Witness Statement to Yoorrook Justice Commission

Minister Mary-Anne Thomas

OFFICIAL

Aboriginal and Torres Strait Islander people should be aware be aware that this document contains names of deceased persons and may contain themes that could be distressing to some.

Yoorrook Justice Commission

Witness Statement

I, Mary-Anne Thomas, Minister for Health, Minister for Health Infrastructure and Minister for Ambulance Services, of 50 Londsdale Street, Melbourne Victoria 3000, affirm and say as follows:

Acknowledgements

1. I would like to first acknowledge the Traditional Owners of the lands and waters on which as the member for Macedon I live and work, the Dja Dja Wurrung, Taungurung and the Wurundjeri Peoples, of the Kulin Nation. I acknowledge and pay my respects to the wisdom and leadership of Traditional Owners and First Peoples right across Victoria, including their ancestors and Elders.
2. I acknowledge that sovereignty was never ceded by First Peoples and that the impact of dispossession and colonisation in Victoria is still felt today.
3. I acknowledge the path that First Peoples leaders and community have paved for future generations. I recognise the strength and resilience of First Peoples.
4. I see the strength and resilience in the successes of the Aboriginal Community Controlled Organisations (**ACCOs**).
5. I acknowledge that the Victorian healthcare system has historically failed and continues to fail to support First Peoples to receive timely, safe and respectful care.
6. I also acknowledge this failure is not just through the absence of treatment and services but harm that was caused, and continues to be caused to First Peoples in the Victorian healthcare system.
7. From the introduction of European diseases, to land dispossession and displacement, the enforcement of segregation and protection policies, Government actions have consistently impacted First Peoples' health and wellbeing.
8. First Peoples do not have equitable access to healthcare or the same health outcomes as other Victorians due to racism, discrimination, and a lack of cultural safety in mainstream health settings.
9. Victoria's health system has not adequately responded to chronic disease in First Peoples' communities. It has neglected the broader determinants of health, such as the social, cultural, historical, and ancestral determinants and the important work of ACCOs has not always been supported.
10. In Victoria health services played a role in the devastating process of removing First Peoples' children from their families and were often the location from which that process commenced. As Minister for Health, I formally and unreservedly apologise for the impact this has had and continues to have on those individuals, their families, community, and their descendants.
11. Only by recognising this confronting and challenging history, can we transform a health system with deep colonial roots to one where First Peoples feel safe and empowered to enter health services to receive the care that they need. It is critically important that this history is not forgotten, as it continues to impact the care that First Peoples receive today.

12. I recognise that First Peoples' self-determination is grounded in international law but that its true meaning comes from First Peoples. In a health context, self-determination means that First Peoples have autonomy over how their healthcare is delivered. In a self-determined health system, First Peoples have genuine decision-making power and meaningful control – they are not merely 'engaged' or 'consulted', or 'advisers' or 'co-designers'.
13. Self-determination for First Peoples means Government ceding power and control. While self-determination has been the Victorian Government's policy since 2015[1], and some positive steps have been taken to achieve self-determination, I recognise that we have a long way to go.
14. Health services should be nurturing places, places of safety and healing. However, I recognise that the mainstream healthcare system has often failed to support First Peoples to receive the care that they need to live healthy and long lives. Due to Victoria's colonial legacy, First Peoples have a lower life expectancy, a higher burden of disease, lower indicia of social and emotional wellbeing, and continue to be impacted by high levels of intergenerational trauma.
15. Hospitals can be unsafe places for First Peoples in a way that almost no other member of Victorian society can begin to comprehend. First Peoples are subject to racism, as patients and staff, by other staff and other patients. No patient should experience racism from their healthcare worker, nor should any First Peoples healthcare worker experience racism at work. Since becoming Minister for Health, the issue most consistently raised by First Peoples health advocates, First Peoples health workers and the broader First Peoples community is a lack of cultural safety – which encompasses racism, including structural racism and a lack of cultural safety, and its negative impacts on health outcomes for First Peoples.
16. The Victorian Government knows culturally unsafe healthcare services mean that First Peoples may not present at hospitals until they are in crisis, if at all, impeding their care and recovery. If they do present to an emergency department, First Peoples may not wait to be seen or may leave without care being completed, due to trauma, racism or not feeling culturally safe, because of their experience in that setting.
17. The health concerns of First Peoples are not always taken seriously, and the clinical and institutional nature of Victoria's health system can cause further trauma and harm for First Peoples.
18. The significant underrepresentation of First Peoples in the public health workforce can deter First Peoples from engaging with healthcare services and receiving care. Only 0.39% of the public health workforce openly identifies as First Peoples. Under-representation can present a barrier for patients in accessing culturally appropriate care (including respectful treatment, empowerment and inclusion in decision-making), and can result in First Peoples working in healthcare carrying increased cultural load in trying to deliver appropriate services and upskill their workplaces in culturally safe practices. Most often without any additional support, monetary or workload adjustments.
19. Historically, the Victorian health sector has failed to value, respect and have regard to First Peoples' teachings and practices in relation to their own health. These teachings and practices have been

[1] Department of Health and Human Services, *Aboriginal governance and accountability framework* (September 2017) <Aboriginal governance and accountability framework (health.vic.gov.au)>; First Peoples - State Relations, 'Plan', *Victorian Aboriginal Affairs Framework Plan* (Web Page, 4 October 2019) <Plan | firstpeoplesrelations.vic.gov.au>.

informed by thousands of years of culture and practices. The health system has failed to align health frameworks and systems with models of healthcare based on First Peoples' ways of knowing, being and doing, and has therefore failed to meet First Peoples' needs. An example of this is Western medicine and healthcare's separation of physical and mental healthcare. This does not align with First Peoples' holistic approach to health and wellbeing, which prioritises the social and cultural determinants of health. I recognise that Government is only just beginning to truly appreciate and understand the importance of culture for First Peoples. We have not fully respected this – often seeing it as 'informal' compared to the Western model. This has resulted in the important work and critical services being delivered by ACCOs not being properly understood or funded appropriately.

20. Our current system and funding agreements do not sufficiently recognise the importance of connection to culture for the social and emotional wellbeing of First Peoples. This includes through the provision of space and time for community to meet and talk in the culturally safe places that only ACCOs can provide. environments n.
21. The Aboriginal Health and Wellbeing Partnership Agreement 2023-33 (**AHW Partnership Agreement**), is a 10-year agreement between the Victorian Government, the Aboriginal Community Controlled Health Organisation (**ACCHO**) sector and mainstream health services, that sets out how we may achieve a health system that is holistic, culturally safe, accessible, empowering and racism-free. ACCOs, Government and mainstream health services are equal partners in the AHW Partnership Agreement and have a shared responsibility for realising its vision of a health system that is holistic, culturally safe, accessible and empowering for First Peoples. The AHW Partnership Agreement, and its accompanying first two-year Action Plan, are driven by the self-determined priorities of ACCOs and First Peoples' communities. I recognise that First Peoples have repeated many of these priorities to Government for many years. I recognise that the AHW Partnership Agreement is not enough, and that Government has the responsibility to lead, act and to improve the healthcare experience and healthcare outcomes for First Peoples. I also recognise that, even with an Agreement like this, Government continues to control budget and policy decisions through Departmental and Cabinet processes.
22. I also acknowledge the limitations of the National Closing the Gap Agreement, including Victoria's participation in the development of Implementation Plans. Closing the Gap was intended to address health inequity for First Peoples, however limited progress has been made. In Victoria, this is in part due to a lack of Investment.
23. Our models of care must be built upon and informed by all the determinants of health – and particularly the social, cultural, historical and spiritual determinants of health for First Peoples. To achieve this, ACCOs must be viewed as a critical part of Victoria's health system. This means equal partnerships with mainstream health services, Government realising the principles of Indigenous Data Sovereignty and funding ACCOs equitably with greater flexibility to deliver what works for their community.
24. I acknowledge that we need improved data collection that addresses the needs of First Peoples in the health system and that measures what matters to First Peoples. The Victorian Government needs to do more to realise First Peoples' data sovereignty, report against Closing the Gap targets, and to hold mainstream health services accountable for community-defined measures for cultural safety. I discuss this below in topic 10.

25. Further, I acknowledge the fundamental importance of self-determination of First Peoples. Since colonisation, First Peoples have been strong, proud advocates for change and for self-determination in all aspects of life. I understand that true self-determination will involve more than transferring responsibility for the administration of programs to First Peoples to manage. In a health context, self-determination means First Peoples make the critical decisions about how health and healthcare is designed, delivered, measured and funded. For example, when it comes to funding, it means First Peoples set the funding priorities and Government supports through sustainable, long-term funding that ACCOs determine how best to use.
26. 164 years after the Colony of Victoria separated from New South Wales, the Victorian Government committed to self-determination in 2015 by seeking to have First Peoples and First Peoples' organisations provide more services to community.
27. I recognise that this is limited self-determination, and that providing funding to deliver Government-defined services is not handing over true power and control. I accept that we have a long way to go before we achieve our goal of transferring decision-making powers and resources to First Peoples over issues affecting their communities, culture and kin. I am committed to addressing racism across the health sector and to ensuring that healthcare and the health sector workplace, is free from racism, discrimination and bias.

Part A – My Statement

28. In my preparation for giving evidence to this Commission, I acknowledge the many First Peoples Elders, leaders and community members who have been so generous sharing their wisdom, knowledge and experience with me, including in my role on the Aboriginal Health and Wellbeing Partnership Forum (the **AHW Forum**). The AHW Forum is a collaboration between the Community-controlled health sector, the mainstream health sector and the Department of Health (**Department**). It is jointly chaired by me and the Chairperson of the Victorian Aboriginal Community Controlled Health Organisation Inc. (**VACCHO**), Mr Michael Graham, a proud Dja Dja Wurrung and Wiradjuri man with decades of experience in improving First Peoples' health and wellbeing.
29. The AHW Forum brings us together around a shared vision of First Peoples having access to a health system that is holistic, culturally safe, accessible, and empowering. It enables me to directly hear First Peoples' voices and to be informed of First Peoples' perspectives on health issues. I acknowledge the dedication and commitment of the AHW Forum members and thank them for their ongoing generosity and assistance.
30. I also acknowledge there continues to be a power imbalance between Forum members and that Government continues to be the primary source of funding and the final decision maker.
31. I want to thank the Board members, CEO and staff of our ACCHOs for the warm welcome I always receive when visiting them and for their generosity in sharing their work, their ideas and their challenges with me.
32. I have also read and had regard to many of the documents before the Commission relating to Victoria's history and its impact on First Peoples – in particular, in relation to health. In addition to reading documents provided to the Commission by the Department, I have read submissions from Community and the health sector. I have listened to some of the evidence before the Commission,

including the powerful evidence of Aunty Jill Gallagher AO, a proud Gunditjmara woman whom I greatly admire and from whom I have learnt a great deal. I feel distress at what I have read and heard, and I am humbled by what I did not know. I bring that humility to this process. In particular, I am deeply saddened by the passing of First Peoples when our health system has not provided adequate care, and I am distressed by the continuing racism First Peoples experience, as noted by First Peoples witnesses in evidence to the Commission. Victoria's health system needs to be a place of care and respect, not one where First Peoples experience racism and inadequate care.

33. I have also prepared this statement after having consulted with subject matter experts from the Department, including the Aboriginal Health and Wellbeing Division of the Department.[2]
34. I also acknowledge and am grateful for the incredibly important work of the Department's Aboriginal Health and Wellbeing Division, under the leadership of the Chief Aboriginal Health Adviser, Nicole McCartney. The Division undertakes very important work to improve the health and wellbeing of First Peoples in Victoria, and I am very thankful for the generosity they have shown me in seeking to build my understanding of the realities for First Peoples in our healthcare system and in assisting me to prepare for participation in the AHW Forum and in the National Aboriginal Health Forums.
35. I confirm that the contents of this statement are true and correct to the best of my knowledge.
36. This statement should be read with the Department's responses to the Commission's Requests for Information.[3]
37. Throughout this statement, I use the term 'First Peoples' to respectfully refer to Aboriginal and Torres Strait Islander people. I use other terms, such as Koori and Aboriginal, where it is used in the name of a program, initiative, or organisation.

Part B – Professional Background

38. My professional qualifications include a Bachelor of Education from the Melbourne College of Advanced Education, a Graduate Diploma in Industrial Relations from Victoria University and a Master of Public Policy from the University of Melbourne. Over the course of my professional life, I have worked as a secondary school teacher, as an organiser in the union movement, and as a communications and management executive in the public, private and community sectors.
39. I was first elected to the Victorian Legislative Assembly in 2014 as the State Member for Macedon. My electorate encompasses the lands of the Wurundjeri, the Dja Dja Wurrung and the Taungurung people.
40. I have been grateful that my experience as a Member of Parliament has brought me into close contact with First Peoples, their living culture and their aspirations for their future. I wish my constituents could have the same opportunities that I have to learn from, work with and develop friendships with First Peoples.

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[2] Divisions of the Department relevant to the content of this Statement include the Hospital and Health Services Division, Community & Public Health, Hospitals & Health Services, Mental Health & Wellbeing, Aboriginal Health, Health Finance, Funding & Investment, eHealth, System Planning, People Operations Legal and Regulatory and Safer Care Victoria.

[3] Department of Health, *Yoorrook Justice Commission Health Workstream Request for Information – Response* (March 2024) (DOH.0006.0001.0006); Department of Health, *Yoorrook Justice Commission Health Workstream Request for Information* (December 2023) (DOH.0004.0002.0008).

41. As you would expect, I have attended many smoking ceremonies and Welcomes to Country, which I always find to be moving, generous and educative. I have had the honour many times of hearing Ms Mandy Nicholson speak and seeing the Djirri Djirri dancers. I am grateful for the opportunities I have had to meet with and listen to Aunty Di Kerr.
42. I consider myself fortunate to have been on Country with Uncle Bill Nicholson at Wil-im-ee Moor-ing in my electorate. The Greenstone Quarry site is on the National Heritage Register and was handed back to the Wurundjeri People in 2012. I have also spent time on a number of occasions with Mr Rodney Carter, CEO of the Dja Dja Wurrung Corporation on Country in the Wombat Forest in my electorate, to understand the Djarra people's aspiration for Djandak including Galk-galk Dhelkunya (Forest Gardening Strategy). I am proud that our Government has worked with the Taungurung, Dja Dja Wurrung and Wurundjeri people to develop a masterplan for Hanging Rock (known to some First Peoples as Ngannelong) that prioritises traditional owner knowledge and culture in its future development.
43. I am presently Minister for Health, Minister for Health Infrastructure and Minister for Ambulance Affairs. I was appointed as Minister for Health in June 2022 and as Minister for Health Infrastructure in December 2022. I was reappointed as Minister for Ambulance Services in October 2023.
44. In December 2022, I was appointed Leader of the House. Prior to my current portfolio responsibilities, I held the following Ministerial roles:
    a. Minister for Medical Research from December 2022 - October 2023;
    b. Minister for Ambulance Services from June 2022 - December 2022;
    c. Minister for Agriculture December from 2020 - June 2022; and
    d. Minister for Regional Development from December 2020 - June 2022.

Part C - My portfolio responsibilities

Minister for Health

45. As Minister for Health, I am responsible for ensuring the maintenance and development of a Victorian public health system that delivers equitable health outcomes for all Victorians, by:
    a. setting the strategic policy direction for the health portfolio; and
    b. making decisions on matters that are referred to me for determination.
46. I am responsible for ensuring a strong public health system with advanced infrastructure, innovative research and continued growth that protects the health and wellbeing of all Victorians.
47. As Minister for Health, I have responsibility for overseeing the Victorian Government's health and hospital laws and initiatives. Broadly speaking, I am accountable to Parliament in respect of the Acts of Parliament that are assigned to me,[4] and for the actions of the organisations and the departments that I am responsible for.
48. Responsibility for the day-to-day operations of our mainstream hospitals and health services rests with their relevant CEOs and Boards, as outlined in the *Health Services Act 1988*.

[4] See General Order dated 2 April 2024, at https://content.vic.gov.au/sites/default/files/2024-04/general-order-dated-2-april-2024.pdf.

49. The AHW Partnership Agreement and the current Aboriginal Health and Wellbeing Partnership Action Plan 2023-2025 (**AHW Action Plan**) (of which I am a co-signatory) are the primary policy documents for First Peoples' health and wellbeing in Victoria. The AHW Partnership Agreement and the AHW Action Plan, which are referenced throughout this statement, are centered on the reform priorities of First Peoples, and align to the National Closing the Gap Agreement. I acknowledge that there is not yet a mechanism to monitor progress towards the outcomes in the AHW Partnership Agreement. Without this, I understand that the Victorian Government will not be accountable for achieving the aims of Closing the Gap and the AHW Partnership Agreement.
50. The AHW Partnership Agreement and the AHW Action Plan continue the reform work commenced under Koolin Balit: Victorian Government strategic direction for Aboriginal health 2012-2022 and Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017-2027. The health strategic directions of Korin Korin Balit-Djak have been transferred and made contemporary with VACCHO into the PHW Partnership Agreement and PHW Action Plan. Korin Korin Balit-Djak contained 194 actions to be completed in that strategy's first three years, many of which pertained to health. I acknowledge the Victorian Government's lack of accountability for that strategy. The Department has learnt from that process with accountability for progress of the AHW Action Plan coming back through the AHW Forum. Through the 10-year AHW Partnership Agreement, Government and mainstream health system signatories share First Peoples' vision of a health system that is holistic, culturally safe, accessible, and empowering. I am committed to realising this vision with the AHW Forum, of which I am co-chair with VACCHO. The AHW Action Plan sets a clear set of actions for the first two years of the AHW Partnership Agreement. These actions have been self-determined by First Peoples. I recognise that Government is only just beginning to realise the meaningful change required to achieve the AHW Partnership Agreement's vision. I also acknowledge that Government and the mainstream health sector need to be more accountable to the AHW Forum, as we work together to implement the actions in the AHW Action Plan. Importantly, I acknowledge that the Victorian Government has not invested sufficiently in the AHW Action Plan and Victoria's implementation of Closing the Gap.

Minister for Health Infrastructure

51. As Minister for Health Infrastructure, my principal responsibility is ensuring that Victorian health service providers have the facilities and technologies that they need to enable our health system to provide care that meets relevant quality and safety standards. Some of the areas that I am presently focused on in my capacity as Minister for Health Infrastructure are the provision of new and upgraded hospitals and ambulance stations, the expansion of public sector aged care and mental health infrastructure, and the provision of additional alcohol and other drugs rehabilitation infrastructure in Victoria.
52. I acknowledge that ACCOs have not received funding equity when it comes to infrastructure. I have visited ACCOs and have seen for myself how they continue to do critical work for community. I acknowledge that existing infrastructure is not always fit for purpose. While ACCOs are eligible for funding through the Metropolitan Infrastructure Health Fund and the Regional Infrastructure Health

Fund, I acknowledge that to date they have not received adequate infrastructure funding, and in some cases, this impacts their ability to deliver their critical services and supports to community.

53. I acknowledge that Government needs to do better at designing hospitals and other mainstream health settings to be culturally from the ground up when commissioning new facilities.

Minister for Ambulance Services

54. As Minister for Ambulance Services, my principal responsibility is ensuring that Victoria's ambulance service:
    a. can rapidly respond to requests for help in emergency situations;
    b. is available to assist with medical transport services when required; and
    c. provides high-quality pre-hospital care to Victorians in both emergency and non-emergency situations.
55. Implementing the 'Reflect' Reconciliation Action Plan is a key deliverable in Ambulance Victoria's 2023-24 Statement of Priorities. The 'Reflect' Reconciliation Action Plan seeks to strengthen relationships between Ambulance Victoria and First Peoples and to improve cultural safety for Ambulance Victoria's workforce and patients. Key actions that Ambulance Victoria is to progress include uplifting the capability of its staff to support the cultural safety of patients, building knowledge and tools to support a more inclusive workplace, and supporting reconciliation events that demonstrate Ambulance Victoria's solidarity with First Peoples and their communities.
56. Together across the three portfolios, my responsibilities are directed towards the achievement of a responsive and resilient health system to serve all Victorians.

Part D - The Victorian health system

Overview of Victoria's health system

57. In Victoria, a devolved governance model underpins the delivery of health services. The key features of the model are articulated in the *Health Services Act* 1988 (Vic). In the model, health services, the Department and myself as Minister each have distinct roles and responsibilities.
58. My role as Minister is to set the strategic policy direction for the health portfolio and to make decisions that are referred to me by the Department. I also appoint the boards that are responsible for the operation, governance, and control of individual health services.
59. The Department:
    a. is the steward of the health system, responsible for developing, proposing and overseeing the health policy established by the Victorian Government;
    b. is the system manager of the health system, designing, funding, and regulating the Victorian health system, including 75 public health services as well as Ambulance Victoria, HealthShare Victoria, Dental Health Services Victoria and Forensicare; and
    c. in some areas, it is also an agent for delivering services and capacity building in the health sector.
60. The Department is separated into several divisions and offices responsible for supporting me to deliver my portfolio responsibilities:

a. **Community and Public Health**, led by Prof. Zoe Wainer, focuses on driving prevention of disease and injury with early intervention, improving population health and wellbeing outcomes and equity, and leading readiness for and response to health threats and broader emergencies. The Chief Health Office, Dr Clare Looker, reports to Prof Wainer and is responsible for delivering statutory functions under the *Public Health and Wellbeing Act 2008* and providing expert clinical and scientific advice and leadership on issues impacting public health.
b. **Aboriginal Health and Wellbeing**, led by Chief Aboriginal Health Advisor, Nicole McCartney, works on driving, coordinating and advising on policy and strategic reform across Government to improve the health of First Peoples in Victoria.
c. **Safer Care Victoria**, led by Acting Deputy Secretary Louise McKinlay, is the State's healthcare quality and safety improvement agency and drives best practice across the healthcare sector by engaging with clinicians and consumers.
d. **eHealth**, led by Deputy Secretary Lance Emerson, enables the department to achieve its strategic and operational objectives through the provision of enterprise technology (including shared services for DH/DFFH), data, analytics and reporting, and digital technology for health services.
e. **Health Funding, Finance and Investment**, led by Deputy Secretary Daen Dorazio, delivers financial, funding, commercial and procurement expertise to focus on broader health sector budget and departmental spend and to support hospital and health service financial performance management, to improve revenue strategies and greater efficiency.
f. **Hospitals and Health Services**, led by Deputy Secretary Jodie Geissler, focuses on ensuring people can access high quality hospital, ambulance and public aged care, and is responsible for the commissioning and performance of hospital and ambulance services.
g. **System Planning**, led by Deputy Secretary Nicole Brady, provides an integrated and joined-up approach to system planning and structural reform, including through clinical planning and asset management to improve health outcomes, health equity and influence the future shape of the health system.
h. **People, Operations, Legal and Regulation**, led by Deputy Secretary Jacinda de Witts, provides Ministerial and portfolio coordination, audit and risk, procurement and contract oversight, reporting and performance, legal services and integrity, workplace and employee relations, and health and environmental regulation.
i. **Mental Health and Wellbeing**, led by Deputy Secretary Katherine Whetton, is responsible for leading and implementing the recommendations of the Royal Commission into Victoria's Mental Health System and stewarding the State's mental health and alcohol and other drugs services.

61. Health services are led by independent boards and are responsible for service delivery to the community. The public hospital system provides emergency, acute and specialist hospital care. The system comprises:
    a. admitted care (including surgery, trauma and critical care, birthing, advanced medical treatments, geriatric care and palliative care);
    b. non-admitted care (outpatient specialist care such as pre- and post-surgery, management of chronic conditions, and rehabilitation);
    c. emergency care (time-critical care in an emergency department); and

d. health workforce training and development.

62. Health services operate independently of the Department. However, as part of designing, funding, and regulating the health system, each health service is required to agree to a Statement of Priorities (**SOP**) and to report to the Department on key performance expectations, targets and funding for the year, including any Victorian Government service priorities that have been set.
63. In total, Victoria has 76 public hospitals and health services. In addition, there are 26 ACCOs who deliver health services.
64. I acknowledge that ACCOs were created because of significant deficits, including racism, in how the mainstream health system has provided services to First Peoples.
65. I also acknowledge that Victoria's health system still does little to incorporate First Peoples' views of health and healthcare, and that it is often a place of trauma, racism and lack of cultural safety for First Peoples. This is why ACCOs are an important part of Victoria's health system. ACCOs need to remain independent so that they remain First Peoples community controlled. However, there is more that Government can do to support ACCOs' vital role in the health system, including greater funding equity, workforce support, and strengthening partnerships with health services ensuring that First Peoples are making decisions about the healthcare First Peoples are receiving.

Systemic racism within the Victorian healthcare system

66. Systemic racism exists within Victorian healthcare services. It is unacceptable that in 2020, 16.3% of First Peoples surveyed experienced racism in health settings.[5]
67. There are many factors that contribute to systemic racism within the Victorian healthcare system. This includes a pervasive bias, both conscious and unconscious, of racist stereotypes that some healthcare providers and practitioners have towards First Peoples. This results in unfair reporting of First Peoples to regulatory bodies, failing to listen to First Peoples about their valid health concerns and ultimately the poorer outcomes that First Peoples experience when they seek healthcare in Victorian healthcare settings. For example, young First Peoples Victorians experience a disease burden 2.3 times more than their non-First Peoples counterparts. Alcohol and drug related emergency presentations among the First Peoples Victorian population are 7.3 times more than compared to non-First Peoples Victorians (population adjusted per 1,000). First Peoples Victorians pass by suicide at a rate almost three times higher than the non-First Peoples population. First Peoples people are, on average, younger than non-First Peoples persons who pass by suicide.
68. Part of my role is to ensure that health services funded and overseen by the Victorian Government provide respectful and culturally appropriate care to all patients and especially to First Peoples because of the ongoing issues arising from intergenerational trauma. I recognise that both health services and Government have not done enough to support First People's holistic view of health and wellbeing or to improve cultural safety in our health system. While the inclusion of cultural safety in the SOPs is positive, as is the provision of Aboriginal Cultural Safety Fixed Grants (ACSFGs) for

[5] Victoria State Government, *Victorian Government Aboriginal Affairs Report* (Report, 2022) 110 <FINAL_Victorian-Government-Aboriginal-Affairs-Report-2022.pdf (content.vic.gov.au)> (DPC.0009.0009.0798) ('Aboriginal Affairs Report 2022').

health services to use alongside their base funding to uplift cultural safety, there is a lack of monitoring and accountability by Government for how funds are used.

69. The Department recognises the importance of supporting and expanding the First Peoples' health workforce as a key enabler of culturally safe healthcare. There are three pillars to the current approach: the Victorian Health Workforce Strategy (including the Mental Health Workforce Strategy); the AHW Partnership Agreement and AHW Action Plan; and the Victorian Aboriginal Health and Wellbeing Workforce Strategy (VACCHO) 2022-2026. There is more to be done to connect these pillars and amplify the impact they can make, in partnerships with First Peoples' organisations.
70. The Department funds a range of scholarships to assist more First Peoples to enter the health workforce. I discuss this in answer to topic 5 below. VACCHO has also developed the Victorian Aboriginal Health and Wellbeing Workforce Strategy, which is a First Peoples-led strategy for building the capacity and expansion of the First Peoples health workforce.
71. To supplement these targeted initiatives, it will be important to address other system-wide factors that lead to culturally unsafe healthcare. These include prioritising prevention and early intervention, strengthening the sustainability of ACCOs, supporting the First Peoples health workforce in mainstream healthcare settings, and ensuring the State's investments are monitored effectively using a shared evidence-base with culturally appropriate measures of success.
72. I recognise that Government needs to do more to eradicate racism in our health system. I am committed to increasing the accountability of mainstream health services.
73. The health indicators of First Peoples in Victoria reflect the legacy of intergenerational trauma and the impacts of systemic racism. At the population level, there is a significant gap between the health status of First Peoples in Victoria compared to the non-First Peoples population. For example, a little over one third of First Peoples adults in Victoria have been diagnosed with depression or anxiety, significantly higher than non-First Peoples adults (27.3%).[6]
74. Further gaps in health outcomes have been identified through indicators such as "Did Not Wait" and "Leave Against Medical Advice" indicators of cultural safety failings in health services. Through reporting on these indicators, it is clear that some individual health services have improved, however, many have seen no significant change, and some are getting worse.
75. This is a significant concern to the Victorian Government, and it is one of the reasons why from 2021, SOPs with health services have specifically included cultural safety as a priority. The then Minister, the Hon. Martin Foley, approved this inclusion in the SOPs on the recommendation of the Department as a measure to improve alignment with the Aboriginal Cultural Safety Framework – although I note there has been a lack of consistency and challenges with enforcement of the SOPs. I have expanded on SOPs, the "Did Not Wait" and "Leave Against Medical Advice" indicators and outcomes in more detail below at Topic 4, *Statement of Priorities*.
76. The onus is on health services to provide culturally safe care, not on First Peoples to complete care in culturally unsafe settings and I acknowledge the need to work with First Peoples to better measure cultural safety, and I reference this further below.

[6] Victorian Agency for Health Information, Findings from the Victorian Population Health Survey 2017: The health and wellbeing of Aboriginal Victorians, https://vahi.vic.gov.au/sites/default/files/2021-12/Aboriginal%20Health%20Wellbeing.pdf

Achieving a better system

77. I recognise that ensuring cultural safety is ingrained across all health services in Victoria is critical to addressing racism. Cultural safety can mean creating environments and services that are safe for First Peoples, where First Peoples' identities and experiences are shared, respected and where there are no wrong doors to care.[7] It can also be defined by First Peoples, as the care they would like to receive and in the manner they would wish to do so, and the design and implementation of health policies, structures and programs that affect First Peoples.[8] Understanding and providing cultural safety means actively promoting understanding, meaning and acceptance. It involves the experience of learning together with shared dignity and respect, through listening, and the exchange of knowledge about individuals' cultural experiences, values and identities.
78. I have a key role to play in this area. As well, health services need to ensure that individuals are not subjected to racism, discrimination or marginalisation based on their cultural background.
79. The Victorian Government continues to drive initiatives to improve cultural safety in health services. I set out a number of these initiatives below to identify the work that is being done, including because they provide examples of how the Victorian Government has worked alongside First Peoples to understand the key areas for reform and to develop appropriate programs to achieve meaningful change.
80. As discussed above, the AHW Partnership Agreement was developed in collaboration with the Victorian First Peoples community-controlled health sector (represented by VACCHO) and signed in 2023. Forming the AHW Partnership Agreement with the Victorian Government was one of 15 priorities set by the First Peoples community-controlled health sector in 2021 through the AHW Forum. VACCHO coordinated this process. ACCOs then presented these priorities to Government at the inaugural AHW Forum in April 2021.
81. Once the AHW Partnership Agreement was established, those priorities were developed into the two-year AHW Action Plan. The AHW Action Plan articulates what the sector needs to deliver to improve the health and wellbeing of First Peoples in Victoria.[9] The collaborative process to develop the AHW Action Plan included one-on-one sessions with stakeholders, multiple workshops held for each priority in ACCHO sector groups, and further opportunities for feedback from the community. The process is an example of the Victorian Government working well with community towards the achievement of common goals. However, I recognise that we have a long way to go before achieving the vision of the AHW Partnership Agreement and supporting partners to implement the AHW Action Plan.
82. Members of the AHW Forum are committed to implementing actions identified in the AHW Action Plan. ACCOs have given Government their reform agenda through the AHW Agreement and the

[7] Department of Health and Human Services, Aboriginal and Torres Strait Islander cultural safety framework (Report, June 2019) 5 <DH Aboriginal and Torres Strait Islander Cultural Safety Framework 2021> (DOH.0005.0001.0952) ('Aboriginal and Torres Strait Islander cultural safety framework').

[8] Lowitja Institute, (2023) *Cultural determinants, cultural safety, and cultural governance: Policy brief*.

[9] Developing the AHW Action Plan included one-on-one sessions and multiple targeted workshops held with any ACCHO sector member wishing to participate in the process, as well as direct feedback on drafts of the action plan from the whole community through Engage Victoria. The AHW Partnership Agreement Forum members comprise myself, Aboriginal health organisations in Victoria, VACCHO and the Department. Associate members include mainstream health organisations that meet the membership criteria, as determined by the co-chairs and I.

AHW Action Plan. It is up to Government to make sure that there is sufficient resourcing to realise the AHW Partnership Agreement's vision and the implementation of the AHW Action Plan. The AHW Action Plan will be reviewed every two years and updated to reflect the most critical matters for systemic health reform. The AHW Action Plan seeks to progress 38 actions across five key domains relating to reforming the health system to improve health and wellbeing outcomes for First Peoples in Victoria. Cultural safety is listed as one of five key domains of the AHW Partnership Agreement and is reflected in the AHW Action Plan.

83. The AHW Partnership Agreement and the AHW Action Plan were signed at the May 2023 AHW Forum. Since then, there have been three subsequent AHW Forums – one in September 2023, one in March 2024 and one on the 13th of this month focused on the development of the state budget and how Government can work more closely with ACCOs on budget priorities and bids.
84. I have also been involved in health-focused First Peoples-led roundtables and forums. Recently, this included co-chairing the AHW Forum held on 13 and 14 March 2024 (**March Partnership Forum**) and participating in the National Aboriginal and Torres Strait Islander Health Roundtable (**National Roundtable**) on 22 March 2024. I have attended every meeting of the AHW Forum since becoming Minister for Health in 2022.
85. In truth, we are only really beginning to appreciate the extent of the change required for our health service to shift from its colonial legacy to one of true self-determination for First Peoples.
86. With this in mind, future priorities for health system reform include addressing matters of First Peoples' data collection and sovereignty, improved cultural safety monitoring and accountability, and the ongoing drafting of the National Health Reform Agreement. The National Health Reform Agreement will include a First Nations Schedule that is co-designed with First Peoples' stakeholders and sets out reforms and actions that need to be taken to promote self-determination in the national healthcare system.

Part E – Responses to the Topics identified by the Commission

87. Some of the topics in the Commission's suggested focus areas for my evidence concern matters in the portfolio of the Minister for Mental Health and Minister for Ageing, the Hon. Ingrid Stitt MP and will be addressed in the Minister's statement. The relevant topics are: the public intoxication reform State-wide model (Topic 1); the Balit Murrup project (Topic 4); drug and alcohol services (Topic 11); funding for ACCOs for Aboriginal Social and Emotional Wellbeing (Topic 16); and aspects of Topic 14 concerning aged care. The balance of the topics are now addressed.

Topic 2: The Aboriginal Cultural Safety Framework, including an explanation of:

- ***whether it is mandatory;***
- ***implementation progress across mainstream services; and***
- ***progress of the joint project with the Department of Families, Fairness and Housing (DFFH) to measure and evaluate the project.***

88. Implementation of the *Aboriginal and Torres Strait Islander Cultural Safety Framework*[10] (**Cultural Safety Framework**) has not been mandated in Victoria. Since 2020-21, the Policy and Funding Guidelines, representing the system-wide terms and conditions for government-funded healthcare organisations (**Policy and Funding Guidelines**), have required health services to ensure that the Cultural Safety Framework guides local policy, service development and practice. However, Government has not taken steps to ensure that health services are adhering to this policy requirement. In particular, the extent and quality of its implementation across mainstream services has not been measured adequately. The monitoring activities undertaken indicate a lack of sufficient implementation of the Cultural Safety Framework across mainstream health services. The joint project with DFFH to measure and evaluate the project has not progressed due to resource limitations within the Department, which I explain further later in my statement.
89. The Cultural Safety Framework was developed in 2019 to assist various sectors including mainstream health services to create culturally safe environments, services and workplaces. It was designed to assist organisations to develop strategies, policies, practices and workplace cultures that address unconscious bias, discrimination and racism. To assist with this, a self-reflective tool was also developed and embedded in the Cultural Safety Framework for users to self-assess their place on a cultural safety journey of continuous learning and practice improvement. I accept that this tool has not been adequately implemented.
90. The Department aims to measure cultural safety through several monitoring activities. These include the SOPs, assessments of ACSFG reports, periodic surveys of hospital cultural safety initiatives, and analysing leave event data such as 'Leave Against Medical Advice' and 'Did Not Wait'. I explain each of these in this statement.
91. The Department's Aboriginal Health and Wellbeing Division is exploring other measures of cultural safety to help identify whether leave events rates can be attributed to cultural safety influences. These include follow up after being discharged from hospital, wait times for both First Peoples and non-First Peoples patients, and the number of presentations for social and emotional wellbeing. Feedback from the April 2024 Aboriginal Health Liaison Forum, run by VACCHO, suggests that patient identification and discharge protocols in hospitals require particular attention. This would help with strengthened monitoring of cultural safety while increasing hospital capacity to follow up with vulnerable patients to ensure improved health and wellbeing outcomes will follow. I acknowledge that Government needs to work with ACCOs and VACCHO to develop self-determined community-

[10] Aboriginal and Torres Strait Islander cultural safety framework (n 13).

defined measures of cultural safety, which Government must then hold health services to account for. I explain this in my statement below.

92. Key findings of the most recent 2020 survey show that all hospitals and health services undertake some planning around First Peoples' health and wellbeing and most have an Executive sponsor, yet few have employed First Peoples staff in Executive positions (which I discuss below in relation to the ACSFGs). Only approximately half of all health services employ First Peoples health staff, and only around 85% of health services said that they provide cultural safety training – despite this being a policy requirement for all health services. We have more work to do to ensure that this training is both expansive and effective, which is why I intend to elevate this requirement to make it a mandatory priority for health services in their 2024-25 SOPs (which I discuss below).

93. The ACSFG is designed to support health services to improve cultural safety in acute settings. The 38 health services receiving an ACSFG must submit an annual plan and report against the use of their funding under the ACSFGs. This includes planning and reporting against cultural safety training.[11] These 38 health services have the largest First Peoples population catchments in their areas. According to an analysis in September 2023 of the 2022-2023 reporting period, 57 per cent of health services receiving the ACSFGs reported that First Peoples cultural safety training is mandatory or is becoming mandatory. However, it is unclear whether this includes all staff in those health services and regardless is clearly a long way from the policy requirement that best-practice First Peoples Cultural Safety Training is provided to all health service employees.

94. An analysis of the ACSFG reports in September 2023 indicated that most grant recipients have established some relationships with local ACCOs. However, only three hospitals reported employing First Peoples staff in leadership roles and just 15 hospitals said that they had a First Peoples employment plan. This is clearly insufficient, and that is why a key priority for future ACSFG recipients is to employ more First Peoples health staff with decision-making power to ensure that patient concerns are captured and acted upon.

95. Progress of the Department's joint project with DFFH to develop a First Peoples cultural safety measurement and assessment tool is addressed under topic 4.

Topic 3: Training to ensure cultural safety for First Nations Victorians within:

- ***mainstream health services; and***
- ***including whether the State is considering mandatory training requirements.***

Mainstream health services

96. Since 2021-22, the Policy and Funding Guidelines have required health services to demonstrate delivery of best-practice First Peoples Cultural Safety Training to all health service employees.[12]

[11] Department of Health (Vic), 'Aboriginal cultural safety fixed grant requirements: Cultural safety planning and reporting' <https://www.health.vic.gov.au/publications/aboriginal-cultural-safety-fixed-grant-guidelines-cultural-safety-planning-and>.

[12] Prior to 2021-22, the Policy and Funding Guidelines stated that funded organisations have "a responsibility for developing an understanding about what cultural safety means for managers, staff, patients and clients. All staff should undertake cultural safety training specific to their region."

However, there is very little enforcement of this requirement. This is the case despite the real and pressing need for all staff to be equipped to provide culturally safe services to First Peoples patients.

97. The survey information before the Commission indicates that cultural safety training for staff is being delivered by a majority of health services.[13] However, this training is not necessarily being provided to all staff and is understood to be of variable quality.

98. My view is that at a minimum, all staff in Victoria's health services must undertake First Peoples Cultural Safety Training. I recognise that the Victorian Government has already identified the need for mandatory cultural safety training in mainstream health services through the AHW Action Plan, [14] but that work has not yet been undertaken to implement this objective. I signed the AHW Action Plan, and I am committed to working with VACCHO and the AHW Forum on when and how this objective can be brought to fruition. We need to move from requiring training on paper, to enforcing the requirement for First Peoples Cultural Safety Training in practice.

99. As I mentioned earlier, as an initial step I will elevate the First Peoples Cultural Safety Training requirement into a mandatory priority in health services' 2024-25 SOP. I expect for this requirement to then be robustly enforced through the Department's performance processes, as I will discuss later in my statement.

Drug and alcohol services and aged care

100. The balance of this topic relates to matters that are overseen by the Minister for Ageing as part of their portfolio responsibilities, and consequently, those matters are addressed by the Minister for Mental Health in their statement.

Topic 4: Measures to ensure cultural safety for First Nations Victorians within hospitals, including:

- ***an explanation of accountability mechanisms under hospital Statements of Priorities;***
- ***further information concerning the Loddon Mallee Health Network's reconciliation / anti-racism work;***
- ***funding for Aboriginal Community Controlled Health Organisations (ACCHOs) to provide prevention activities and work with mainstream health services to improve cultural safety;***
- ***other actions and measures taken to monitor, address and eliminate racism within health services;***
- ***the progress and results of the implementation of the Aboriginal Cultural Safety Workplace Measurement and Assessment Tool; and***
- ***progress of the selection and implementation of cultural safety initiatives at participating hospitals (regarding the Hospitals Collaborative Project).***

[13] See documents ranging from DOH.0007.0001.001 to DOH.0007.0001.1215 (inclusive) regarding cultural safety training provided in health services.

[14] AHW Partnership Agreement Action Plan (n 14) 8.

Monitoring of health services' performance

101. Pursuant to the *Health Services Act* 1988 (Vic), the objectives, priorities and key performance outcomes to be met by each health service must be included in an annual SOP. SOPs are funding agreements between individual health services and the Department. They are guided by the Department's Strategic Plan 2023-27 and are developed in consultation with me.

Statements of Priorities

102. All Victorian public healthcare services must agree to a SOP, other than six multipurpose facilities.
103. Since 2019-20,[15] health services have had to include information in their SOPs on how they will enhance cultural safety and patient outcomes for First Peoples patients.
104. A key focus of 2023-2024 SOPs is the strengthening of programs that support First Peoples' access to services. The specific strategic priority that each health service has agreed to in the 2023-2024 SOP in relation to cultural safety is:

> *"Improving equitable access to healthcare and wellbeing*
>
> - *Ensure that Aboriginal people have access to a health, wellbeing and care system that is holistic, culturally safe, accessible, and empowering."*

105. It is through this priority that health services contribute to improving cultural safety in Victorian health services. Underneath that priority, individual health services have the option to choose from goals that the Department has suggested or to apply their own goals if they wish to emphasise a particular existing strategy or program.
106. The relevant priority relating to First Peoples cultural safety is subjective in nature. It is expressed in flexible terms and does not contain specific mandatory actions or standards, including in relation to cultural safety training. The intention is that under the devolved model, independent health services themselves determine how to address the priorities in their SOP. In my view, the subjective nature of this priority makes it difficult for the Department to evaluate the quality or completeness of its implementation.
107. The accountability mechanisms for SOPs are not strong for qualitative priorities like cultural safety. Performance is monitored by the health services self-reporting to the Department on their plans, actions and progress to achieve that priority throughout the year. The Department convenes quarterly performance management meetings with health services during which performance issues are routinely addressed. In preparation for those meetings, health services must report to the Department on implementation of the priorities agreed in the SOP.[16]
108. If the Department has a concern that a health service is not adequately achieving progress towards a priority, including a priority relating to cultural safety, the Department can request that the health service develops a remediation plan and then reports on progress against that plan in future

[15] Aboriginal and Torres Strait Islander Cultural Safety Framework (n 13) 6-7.

[16] Cultural safety outcomes are also published by individual health services in their annual reports. This is a public record of progress that health services have made against an SOP during a year.

performance meetings. However, I am not aware that this has ever occurred with respect to cultural safety.

109. Where progress against a priority can be measured *quantitatively*, the Department tracks that progress via key performance indicators.

110. 2023-24 SOPs for health services were amended to include two quantifiable measures. These measures are "Percentage of Aboriginal emergency department presentations who did not wait to be seen" and "Percentage of Aboriginal admitted patients who left against medical advice".[17] The Department collects data on these two measures and has set targets for both.
    a. "Did Not Wait" means a person did not wait for clinical care after triage in emergency.
    b. "Leave Against Medical Advice" is where a person leaves the health service before the clinic team recommends discharge.

111. Currently, the target is for each health service to reduce the gap between rates of First Peoples and non-First Peoples patients for measures of Did Not Wait and Leave Against Medical Advice by 25 per cent each year. Future work involves aligning this more closely to commitments under the National Agreement on Closing the Gap. As such, I intend for the proposed target in 2024-25 to be 'no gap between the rates of First Peoples and non-First Peoples' for both measures. These targets are discussed as part of health services' quarterly performance meetings.

112. These two measures do not expressly measure cultural safety. They are what I consider to be "proxy" cultural safety measures, as results can indicate that a health service may not be operating in a way that is culturally safe. If First Peoples patients have high rates of leave events compared to non-First Peoples patients, it is highly likely to indicate equity issues in the healthcare First Peoples patients are receiving.

113. The Aboriginal Health and Wellbeing Division of the Department worked to identify these measures, based on academic research.[18] The First Peoples health sector is aware of these proxy cultural safety measures, but was not directly involved in their formulation. More work needs to be done with community to look at additional cultural safety measures, including First Peoples health workforce, discharge planning and other community defined measures. The Department has supported VACCHO to commence the development of cultural safety standards and accreditation for health services, and I would like to see Government align measurements for cultural safety to this work, with accountability for adherence and implementation by health service shared back to community.

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[17] Department of Health, 'Victorian Health Services Performance Monitoring Framework', *Performance monitoring framework* (Web Page, 6 October 2023) <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework> 5.

[18] Australian Institute of Health and Welfare, *Cultural safety in health care for Indigenous Australians: monitoring framework* (Report, 7 July 2023) 31 < https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/summary>; Australian Institute of Health and Welfare, '3.09 Self-discharge from hospital', *3.09 Self-discharge from hospital - AIHW Indigenous HPF* (Web Page, 2 April 2024)< https://www.indigenoushpf.gov.au/measures/3-09-discharge-against-medical-advice>; Australian Commission on Safety and Quality in Health Case, *Understanding leave events for Aboriginal and Torres Strait Islander peoples and other Australians from health service organisations: A Systematic Literature Review* (Report, June 2020) <https://www.safetyandquality.gov.au/sites/default/files/2020-07/understanding_leave_events_for_aboriginal_and_torres_strait_islander_people.pdf>; Deeble Report

We must also improve our use of the ACSFGs reports and patient surveys, such as the Victorian Healthcare Experience Survey, to better understand and address these issues.

114. There has been mixed progress on these cultural safety proxy indicators, which were formally introduced in 2023-24, but they do give us some indicators we can use to better understand the problem.
115. Statewide performance against the 'Percentage of Aboriginal emergency department presentations who 'did not wait to be seen' indicator has shown a reduction from 8.2% at March 2023 to a rate of 7.7% at March 2024. Over the same period, some health services with well-developed cultural safety programs had significant improvements. Bass Coast's rate improved from 10.5% to 4.7%. South West Healthcare's rate improved from 11.3% to 4.1%. Monash Health's Clayton campus improved from 3.56% to 1.0%. [19]
116. This data is routinely raised by the Department at the quarterly performance discussions with health services. These discussions focus on what actions are seen to have been effective, if the data has improved, or on what actions the health service intends to implement, if the data has deteriorated.
117. The overall system performance for the indicator for Left Against Medical Advice has deteriorated slightly over the same period from March 2023 to March 2024. The Statewide rate deteriorated from 2.4% to 2.6%, although some individual health services have demonstrated good progress.[20] Latrobe Regional Health's rate improved from 4.4% to 1.3%. The Royal Women's rate improved from 6.5% to 1.5%.
118. As with the Did Not Wait indicator, the Department uses the Performance Monitoring Framework (**PMF**) [21] to understand local success factors, and to seek remedial action where needed.
119. The PMF describes how the Department monitors and manages the performance of health services, and in particular, how it holds them to account for adhering to policy and funding requirements and for delivering their commitments in the SOP.
120. Monitoring implementation through SOPs in relation to qualitative measures, such as cultural safety, has been challenged by the variance in reports received from health services. There has also been limited co-ordination between Government and health services on which goals and deliverables health services should prioritise. This has resulted in most health services indicating in their quarterly performance discussions with the Department that they are working on projects that focus on partnerships with Community, or, on projects that aim to create a welcoming environment for First Peoples.

New Performance Management approach

121. This year the Department undertook a review and reset of the PMF.
122. Under the new PMF, which will take effect from 1 July 2024, the intention is for health services to be assessed and allocated to one of four 'tiers' depending on their performance. The assessment and

[19] This data is sourced from the Victorian Emergency Minimum Dataset, quarterly results for the period ending 31 March 2023 and compared to the quarterly results for 31 March 2024. The dataset is managed by the Department of Health

[20] This data is sourced from the Victorian Admitted Episodes Dataset, quarterly results for the period ending 31 March 2023 and compared to the quarterly results for 31 March 2024. The dataset is managed by the Department of Health.

[21] Department of Health, 'Victorian Health Services Performance Management Framework', *Performance monitoring framework* (Web Page, 6 October 2023) <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework>.

tier allocations will be centred around the health service's performance against core Government priorities. I expect that these priorities will include the provision of culturally safe services for First Peoples Victorians.

123. The levels of autonomy, support, and Departmental monitoring or intervention for each health service will vary across the tiers in line with the health services' requirements.
124. I expect that health services will only be allocated to the highest tier, "Enhanced Autonomy," if they are demonstrating satisfactory progress on their two cultural safety SOP measures ('no gap' in rates of 'leave against medical advice' and 'did not wait' in emergency departments for First Peoples and non-First Peoples patients).
125. I further expect that health services will be placed on lower tiers, with intensified Departmental oversight and the risk of formal accountability escalations, where there are significant concerns about cultural safety and a failure on the health service's part to design and implement an effective plan to address such failures. These escalation options include (and are not limited to) measures such as independent reviews and audits, mandated improvement plans, and the appointment of a Ministerial delegate to the Board of the health service.
126. In addition, from 1 July 2024, I intend to elevate the requirement for health services to deliver best practice cultural safety training. This will occur through a mandatory SOP Part A goal for all health services of:

> *'Improving equitable access to healthcare and wellbeing' by 'expanding the delivery of high quality cultural safety training across staff, with training aligned with the Aboriginal and Torres Strait Islander cultural safety framework, and delivered by independent, expert and community-controlled organisations invited and empowered to challenge established practices and thinking and drive effective change.'*

127. I will expect this training to be delivered within existing training budgets and not from funding for First People's services. A lack of cultural safety is a legacy of colonialism. I understand that health services use their ACSFGs to fund Aboriginal Hospital Liaison Officers (**AHLOs**), who provide critical cultural supports to First Peoples as they enter health services. Health services also use this funding to support partnerships with ACCOs and First Peoples recruitment efforts. Additionally, it is important to note that it should not be the role of AHLOs to deliver this training in addition to their existing roles. Health services will need to work with ACCOs and other First Peoples organisations to ensure that their staff are appropriately trained in cultural safety.
128. Further, I expect the Department to improve performance measurement and oversight for both cultural safety and equitable access for First Peoples to services more broadly. These activities include:
    a. setting minimum standards and expectations for health services to meet on cultural safety, including providing more specific guidance around what is expected to meet the requirement of 'high-quality' training, such as having this training delivered by independent, expert and community-controlled organisations;

b. broadening their oversight of health service performance on equity of access for First Peoples, to "*Ensuring that there are no gaps in timeliness of access for Aboriginal and non-Aboriginal Victorians with equivalent need*".
   i. This will include expanding measurement and analysis of waiting times for First Peoples and non-First Peoples patients for key hospital services such as emergency care, outpatient appointments and planned surgery.
   ii. The Department will be reviewing these data, and sharing and discussing results with health services. Where a given health service has significant gaps in performance on these measures, the expectation to address these will be clearly communicated, with a view to having clear improvement plans in place and reflected in 2025-26 SOPs; and
c. in partnership with VACCHO, creating an independent and community-controlled accreditation system of cultural safety within health services.

Loddon Mallee Health Network's reconciliation / anti-racism work

129. The Health Service Partnership for the Loddon Mallee Region (the Partnership) has made a commitment to an anti-racism strategy. Health Service Partnerships bring individual health services together to work on a small number of strategic system priorities. Members engage collaboratively and inclusively in the Partnerships and decision making is by consensus. Contribution to the Partnership priorities is through their individual SOPs.
130. Health service CEOs in the Partnership have been invited to participate in Critical and Conscious Training led by an Aboriginal community-controlled consulting agency. Two face-to-face days have been completed by six CEOs. The CEOs will reconnect after three months to demonstrate and share their actions towards improving cultural safety for First Peoples within their health service. A second initiative is targeted more broadly at health workers across the Partnership. Sessions will commence in August 2024 and will be open to all health workers in partnering health services for Truth Telling information and learning sessions.
131. The sessions will focus on racism, unconscious bias, ongoing impacts of colonisation and self-reflecting on participants' own cultures. Participants will be able to access a resource library via a webpage. The initiative involves five online sessions, debrief post sessions, individual Truth telling action plans, ongoing Truth telling circles and an Anti-Racism learning cycle. The sessions will be led by an experienced First Peoples Educator who has been employed by the Partnership as First Nations Strategic and Partnership Lead.

*Funding for Aboriginal Community Controlled Health Organisations (**ACCHOs**) to provide prevention activities and work with mainstream health services to improve cultural safety.*

132. Of the $87.093 million that the Department invested in ACCOs in 2023-24, approximately $40.56 million is targeted to prevention and early invention. This represents only 0.2 % of the Department's spend on health and wellbeing services. This is despite the importance of ACCO's holistic model of care, which prioritises culture and prevention and early intervention. Recent examples are described below.

133. The “Strengthening life-long Aboriginal health and wellbeing through access to early intervention and holistic care (**Urgent Care Pathways**)” is funded through the 2023-24 State Budget allocation of $35.04 million for successful ACCHOs to deliver 100,000 culturally informed, prevention focused episodes of care over four years (by 2027).
134. The Urgent Care Pathways funding allocation for the first year 2023-24 is $4.332 million (GST inclusive) followed by $7.857 million (2024-25 FY), $11.294 million (2025-26 FY) and $11.570 million (2026-27 FY).
135. The Urgent Care Pathways Initiative aims to significantly improve the health of First Peoples living in Victoria and reduces the demand on Victorian hospitals. By redirecting treatment for Potentially Preventable Hospitalisations (**PPHs**) among First Peoples from hospitals to ACCHOs, First Peoples in Victoria will receive holistic, culturally safe and timely preventative care to reduce the need for acute treatment. The funding supports the extension of the ACCHO’s clinical hours of operation, the expansion of the ACCHO workforce through the employment of nurses, general practitioners, transport drivers and other culturally safe support workers to reduce barriers to ACCHO services.
136. Successful ACCHO applicants were those located in areas with high PPHs that displayed a proposed service model that upscales from their existing clinical services and in doing so; increases episodes of care, utilising a professional attendance, by a general practitioner, to conduct a health assessment of a First Peoples patient, in a place other than a hospital.[22] This assists in the reduction of PPHs, and of GP-like presentations in Emergency Departments in Victorian hospitals.
137. The 2023/24 State budget allocated funding for the establishment of 22 Women’s Health Clinics across Victoria, including a dedicated Aboriginal Women’s Health Clinic and a mobile women's health clinic. All 22 clinics will incorporate Aboriginal Cultural Safety and self-determination principles in the model of care. For the Aboriginal Women's Health Clinic, the model of care will be developed through extensive co-design with VACCHO and ACCHOs. All clinics will additionally be subject to the cultural safety SOPs of health services in providing targeted services or advice, based on current health trends, to First Peoples women.
138. The 2024-25 State Budget includes funding for the Culture and Kinship Program, which is aimed at funding ACCOs to support young people’s connections to culture to reduce significant social and emotional wellbeing and alcohol and other drugs issues.
139. While recent investments in prevention and early invention are steps in the right direction, I acknowledge that the Victorian Government is only starting to realise the importance of investing in ACCOs prevention and early invention services that are grounded in First Peoples culture.
140. I also recognise that there has been minimal investment to date in ACCOs working with mainstream health services to improve cultural safety. Over recent years, VACCHO has received funding from the Department to progress cultural safety standards and an accreditation model, with additional funding announced in this year's State Budget. I recognise that investment will be required to establish a standards and accreditation model that is First Peoples-led in design and implementation.

[22] Australian Government Department of Health and Aged Care, 'Medicare Benefits Schedule - Item 715', *Item 715 | Medicare Benefits Schedule* (Web Page) <https://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=715>.

141. I also recognise that the Victorian Government needs to hold mainstream health services to greater account for the funding they receive to improve cultural safety. This includes the Aboriginal Cultural Safety Fixed Grants, which I detail elsewhere in this statement.

Other actions and measures taken to monitor, address and eliminate racism within health services

142. It is unacceptable that racism still exists in Victoria's health system, for patients, and for our workforce. As Minister for Health, it is my responsibility to ensure the Department and health services are doing all that they can monitor, address and eliminate racism in health settings.
143. I am aware that many health services have Reconciliation Action Plans or Cultural Safety Plans, and that there are meaningful ways to engage staff to ensure racism is addressed in health settings. For example, I am aware that the Royal Children's Hospital has done a 'Grand Round' on racism and the impact it has on children and youth, recognising it as a major public health crisis. I am also aware of the adoption of the national campaign 'Racism. It Stops with Me'. We need our hospitals to engage staff to take action to eliminate racism, and this needs enduring commitment.
144. In reviewing some of the existing Reconciliation Action Plans and cultural plans of our hospitals it is clear that there are efforts to engage across hospital teams, with local communities, to drive better understanding of patients, the impact of past injustices and racism, and to work in partnership to build better relationships. However, it is also clear that more needs to be done, as the lived experience of too many First Peoples – both patients and staff – is that they have experienced racism in healthcare settings. This is in the statistics, and this is what has been shared with the Commission, with my department, and with me directly.
145. With my intent to mandate cultural safety training in all hospitals, I set an expectation that this training will address racism. Cultural safety training must be underpinned by a cultural safety plan in each hospital that encourages patients and staff to speak up when racism occurs, and identifies a range of actions health services will undertake to stand against racism. I understand the Commission has been presented with information directly from Aboriginal Health Liaison Officers that there is a preference that they prepare the plan, in collaboration with management [BAL7.10000.10000.0021].
146. The mechanism to action this expectation is the Department's Policy and Funding Guidelines. The Policy and Funding Guidelines set out requirements that health services must comply with in addition to their contractual and statutory obligations, outline the activities required for funding, and detail expectations of administrative and clinical conduct of health services.
147. The Policy and Funding Guidelines 2023-24 address cultural safety in a number of areas, stating:

    To strengthen the cultural safety of healthcare across the organisation, and to improve Aboriginal health outcomes, health and community services are required to demonstrate:

    - CEO and executive leadership to drive cultural safety and Aboriginal self-determination
    - partnerships with ACCHOs, respected Aboriginal leaders and Elders, and Aboriginal communities to deliver healthcare improvements
    - Aboriginal employment plans that are in line with agreed public service workforce targets, and demonstration of increased Aboriginal employment, including leadership positions and across all clinical and non-clinical roles

- plans to identify and prioritise the health, wellbeing and service needs of the Aboriginal catchment population and service users – including improved patient identification, discharge planning and outpatient care.
- delivery of best-practice Aboriginal cultural safety training to all health service employees
- a culturally safe welcoming environment, with Aboriginal cultural symbols and spaces demonstrating, recognising, celebrating and respecting Aboriginal communities and culture.
- effective Aboriginal client and patient identification, including quality improvement processes to continually improve in this area.
- strategies to increase transparency and accountability of cultural safety across health services by monitoring Aboriginal health data, and cultural safety indicators and targets. This includes oversight by the health service board, executive and Aboriginal governance groups, and data-sharing agreements with ACCHOs.

148. These Guidelines will be amended to explicitly reference the requirement of a cultural safety plan that addresses racism. As I share above (Topic 2), strong enough steps have not been taken to ensure health services have been adhering to this policy requirement. Through the new performance management approach (Topic 4) health services will be held to account against performance tiers and associated expectations for remediation, including for cultural safety.
149. Everyone in our hospitals has a role to play in addressing racism, but the responsibility for driving that change rests with boards and senior leaders. Through collaborative arrangements such as Health Service Partnerships there are further opportunities to drive systemic change., Through Health Service Partnerships, which are regional groupings of hospitals, eight projects focused on improving outcomes for First Peoples have been established. This includes the Loddon Mallee 'Advance reconciliation and anti-racism efforts, fostering cultural safety' project, and a project in Hume focusing on improving cultural safety post-Referendum. For completeness, the projects are listed here.

Health Services Partnership	Aim	Recruitment Update	Work with Patients
Barwon South-West (BSW)	Improve health outcomes for Aboriginal and Torres Strait Islander people, particularly in ED/UCCs, by enhancing health literacy and cultural safety.	Position description developed and project officer roles advertised.	Enhancing cultural awareness, skills, and knowledge in ED/UCC staff to improve the experiences of First Peoples within these settings.
Gippsland	Improve Aboriginal patient health outcomes post-ED/UCC	Project Lead appointed with	Focus on improving clinical care and discharge planning for Aboriginal patients,

	presentations and outpatient support.	support from an Aboriginal Elder.	utilising culturally appropriate telehealth, and preventing avoidable admissions to ED.
Grampians	Establish culturally appropriate discharge planning and Aboriginal health meetings.	Coordinated efforts with existing Aboriginal Liaison Officer (ALO) teams.	Collaborative approach across sites to improve discharge planning and enhance cultural safety training for staff.
Hume	Improve discharge planning support for First Peoples experiences to reduce preventable ED/UCC presentations.	First Peoples experiences research team onboarded; research protocol developed.	Focus on implementing Aboriginal research methodologies and enhancing cultural safety post-Referendum.
Loddon Mallee	Advance reconciliation and anti-racism efforts, fostering cultural safety.	Onboarding of Anti-Racism lead.	Focus on cultural safety training, building authentic relationships, and supporting First Peoples experiences research projects.
West Metro HSP	Identify and resolve service gaps, including after-hours support.	Recruitment ongoing for various roles including Aboriginal Health Liaison Officer.	Implementation of after-hours resources and nursing outreach to enhance access to emergency services.
South East Metro	Improve access to specialist diabetes care for First Peoples experiences.	Progressing memoranda of understanding with Aboriginal health services.	Overcoming recruitment barriers to enhance service provision and patient care.
North East Metro	Enhance identification of Aboriginal patients and improve access to after-hours support.	Recruitment ongoing for various roles including AHLO and nursing outreach.	Implementing initiatives to increase patient identification and improve access to culturally appropriate care, including VVED utilisation.

The progress and results of the implementation of the Aboriginal Cultural Safety Workplace Measurement and Assessment Tool

150. Progress on the implementation of the Aboriginal Cultural Safety Workplace Measurement and Assessment Tool has been delayed due to the lead role for implementing the Tool being vacant since August 2022. Following unsuccessful recruitment, the department engaged a specialist First Peoples recruitment agency (Pipeline Talent) to recruit to this position as well as a support position (both First Peoples designated roles). Additionally, a new Aboriginal cultural safety team was established within the Department's Aboriginal Health and Wellbeing Division. Further resources have been allocated to this team which will have responsibility for both internal and health sector focused First Peoples cultural safety.
151. The team will consider how the tool now fits into broader work to improve cultural safety in health services, including improvements to SOPs, the PMF, additional mandatory standards and accreditation, and working with VACCHO and First Peoples on how to measure cultural safety with community-defined self-determined measures.

Progress of the selection and implementation of cultural safety initiatives at participating hospitals (regarding the Hospitals Collaborative Project)

152. Progress on the implementation of cultural safety initiatives as part of the Hospitals Collaborative Project is detailed later in my statement at Topic 8 below.

Topic 5: Comparative rates and levels of employment of First Peoples in the health sector, including:

- ***in relation to staff employed by the Department of Health directly, number of First Peoples within leadership positions (VPS 6 (or equivalent) and above), including as a proportion of total number staff in those roles); and***
- ***in relation to staff not employed by the Department of Health directly, whether the State is considering encouraging mainstream services to report on this data.***

Department Workforce

153. As at 30 April 2024, the Department has 26 staff that identify as First Peoples, accounting for 1.0% of the Department's workforce (2548). Nine of the 26 First Peoples staff are in leadership positions (VPS6 level or higher). This accounts for 1.1% of leadership positions in the department.
154. These figures include Safer Care Victoria but exclude the Victorian Health Building Authority (VHBA) due to recent machinery of Government changes. Excluding VHBA reduces the First Peoples workforce by 3 staff.

Health Sector Workforce

155. At present, only 0.39% of Victoria's public hospital workforce identify as First Peoples. This is disproportionate to the at least 1.0% of Victorians who identify as First Peoples (according to the ABS), noting that First Peoples' communities often state that 3% of people in Victoria identify as First Peoples.

156. The Victorian Health Workforce Strategy is the overarching strategic plan to achieve a modern, suitable and engaged healthcare workforce. This strategy has identified the need to increase First Nations representation in mainstream roles while also developing, deploying and enabling new roles in new setting, such as the Aboriginal Health Practitioner.
157. The State cannot have a culturally safe healthcare system without a large workforce of First Peoples healthcare workers. The Department is providing funding support for a range of community-led workforce initiatives to expand and upskill the First Peoples health workforce, including graduate and postgraduate scholarship programs, cadetships and traineeships. To support the growth of the First Peoples health workforce now and into the future, I recommend the Department work collaboratively with the Department of Education and Training to support health and wellbeing education and training programs for First Peoples community to increase the number of First Peoples joining the health sector.
158. Our health system needs to significantly increase First Peoples employment, including First Nations specific roles and significantly expanding representation within mainstream professions and leadership roles. Recognising the significant work to be done, and the need for all to share the cultural load, I aspire to have a health system where First Nations leadership, ways of being and knowing are endemic across all levels of our healthcare system, from leading care delivery to highest levels of governance.
159. The Victorian Health Workforce Strategy commits to increasing Aboriginal and Torres Strait Islander representation to a level equal to the Victorian population by 2034.[23] To achieve this, in addition to the other actions discussed I intend to mandate First Peoples employment plans for the 38 health services receiving ACSFGs**.** These health services account for most of the employment in the sector. The guidelines for the Aboriginal Cultural Safety Fixed Grants already encourage health services to develop and monitor Aboriginal Employment Plans with organisational targets for employment of First Peoples staff. However, as I noted earlier just 15 of the 38 health services receiving the grants said that they had a First Peoples employment plan.[24] Therefore, the department will strengthen its guidance to health services to make clear that they are required to have a First Peoples employment plan. These plans must be aligned to the 5-year Aboriginal employment strategy for the Victorian public sector, Barring Djinang. And the plans must include an employment target that is reflective of their local First Peoples population, noting these vary across the state and are much larger in certain areas.
160. Health services that do not receive Aboriginal Cultural Safety Fixed Grants, but do serve a significant local Aboriginal population, will also be directed to develop First Peoples employment plans and targets.[25] The mechanism for enforcing this requirement will vary: where the health service has a Statement of Priorities, this will be included as a mandatory deliverable. Where the health service does not have an SOP, the expectation would be directly communicated to them by the department.

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[23] https://content.health.vic.gov.au/sites/default/files/2024-02/victorian-health-workforce-strategy.pdf, p 22

[24] An analysis of the ACSFG reports in September 2023 found that just 15 hospitals said that they had a First Peoples employment plan.

[25] It is not proposed that all of these smaller health services be required to develop plans where they do not have significant local First Peoples populations, given some of these health services are very small, are experiencing severe challenges attracting workforce across the board.

Topic 6 - Measures to ensure that the health complaints process is culturally safe for Victorian First Peoples, including whether there are alternative options to raising the complaint with the health service where the incident may have occurred.

161. I would like to acknowledge the importance of ensuring First Peoples have a culturally safe way to raise concerns or provide feedback regarding the health care they receive. It is equally important that their complaints are heard and , taken seriously and that they feel safe throughout the process.
162. Each public hospital and health service has its own internal complaints management system and process for managing complaints related to the health services which it provides. Whilst the department does not stipulate requirements for these complaints processes, we do clearly state that health services are expected to demonstrate compliance with the Health Complaints Act 2016 Complaint Handling Standards and regularly review their complaints management procedures, as part of their ongoing quality and safety governance process.
163. I understand that ordinarily, each hospital will have its own complaint liaison officer and/or patient representatives who assist patients with their complaints about the hospital. The complaints process of each public hospital and health service should allow for reasonable adjustments to support the complainant to fully participate in the complaint process, including ensuring culturally safe interactions for all and provide appropriate translation services as required for persons from culturally and linguistically diverse backgrounds.[26]
164. I understand it can be difficult to raise a complaint directly with a service that you have lost trust in. External options that may be available to a patient are the Health Complaints Commissioner or the Victorian Equal Opportunity and Human Rights Commission. However, I also acknowledge that such formal complaints processes can be complex may not work for First Peoples as they do not align with First Peoples ways of working. For example, these processes may be too siloed, restrictive or culturally unsafe.
165. The Department does not regulate individual health practitioners, and therefore it is unable to address complaints against individual health practitioners, including those which relate to racism, discrimination, or bias. For individual health practitioners, complainants are referred by the Department to the Australian Health Practitioner Regulation Agency (AHPRA) as the accredited regulating body for health care professionals across Australia.
166. From time to time, people write to me with concerns or complaints about their health care experiences, or their local MP may raise them with me on their behalf. When I receive complaints in this way, I require the department (including Safer Care Victoria) to engage directly with the complainant, and the relevant health service if appropriate, to respond to the complaint, and hopefully to resolve it.
167. The Department is in the process of reviewing its own complaints management policies and practices to improve consistency, responsiveness, and data reporting. Under current practices:

a. All staff are required to take part in the Department's cultural safety compliance eLearning training, and periodic refreshers.
b. The Department's complaints and feedback management system enables First Peoples to self-identify as First Peoples if they wish to, while also enabling complainants to lodge anonymous complaints.
c. Feedback may also be provided via third parties such as ACCHOs, or directly through the Aboriginal Health and Wellbeing Division.

168. While the investigation and resolution of health complaints is most often a matter for health services, Safer Care Victoria can play the role of intermediary to support complainants who may not wish to engage directly with a health service.

Topic 7 - Funding and reporting requirements for ACCHOs, and measures to reduce the burden of same, including an update on progress on the Outcomes-Based Funding project.

169. The First Peoples community-controlled health sector plays a central and highly respected role in providing safe, effective health and wellbeing services to First Peoples living in Victoria.
170. Service Agreements detail funding arrangements between ACCOs and the Department. These agreements last for four years. Funding is delivered either monthly, quarterly, six-monthly or in a lump sum.
171. All departmental funding to ACCOs must adhere to the Department's policy and funding guidelines and rules. The funding rules set out financial parameters, detailed pricing, and budgetary targets. Funding is administered through multiple output initiatives, each containing one or more Budget Paper measures. I acknowledge that this Western funding agreement and contract management style creates a power imbalance with ACCOs when government should be progressing self-determination. Government should have relationships with ACCOs that are based on trust, partnership and open communication. Most importantly, Government needs to give back power and control to ACCOs for how they manage their funding to deliver services and supports to their communities.
172. Having regard to the current system of funding for ACCOs, the short-term funding models historically used to fund ACCHOs and ACCOs have constrained the ability of these organisations to effectively serve their communities by creating administrative burdens and limiting the ability of these organisations to hire and retain First Peoples staff.
173. Funding and investment systems for ACCHOs and ACCOs have been framed around programmatic, siloed activities and outputs rather than on cohort-wide systems that allow a broader, interconnected focus on the social and cultural determinants of health. I recognise that this is incompatible with First Peoples' models of care that prioritise the provision of holistic, prevention-focused, strengths-based, trauma-informed and culturally appropriate services. It also hinders the ability of ACCOs to plan and future proof the delivery of the programs and services they offer.
174. The provision of funding in such a manner also creates a significant burden of regulatory reporting obligations that ACCOs are required to comply with.

175. At my first Partnership forum in August 2022, I committed to transitioning funding arrangements to a self-determined, long-term, outcomes-based funding (**OBF**) approach for First Peoples' health services.
176. In February 2023, the Department consulted with 25 Victorian ACCOs to commence the process for funding reform. From this consultation, and commitments made under the AHW Partnership Agreement and Action Plan, the OBF Project has emerged.
177. The Department will continue to work in partnership with ACCOs to co-design the plan for implementing the OBF Project. The Department will be guided by the AHWF Agreement and Action Plan. This includes an action that an overall plan is developed to transition the community-controlled health sector to OBF. Another round of consultations is planned for May and June 2024 to inform the four proposed components to the OBF Project, set out below, and how this will be implemented in a phased approach:
    a. Sustainability – Providing ACCOs with four-year in place of single-year funding where there is an existing recurrent funding source.
    b. Reporting – Reducing the number of reports ACCOs must provide to the Department while ensuring the Department's accountability for the use of public funds.
    c. Outcomes – Shifting the focus of funding, reporting and accountability from activity-based to ACCO self-determined outcomes.
    d. Self-determination – Pooling funding across program streams to provide ACCOs with greater flexibility in funding and services offered and to further self-determination.
178. The Action Plan includes an action that the Department develop and implement a policy so that operational funding for ACCOs is recurrent or multi-year (4-year minimum) unless it meets strict criteria that justifies funding being issued as a 12-month (or less) contract. Once implemented, this would apply to existing and new funding arrangements and includes indexation.
179. As of 1 July 2023, Stage 1 of the OBF transition was complete, with ACCO funding consolidated into recurrent 4-year streams where there was an existing recurrent source. In 2023-24, the Department funded ACCOs $87.093 million. $41.026 million of this was short-term funding. This means that despite the OBF reforms, 47% of the Department's funding to ACCOs is short-term.
180. Stage 2, which relates to reporting, is underway with a focus on reviewing ACCO reporting requirements and how these might be simplified. The intention is to consolidate ACCO reporting requirements into a single annual report and financial acquittal. The Department and VACCHO are currently establishing an ACCO sector 'Funding Reform Working Group' that will co-design future work on the OBF Project.
181. Further work is required in relation to stage 3 and stage 4.
182. The aim is to reduce the administration burden of ACCOs, with one point of contact within the Department for programs in scope.
183. I am optimistic that the transition to OBF will optimise the use of funding for ACCOs, to meaningfully improve First Peoples' health and wellbeing.
184. ACCOs and ACCHOs need to be sufficiently funded to do the important work they do. I acknowledge that the OBF Project, while a positive reform, will not provide ACCOs with additional funding. It is focused on supporting ACCOs to use their current funding in a more self-determined manner that aligns to First People's understanding of holistic health and wellbeing. In 2023-24 ACCOs only

received 0.4% of the Department's funding for health services. I acknowledge that ACCOs should receive greater equity in funding, particularly for the prevention services they provide that are grounded in Culture. In addition to improving First Peoples' health and wellbeing, this will reduce costs on the rest of Victoria's health system.

Topic 8 - The Hospitals Collaborative Project, including an explanation of any barriers and opportunities to improve cultural safety for Victorian First peoples identified through the Project to date.

185. In recognition of the need to improve cultural safety in Victorian public hospitals, the Department in partnership with VACCHO, ACCHOs, and Safer Care Victoria established the Aboriginal Cultural Safety in Hospitals Collaboration Project (**Collaboration Project**). The Collaboration Project is also referred to by partners as "the Collaborative".
186. The intent of the Collaboration Project is to identify the barriers and opportunities to improve cultural safety, and to jointly select initiatives to improve cultural safety in hospitals, with a view to scaling them across health services following a period of learning and evaluation.
187. The Collaboration Project commenced in 2023 with a focus on emergency departments, recognising that they are a key entry point to hospitals, and a place that can often be culturally unsafe for First Peoples. Five health services, a mix of metro and rural, agreed to participate, along with several ACCHOs from the same locations as the health services, and VACCHO.
188. As part of the Collaboration Project, Aboriginal-led community engagement took place (through face to face and online surveys) to hear firsthand the experience of First Peoples in emergency departments and urgent care centres. Key themes that arose through that consultation process include discrimination, long wait times, a lack of empathy demonstrated by staff, physical layout of emergency departments feeling unsafe and inaccessible, dismissal of the patient's wishes or concerns, and an absence of Aboriginal Health Liaison Officers.
189. Twelve initiatives across the five services were identified through the Collaboration Project consultation process as opportunities to improve cultural safety including employing an Aboriginal health practitioner in emergency departments, enhancing and expanding Aboriginal Health Liaison Officer roles to provide greater coverage across the week, establishing better referral pathways between hospitals and ACCOs including opportunities for dedicated brokerage funding, and mandatory training led by First Peoples.
190. One key initiative focussed on long waiting times in emergency departments provides an example of the potential for significant changes to how First Peoples are triaged for care, and therefore the expected timeliness of that care. The initiative prioritises First Peoples presenting at emergency departments such that they can only be categorised as a Category 3 patient ('urgent patient') or higher and cannot be categorised as a 'Category 4 or 5' ('semi-urgent' or 'non-urgent') patient. Patients in Category 3 must be seen within 30 minutes of presenting to an emergency department. While evaluation of this initiative will need to occur with the partners in the Collaboration Project, it provides an example of an initiative that could be scaled and mandated across all Victorian emergency departments.

Topic 9 - Funding, availability of, and access to sexual health services for Victorian First Peoples, including:

- ***funding provided to the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) to provide sexual health services;***
- ***whether regional ACCHOs are funded to provided sexual health services (including given the disproportionate burden of sexually transmitted infections and blood-borne viruses on Victorian First Peoples);***
- ***actions and measures taken by the Department to address the barriers identified in response to Question 18 of the Request for Information; and***
- ***funding committed to the implementation of the Aboriginal Sexual and Reproductive Health Plan 2022-2030.***

Funding to VACCHO to provide sexual health services

191. VACCHO receives annual recurrent funding of $1,138,000 to provide dedicated health services to First Peoples in Victoria, including sexual health services.
192. The Victorian Aboriginal Health Service (**VAHS**) has also been funded $211,847.52 to provide clinical care delivery in sexual health and viral hepatitis for First Peoples in Victoria. This is Victoria's only recurrent funding for dedicated First Peoples sexual and reproductive health and viral hepatitis services.

Whether regional ACCHOs are funded to provided sexual health services

193. There is no specific funding to regional ACCHOs to provide sexual health services.

Actions and measures taken by the Department to address the barriers identified in response to Question 18 of the Request for Information

194. The Department identified that increasing the number of First Peoples Health Workers (both male and female) available to ACCOs would improve the provision of sexual health services to First Peoples communities. This is in the context of the consumer perspective and who First Peoples consider is best placed to deliver care given the sensitivity of sexual health related matters within community.
195. VACCHO in partnership with the Department is providing scholarships to support First Peoples students in their professional development. Training scholarships valued at up to $4,000 are available to First Peoples health workers and practitioners to support one year of professional development activity.
196. I acknowledge that despite the Victorian Government being committed to increasing the number of First Peoples employed in the health sector, and whilst the number of First Peoples employed has doubled since 2016 (from 256 to 574), this is still a disproportionately small number when compared to the public workforce as a whole. At a policy level, there is a long-term expectation of the Department to create a 'strong and sustainable' workforce through implementation of targeted reforms under the Action Plan.

Funding committed to the implementation of the Aboriginal Sexual and Reproductive Health Plan 2022-2030

197. VACCHO was provided non-recurrent funding of $1,000,000 ($250,000 per annum for four years) from 2022-23 to 2025-26 for implementation of the Victorian Aboriginal Sexual and Reproductive Health Plan 2022-2030.

Topic 10 - Progress within Victoria against Health related Closing the Gap targets, including an explanation of:

- ***why there does not appear to be comparative data available in relation to the socio-economic targets;***
- ***the data being used to determine that the number of deaths in Victoria is too small to be measured.***

Why there is a lack of comparative data in relation to socio-economic targets

198. I acknowledge that there are no comparative data available for Victoria in relation to:
Target 1: *Everyone enjoys long and healthy lives*
Target 14: *People enjoy high levels of social and emotional wellbeing*.
199. First Peoples' Life Expectancy and Suicide Rates are not reported for Victoria as part of its Closing the Gap reporting.
200. It is also useful to highlight that the Department does not provide or 'own' the data for these Closing the Gap measures. The Australian Bureau of Statistics is the official data source. The measures are calculated using the Australian Bureau of Statistics' population count, and the Life Tables and Cause of Death datasets.
201. The *Cause of Death* datasets are compiled from each jurisdiction's death registration data. In Victoria:
    a. death registration data is owned and reported by the Registry of Births, Deaths and Marriages, within the Department of Government Services; and
    b. suicide data is owned and reported by the Coroners Court of Victoria.

Reasons life expectancy data are not reported for Victoria

202. The Australian Bureau of Statistics has determined that statistically reliable life expectancy estimates cannot be produced for First Peoples in Victoria.[27] This determination was reached in 2023, after the Australian Bureau of Statistics assessed the feasibility of providing separate life expectancy and suicide estimates for Victoria and South Australia in response to a request from the Commonwealth Government.
203. There are several reasons for that determination. The reasons include the fact that an estimated 46% of deaths of First Peoples in Victoria are incorrectly classified; data may not be collected

[27] https://www.abs.gov.au/articles/independent-review-abs-aboriginal-and-torres-strait-islander-life-expectancy-estimates Australian Bureau of Statistics, 2023.

because health services either lack the systems to collect data, or because patients do not wish to be identified as First Peoples. Further, there is also a low degree of confidence in First Peoples population estimates for Victoria over the last decade. Additionally, the number of deaths within each age and sex category is small from the perspective required for the calculation of life expectancy estimates.

204. However, the Victorian Agency for Health Information (VAHI) within the Department[28] is working with Births, Deaths and Marriages Register to be able to provide these data in the future. Without the measurement, even with a lower than desired degree of confidence, purposeful improvement is compromised.

Reasons the suicide rate data are not reported for Victoria

205. The Closing the Gap target concerns the rate of mortality due to suicide. Calculation of the mortality rate requires the use of First Peoples population estimates within each age group. Those estimates are considered too small or unreliable to calculate accurate mortality rates.

206. The Coroners Court of Victoria reports the number of suspected suicides annually. The Coroners Court has a holistic process to ensure that First Peoples Victorians are accurately identified. This information is published in supplementary tables to the Closing the Gap report.

207. The Department of is assessing this approach as a means of reporting age-standardised mortality rates due to suicide for Aboriginal and Torres Strait Islander people in Victoria.

Further comment regarding data collection

208. I acknowledge that data concerning First Peoples in the health system are limited and fragmented. The lack of data makes it impossible for the Department to report on matters such as contributing factors to avoidable deaths according to First Peoples' ethnic or racial status. It is unacceptable that, despite multiple initiatives focused on 'Closing the Gap', data collection for First Peoples remains so deficient. I acknowledge that this is a major limitation to the State's ability to improve healthcare for First Peoples.

209. I am committed to improving data collection in this area and will continue to support research and quality improvement initiatives, informed by First Peoples health partners and in partnership with the First Peoples community to improve health outcomes for all First Peoples in Victoria.

210. In particular, the Department has shared with VACCHO several core health administrative datasets over the past year and continues to support efforts to build the capability of VACCHO staff to understand and use those datasets. Discussions between VACCHO and the Centre for Victorian Data Linkage have commenced and a formal data sharing agreement with VACCHO will be established once agreement has been reached on the scope of that data sharing.

211. Joint work is also underway between the Department and VACCHO to develop a shared understanding of First Peoples' data sovereignty, to form the basis of a Health Data Sovereignty

[28] VAHI is now incorporated within the eHealth Division with the Department.

Framework. It is intended that this Framework will guide joint decision-making in relation to the use and publication of health-related information about First Peoples in Victoria.

212. The Department is also working with VACCHO to help identify analysis, metrics and dashboards that highlight issues of cultural safety within health services and to identify and track progress towards eliminating health inequities between First Peoples and non-First Peoples in Victoria.

Topic 12 - The continuity of care model of maternity care for women having a First Nations baby as delivered at Western Health and Mercy Hospitals, and opportunities for expansions across Victoria.

213. In the maternal and newborn care setting, midwife-led continuity of care refers to a model whereby care is provided by the same midwife, or small team of midwives, during pregnancy, labour and birth, and the postnatal periods with referral to specialist care as needed.
214. In Victoria, midwifery-led continuity of care models are available through several public hospitals, through Koori Maternity Services whereby the same midwife can provide care throughout pregnancy and the postnatal period and provide support for the woman during labour and birth, and through privately practising midwives.[29]
215. Continuity of care in maternity care involves collaboration, a collective understanding and shared responsibility by all practitioners involved in a woman's maternal care to improve health and wellbeing outcomes of a woman and her family.[30]
216. The identified programs at Western Health and Mercy Hospitals both involve delivering culturally sensitive models of care using a case load midwifery model. In addition, the Royal Women's Hospital and Monash Health Koori Maternity Services have been noted as successful clinics for First People women having babies, which I detail below.
217. The Maternity and Newborn Capability Frameworks[31] outline the minimum requirements for safe and high-quality maternity and newborn care in Victoria. These requirements include providing culturally safe care in line with the Koori Maternity Services Guidelines[32]. The Guidelines outline the importance of continuity of care models and how services can best implement this through a collaborative approach to support all levels of pregnancy care risk for First Peoples.
218. Given the success of these programs, there are opportunities for the Department to continue to work with services to expand access to continuity of care models for women having First Peoples babies across Victoria. Consideration is presently being given to expanding those maternity services which deliver culturally safe care to First Peoples women. As part of this consideration, the Department is reviewing a number of maternity continuity of care models provided through maternity services to assess whether it is possible to tailor these models to women having First Peoples babies. This is

[29] Maternity models of care in Australia, 2023, Continuity of carer - Australian Institute of Health and Welfare (aihw.gov.au)

[30] Department of Health and Human Services, *Koori Maternity Service Guidelines* (Report, March 2017) 31.

[31] Department of Health, 'Capability frameworks for maternity and newborn services', *Capability frameworks for maternity and newborn services* (Web Page, 24 October 2023) <https://www.health.vic.gov.au/patient-care/capability-frameworks-for-maternity-and-newborn-care-in-victoria>.

[32] Department of Health, 'Aboriginal maternity services', *Aboriginal maternity services | health.vic.gov.au* (Web Page, 7 December 2023) <https://www.health.vic.gov.au/patient-care/aboriginal-maternity-services> ('Aboriginal maternity services').

particularly important given that health services and maternity wards can be a place of trauma for First Peoples due to Stolen Generation and ongoing racism and a lack of cultural safety.

219. Below is an overview of maternity continuity of care models that women having a First Peoples baby currently have access to in Victoria, including those at Western Health and Mercy Health:

Galinjera Maternity Program – Western Health

220. Western Health's Galinjera[33] Maternity Program provides continuity of care for First Peoples women and families at Joan Kirner Women's and Children's Hospital in St Albans. It is operated by a small team of dedicated midwives and doctors. Regular visits with a midwife known to the First Peoples woman/mother help to make both the First Peoples woman/mother and baby feel safe, supported and well cared for.

Nangnak Baban Murrup Maternity Group Practice Clinic – Mercy Hospital for Women

221. Nangnak Baban Murrup[34] Maternity Group Practice is a clinic providing care and support for women who are pregnant with a First Peoples baby, through a maternity group practice model. This clinic is located in Heidelberg. Throughout their experience, women may be supported by doctors, midwives, Aboriginal hospital liaison officers, social workers, psychologists, psychiatrists, paediatricians and diabetes educators.

Baggarrook Midwifery Care – Royal Women's Hospital

222. In the Baggarrook midwifery care model, one midwife provides care during pregnancy, birth and after the birth. There are other Baggarrook midwives available to provide support if needed. The Baggarrook midwives work closely with the Aboriginal Health team from Badjurr-Bulok Wilam, to provide women with the care and support that they need. Baggarrook midwives are 'on call' and can be contacted with any questions or concerns. There are currently a team of three Baggarrook midwives providing care. Baggarrook means "woman" in the Woiwurrung language.[35]

The BUBUP Clinic – Monash Health

223. The BUBUP Clinic is a maternity clinic for First Peoples families run by the Aboriginal Midwives team. Continuity of care is provided from booking in for pregnancy care at Monash, through to home visits after baby is born. First Peoples families planning to birth at Dandenong Hospital or Casey Hospital are provided access to this clinic.[36]

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[33] Western Health, 'Options for pregnancy care', *Options for pregnancy care* (Web Page, 2023) <https://www.westernhealth.org.au/Services/Womens_and_Children/MaternityServices/Pages/Options-for-pregnancy-care.aspx#Galinjera>.

[34] Mercy Health, 'Overview', *Nangnak Baban Murrup Maternity Group Practice Clinic* (Web Page) <https://health-services.mercyhealth.com.au/service/nangnak-baban-murrup-clinic/>.

[35] The Royal Women's Hospital, 'Baggarrook midwifery care', *Baggarrook midwifery care The Royal Women's Hospital* (Web Page) <https://www.thewomens.org.au/patients-visitors/clinics-and-services/pregnancy-birth/pregnancy-care-options/baggarrook-midwifery-care/>.

[36] Monash Health Women's, Aboriginal and Torres Strait Islander families', *Aboriginal and Torres Strait Islander families - Monash Women's* (Web Page) <https://monashwomens.org/patients/pregnancy-care/support-services/aboriginal-and-torres-strait-islander-families/>.

Koori Maternity Services and improved pregnancy outcomes

224. Koori Maternity Services[37] provides flexible, holistic and culturally safe pregnancy care, birth support and postnatal care for First Peoples women, women having First Peoples babies and their families. This can include continuity of care models provided through the Koori Maternity Services workforce of midwives, Aboriginal Health Practitioners and Aboriginal Health Workers as suited to the needs of women and the local community.
225. Koori Maternity Services are delivered by ACCOs and public hospitals through 14 sites across Victoria, including in:
    a. ACCO Koori Maternity Services providers: Dandenong and District Aborigines Co-operative; Gippsland and East Gippsland Aboriginal Co-operative; Gunditjmara Aboriginal Co-operative Limited; Mallee District Aboriginal Services Limited; Mungabareena Aboriginal Corporation; Njernda Aboriginal Corporation; Ramahyuck District Aboriginal Corporation; Rumbalara Aboriginal Co-operative Limited; Victorian Aboriginal Health Service Co-operative Limited; Wathaurong Aboriginal Co-Operative Limited; and
    b. Public hospital Koori Maternity Services providers: Northern Health; Peninsula Health; and Western Health.

[37] Aboriginal maternity services (n 38).

226. In 2017-18, the Department introduced, for the first time, a measure of perinatal mortality (stillbirths and early neonatal deaths) into the budget paper three (BP3) as a key performance outcome (Admitted Services Output). The purpose of introducing this specific BP3 measure Perinatal mortality rate per 1000 of babies of Aboriginal mothers was to make visible the higher rates of perinatal loss among Aboriginal women compared to non-indigenous women and to drive improvement.
227. In the years since the introduction of this measure, the target has been progressively reduced, fewer deaths, such that in 2021-22 the target – 8.7 per 1,000 births – was set to be at the same rate as currently reported for non-Indigenous women. In essence, seeking to entirely close the gap between Aboriginal and non-Aboriginal women.
228. In 2022-23, the perinatal mortality rate per 1,000 of babies of Aboriginal mothers in Victoria was 11.3, significantly lower than the rate nationally for Aboriginal and Torres Strait Islander women: 17.3 in 2021 but still higher than the rate for non-Indigenous mothers in Victoria: 8.5.
229. As part of a national initiative, the National Preterm Birth Prevention Program, Safer Care Victoria and Koori Maternity Services have commenced a dedicated improvement collaborative to reduce the rate of preterm birth, a major cause of perinatal loss, among Aboriginal women.
230. Specifically, Safer Care Victoria is partnering with VACCHO through the National Preterm Birth Prevention Program to improve the experience and outcomes of Aboriginal families. To date this has involved:
    a. a partnership with Mungabareena Aboriginal Cooperation and Northeast Health Wangaratta to provide tailored antenatal and postnatal care for all Aboriginal families.
    b. supporting public health services participating in the National Preterm Birth Prevention Collaborative to partner with their local Koori Maternity Service to safely reduce early term and preterm births for Aboriginal families. For example, Northern Health's Koori Maternity Service midwife was an integral part of their project team.
    c. promotion of existing partnerships between Koori Maternity Services and mainstream maternity services to share culturally safe care across services through the Preterm Birth Prevention education program.

Topic 13 - Reflections on the COVID-19 public health response in Victoria, including in relation to the First Peoples-led community response and self-determination.

231. The Joint COVID-19 Aboriginal Community Taskforce (the **Taskforce**) was established in March 2020 to support a comprehensive, coordinated and culturally safe response to COVID-19 impacts on First Peoples in Victoria.
232. The Taskforce was a mechanism for coordination and collaboration across government departments so that responses were informed by the needs of First Peoples Victorians. It was also a way of identifying risks, issues and interdependencies that impact on the effectiveness of the COVID-19 response for First Peoples communities. At the height of the COVID-19 pandemic, the taskforce, along with the leadership of the Chief and Deputy Chief Aboriginal Health Advisers, enabled swift, responsive and culturally safe measures to be put in place. Clear governance, including inter-departmental coordination of COVID-19 response measures was important to avoid "double up" in responses, enable clear decision making and importantly, ensure that cultural safety remained a foundational principle throughout the pandemic.

233. The broader COVID-19 ‘one-size fits all’ approach was not well suited to Victorian First Peoples communities, as it created barriers for people to access information and support services. In response, in 2020 the Department partnered with VACCHO and the broader First Peoples community-controlled sector to develop culturally appropriate COVID-19 communications and engagement strategies which were informed by and reflected the needs of First Peoples communities in Victoria. These included use of social media platforms with high profile community members to share tailored messages with a strong focus on self-determination, campaign collateral, the establishment of the Victorian Aboriginal COVID-19 Infoline, and community and media events.
234. I recognise that ACCOs and ACCHOs were proactive in supporting community through the pandemic and the Department needed to remove barriers to support this. This included strong community engagement and leadership, provision of culturally safe care, communication strategies and efficient outreach. A place-based engagement approach to distribute vaccination, rapid antigen tests, masks and engagement material were found to be the most effective strategy for increasing vaccination and spreading public health awareness. For example:
    a. COVID-19 vaccinations were available from local First Peoples community organisations, pop up clinics and door to door visits rather than mass vaccination hubs.
    b. The influence of community leaders was leveraged and information on vaccinations and preventative measures was shared through ‘yarning’ circles with community members.
    c. Aboriginal Health Practitioners and Workers were upskilled so that they could administer vaccines, supporting self-determination within the community.
235. The success of this approach was evident by Victoria having achieved higher vaccination rates for First Peoples than all other states, with 86 per cent of the population receiving two doses by 6 January 2022.
236. The ACCHO sector did critical and pro-active work during the height of the COVID-19 pandemic, which had a significant impact on the outcomes of the pandemic response for First Peoples in Victoria. ACCHOs provided culturally safe and timely health services for First Peoples communities’ holistic health, social and emotional wellbeing needs during the response. A wide range of activities was undertaken by ACCOs, including response management, care coordination, clinical service delivery, patient liaison and education, in-reach care services including 'hospital in the home', culturally safe brokerage and sub-contracting services, staff furloughing and backfilling, and a range of other activities. The sector also coordinated emergency relief, complex care coordination for families, and communications for community on testing and vaccination.
237. This experience and these health outcomes show us the genuine benefits of respectful partnerships between Government, ACCHOs and the community health sector. Those relationships, premised on respect and empowerment, improved the health of First Peoples in Victoria during the pandemic. Good governance and decision-making processes, with clear coordination, and cultural safety as foundational to each of these steps, resulted in genuine outcomes. Cultural safety meant place-based treatment, community leadership and culturally secure care.
238. In late 2021, ACCOs were invited to submit applications to the $12m COVID-19 Response and Recovery Fund. This one-off funding was for ACCOs to provide both urgent healthcare and general care pathways for First Peoples communities impacted by the COVID-19 pandemic. The submissions process was designed to offer ACCOs the flexibility to determine how to allocate the

funding based on the immediate challenges and needs of their local communities. ACCOs could submit more than one application, based on the extent to which support was needed in their local communities. Each application was capped at $300,000 so as many ACCOs as possible could have access to the funds. ACCOs were invited to submit as many applications as was necessary to support Community's evolving needs during response and recovery, with 17 ACCOs receiving funding.

239. The COVID-19 Fund and Aboriginal Health Workforce Fund both commenced in 2021-22 and ceased in June 2023. Last year's State Budget included $35 million in new funding for the Urgent Care Pathways initiative, which is designed to fund additional prevention and early intervention services in ACCOs and reduce potentially preventable hospitalisations. This year's State Budget includes new funding for the Culture and Kinship Program, which will fund ACCOs to improve the physical and mental health and wellbeing of First Peoples in Victoria between 12-24 years of age. The program will re-establish the participant's pride in First Peoples culture, foster good mental health and wellbeing and steer participants away from drug and alcohol misuse.
240. I acknowledge that short-term funding creates financial sustainability risks for ACCOs and limits their ability to improve First Peoples health and wellbeing outcomes in the longer-term. This is why the Department is transitioning all ACCOs to longer-term, self-determined outcomes-focused funding (the OBF Project). The first phase of the OBF Project was completed in July 2023, where the department transitioned ACCOs from single year funding agreements to four-year agreements where there is a recurrent funding source. Funding of ACCOs remains a recurrent challenge, and I commit to continuing to work to address this.

Topic 14 - Aged care and palliative care for First Peoples in Victoria, including:

- ***An explanation of why there are no dedicate (sic) First Peoples palliative care beds in Victoria – noting that the Commonwealth-funded facilities with designated places for First Peoples are not funded to provide palliative care services***

Palliative care for First Peoples

241. The Department funds hospital admissions ("admitted services") for all Victorians including palliative care admissions for First Peoples.
242. Admitted palliative care services are provided by public hospitals as part of their broader suite of clinical streams and programs in response to their community needs. The health services delivered by public hospitals are distinctly different from the aged care services delivered through Commonwealth-funded facilities with designated places for First Peoples.
243. More work is needed in this area, and we must consider greater flexibility across services.
244. Public hospitals with palliative care services are not designed in a way that is dedicated to specific population cohorts. The reason is that the clinical care required to be delivered must both be personalised and be able to accommodate all Victorians irrespective of their gender, cultural, religious, or socioeconomic factors. To ensure equity of access, palliative care beds are open to all Victorians to avoid any unintended consequences that may arise by limiting access to specific groups.
245. In early 2016, First Peoples contributed to consultations informing Victoria's End of life and Palliative Care policy framework. The policy framework aims to enable health services to support all Victorians

and their families to receive the best possible end of life care that places them at the centre where their preferences, values, dignity and comfort are respected and reflected in their care. [38]

246. The Department's End of Life and Palliative Care policy framework was informed by these findings and consultation with First Peoples. It aims to enable health services to support all Victorians and their families to receive the best possible end-of-life care that places them at the centre where their preferences, values, dignity and comfort are respected and reflected in their care.

Topic 15 - Funding and expenditure on First Peoples' health, including:

- ***An explanation of what the amount of expenditure on First Peoples health is as a proportion of total Victorian health expenditure, noting that this amount was $139,380,079 in 2021-2022***
- ***Aboriginal cultural safety grants, including:***
    - ***How the $29 million was allocated (the total number of hospitals that received monies, amounts received);***
    - ***Hospitals did not receive the grant and, if so, an explanation of how cultural safety is financially supported at those hospitals;***
    - ***What proportion of the $29 million is spent on Aboriginal Health Liaison Officer Wages; and***
    - ***What proportion of the $29 million is available for programs and activities to strengthen cultural safety in the hospital.***

Proportional expenditure on First Peoples health

247. In the 2021-22 financial year the published total Victorian Government health expenditure was $18,994,981,433.[39] In this period, the proportion of the amount of expenditure as a proportion of total Victorian health expenditure on First Peoples health was 0.73% ($138,663,364.46).

Aboriginal cultural safety grants allocation

248. The table below sets out how the $29 million was allocated by hospital.

Health Service Name	Agency Name	2021-22 Grant ($)
119 - East Grampians Health Service	714 - East Grampians Health Service	150,000
120 - Echuca Regional Health	715 - Echuca Regional Health	446,000

[38] Victorian Aboriginal Community Controlled Health Organisation and Department of Health and Human Services, 'Victoria's end of life and palliative care framework', *Victoria's end of life and palliative care framework* (Infographic, 28 August 2023) <https://content.dhhs.vic.gov.au/sites/default/files/2021-04/Pall-Care-Aboriginal-VACCHO-final.pdf>.

[39] Australian Institute of Health and Welfare, 'Data tables: Health expenditure Australia 2021-22', *Health expenditure Australia 2021-22'* (Excel Spreadsheet, 25 October 2023) Table 17c <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2021-22/data>.

Health Service Name	Agency Name	2021-22 Grant ($)
139 - Gippsland Southern Health Service	734 - Gippsland Southern Health Service	150,000
17 - Austin Health	610 - Austin Health	1,051,000
1823 - Mildura Base Public Hospital	1824 - Mildura Base Public Hospital	1,320,515
186 - Latrobe Regional Hospital	781 - Latrobe Regional	730,000
209 - Maryborough District Health Service	807 - Maryborough District Health Service	150,000
238 - Castlemaine Health	838 - Castlemaine Health (Mt. Alexander)	150,000
266 - Peninsula Health	866 - Peninsula Health (Mornington)	770,000
269 - Peter MacCallum Cancer Institute	870 - Peter MacCallum Cancer Institute	245,000
27 - Bairnsdale Regional Health Service	621 - Bairnsdale Regional Health Service	540,000
273 - Portland District Health	874 - Portland District Health	150,000
281 - Ramsay Health Care Australia Pty Ltd	882 - Ramsay Health Care (Mildura)	19,515
286 - The Royal Childrens Hospital	887 - The Royal Children's Hospital	2,687,000
289 - Royal Victorian Eye & Ear Hospital	892 - Royal Victorian Eye & Ear Hospital	150,000
290 - The Royal Womens Hospital	893 - The Royal Womens Hospital	712,000
310 - Monash Health	917 - Monash M.C.	2,389,000
32 - Grampians Health	626 - Grampians Health	982,000
	933 - Stawell	150,000
	980 - Wimmera Health Care Group	165,000
325 - St Vincents Hospital Melbourne Limited	945 - St Vincents Hospital Melbourne Limited	1,437,000

Health Service Name	Agency Name	2021-22 Grant ($)
330 - Swan Hill District Health	951 - Swan Hill District Health	315,000
349 - Northeast Health Wangaratta	970 - Northeast Health Wangaratta	299,000
355 - West Gippsland Healthcare Group	976 - West Gippsland Healthcare Group	152,000
370 - Benalla Health	991 - Benalla Health	150,000
371 - Bendigo Health	992 - Bendigo Health	1,428,000
382 - Kyabram District Health Services	1003 - Kyabram District Health Services	150,000
417 - Bass Coast Health	1038 - Bass Coast Health (Wonthaggi)	150,000
458 - Albury Wodonga Health	1083 - Albury Wodonga Health	462,000
464 - Barwon Health	1092 - Barwon Health (Geelong)	1,282,000
475 - Western District Health Service	1105 - Western District Health Service - Hamilton	150,000
477 - Mercy Hospitals Victoria Limited	1107 - Mercy Hospitals Victoria Limited	1,009,000
481 - Goulburn Valley Health	1113 - Goulburn Valley Health	1,463,000
488 - South West Healthcare	1121 - South West Healthcare (Warrnambool)	451,000
489 - Central Gippsland Health Service	1122 - Central Gippsland Health Service	265,000
505 - Western Health	1080 - Djerriwarrh Health Services (Bacchus Marsh or Melton)	150,000
	1139 - Footscray Health (Western Health)	1,419,000
506 - Northern Health	1145 - Northern Health	1,243,000
507 - Eastern Health	1147 - Box Hill Hospital (Eastern)	824,000
508 - Alfred Health	1153 - Alfred Health	1,449,000

Health Service Name	Agency Name	2021-22 Grant ($)
509 - Melbourne Health	1158 - The Royal Melbourne Hospital - City Campus	1,403,000
93 - Colac Area Health	688 - Colac Area Health	150,000
Grand Total		**28,869,000**

Cultural safety implementation by non-ACSFG recipients

249. The Department does not collect information on how cultural safety is paid for by hospitals not receiving an ACSFG. Hospitals who receive an ACSFG also receive a 4% loading provided for clinical care for First Peoples patients as part of the national funding model set out in the National Health Reform Agreement. Victoria uses this national model to purchase health services from activity-based funded health services in Victoria. The loading was established after a national review undertaken by the Independent Hospital Pricing Authority which found the cost of clinical inpatient care to be 4 % more for First Peoples patients than non- First Peoples patients.
250. The 4% rate is set by the Independent Health and Aged Care Pricing Authority (**IHACPA**) which is responsible for managing the national funding model.[40] I am informed by IHACPA that this rate will be reduced to 3% in 2024-25, which will be offset by adjustments towards dialysis, radiotherapy and targeted to First Peoples living in remote communities. First Peoples in Victoria will not receive the benefits of these adjustments as the State does not have remote areas under Commonwealth criteria, and Victoria is more concerned with rates of iron deficiency and diseases of the circulatory system, which are not captured under the dialysis and radiotherapy adjustments.

Proportion of cultural safety grants spend on AHLO wages and programs

251. The proportion of the total sum spent on Aboriginal Health Liaison Officer wages, and on programs and activities, is currently not known. This information is not sought by the Department from hospitals. The Department is currently working to improve accountability through reporting under the ACSFGs, including by requiring standardising reports on factors including this one. Collecting this data will assist the Department to monitor how much health services are spending on AHLO wages and programs as a portion of their fixed grant.

Topic 17 - Comparative funding between mainstream and ACCOs, including an explanation of:

- ***The disparity between funding for ACCOs (commonly fixed-term 1-year funding), in comparison to funding for community health services and mainstream hospitals (commonly on an ongoing basis).***
- ***Why ACCOs received a comparatively low proportion of spending in 2022-2023 (0.4%), notwithstanding the broad range of services they provide.***

[40] National Efficient Price Determination 2024–25 | Resources | IHACPA

- ***Whether the Department of Health anticipates there will be an increase or a decrease of the proportion of spending allocated to ACCOs in 2023-2024, as compared to 2022-2023.***
- ***An explanation of the disparity between funding for ACCOs and community health services.***
- ***For mainstream providers receiving funding to deliver services to First Peoples***
    - ***Whether cultural safety training is required as part of the service agreements; and***
    - ***How services report that they are delivering services to First Peoples, and related health outcomes.***

The disparity between funding for ACCOs and mainstream hospitals

252. The disparity in funding between mainstream hospitals and ACCOs arises in part because, while the States are responsible for funding hospitals, the Commonwealth Government is largely responsible for funding primary care through the Medicare Billing Scheme.
253. I accept that the services provided by ACCOs are needed by First Peoples on an ongoing basis, despite the fact that a higher proportion of ACCO state-funded services have typically been funded for specified projects or budget initiatives, rather than for permanent service provision. Regrettably, ACCOs' funding has largely been framed around specific projects and outputs. This is not compatible with First Peoples models of care, which prioritise holistic care and systems that allow a focus on the social and cultural determinants of health rather than simply addressing a specific project or problem presented.
254. I also accept that admitted services do cost more, and that this in part causes the funding disparity. However, if greater funding was giving to ACCOs, particularly for prevention and early intervention services, we would likely see savings across other parts of the health system.
255. Additionally, I know that this short-term funding model causes operational difficulties for many ACCOs – the response to question 7 above outlines the shift to Outcomes Based and longer-term Funding arrangements.

Why ACCOs received a comparatively low proportion of spending in 2022-2023 (0.4%), notwithstanding the broad range of services they provide

256. ACCOs provide a broad range of health services and to support this service provision, ACCOs receive funding from both State and Commonwealth sources.
257. There is a significant disparity both in State funding for ACCOs and mainstream hospitals, as well as a disparity in Commonwealth funding for the two categories of Health.
258. The information provided by the Department does not include Commonwealth funding, which goes some way to explaining the disparity. Commonwealth funding is a significant source of funding for ACCOs, which are part-funded by Commonwealth sources because primary health funding is a Commonwealth funding responsibility, and many ACCOs primarily provide primary health services.
    a. In 2023, the Victorian Government completed its Expenditure Review under the National Agreement on Closing the Gap. This showed not only that overall expenditure on programs or services specifically designed to support First Peoples (targeted expenditure) grew from $423m in 2019-20 to $747m in 2022-23, but ACCOs were delivering 55% of targeted expenditure in 2022-23.

b. The Department had the second largest total targeted expenditure of the Victorian Government in 2022-23 ($141m).
c. Even so, it is recognised the ACCOs do not receive equitable funding considering the range of services they provide to First Peoples community, who experience significantly poorer health and wellbeing outcomes compared to non- First Peoples Victorians. This is why the AHW Action Plan includes a specific action to establish a policy that all funding for prevention and early intervention programs related to First Peoples health and wellbeing in Victoria is first offered to ACCOs.

259. The following tables set out the ACCO and mainstream health services funding for 2022-23 and 2023-24 and the percentage of the Department's total budget for ACCO and mainstream health services funding for the same periods.

Table 1: ACCO and mainstream health services funding for 2022-23

2022-23	ACCO	Community Health Service	Mainstream Hospital	Total
Fixed term 1 year	$ 56,575,272.09	$ 336,840,006.15	$ 884,712,292.17	$ 1,278,127,570.41
Multi Year	$ 3,808,494.00	$ 122,021,920.19	$ 384,993,649.24	$ 510,824,063.43
Ongoing	$ 31,684,151.78	$ 802,469,029.66	$ 19,807,693,437.62	$ 20,641,846,619.06
Total	$ 92,067,917.87	$1,261,330,956.00	$ 21,077,399,379.03	$ 22,430,798,252.90

Table 2: Percentage of Department's total budget for ACCO and mainstream health service funding for 2022-23

2022-23	ACCO	Community Health Service	Mainstream Hospital	Total
Fixed term 1 year	4.4%	26.4%	69.2%	100.0%
Multi Year	0.7%	23.9%	75.4%	100.0%
Ongoing	0.2%	3.9%	96.0%	100.0%
Total	0.4%	5.6%	94.0%	100.0%

Whether the Department of Health anticipates there will be an increase or a decrease of the proportion of spending allocated to ACCOs in 2023-2024, as compared to 2022-2023.

260. It is anticipated that there will be a reduction in funding from the Department to ACCOs in 2023-24 compared to 2022-23. The reduction is in part because during the 2022-2023 financial year, a final payment from the Aboriginal Health Workforce Fund of $16.8m was made to ACCOs. This payment was part of an initiative approved in the 2020-21 Budget, in response to the COVID-19 pandemic to support ACCHOs and their workforce respond to and recover from COVID-19. The broader health system is returning to pre-COVID funding levels.
261. There have been additional State budget outcomes approved, including the $35 million Urgent Care Pathways initiative over four years (commencing in 2023-24), although it is noted that overall ACCO and ACCHOs funding has returned to pre-pandemic levels. The 2024-25 State Budget recently announced includes some additional funding for ACCOs. The additional funding is a Culture and Kinship program and additional funding to VACCHO for cultural safety accreditation.
262. I acknowledge that more needs to be done to improve funding sustainability for the ACCO and ACCHO sector so they can be supported to play their integral role in Victoria's health system. This includes efforts to increase funding certainty and self-determined flexibility through the OBF project**,** and transitioning services and associated funding from mainstream to First Peoples community-control where possible. In particular, ACCOs should receive greater funding for prevention. This will improve First People's health and wellbeing and also reduce costs on the rest of the health system.

An explanation of the disparity between funding for ACCOs and community health services.

263. Funding should be allocated by Government having regard to need and priority. ACCOs and ACCHOs employ First Peoples communities' holistic approaches to health and wellbeing, which includes prevention-focused, wrap around services that are embedded within First Peoples Culture. The community-controlled sector provides a wide range of services to community[41], as noted in VACCHO's member's services profile.
264. Greater effort needs to be spent on ensuring increased funding equity for First Peoples, given the gap in health and wellbeing outcomes. Some work has already been undertaken by the Department on this front to make improvements, but more needs to be done. The steps taken to date have included:
    a. working in partnership with VACCHO and the AHW Forum on State Budget submission priorities to increase investment in First Peoples health and wellbeing;
    b. prioritising funding for services for First Peoples community to ACCOs, and where possible transitioning services and associated funding from mainstream to ACCOs; and
    c. improving funding sustainability for existing recurrent funding and self-determined flexibility to outcomes through the OBF Project.

[41] Victorian Aboriginal Community Controlled Health Organisation, 'VACCHO Member Service Profile', *Members - VACCHO* (Infographic, March 2024) <https://cdn.intelligencebank.com/au/share/NJA21J/a7eD7/XoWlA/original/VACCHO+Member+Service+Profile+V3>.

For mainstream providers receiving funding to deliver services to First Peoples, whether cultural safety training is required as part of the service agreements and how services report that they are delivering services to First Peoples, and related health outcomes?

265. Since 2021-22, the Policy and Funding Guidelines have required health services to demonstrate delivery of best-practice Aboriginal cultural safety training to all health service employees. However, there is very little enforcement of this requirement. The Government recognises that this needs to change. Government needs to ensure that the people providing healthcare to First Peoples communities understand Victoria's colonial history and the ongoing effects this has and one way to do this is to disseminate information through training.
266. I am mindful of the pressing need for all health service staff to undertake training. This is why I intend for the 2024-25 Statements of Priorities to include a mandatory priority for all health services to expand the delivery of high-quality cultural safety training across their staff. I also expect the department in 2024-25 to work through how training can become universal, independent, and of high quality. This includes developing minimum quality standards and expectations of training, and considering who will provide it to avoid increasing burden on existing Aboriginal staff in health services, and to ensure that training is provided by independent experts who are able to safely challenge organisational practices and thinking in mainstream services.
267. Currently, under the ACSFGs, health services in receipt of a grant are required to report on cultural safety training. However, Government needs to improve accountability for the Fixed Grants, including minimum requirements for reporting and clarity on consequences for failing to provide adequate information.

Topic 18 - Services to support First Peoples' health and wellbeing from the perspective of:

- ***The harm and trauma of colonisation (historic and ongoing);***
- ***International human rights frameworks; and***
- ***The principles of self determination***

Harm and trauma of colonisation

268. The brutal history of colonisation in Victoria presents significant ongoing challenges. The State has been complicit in a system that has benefited colonisers and their descendants and that continues to lead to intergenerational trauma, poor health outcomes for First Peoples, reduced life expectancies, and significant negative impacts on First Peoples' social and emotional wellbeing.
269. First Peoples' communities continue to live with the effects of intergenerational trauma connected to colonisation, including the policies that gave rise to the Stolen Generations.
270. Everyday experiences of racism have pervasive negative effects on First Peoples' social and emotional wellbeing and overall health. Additionally, inadequate healthcare – including mental health, alcohol and other drugs, and trauma care – are causally linked to the historical and contemporary over-representation of First Peoples in the criminal justice system.
271. The State must address the underlying health and wellbeing factors that have historically limited First Peoples from participating in programs, education, training and social engagement that help to reduce this over-representation. It must do so in a manner that is culturally safe and meets the

specific physical, social, emotional, spiritual and cultural wellbeing needs of First Peoples. It is unacceptable that in 2020, 16.3 % of First Peoples Victorians surveyed experienced racism in health settings.[42]

272. ACCOs deliver services that strengthen social and emotional wellbeing and connect First Peoples to culture, they are well placed to continue to address the ongoing harm and trauma of colonisation.
273. As Minister, I expect all First Peoples families to be able to present to an emergency department, anywhere in the State, with a sick or injured child and feel supported. They must not be afraid that the consequence of a hospital admission will be that their child is taken from them. First Peoples must be able to attend at a health service and receive appropriate, respectful and culturally safe care.
274. Additionally, First Peoples staff employed by the Department, and by mainstream health services, need to feel they are valued and respected. I acknowledge that this has not been, and is not always, the case. I am committed to change.
275. Despite injustices and intergenerational trauma, there is incredible leadership, strength and resilience in First Peoples communities in Victoria.

Principles of self determination

276. Self-determination and the rights of First Peoples to enjoy their culture underpin the Department's efforts to work with First Peoples community to improve social and emotional wellbeing outcomes.
277. The Department continues to initiate and implement systemic reforms to support better health and wellbeing outcomes for First Peoples in Victoria. These reforms seek to enable greater self-determination through stronger and more collaborative partnerships with health services, hospitals, and ACCHOs. These reforms and initiatives are detailed throughout my statement and specifically include how they are monitored and evaluated.
278. The Department actively engages with self-determination through partnerships with the ACCHO sector and the AHW Partnership Agreement, Forums and Action Plan..
279. I acknowledge that transformational reform is needed in the health system to heal the relationship between the State and First Peoples. I want to move towards a more holistic model of health that directly responds to and represents the specific social and emotional wellbeing needs of First Peoples. It is important that self-determination is embedded within the health system and that reform is led by First Peoples.
280. I affirm my commitment to working closely with First Peoples communities on the road to Treaty. I continue to recognise and appreciate the importance of First Peoples' self-determination and will continue to seek First Peoples' participation in the transformation of systems, policies, and programs that impact on their own lives, their families, and communities.

International human rights frameworks

281. The United Nations Declaration into the Rights of Indigenous Peoples (UNDRIP) provides a framework for minimum standards for the standards of the survival and dignity of Indigenous people.

[42] Aboriginal Affairs Report 2022 (n 8).

I recognise that central to UNDRIP is the principle of self-determination. It is this principle which guides the Victorian Government in its approach to the affairs of First Peoples.

Topic 19 - Reflections on key opportunities and challenges within the health system for and in respect of Victorian First Peoples including as arising from responses to the above questions.

282. Victoria's colonial past and present includes wrongs committed against First Peoples in our health services. This has had a devasting and long-lasting effect. The effect is ongoing. I acknowledge that racism and a lack of cultural safety continues today.

283. I recognise that Victoria's health system needs to work better as a whole to improve First Peoples health and wellbeing outcomes. This includes ensuring that there are adequate is increased accountability on both the Victorian Government and mainstream health services to implement commitments in the National Agreement on Closing the Gap and Victoria's Aboriginal Health and Wellbeing Partnership Agreement. Otherwise, commitments can be empty promises.

284. It is important that as Minister I exercise the powers available to me to make clearer what hospitals and health services must do to better improve equitable service delivery for First Peoples, and the consequences for failing these requirements. I am considering using standards and accreditation to achieve these outcomes as I consider this would be most in line with community-defined priorities and actions set out in the Aboriginal Health and Wellbeing Partnership Agreement and Action Plan. Areas of focus need to be:
    a. identifying First Peoples patients so we can better understand and track services delivered and outcomes achieved;
    b. improving data collection and analysis, and adhering to Indigenous Data Sovereignty, including so the Victorian Government is accountable for improving life expectancy and rates of passing by suicide, and for the broader determinants of health.
    c. increasing and supporting the development of the First Peoples health workforce, including in executive and leadership positions.
    d. providing culturally safe healthcare and eliminating racism so First Peoples feel safe enough to receive care in health services within Victoria.
    e. mandatory cultural safety training for all health services staff.
    f. working in partnership with ACCOs, including for discharge planning to improve outcomes and reduce readmission rates; and
    g. monitoring how investment is being used to practically improve outcomes for First Peoples.

285. I am committed to making all parties to AHW Partnership Agreement more accountable to the AHW Forum. ACCOs are already accountable to the AHW Forum and actively participate in it. We will focus on increasing government and mainstream sector representation, accountability, engagement, and responsiveness.

286. I believe there are also opportunities for government and health services to improve their partnerships with the First Peoples community-controlled health sector. For example, formal memoranda of understanding for patient referrals and discharge planning could be established. There is much for hospitals and health services to learn from ACCOs and ACCHOs on how to better

address the social and cultural determinants of health of First Peoples. This is critical to ensuring that First Peoples can receive adequate care in health services.

287. There are also opportunities to learn from First Peoples' holistic, person-centred view of health, I acknowledge that more must be done to emphasis the critical role ACCOs play in Victoria's health system. The Department is working to improve funding relationships with ACCOs so they are based on open communication, trust and partnership through the OBF Project. The aim is to transition all ACCOs to more sustainable, self-determined outcomes-focused funding. However, I acknowledge that this is only where the Department has an existing funding source, and that more needs to be done to provide ACCOs with equitable funding. Through the OBF Project, the Department will transition power and control to ACCOs so they can have increased self-determination in how they use the funding the Department provides to serve their communities. I acknowledge that providing ACCOs with true self-determination over funding has a long way to go.
288. I also recognise that the government does not have clear oversight of how Victoria is tracking to improve First Peoples health and wellbeing outcomes in the longer-term. I recommend the establishment of a clear outcomes framework that aligns to funding for First Peoples health and wellbeing in mainstream providers and ACCOs that includes measures for Victoria for life expectancy ad passing by suicide. Government, health services and ACCOs would report into this outcomes framework, which would be monitored by the AHW Forum.

Part F - Concluding remarks

289. The Victorian Government shares the First Peoples community's vision of First Peoples accessing a health system that is holistic, culturally safe, and empowering. The health system has not and continues to fail to truly serve First Peoples in Victoria. We have failed individuals, we have failed families, and we have failed communities.
290. ACCOs are heavily reliant on government funding, but what is needed is government handing over power and control. The Department must create space for community, family and individual self-determination when it comes decisions about the healthcare First Peoples receive. Self-determination requires a shift of power. For example, outcomes-focused funding requires the Department to engage with the community, ask what they need, ask what works for community, and then accept accountability for delivery of health services within that context.
291. Self-determination presents the Department with an opportunity, and a way in which to start addressing these significant challenges. It requires a shift of power throughout the operations of the State and will require community organisations and hospitals and mainstream health services to work in genuine partnerships and prioritise First Peoples voices.
292. I look forward to the findings and recommendations of the Commission. I remain committed to working with the Commission and First Peoples communities and organisations, as we continue to work towards a more holistic model of health that directly responds to and represents the specific social and emotional wellbeing needs of First Peoples.

Sign here :… [redacted]

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Date : 14/06/2024

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Date : 14/6/24