in order to achieve equality in health outcomes and life expectancy by 2030;
- ensuring that primary health care services and health infrastructure capable of bridging the health gap is in place by 2018; and
- supporting and developing Aboriginal and Torres Strait Islander community controlled health services in urban, rural and remote areas.

As at July 2009, QH is finalising an evidence-based policy framework entitled *Making Tracks towards closing the gap on health outcomes for Indigenous Queenslanders by 2033* for publication. It will provide an overarching policy framework for closing the gap and be supported by triennial implementation plans detailing specific initiatives including those funded and implemented through the *Closing the Gap on Indigenous Health Outcomes NPA* and *Indigenous Early Childhood Development NPA* and existing initiatives that are already contributing to achieving sustainable health gains for Indigenous Queenslanders.

Other Queensland Government policies and plans relevant to Closing the Gap include:

- *Advancing Health Action*, which includes reducing the gap for rural communities and for all Indigenous Queenslanders;
- *Toward Q2: Tomorrow's Queensland*[v], which includes targets to cut by one-third obesity, smoking, heavy drinking and unsafe sun exposure by 2020, and to have the shortest public hospital waiting times in Australia by 2020; and the
- *Queensland Statewide Health Services Plan 2008-2012*[vi], which includes the transition of health services to Community Controlled organisations, where appropriate; engaging clinicians across the health system; enhancing the capacity of the mainstream workforce to provide culturally appropriate information and culturally competent services.

Through COAG the Queensland Government has also committed to Indigenous NPAs in Indigenous Remote Service Delivery, Indigenous Economic Participation, Indigenous Remote Housing and Indigenous Early Childhood Development. The Indigenous Early Childhood Development NPA includes Queensland Government health-related spending of $21.25M over four years on maternal and child health services.

2 NATIONAL REFORMS

The five reforms identified below reflect system-level changes to support combined efforts to close the gap in Aboriginal and Torres Strait Islander health outcomes. A number of these reforms are being pursued through mechanisms outside of the National Partnership Agreement, while others rely upon joint and/or complementary activity by the Commonwealth and State and Territory governments through the NPA. Further detail on specific activities to address national reforms is embedded within the implementation plan.

2.1 National minimum service standards for all organisations providing primary health care services to Aboriginal and Torres Strait Islander populations

Accreditation frameworks are an explicit statement of the expected level and quality of care to be provided to patients by health services and are a means of assessing the performance of these services.

- In Queensland, primary health care (PHC) services to Aboriginal and Torres Strait Islander populations are provided by A&TSICCHOs, GPs and QH. A&TSICCHOs and GPs are primarily funded by and accountable to DoHA. Through the development of a Queensland Framework for Indigenous Primary Health Care (see initiative QG2), QH will work with DoHA on the application of national minimum service standards in Queensland to ensure consistency of service standards regardless of the provider of services.

2.2 Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets

Addressing quality issues in data reporting, including accuracy and coverage, is necessary to inform the evidence base and monitor progress against COAG targets and performance indicators.

- Through the development of a Queensland Framework for Indigenous Primary Health Care (see initiative QG2) , QH will work with DoHA to improve the quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets collected and reported by QH. In 2008, QH introduced Key Performance Indicators for QH Health Service Districts, including an indicator on the proportion of Aboriginal and Torres Strait Islander separations accurately identified as being of Aboriginal and Torres Strait Islander descent.

2.3 Infrastructures to support transitions and linked records between primary, in-patient and specialist services

A shared electronic health record is an important systemic opportunity to improve the quality and safety of health care in Australia.

- QH is engaged in the national agenda to progress towards shared electronic health records compliant with the national standards and guidelines of the National eHealth Transition Authority (NeHTA), including data collection and linked admission and discharge information between primary, in-patient and specialist services. The development of a Queensland Framework for Indigenous Primary Health Care (see initiative QG2) and the Aboriginal and Torres Strait Islander Hospital Liaison Service project (see initiative QG6.3) will reflect progress made on this agenda.

2.4 Workforce: increase the number of Aboriginal and Torres Strait Islander people in the health workforce, reform and improve the supply of the health workforce generally including the adoption of complementary workplace reforms.

The limited availability of a culturally competent workforce to provide health care to Aboriginal and Torres Strait Islander people is the single biggest risk to achievement of the objectives of the reforms under the NPA.

- Queensland Government activities will build upon complementary efforts being progressed through all National Partnership Agreements and existing government agency efforts.
- In general, QH initiatives under this NPA will create employment opportunities for Aboriginal and Torres Strait Islander people in the health sector and across a variety of health or health related disciplines and professions.
- The development of an Aboriginal and Torres Strait Islander Cultural Capability Framework (see initiative QG6.4) and The Southern Queensland Centre of Excellence in Indigenous Primary Health Care (see initiative QG3) will strengthen the cultural competency of the health workforce in general.

2.5 Cultural Security: Improved cultural security in health service delivery in all organisations providing care to Aboriginal and Torres Strait Islander people.

To ensure health services are respectful of, and responsive to, the needs of Aboriginal and Torres Strait Islander people, targeted investment is required to improve the quality and cultural security of health service delivery.

- A number of QH initiatives under this NPA will work to improve the quality and cultural security of health service delivery by ensuring the importance of cultural security is embedded in policy, in training and at the service front, these initiatives include:
  - Aboriginal and Torres Strait Islander Cultural Capability Framework (see initiative 6.4)
  - Queensland Framework Indigenous Primary Health Care (see initiative QG2)
  - Southern Queensland Centre for Excellence in Indigenous Primary Health Care Centre (see initiative QG3)
  - Aboriginal and Torres Strait Islander Hospital Liaison Service (see initiative QG 6.3)

3 IMPLEMENTATION PLAN

Implementation will be undertaken consistent with the following principles:

1. National Service Delivery Principles for Indigenous Australians (Appendix A);
2. National Principles for Investment in Remote Locations (Appendix B); and
3. Queensland's Guiding Principles for Implementation (Appendix C).

To have an impact on the Performance Indicators in this NPA will require the collective effort of initiatives to be rolled out by both the Queensland Government and Commonwealth Government:

Priority Area	Objective	Performance Indicators
Tackle smoking – the single biggest killer of Indigenous people Healthy transition to adulthood Making Indigenous health everyone's business	Preventative Health	1. Incidence/prevalence of important preventable diseases and injury. 2. Proportion of babies born of low birth weight. 3. Teenage birth rate. 4. Risk factor prevalence. 5. Immunisation rates for vaccines in the national schedule. 6. Cancer screening rates (breast, cervical, bowel). 7. Number of women with at least 1 antenatal visit in the 1st trimester of pregnancy. 8. Tobacco smoking during pregnancy. 9. Social and emotional well-being. 10. Health promotion.
Primary health care service that can deliver	Primary Health Care Sustainability	11. Access to GPs, dental and primary health care professionals. 12. Proportion of diabetics with HbA1c below 7%. 13. Life expectancy (incl. gap b/w Indigenous & non-Indigenous). 14. Infant/young child mortality rate (incl. gap b/w Indigenous & non-Indigenous). 15. Potentially avoidable deaths.Selected potentially preventable hospitalisations. 16. Time between GP/specialist visits. 17. Chronic disease management. 18. Indigenous Australians in the health workforce. 19. Expenditure on health services (including mainstream vs. Indigenous -specific). 20. Aboriginal and Torres Strait Islander people in tertiary education for health related disciplines. 21. Recruitment and retention
Fixing the gaps and improving the patient journey	Hospital and hospital-related care	22. Waiting times for services. 23. Selected adverse events in acute and sub-acute care settings. 24. Unplanned/unexpected readmissions w/in 28 days of surgical admissions. 25. Survival of people diagnosed with cancer (5 year relative rate). 26. Rates of services provided for public and private hospitals per 1,000 weighted populations by patient type. 27. Rates of discharge from hospital against medical advice.
	Patient experience	28. Access to services by type of service compared to need. 29. Nationally comparative information that indicates levels of patient satisfaction around key aspects of care they received. 30. Barriers to accessing care.

3.1 Priority Area: Tackle Smoking

Collectively, the Queensland Government (QG) initiatives under Tackle Smoking address the following aspects of this NPA:

Expected outcomes (State and Commonwealth)	Expected outputs (State Government)	Performance Benchmarks (State and Commonwealth)
▪ Reduced smoking rate ▪ Reduced burden of tobacco related disease for Indigenous communities	▪ Social marketing campaigns to reduce smoking-related harms among Aboriginal and Torres Strait Islander peoples. ▪ Indigenous specific smoking cessation and support services. ▪ Strategies to improve delivery of cessation services, including nicotine replacement therapy. ▪ Continued regulatory efforts to encourage reduction/cessation in smoking.	**S1.** Number and key results of culturally secure community education/ health promotion/ social marketing activities to promote quitting and smoke-free environments. **S2.** Key results of specific evidence based Aboriginal and Torres Strait Islander brief interventions, other smoking cessation and support initiatives offered to individuals. **S3.** Evidence of implementation of regulatory efforts to encourage reduction/ cessation in smoking in Aboriginal and Torres Strait Islander people and communities. **S4.** Number of service delivery staff trained to deliver the interventions.

Queensland Government Initiatives						
What are we aiming to do?	**Why are we doing it?**	**How will we do it?**	**Who will do it?***	**When will it be done?**	**How will we check progress?**	**What is the cost?**
Reduce the smoking rate in Aboriginal and Torres Strait Islander Queenslanders and the burden of tobacco related chronic disease for Aboriginal and Torres Strait Islander communities. *Joint initiative with the Commonwealth Government.*	▪ More than 50% of Aboriginal and Torres Strait Islander Queenslanders smoke tobacco, compared with 17% of all Queenslanders 14yrs plus[vii]. ▪ Smoking contributes to 21% of the burden of disease and 1/5th of all deaths[viii]. ▪ Evaluation of the QH 'SmokeCheck' program shows that it increases health professionals' worker self-efficacy, confidence and skills in conducting brief interventions to help their Aboriginal and Torres Strait Islander clients to critically think about their smoking, move towards being ready to quit, cut down the number of cigarettes they smoke, and quit smoking altogether.	**QG1.1** Expand SmokeCheck, including additional capacity, new service delivery model which is linked to Quitline (see QG2) and increased brief intervention training and support for health professionals. *Integrates with Commonwealth Govt initiative A1.* **QG1.2**. Enhance QH Quitline to provide culturally sensitive services including e.g. counselling with free nicotine replacement therapy (NRT) and increased promotion of the service in Aboriginal and Torres Strait Islander communities. *Integrates with Commonwealth Govt initiative A1.* **QG1.3.** Encourage and support QH and Community Controlled Health Organisation Aboriginal and Torres	Alcohol, Tobacco and Other Drugs Branch (ATODSB), QH Key partners incl: ▪ QH Health Service Districts ▪ DoHA ▪ Community control health sector ▪ Corrective Services	**2009-10** ▪ Phase 1 recruitment and up-skilling of additional SmokeCheck program delivery personnel. ▪ SmokeCheck service delivery model revised and piloted. ▪ Aboriginal and Torres Strait Islander specific performance requirements in Quitline Service Agreement. ▪ State-wide promotion and delivery of free staff quit smoking program. ▪ Investigation of options for the delivery of smoking cessation services in custodial settings. ▪ Partnership, program and funding arrangements agreed with the Commonwealth for local social marketing and community education activities. ▪ Review of existing programs that support smoke-free messages and	**Benchmark S4** *Measurement:* ▪ Number of health professionals trained to deliver SmokeCheck. **Benchmark S2 & F2** *Measurement:* ▪ Number of Aboriginal and Torres Strait Islander Qlders receiving smoking cessation support from Quitline. ▪ Number of Aboriginal and Torres Strait Islander Qlders registered in the	**2009-10:**$1,370,000 **2010-11:**$1,950,000 **2011-12:**$2,150,000 **2012-13:**$3,500,000 **Total: $8,970,000**

	▪ Evaluation of the QH Event Support Program (ESP) shows that among participants and spectators there is an up to 80% recall of the smoke-free messages being promoted at ESP events.	Strait Islander Health Workers who smoke to participate in the 16-week QH staff quit smoking program (which includes NRT). **QG1.4.** Establish and provide culturally sensitive smoking cessation services for offenders in custody, including e.g. SmokeCheck program implementation and improved access to Quitline. **QG1.5.** Implement quit smoking promotions through localised social marketing and community education activities. *Integrates with Commonwealth Govt initiative A1.* **QG1.6.** Review and enhance existing programs which support local promotion and awareness raising for smoke-free messages. Includes activities to support tobacco regulatory efforts. *Integrates with Commonwealth Govt initiative A1.* Note: under the National Partnership Agreement for Indigenous Early Childhood, QH will tailor and deliver the SmokeCheck program to antenatal care providers, and implement an Indigenous Youth Wellbeing Program and other initiatives to improve sexual health and teenage health and wellbeing (including smoking).		the implementation of existing regulatory efforts. **2010-11** Phase 2 recruitment and up-skilling of additional SmokeCheck program delivery personnel. ▪ Implementation and evaluation of revised SmokeCheck service delivery model. ▪ State-wide promotion and delivery of free staff quit smoking program. ▪ Delivery of smoking cessation services in custodial settings (pending review and funding). ▪ Implementation and evaluation of local social marketing and community education activities (pending Commonwealth arrangements). **2011-12** ▪ Implementation and evaluation of SmokeCheck program. ▪ State-wide promotion and delivery of free staff quit smoking program. ▪ Delivery of smoking cessation services in custodial settings (pending review and funding). ▪ Implementation and evaluation of local social marketing and community education activities (pending Commonwealth arrangements). **2012-13** ▪ Implementation and evaluation of SmokeCheck program. ▪ State-wide promotion and delivery of free staff quit smoking program. ▪ Delivery of smoking cessation	QH staff quit smoking program. ▪ % of self-reported behaviour change at post intervention follow-ups. **Benchmark S1 & F2** *Measurement:* ▪ Number of localised social marketing and community education activities. ▪ % recall of anti-smoking messages promoted through social marketing and community education activities. **Benchmark S3** *Measurement:* ▪ Number of localised community education activities to support increased smoke-free awareness and tobacco regulatory efforts.	

				services in custodial settings (pending review and funding). ▪ Implementation and evaluation of local social marketing and community education activities (pending Commonwealth arrangements).		

Joint Initiatives						
What are we aiming to do?	**Why are we doing it?**	**How will we do it?**	**Who will do it?***	**When will it be done?**	**How will we check progress?**	**What is the cost?**
Reduce the Indigenous smoking rate and the burden of tobacco related chronic disease for Aboriginal and Torres Strait Islander communities. *This initiative will be implemented in partnership with the Commonwealth government measure (A1) and Qld Government initiatives QG1.1, 1.2, 1.5 & 1.6.*	▪ If the smoking rate among Aboriginal and Torres Strait Islander Australians was reduced to the rate of the non-Aboriginal and Torres Strait Islander population, the overall Aboriginal and Torres Strait Islander burden of disease would fall by around 6.5%, and save around 420 Aboriginal and Torres Strait Islander lives per year. This equates to an additional four extra years of life expectancy. ▪ Evidence from New Zealand in reducing Maori smoking rates and national formative research commissioned under the Aboriginal and Torres Strait Islander Tobacco Control Initiative will inform this priority area.	Commonwealth to work with the QG, Qld Non Government Organisations (NGOs) to: ▪ Establish a national network of tobacco action coordinators. ▪ Implement local strategies including media placement. ▪ Consult and engage with local communities. ▪ Sponsor community events and establish quit smoking role models and ambassadors. ▪ Provide workforce training and support units. ▪ Enhance Quitline to provide culturally sensitive services. ▪ Train health and community workers to deliver tobacco action programs. ▪ Implement targeted tobacco cessation programs.	QH's ATODSB and Aboriginal and Torres Strait Islander Health Strategy Unit (A&TSIHSU) in partnership with Mental Health and Chronic Disease Division and Business Group (DoHA), Aboriginal and Torres Strait Islander and non-Indigenous health and community organisations.	**2009-10** ▪ Partnership, program and funding arrangements agreed with Commonwealth. ▪ Refer to Commonwealth implementation plan for detail.	**Benchmark S1** *Measurement*: ▪ Number of tobacco action coordinators. *Measurement*: ▪ Number of Aboriginal and Torres Strait Islander participants in smoking cessation and support activities. **Benchmark S4** *Measurement*: ▪ Number of health workers and community educators trained in smoking cessation.	This measure will be funded by the Commonwealth.

Assist Aboriginal and Torres Strait Islander Australians to reduce their risk of chronic disease and better manage their conditions and lifestyle risk factors through the adoption of healthy lifestyle choices. *This initiative will be implemented in partnership with the Commonwealth government measure (A2), complements Qld government initiatives QG1.1-1.6, and forms a continuum with Commonwealth government initiative (B4).*	▪ Many chronic diseases can be prevented or delayed through intervention, effective management and lifestyle change; and. ▪ Access to affordable chronic disease lifestyle risk reduction programs is a barrier to good health outcomes for Aboriginal and Torres Strait Islander Australians. Significant ongoing personalised support is needed to encourage self management of lifestyle risk factors and prevent chronic disease[ix].	Commonwealth to work with the QG and Qld NGOs to: ▪ Recruit and train over 100 Aboriginal and Torres Strait Islander healthy lifestyle workers to deliver activities and programs that target the key lifestyle contributors to chronic disease. ▪ Deliver lifestyle risk reduction sessions to 25,000 individuals and families, particularly targeting those who are considered to be at high risk of developing a chronic disease.	QH's Chronic Disease Unit and A&TSIHSU in partnership with DoHA's Mental Health and Chronic Disease Division, Aboriginal and Torres Strait Islander and non-Indigenous health and community organisations.	**2009-10** ▪ Partnership, program and funding arrangements agreed with Commonwealth. ▪ Refer to Commonwealth implementation plan for detail.	*Measurement*: ▪ Number of healthy lifestyle workers funded and trained. ▪ Number of healthy lifestyle sessions and activities conducted. ▪ Number of participants in healthy lifestyle sessions and activities. **Benchmark S4** *Measurement*: ▪ Number of healthy lifestyle workers funded and trained.	This measure will be funded by the Commonwealth.
Improve Aboriginal and Torres Strait Islander Australians' awareness of, and access to, health measures to better promote their health and wellbeing. *This initiative will be implemented in partnership with the Commonwealth government measure (A3) and Qld government initiatives QG1.1-1.6*	▪ The World Health Organization's Ottawa charter recommends a five pronged approach for health promotion, including public awareness campaigns.[x] ▪ Health promotion is an important factor in reducing risk factors at the population level[xi].	Commonwealth to work with the Qld government and Qld NGOs to: ▪ Partner with communities to develop local-level information and communication activities. ▪ Implement local strategies, including media placement.	QH's Chronic Disease Unit and A&TSIHSU in partnership with DoHA's Business Group, Aboriginal and Torres Strait Islander and non-Indigenous health and community organisations.	**2009-10** ▪ Partnership, program and funding arrangements agreed with Commonwealth. ▪ Refer to Commonwealth implementation plan for detail.	**Benchmark S1** *Measurement*: ▪ Number and type of targeted activities undertaken. ▪ Number and type of culturally appropriate information resources developed. ▪ Description of dissemination of information undertaken.	This measure will be funded by the Commonwealth.

Internal Governance and Management∗	The QG initiatives will be implemented, managed and governed through QH. The intention is that each QG initiative will be championed/sponsored by an appropriate Deputy Director-General (DDG) in QH. QH's ATODSB has ready access to relevant expertise in Aboriginal and Torres Strait Islander Tobacco use and social marketing. ATODSB will work closely with the A&TSIHSU to ensure appropriate linkages and coordination and community/stakeholder involvement, including a Tacking Smoking Qld Technical Advisory Group, as outlined below. QH is represented on the National Technical Advisory Group for this initiative. The Joint initiatives will also involve the Chronic Disease Unit.
Linkages and Coordination∗	The QATSIHP will provide advice on priorities and opportunities for integrated activity at a regional level, based on the advice from Queensland's 9 RHFs. Input will also be sought from the TSHP. Membership of QATSIHP, RHFs and the TSHP currently includes Commonwealth and QG, the Aboriginal and Torres Strait Islander Community Controlled Health Sector, and the Divisions of General Practice. For RHFs, other health providers/stakeholders relevant to the region are invited. For the implementation of these initiatives other stakeholders will be invited to the QATSIHP, RHF and TSHP as appropriate. Across QG, the Strong Indigenous Communities CEO Group and relevant officer level groups will be used to ensure integration will relevant initiatives occurring in other sectors. At a national level, coordination across governments will be provided through existing whole-of-government arrangements, including the National Aboriginal and Torres Strait Islander Health Officials Network (NATISHON), the Australian Health Ministers Advisory Council (AHMAC) and the Australian Health Ministers Conference (AHMC).
Community/ Stakeholder Involvement∗	The A&TSIHSU will facilitate the establishment of a Tackling Smoking Qld Technical Advisory Group that will include, at minimum, representation from QH, DoHA and QAIHC, and will report to the QATSIHP. The QATSIHP, RHFs, and TSHP include community and non-government representation. Additionally, the Queensland Aboriginal and Torres Strait Islander Council (QATSIC), the Indigenous Mayors' Roundtable, and local Negotiation Tables will be engaged and able to provide advice on key policy issues and community engagement strategies. Aboriginal and Torres Strait Islander Queenslanders will be formally involved design, monitoring and evaluation of the Tackle Smoking initiatives at the local level, in ways that suit the specifics of the program being rolled out locally. For example, local focus groups of smokers, non-smokers, service providers and other relevant stakeholders may be established. Specific targeted focus groups may also occur eg with Aboriginal and Torres Strait Islander youth.

∗ Note, identified based on QH, Queensland Government, other government and non-government structures and stakeholders as at July 2009. Internal organisational changes and/or machinery of government changes may impact on "who will do it" and key stakeholders.

3.2 Priority Area: Primary Health Care Services That Can Deliver

Collectively, the QG initiatives under Primary Health Care (PHC) Services That Can Deliver address the following aspects of this NPA:

Expected outcomes (State and Commonwealth)	Expected outputs (State Government)	Performance Benchmarks (State and Commonwealth)
▪ Implementation of national best practice standards and accreditation processes for Aboriginal and Torres Strait Islander health services delivering PHC ▪ Increased uptake of MBS-funded PHC services by Aboriginal and Torres Strait Islander people ▪ Improved access to quality PHC through improved coordination across the care continuum, particularly for people with chronic diseases and/or complex needs ▪ Provision of improved cultural security in services, and increased cultural competence of the PHC workforce	▪ Introduce minimum service standards for all organisations providing PHC services to Aboriginal and Torres Strait Islander populations. ▪ Ensure that PHC services have the capacity to deliver the coordination and continuity of care necessary to meet the needs of Aboriginal and Torres Strait Islander clients. ▪ Expand allied health and acute care services to address the increased referrals for coordinated care by PHC services. ▪ Review and refocus own purpose outlays in PHC to prioritise core service provision and evidence-based regional priorities.	**P1.** Number of Indigenous specific health services meeting national minimum standards. **P2.** Number of Aboriginal and/or Torres Strait Islander people receiving a MBS Adult Health Check **P3.** Number of new allied health professionals recruited. **P4.** Increased effort to refocus own purpose outlays in primary care to prioritise core service provision and evidence-based Indigenous health regional priorities. **P5.** Improved patient referral and recall for more effective health care, and in particular, chronic disease management. **P6.** Improved/new IT systems operational to support interface between systems used in PHC sector and other parts of the health system. **P7.** Evidence of implementation of cultural competency frameworks across the applicable health workforce.

What are we aiming to do?	Why are we doing it?	How will we do it?	Who will do it?*	When will it be done?	How will we check progress?	What is the cost?
Improve the quality and appropriateness of PHC services delivered by QH	▪ For all ages, Indigenous Queenslanders are hospitalised at much higher rates than non-Indigenous Queenslanders for potentially preventable conditions[xii] ▪ The evidence shows that to bridge the health gap between Aboriginal and Torres Strait Islander and non-Indigenous Australians the most effective interventions, along side health prevention	**QG2.** Develop a Queensland Framework for Indigenous Primary Health Care that will outline key principles for ensuring Indigenous Queenslanders have access to appropriate PHC. Principles will address: – Models of Care (Minimum standards/core programs) *(link to QG3)* – Performance accountability – Continuous improvement *(link QG4)*	QH's A&TSIHSU in partnership with relevant QH policy, program and corporate services areas, DoHA and QAIHC	**2009-2010** ▪ Policy development commences. ▪ Consultation with stakeholders. ▪ Review of own purpose outlays commences. ▪ See also QG4, QG5 & QG6.4. **2010-2011** ▪ Review of own purpose outlays concludes. ▪ Minimum Aboriginal and Torres Strait Islander PHC data set and endorsed by EMT.	**Benchmark P1** *Measures* ▪ Number of "Aboriginal and Torres Strait Islander focused" QH PHC facilities meeting National Minimum Standards. **Benchmark P4.** *Measures* ▪ Evidence of effort to refocus own purpose outlays. **Benchmark P6** *Measures*	Consolidated, estimated costings for all initiatives under this priority area, up to: **$90.79M over 4 years**. Note. Costs as shown in NPA may be reprioritised between financial years and priority areas depending on outcomes of year 1 consultation and review activities.

	and education, will be those that focus on improved early diagnosis, treatment and management of the diseases and illness that together contribute to two-thirds of the health gap – cardiovascular disease, diabetes, chronic respiratory disease, cancers, mental disorders and injury. These interventions typically and appropriate occur in the PHC service setting. ▪ Improving Qld PHC services and improving access to allied health and specialist services in a community setting are key strategies for reducing these hospitalisation rates	– Coordinated Care across the continuum – Skilled and multidisciplinary workforce *(link to QG5 & QG6.4)* – Partners in Primary Health Care – Community participation (transition to community control) Development will include a review of own purpose outlays as per the requirement of the NPA.		▪ Policy endorsed by EMT. ▪ See also QG4, QG5 & QG6.4. **2011-2012** ▪ QH reporting against Aboriginal and Torres Strait Islander PHC data set commences. ▪ Opportunities for increased community control of PHC progressed. ▪ See also QG4, QG5 & QG6.4. **2012-2013** ▪ Results of annual CQI audits available. ▪ Ongoing reporting minimum Aboriginal and Torres Strait Islander PHC data set reporting. ▪ Opportunities for increased community control of PHC progressed. ▪ See also QG4, QG5 & QG6.4.	▪ Evidence of effort to develop and implement improved PHC information systems able to interface with other parts of the health system. **Benchmark P7** *Measures* ▪ Evidence of implementation of cultural competency frameworks across the applicable health workforce.	
		QG3. Establish a Centre of Excellence in Indigenous PHC. The Centre will provide increase service capacity to the South Brisbane Aboriginal and Torres Strait Islander population, provide medical internships and trainee places for health	QH's Inala Aboriginal and Torres Strait Islander PHC service, Metro South HSD	**2009-10** ▪ Expansion/refurbishment of Inala Community Health Centre. ▪ Clinical and corporate Governance structure updated. ▪ New positions recruited. **2010-11**	**Benchmark P1** *Measures* ▪ Centre of excellence meets national minimum standards. ▪ # capacity building outreach visits per year (aim 2) ▪ # of published research papers	

		professionals, and undertake research and practice that can be used to inform excellence in Aboriginal and Torres Strait Islander PHC service delivery across the state.		▪ Medical and allied health student rotations commence. ▪ Aim 90% of patients receiving appropriate heath checks & Enhanced primary care items across lifespan. ▪ Research projects commenced. ▪ Capacity building outreach visits commence (min 2 per year) **2011-2012** ▪ Medical and allied health student rotations continue. ▪ Aim 90% of patients receiving appropriate heath checks & Enhanced primary care items across lifespan. ▪ Research projects continue. ▪ Capacity building outreach visits continue (min 2 per year). **2012-2013** ▪ Medical and allied health student rotations continue. ▪ Aim 90% of patients receiving appropriate heath checks & Enhanced primary care items across lifespan. ▪ Research projects	**Benchmark P2** *Measures* ▪ % of patients receiving appropriate Health checks across the lifespan (baseline: 70% for adult health Check and 35% for child health check.) ▪ % of eligible chronic disease patients receiving Enhanced primary care items **Benchmark P5 & P7** *Measures* ▪ # Medical student places offered. ▪ # new positions recruited	

				continue. ▪ Capacity building outreach visits continue (aim 2 per year).		
		QG4. Expand the Audit and Best Practice in Chronic Disease (ABCD) program from 22 sites to up to 60 sites in Queensland	QH's A&TSIHSU in partnership with QH's Office of Rural and Remote Health and relevant QH policy, program and corporate services areas, DoHA and QAIHC	**2009-10** ▪ Contract for existing sites and expansion negotiated. ▪ New sites identified and agreed by relevant stakeholders. ▪ Recruitment of new positions commences. **2010-11 onwards** ▪ Recruitment finalised ▪ New sites come 'on-line' ▪ Audits undertaken at sites ▪ Site and state-wide reports produced ▪ Site response plans developed	**Benchmark P1** *Measure* Sites meeting national minimum standards. **Benchmark P2** *Measure* Number of Aboriginal and/or Torres Strait Islander people receiving a MBS Adult Health Check at sites. **Benchmark P5** *Measure* Evidence of Improved patient referral and recall for more effective chronic disease management at sites	
Increase access to allied health and specialist services to support Qld PHC service providers	Initiative QG5 is designed to aid the Qld Health system to adequately manage the flow on effect of increased Commonwealth investment in PHC -increased PHC will mean an increase in detection of illness and demand for more acute allied health and specialist services, if these services can be provided in the community it will assist in preventing hospital admissions	**QG5.** Fund more health professionals, including allied health and specialists, to work as part of chronic disease multidisciplinary teams providing community-based care for Indigenous Queenslanders. *(links with C'wealth initiative (B5))*	QH's A&TSIHSU in partnership with relevant QH policy, program and corporate services areas, DoHA and QAIHC	**2009-10** ▪ Multi-disciplinary care team framework (including governance and referral pathways) established. ▪ Need assessment - sites/scope of multidisciplinary care teams identified in consultation with stakeholders. ▪ Recruitment/service purchase commences. **2010-11 onwards** ▪ Recruitment/service	**Benchmark P3** *Measure* ▪ Number of new allied health professionals recruited/services purchased. **Benchmark P5** *Measure* ▪ Number of referrals and completed referrals to multi-disciplinary teams.	

				purchase continues. ▪ Services provided.		

Joint Initiative						
What are we aiming to do?	**Why are we doing it?**	**How will we do it?**	**Who will do it?∗**	**When will it be done?**	**How will we check progress?**	**What is the cost?**
Support Aboriginal and Torres Strait Islander Australians to better manage or self-manage their chronic disease. *This initiative will be implemented in partnership with the Commonwealth government measure (B4), complements the Qld Government initiative QG2, 3 & 4, and forms a continuum with Commonwealth government initiative (A2).*	▪ Many chronic diseases can be prevented and its progressed delayed through intervention, effective management and lifestyle change; and. ▪ Access to affordable chronic disease risk reduction/self management programs is a barrier to good health outcomes for Aboriginal and Torres Strait Islander Australians. Significant ongoing personalised support is needed to encourage self management of lifestyle risk factors to prevent chronic disease or to slow its progression.[xiii]	Commonwealth to work with the Qld government and Qld NGOs to: ▪ Fund the delivery of 400 healthy lifestyle/self management workforce training programs. ▪ The training will provide the competency-based skills appropriate to support lifestyle change and self management skills in Aboriginal and Torres Strait Islander people who have established chronic disease or who are at risk of developing a chronic disease. ▪ The trained workforce will deliver sessions and activities to 50,000 Aboriginal and Torres Strait Islander individuals and families with established chronic disease or who are at high risk of developing a chronic disease.	QH's Chronic Disease Unit and A&TSIHSU in partnership with DoHA's Mental Health and Chronic Disease Division, and Aboriginal and Torres Strait Islander and non-Indigenous health and community organisations.	**2009-10** ▪ Partnership, program and funding arrangements agreed with Commonwealth. ▪ Refer to Commonwealth implementation plan for detail.	**Benchmark P5** *Measurement*: ▪ Number of workers provided with training on supporting healthy lifestyle change and self management. ▪ Number of participants, activities and sessions.	This measure will be funded by the Commonwealth.

Internal Governance and Management∗	The QG initiatives will be implemented, managed and governed through QH. The intention is that each QG initiative will be championed/sponsored by an appropriate DDG in QH. QG3 will be implemented and managed by the QH's Inala Aboriginal and Torres Strait Islander PHC service, governed through QH's metro south HSD. Key stakeholders within QH, such as the A&TSIHSU and Workforce Coordination and Planning branch will also be engaged along with key external stakeholders such as the tertiary institutions delivering medical, nursing, and allied health training. Implementation of QG2, 3 & 5 will be led by the QH A&TSIHSU initially. Expert/specialist working groups will be established with key internal and external stakeholders and ongoing management transition to appropriate areas.
Linkages and Coordination∗	The QATSIHP will provide advice on priorities and opportunities for integrated activity at a regional level, based on the advice from Queensland's 9 RHFs. Input will also be sought from the TSHP. Membership of QATSIHP, RHFs and the TSHP currently includes Commonwealth and QG, the Aboriginal and Torres Strait Islander Community Controlled Health Sector, and the Divisions of General Practice. For RHFs, other health providers/stakeholders relevant to the region are invited. For the implementation of these initiatives other stakeholders will be

	invited to the QATSIHP, RHF and TSHP as appropriate. Across QG, the Strong Indigenous Communities CEO Group and relevant officer level groups will be used to ensure integration will relevant initiatives occurring in other sectors. At a national level, coordination across governments will be provided through existing whole-of-government arrangements, including NATISHON, AHMAC, and AHMC.
Community/ Stakeholder Involvement∗	The QATSIHP, RHFs, and TSHP include community and non-government representation. Additionally, the Queensland Aboriginal and Torres Strait Islander Council (QATSIC), the Indigenous Mayors' Roundtable, and local Negotiation Tables will be engaged and able to provide advice on key policy issues and community engagement strategies. Aboriginal and Torres Strait Islander Queenslanders will be formally involved design, monitoring and evaluation of the initiative through consultation with 'focus groups' (or similar) elders groups/community groups, and the opportunity for participant feedback.

∗ Note, identified based on QH, Queensland Government, other government and non-government structures and stakeholders as at July 2009. Internal organisational changes and/or machinery of government changes may impact on "who will do it" and key stakeholders.

3.3 Priority Area: Fixing the Gaps and Improving the Patient Journey

Collectively, the QG initiatives under Fixing the Gaps and Improving the Patient Journey address the following aspects of this NPA:

Expected outcomes (State and Commonwealth)	Expected outputs (State Government)	Performance Benchmarks (State and Commonwealth)
▪ Reduced average length of stay in the long term ▪ Improved level of engagement between Aboriginal and Torres Strait Islander patients, referred care providers and primary level providers (private or public) to deliver better follow up and referral processes ▪ Improved long term stability in primary provider choice ▪ Improved patient satisfaction with the care and patient journey (based on domains of concern to patients) ▪ Reduced admissions and incomplete treatments for Aboriginal and Torres Strait Islander patients	▪ Workforce strategies developed in partnership with Aboriginal and Torres Strait Islander communities to improve continuity of care and coordination with health services. ▪ Strategies to improve the cultural security of services and practice within public hospitals. ▪ Improved access to acute care (and sub acute) systems for Aboriginal and Torres Strait Islander people. ▪ In-hospital care managers provided to coordinate and follow up care transitions. ▪ New culturally secure transition care services to address issues of social isolation and/or geographic remoteness, language, health literacy and other social factors established. ▪ Transport and accommodation support provided for rural and remote patients and their families.	**F1.** Number of new case managers/ Indigenous Liaison Officers recruited and operational. **F2.** Number of culturally secure health education products and services to give Indigenous people skills and understanding of preventative health behaviours, and self management of some chronic health conditions. **F3.** Key results of strategies to improve cultural security of services and practice within public hospitals. **F4.** Increased percentage of Aboriginal and/or Torres Strait Islander people with a chronic disease with a care plan in place. **F5.** Percentage of Aboriginal and Torres Strait Islander people participating in rehabilitation programs intended to reduce hospitalisation of people with chronic disease. **F6.** Increased number of culturally appropriate transition care plans/procedures/best practice guidelines to reduce readmissions by (percentage/proportion). **F7.** Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets.

What are we aiming to do?	Why are we doing it?	How will we do it?	Who will do it?*	When will it be done?	How will we check progress?	What is the cost?
Ensure more Aboriginal and Torres Strait Islander Queenslanders who need hospital treatment are able to access and complete treatment, and that there is adequate interface between hospital and PHC services.	▪ Cost, transport, accommodation and the cultural capability of health professionals impact on Aboriginal and Torres Strait Islander Australian's access to health services. The HPF 2008[xiv] reports: a) There are large disparities between the Aboriginal and Torres Strait Islander and non- Aboriginal and Torres Strait Islander population in	**QG6.1.** Establish new, or expand existing, Accommodation facilities in high need locations. *Links with QG election commitment for Patient Accommodation.*	QH's A&TSIHSU in partnership with QH HSDs, Integrated Patient Health Transport Unit, Capital Works and Asset Mgmt Branch and Procurement Unit, and RHFs	**2009-10** ▪ Needs analysis. ▪ Consultation with stakeholders. **2010-11** ▪ Service auspice for new or expanded patient accommodation facilities identified. ▪ Service models negotiated and contract/s issued. ▪ Construction/refurbishment	*Measures* ▪ Sites identified. ▪ Service utilisation.	Consolidated, estimated costings for all initiatives under this priority area, up to: **$47.4M over 4 years** Note. Costs as shown in NPA may be reprioritised between financial years and priority

This initiative is designed to ensure the Qld Health system can adequately manage the flow on effect of increased Commonwealth investment in PHC.	access to certain key hospital procedures that cannot entirely be explained by diagnosis, age, sex or place of residence and this situation has not improved in recent years. Between July 2004 and June 2006, excluding care involving dialysis, 55% of hospital separations for Aboriginal and Torres Strait Islander peoples in public hospitals had a procedure recorded compared to 80% of hospital separations for other people. b) Discharge from hospital against medical advice. There have been significant increases in the rate at which Aboriginal and Torres Strait Islander peoples are discharged from hospital against medical advice in recent years. For the period 2004–05 to 2005–06, Aboriginal and Torres Strait			commenced. **2011-12** ▪ Construction/refurbishment ongoing ▪ Completed services operational. **2012-13** ▪ Construction/refurbishment finalised. ▪ All services operational.		areas depending on outcomes of year 1 consultation and review activities.
		QG6.2. Establish new, or improve existing, patient transport options in high need locations.	QH's A&TSIHSU in partnership with QH HSDs, Integrated Patient Health Transport Unit, Capital Works and Asset Mgmt Branch and Procurement Unit, and RHFs	**2009-10** ▪ Issues and needs analysis. ▪ Consultation with stakeholders. **2010-11** ▪ Service models negotiated. **2011-12** ▪ Enhanced services operational. **2012-13** ▪ Enhanced services operational.	*Measures* ▪ Sites identified. ▪ Service utilisation	

	Islander peoples discharged from hospital against medical advice at 13 times the rate of other Australians. c) Approximately 16% of Aboriginal and Torres Strait Islander peoples felt they were treated badly when they sought health care because they were Aboriginal and/or Torres Strait Islander. ▪ Initiatives Q6.1 & 6.2 are designed to aid the Qld Health system to adequately manage the flow on effect of increased Commonwealth investment in PHC. Increased PHC will mean an increase in detection of illness and those people that can't be managed by allied health and specialist services in the community (QG5) may need to go to hospital; appropriate transport and accommodation is key to ensuring people attend hospital in a timely fashion and stay for their complete treatment – timely and complete treatment reduces the likelihood of readmission when the illness is more advance and more	**QG6.3** Aboriginal and Torres Strait Islander Hospital Liaison Service	QH's A&TSIHSU in partnership with QH HSDs, HR, Workforce Planning and Coordination Branch and RHFs.	**2009-10** ▪ Consultation with stakeholders. ▪ Map existing IHLO positions ▪ Review of IHLO roles and governance structure. ▪ Develop an evidence based approach to identify an appropriate IHLO workforce benchmark. ▪ Undertake a gap analysis against benchmark and prioritise facilities for additional positions. ▪ Role requirements, benchmark and prioritisation endorsed by EMT and communicated to QH HSD. **2010-11** ▪ Review recommendations progressed. **2011-12** ▪ Recruitment complete ▪ Services operational **2012-13** ▪ Services operational	*Measure* ▪ Status of review. **Benchmark F1** *Measures* ▪ Number of new case managers/ Aboriginal and Torres Strait Islander Liaison Officers recruited and operational compared to number of new positions identified for filling. **Benchmark F7** *Measures* ▪ Increase Aboriginal and Torres Strait Islander identification compared to 2008/09 baseline **Benchmark F3** *Measures* ▪ Decrease in Aboriginal and Torres Strait Islander discharge against medical advice compared to 2008/09 baseline.	

	expensive to treat. ▪ Initiatives QG6 & 7 are designed to aid the Qld Health system to adequately manage the flow on effect of increased Commonwealth investment in PHC - increased PHC will mean an increase in detection of illness and those people that can't be managed by acute allied health and specialist services in the community (QG5) may need to go to hospital, appropriate admission and discharge from hospital is important to ensuring patients get the right clinical treatment when they are in hospital and the right post-operative/rehabilitative treatment when they leave hospital – better treatment pre, during and post hospital admission reduces the likelihood of readmission when the illness is more advance and more expensive to treat.	**QG6.4** Cultural Capability Framework – finalise the development of a QH organisation-wide Framework for Aboriginal and Torres Strait Islander Cultural Capability based on the AHMAC endorsed Cultural Respect Framework. *Links with QG Whole-of-Government Reconciliation Action Plan.*	QH's A&TSIHSU in partnership with HR, Workforce Planning and Coordination Branch and RHFs.	**2009-10** ▪ Convene project reference group. ▪ Draft Framework. ▪ Consultation. ▪ Identify existing training packages and products for modification and/or use by QH. ▪ Draft Implementation Plan. ▪ Launch Framework. **2010-11 onwards** ▪ Continue to embed cultural capability framework implementation within QH.	**Benchmark P7** *Measures* ▪ Evidence of implementation of cultural competency frameworks across the applicable health workforce. **Benchmark F3** *Measures* ▪ Key results of strategies to improve cultural security of services and practice within public hospitals ▪ Number of project reference group meetings ▪ Number and breadth of consultation. ▪ Draft documents prepared. ▪ Plan launched.	
		QG7. Care Connect Initiative – a pilot initiative to improve screening, discharge and post discharge follow up care.	QH's Metro North HSD in partnership with A&TSIHSU, local NGO service providers, RHF and the community.	**2009-10** ▪ Clinical and administrative governance model agreed. ▪ Consultation with stakeholders. ▪ Operational site identified. **2010-11 onwards** ▪ Recruitment finalised. ▪ Service operational.	**Benchmark F6** *Measures* ▪ Culturally appropriate transition care planning guidelines developed. *Measures* ▪ Number of case coordination episodes.	

Internal Governance and Management∗	The QG initiatives will be implemented, managed and governed through QH. The intention is that each QG initiative will be championed/sponsored by an appropriate DDG in QH. Initiatives QG6.1 & 6.2 will be lead by the QH A&TSIHSU and a specialist working group will be established with likely representation from Integrated Patient Health Transport branch, Planning and Coordination branch, Capital Works and Asset Mgmt branch, Procurement branch and relevant HSDs. Initiative QG6.3 & 6.4 will be led by A&TSIHSU and a specialist working group established with likely representation from HR and Workforce Planning and Coordination Branch. Initiative QG7 will be implemented by the Metro North HSD who will establish appropriate hospital and community health service working groups. The A&TSIHSU will ensure appropriate linkages and coordination and community/stakeholder involvement as outlined below.
Linkages and Coordination∗	The QATSIHP will provide advice on priorities and opportunities for integrated activity at a regional level, based on the advice from Queensland's 9 RHFs. Input will also be sought from the TSHP. Membership of QATSIHP, RHFs and the TSHP currently includes Commonwealth and QG, the Aboriginal and Torres Strait Islander Community Controlled Health Sector, and the Divisions of General Practice. For RHFs, other health providers/stakeholders relevant to the region are invited. For the implementation of these initiatives other stakeholders will be invited to the QATSIHP, RHF and TSHP as appropriate. Across QG, the Strong Indigenous Communities CEO Group and relevant officer level groups will be used to ensure integration will relevant initiatives occurring in other sectors. At a national level, coordination across governments will be provided through existing whole-of-government arrangements, including NATISHON, AHMAC, and AHMC.
Community/ Stakeholder Involvement∗	The QATSIHP, RHFs, and TSHP include community and non-government representation. Additionally, the Queensland Aboriginal and Torres Strait Islander Council (QATSIC), the Indigenous Mayors' Roundtable, and local Negotiation Tables will be engaged and able to provide advice on key policy issues and community engagement strategies. Aboriginal and Torres Strait Islander Queenslanders will be formally involved design, monitoring and evaluation of the initiative through consultation with 'focus groups' (or similar) elders groups/community groups, and the opportunity for participant feedback.

∗ Note, identified based on QH, Queensland Government, other government and non-government structures and stakeholders as at July 2009. Internal organisational changes and/or machinery of government changes may impact on "who will do it" and key stakeholders.

3.4 Priority Area: Healthy Transition to Adulthood

Collectively, the QG initiatives under Healthy Transition to Adulthood address the following aspects of this NPA:

Expected outcomes (State Government only)	Expected outputs (State Government only)	Performance Benchmarks (State Government only)
▪ Increased sense of social and emotional wellbeing ▪ Reduced uptake of alcohol, tobacco and illicit drugs ▪ Reduced rates of sexually transmissible infections ▪ Reduced hospitalisations for violence and injury ▪ Reduced excess mortality and morbidity among Aboriginal and Torres Strait Islander men	▪ Create/enhance youth outreach networks to support early diagnosis, treatment and advice to at-risk young Aboriginal and Torres Strait Islander peoples. ▪ Expand and integrate mental health and substance use services. ▪ Expand diversionary activities within the juvenile justice system and provide health and wellbeing checks for young Aboriginal and Torres Strait Islander offenders. ▪ Improve the network of family-based alcohol/drug treatment, rehabilitation and support services.	**H1.** Number of additional health professionals (including drug/alcohol/mental health/outreach teams) recruited and operational in each 6 month period.

What are we aiming to do?	Why are we doing it?	How will we do it?	Who will do it?*	When will it be done?	How will we check progress?	What is the cost?
Increase access to early intervention health services, particularly in the areas of sexual health, mental health and drug and alcohol services targeting 8-18 year old Aboriginal and Torres Strait Islander Qlders, particularly young those in or at risk of entering the juvenile justice system, and young males.	Aboriginal and Torres Strati Islanders up to 18 years represent approx half of Queensland's Aboriginal and Torres Strait Islander population Aboriginal and Torres Strait Islander young people are more likely to: ▪ die young ▪ be hospitalised ▪ have low levels of educational achievement and completion ▪ be the victims of abuse and/or neglect ▪ come into contact with the criminal justice system ▪ experience disability. ▪ experience motherhood by 17 years or less ▪ be unemployed or not in the labour force[xv].	**QG8.** Recruit and network appropriate health professionals to deliver programs with focus in areas such as such as youth health, male health, and integrated drug & alcohol and mental health service delivery.	QH's A&TSIHSU in partnership with HSDs, ATODSB, Maternity & Child Health & Safety Branch (M&CHSB), RHFs, NGOs, Department of Communities (DoCs), and Corrective Services.	**2009-10** ▪ Needs based analysis of areas of need. ▪ Consultation with stakeholders. ▪ Locations identified for service enhancements. **2010-11** ▪ Service models negotiated and contract/service agreements (or equivalent) in place ▪ Recruitment commences. **2011-12** ▪ Services operational. **2012-13** ▪ Services operational.	**Benchmark H1** *Measure* ▪ Number of additional health professionals recruited and operational in each 6 month period.	Consolidated, estimated costings for all initiatives under this priority area, up to: **$11.86M over 4 years** Note. Costs as shown in NPA may be reprioritised between financial years and priority areas depending on outcomes of year 1 consultation and review activities.

Internal Governance and Management∗	This QG initiative will be led by QH but other QG Departments eg DoCs and Corrective Services will provide critical information in terms of identifying need/priorities and on existing non-health systems/programs that this initiative could complement. The intention is that each QG initiative will be championed/sponsored by an appropriate DDG in QH. The A&TSIHSU will lead the establishment of a expert working group involving DoCs, Corrective Services, QH ATODS branch, and QH M&CHSB. The A&TSIHSU will ensure appropriate linkages and coordination and community/stakeholder involvement as outlined below.
Linkages and Coordination∗	The QATSIHP will provide advice on priorities and opportunities for integrated activity at a regional level, based on the advice from Queensland's 9 RHFs. Input will also be sought from the TSHP. Membership of QATSIHP, RHFs and the TSHP currently includes Commonwealth and QG, the Aboriginal and Torres Strait Islander Community Controlled Health Sector, and the Divisions of General Practice. For RHFs, other health providers/stakeholders relevant to the region are invited. For the implementation of these initiatives other stakeholders will be invited to the QATSIHP, RHF and TSHP as appropriate. Across QG, the Strong Indigenous Communities CEO Group and relevant officer level groups will be used to ensure integration will relevant initiatives occurring in other sectors. At a national level, coordination across governments will be provided through existing whole-of-government arrangements, including NATISHON, AHMAC, and AHMC.
Community/ Stakeholder Involvement∗	The QATSIHP, RHFs, and TSHP include community and non-government representation. Additionally, the Queensland Aboriginal and Torres Strait Islander Council (QATSIC), the Indigenous Mayors' Roundtable, local Negotiation Tables and the Queensland Aboriginal and Torres Strait Islander Human Services Coalition will be engaged and able to provide advice on key policy issues and community engagement strategies. Aboriginal and Torres Strait Islander Queenslanders will be formally involved design, monitoring and evaluation of the initiative through consultation with 'focus groups' (or similar) elders groups/community groups, and the opportunity for participant feedback.

∗ Note, identified based on QH, Queensland Government, other government and non-government structures and stakeholders as at July 2009. Internal organisational changes and/or machinery of government changes may impact on "who will do it" and key stakeholders.

3.5 Priority Area: Making Indigenous Health Everyone's Business

Collectively, the QG initiatives under Making Indigenous Health Everyone's Business address the following aspects of this NPA:

Expected outcomes (State Government only)	Expected outputs (State Government only)	Performance Benchmarks (State Government only)
▪ Improved multi-agency, multi-programme and inter-sectoral collaboration and coordination to meet the needs of Indigenous families and communities ▪ Improved access to targeted early detection and intervention programs by high need Indigenous families ▪ Reduced waiting times for health services ▪ Reduction in early mortality	▪ Improve coordination of service delivery for families that have high level of contact with services such as child protection, juvenile justice, corrections, housing and health services.	**M1.** To be determined at a jurisdiction level – Qld will develop as part of program/initiative design in year 1.

What are we aiming to do?	Why are we doing it?	How will we do it?	Who will do it?*	When will it be done?	How will we check progress?	What is the cost?
Improved multi-agency, multi-programme and inter-sectoral collaboration and coordination to meet the needs of vulnerable Aboriginal and Torres Strait Islander families.	In 2004–05, approximately 15% of Aboriginal and Torres Strait Islander Australians reported they needed to go to a doctor in the last 12 months, but didn't, 8% needed to go to another health professional and 7% needed to go to hospital, but didn't. The most common reasons why Aboriginal and Torres Strait Islander people did not go to a doctor when needed were that they decided not to seek care (26%), too busy (24%), transport/distance difficulties (14%) and waiting time too long or not available at time required (14%)[xvi]. Improvements in health outcomes for Aboriginal and Torres Strait Islander peoples will be achieved by the health sector working with other sectors to influence health-seeking behaviours, particularly among young, vulnerable and disengaged population groups.	**QG9.** Establish a 'family support' pilot program in an urban location to ensure vulnerable families are informed of and able to access health services or programs, regardless of how they enter the social service system.	QH's A&TSIHSU in partnership withQH's M&CHSB, DoCs, Corrective services, Department of Housing, relevant QH HSD and relevant non-government stakeholders.	**2009-10** ▪ Research equivalent programs. ▪ Consultation with relevant government and NGO stakeholders. ▪ Identify ideal models for integrated social service collaboration and coordination and address barriers to ideal model. **2010-11** ▪ Ongoing consultation ▪ Location for pilot identified. ▪ Pilot program designed. ▪ Cross-agency cooperation framework agreed. **2011-12** ▪ Contract/ service agreement (or equivalent) in place. ▪ Pilot implementation	**Benchmark M1** *Measure* ▪ Number of agencies engaged. ▪ Number of families targeted. ▪ Number of completed referrals to health services.	Consolidated, estimated costings for all initiatives under this priority area, up to: **$3.2M over 4 years** Note. Costs as shown in NPA may be reprioritised between financial years and priority areas depending on outcomes of year 1 consultation and review activities.

				2012-13 ▪ Ongoing pilot implementation ▪ Evaluation		

Internal Governance and Management∗	This QG initiative will be led by QH but other QG Departments eg DoCs, education, child safety and Corrective Services will provide critical information in terms of identifying need/priorities and on existing non-health services that this initiative needs to link with. The intention is that each QG initiative will be championed/sponsored by an appropriate DDG in QH. The A&TSIHSU will lead the establishment of a expert working group involving DoCs, Corrective Services, and QH M&CHSB. The A&TSIHSU will ensure appropriate linkages and coordination and community/stakeholder involvement as outlined below.
Linkages and Coordination∗	The QATSIHP will provide advice on priorities and opportunities for integrated activity at a regional level, based on the advice from Queensland's 9 RHFs. Input will also be sought from the TSHP. Membership of QATSIHP, RHFs and the TSHP currently includes Commonwealth and QG, the Aboriginal and Torres Strait Islander Community Controlled Health Sector, and the Divisions of General Practice. For RHFs, other health providers/stakeholders relevant to the region are invited. For the implementation of these initiatives other stakeholders will be invited to the QATSIHP, RHF and TSHP as appropriate. Across QG, the Strong Indigenous Communities CEO Group and relevant officer level groups will be used to ensure integration will relevant initiatives occurring in other sectors. At a national level, coordination across governments will be provided through existing whole-of-government arrangements, including NATISHON, AHMAC, and AHMC.
Community/ Stakeholder Involvement∗	The QATSIHP, RHFs, and TSHP include community and non-government representation. Additionally, the Queensland Aboriginal and Torres Strait Islander Council (QATSIC), the Indigenous Mayors' Roundtable, local Negotiation Tables and the Queensland Aboriginal and Torres Strait Islander Human Services Coalition will be engaged and able to provide advice on key policy issues and community engagement strategies. Aboriginal and Torres Strait Islander Queenslanders from the pilot location will be formally involved design, monitoring and evaluation of the initiative through consultation with 'focus groups' (or similar) elders groups/community groups, and the opportunity for pilot participant feedback.

∗ Note, identified based on QH, Queensland Government, other government and non-government structures and stakeholders as at July 2009. Internal organisational changes and/or machinery of government changes may impact on "who will do it" and key stakeholders.

4 RISK MANAGEMENT

Risk management strategies will be integrated into the project management of each initiative. Some of the broad/common risks to the whole Queensland Government Package are outlined below, including how these risks may be identified and managed strategically.

Risk	Origin/cause/source of risk and trigger point for deploying strategies	Risk mitigation/control strategies
Stakeholder engagement delays.	Delays in Stakeholder meetings (unable to schedule suitable dates etc…)	Consider alternative methods of engagement such as 'communiqués
External and internal criticism of initiatives (or of the process).	Informal discussions with Stakeholder. Issues identified/raised formally through QATSIHP.	Regular engagement Involvement in implementation design.
Short timeframes means expediency is prioritised at the expense of quality.	Stakeholder dissatisfaction with implementation models and approach.	Where possible identify existing (including interstate or international) best practice service model that could be built on.
Implementation delays due to infrastructure issues and workforce shortages.	Monitoring contracts or service level agreements	Use broad and innovative recruitment approaches.
Poor coordination resulting in Commonwealth and State initiatives duplicating effort.	Reports from service providers and stakeholders	Continuous engagement between State and Commonwealth, particularly through Partnership and Regional Health Forums.
Scale of initiatives have to be revised because of cost increases, particularly salary costs	QH Budget monitoring. Enterprise Bargaining monitoring.	Build flexibility into services and service models eg consider fee-for-service arrangements and program outcomes rather than inputs so that inputs can be adjusted if costs change.

5 REVIEW AND EVALUATION

As appropriate, each Queensland Government initiative being rolled out through this implementation plan will incorporate review and evaluation suitable to the nature of the initiative but linked to the outcomes, outputs and performance benchmarks of this NPA. This will allow information to be aggregated to provide an overall picture of performance. A broader review and evaluation strategy will be negotiated with Commonwealth, who will engage an independent evaluation in 2012-13. The performance indicators in this NPA are consistent with performance indicators in existing monitoring frameworks, such as the Aboriginal and Torres Strait Islander Health Performance Framework, and in other COAG agreements, such as the National HealthCare Agreement and National Indigenous Reform Agreement. As such, review and evaluation of this NPA will draw from existing data sets and data improvements occurring through COAG. Review and evaluation will also inform and, as appropriate, be informed by, Queensland Aboriginal and Torres Strait Islander affairs governance structures such as*:

- Queensland Aboriginal and Torres Strait Islander Health Partnership;
- Strong Indigenous Communities CEO committee;
- Queensland Aboriginal and Torres Strait Islander Council;
- Queensland Aboriginal and Torres Strait Islander Human Services Coalition
- Torres Strait Health Partnership;
- Regional Health Forums;
- Indigenous Mayors' Roundtable;
- Local Negotiation Tables;

* Note, based government and non-government structures and stakeholders as at July 2009. Internal organisational changes and/or machinery of government changes may result in changes over the duration of this NPA.

6 APPENDIX A: NATIONAL INDIGENOUS REFORM AGREEMENT'S SERVICE DELIVERY PRINCIPLES FOR INDIGENOUS AUSTRALIANS:

Service Delivery Principles for Indigenous Australians are detailed within the COAG National Indigenous Reform Agreement. Implementation of this Plan will advance these Service Delivery Principles as described below:

6.1 Priority Principle:

Programs and Services should contribute to Closing the Gap by meeting the targets endorsed by COAG while being appropriate to local community need.

The activities in this implementation plan are designed on the evidence-base of what is required to meet the COAG targets. To ensure activities are appropriate to local community needs, the existing regional health forums will be used to inform the design and delivery of services. Where local health forums (or equivalent) exist, these will also be utilised.

6.2 Indigenous engagement:

Engagement with Indigenous men, women and children and communities should be central to the design and delivery of programs and services.

The Queensland Aboriginal and Torres Strait Islander Health Partnership, the Torres Strait Health Partnership, Regional Health Forums, local health forums (or equivalent), and other relevant stakeholder bodies and groups will be engaged in the design, delivery and evaluation of initiatives.

Where services are to be delivered by non-government organisations, contracts will include the requirement to engage with local Aboriginal and Torres Strait Islander people in the design, delivery and evaluation of programs. Where Queensland Health is the provider of services, this will also be a requirement and will be monitored through the Queensland Aboriginal and Torres Strait Islander Health Partnership, and the Torres Strait Islander Health Partnership.

6.3 Sustainability:

Programs and services should be directed and resourced over an adequate period of time to meet the COAG targets.

To Close the Gap in Indigenous life expectancy by 2030, and to half mortality rates of Aboriginal and Torres Strait Islander children under five by 2018 will require ongoing effort and effort in areas not covered in the implementation plan. However, the activities in this implementation plan provide a sound, evidenced-based foundation that will make a difference and on which further investment can be made.

The initiatives in this implementation are evidence based, and the smoking, PHC, healthy transition to adult, and making Indigenous health everyone's business initiatives, in particular, focus on early intervention and empowerment of individuals in the management of their health and health care.

Programs will be implemented in such a way that allows flexibility to adapt to changing local needs, where they are consistent with the COAG Closing the Gap targets; wherever possible, within legislated accountability requirements, opportunities for program integration and reduction of administrative burden will sought. A capacity building approach will be taken with all program implementation.

6.4 Access:

Programs and services should be physically and culturally accessible to Indigenous people recognising the diversity of urban, regional and remote needs.

Programs and Services will be implemented through the best available provider in a region or community, with consideration given to clinical (professional) competency and cultural competency. Where ever available and appropriate, Community Controlled Health Organisations will be used to deliver services, as the evidence shows that where Community Controlled Health Organisations work well they can deliver significantly better health outcomes. New models of service delivery will be explored to ensure that services are physically accessible and culturally appropriate, for example, multi-disciplinary care teams including Aboriginal and Torres Strait Islander health workers.

6.5 Integration:

There should be collaboration between and within Governments at all levels and their agencies to effectively coordinate programs and services.

Implementation will occur through the Queensland Aboriginal and Torres Strait Islander Health Partnership (or the Torres Strait Health Partnership) and Regional Health Forums, which include representation from State, Commonwealth and Community. Where specific working groups or reference groups need to be established, all relevant government agencies will be invited to participate.

The QG Strong Indigenous Communities CEO Group, and relevant officer level groups, provides and appropriate mechanism for engagement across QG agencies and will assist in ensuring integrated strategies.

Within QH, currently consideration is being given to the establishment of a working group to the QH Executive Management Team as a structure to ensure integration and coordination within QH.

6.6 Accountability:

Programs and Services should have regular and transparent performance monitoring, review and evaluations.

Performance reporting will be required on at least a 6 monthly basis for all initiatives. To ensure transparency, reports will be through the relevant Partnerships and Forums, which include community representation. Review and evaluation mechanism will be costed and designed into all initiatives from the outset.

7 APPENDIX B: NATIONAL PRINCIPLES FOR INVESTMENTS IN REMOTE LOCATIONS

The following principles, as detailed in the COAG National Indigenous Reform Agreement, will be considered for any investment in remote locations:

a) remote Indigenous communities and remote communities with significant Indigenous populations are entitled to standards of services and infrastructure broadly comparable with that in non-Indigenous communities of similar size, location and need elsewhere in Australia;

b) investment decisions should aim to: improve participation in eduction/training and the market economy on a sustainable basis; and reduce dependence on welfare where possible; and promote personal responsibility, engagement and behaviours consistent with positive social norms;

c) priority for enhanced infrastructure support and service provision should be to larger and more economically sustainable communities where secure land tenure exists, allowing for services outreach to access by smaller surrounding communities, including:

    i. recognising Indigenous peoples' cultural connections to homelands (whether on a visiting or permanent basis) but avoiding expectations of major investment in service provision where there are a few economic or educational opportunities; and

    ii. facilitating voluntary mobility by individuals and families to areas where better education and job opportunities exist, with higher standards of service.

8 APPENDIX C: QUEENSLAND'S GUIDING PRINCIPLES FOR IMPLEMENTATION

Queensland implementation will be in line with national service delivery principles for Indigenous Australians and the following principles:

- Partnerships – working across Government, and with the full range of service providers, and in partnership with Indigenous communities, provides the best opportunity to improve health and the broader determinants of health.

- Cultural Respect – the cultural diversity, rights, views, values and expectations of Indigenous Queenslanders must be respected in the delivery of culturally appropriate health services.

- Indigenous health is everyone's business – improving the health status of Indigenous Queenslanders is a core responsibility and high priority for the whole health sector.

- Holistic health – improvement of the health status of Indigenous Queenslanders must include attention to physical, spiritual, cultural, emotional and social well-being, community capacity and governance.

- Community control of PHC services – recognising the demonstrated effectiveness of A&TSICCHOs in providing comprehensive PHC and working with them to improve the overall level and quality of health service provision; and supporting community decision-making as a fundamental component of health care provision.

- Accountability – for consultation, transparent decision-making and effective, sustainable services.

In addition, implementation of initiatives included in this plan will be guided by the following implementation principles:

- Meaningful consultation with key stakeholders including A&TSICCHOs, the Australian Government and non-government health service providers in the design, location and delivery of services and programs to ensure effective coordination and integration with existing programs, utilising established collaborative mechanisms such as Regional Health Forums and Health Partnership working group structures. For example, implementation of workforce initiatives within this plan that impact on community and/or PHC services provision will be considered by the Health Partnership's Workforce Working Group.

- Meaningful consultation with Indigenous communities to inform the design and delivery of site specific programs and services to maximise the likelihood of effectiveness and participation by community members.

- Identification of the most effective delivery mechanisms for new services and programs including utilising non-government service provider organisations (particularly A&TSICCHO) where they exist and where to do so would enhance the effectiveness of the service or program.

9 APPENDIX D: ACRONYMS AND REFERENCES

A&TSICCHOs	Aboriginal and Torres Strait Islander Community Controlled Health Organisations
A&TSIHSU	Aboriginal and Torres Strait Islander Health Strategy Unit
ABCD	Audit and Best Practice in Chronic Disease
ABS	Australian Bureau of Statistics
AHMAC	Australian Health Ministers Advisory Council
AHMC	Australian Health Ministers Conference
ATODSB	Alcohol, Tobacco and Other Drugs Branch
CEO	Chief Executive Officer
COAG	Council of Australian Governments
CQI	Continuous Quality Improvement
DDG	Deputy Director-General
DoCs	Department of Communities
DoHA	Department of Health and Ageing
EMT	Executive Management Team
ESP	Event Support Program
GP	General Practice
HPF	Health Performance Framework
HSD	Health Service District
IHLO	Indigenous Hospital Liaison Officer
IT	Information Technology
M&CHSB	Maternity and Child Health and Safety Branch
NATSIHON	National Aboriginal and Torres Strait Islander Health Officials Network
NGOs	Non Government Organisations
NPA	National Partnership Agreement
NRT	Nicotine Replacement Therapy
PHC	Primary Health Care
QAIHC	Queensland Aboriginal and Islander Health Council
QATSIC	Queensland Aboriginal and Torres Strait Islander Council
QATSIHP	Queensland Aboriginal and Torres Strait Islander Health Partnership
QG	Queensland Government
QH	Queensland Health
Qld	Queensland
RBH	Royal Brisbane Hospital
RFDS	Royal Flying Doctors Service

RHF	Regional Health Forums
TSHP	Torres Strait Health Partnership
TSRA	Torres Strait Regional Authority

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