ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SUBMISSION

Implementation Plan Advisory Group (IPAG) Consultation 2017

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SUBMISSION

The Royal Australasian College of Surgeons (RACS) is a non-profit organisation training surgeons and maintaining surgical standards in Australia and New Zealand. The College's purpose is to be the unifying force for surgery in Australia and New Zealand, with FRACS standing for excellence in surgical care. **The Royal Australasian College of Surgeons acknowledges Aboriginal and Torres Strait Islander peoples as the first inhabitants, traditional owners and custodians of Australia together with their continuing spiritual connection to land and sea.**

In addition to our co-authored submission with the Australian Society of Otolaryngology Head and Neck Surgery (ASOHNS), RACS also provides the following submission to the Implementation Plan Advisory Group's (IPAG) consultation on the *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.*

RACS recognises that improving the health of Aboriginal and Torres Strait Islander peoples is a public health priority. The Australian Government's *National Aboriginal and Torres Strait Islander Health Plan* 2013-2023 (the 'Plan') and its associated Implementation Plan provide a crucial strategy that underpins much of the government and non-government work aimed at addressing the social and cultural determinants of health. In particular the Plan places a strong and healthy cultural identity at the centre of priorities for action.

RACS affirms the overarching vision and goal of the Plan to ensure 'The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable', and to undertake 'Targeted, evidence-based action that will contribute to achieving equality of health status and life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by 2031.

RACS is committed to:

- Demonstrating leadership, excellence and advocacy in relation to Aboriginal and Torres Strait Islander health.
- Increasing the number of Aboriginal and Torres Strait Islander specialists to improve equity and support closing the gap in health outcomes.
- Educating the Fellowship and wider community to recognise Aboriginal and Torres Strait Islander health issues and promote culturally safe practice.

RECOMMENDATIONS

1. Better embed trauma and cancer in the Closing the Gap targets and the priorities and actions of the Plan and Implementation Plan.
2. Ensure Aboriginal Liaison Officers are adequately resourced to participate in cancer teams and prevention programs.
3. Invest in research to better understand Indigenous road injury so that evidence-based programs can be developed/supported.
4. Consider the recommendations included in the RACS Alcohol Related Harm and Domestic Violence position papers.
5. Ensure regional hospitals have good facilities, stable well-trained staff, good connections to the city and culturally competent clinical and support staff.

SUBMISSION

WHAT ARE THE GAPS IN THE CURRENT IMPLEMENTATION PLAN?

Trauma

The absence of direct reference to trauma (specifically physical injury), in the Implementation Plan is of concern to RACS, which has a highly dedicated bi-national committee of trauma experts. RACS recognises that injury is a National Health Priority Area and is:

- the leading cause of death for people under the age of 45;
- a major cause of disability and lost productivity;
- second only to cardiovascular disease for hospital-related expenditure; and
- an $18 billion cost to the Australian economy every year.[1]

The RACS Trauma Committee advocacy goals are to:

1. Promote trauma as a significant public health issue
2. Improve trauma care and resourcing
3. Improve road safety
4. Reduce alcohol-related harm
5. Prevent falls in the elderly
6. Reduce death and disability from quad bike accidents
7. Support firearm safety standards

Transport-related injury is a leading cause of death and serious disability among both Aboriginal and Torres Strait Islander and non-Indigenous Australians. Aboriginal and Torres Strait Islander infants, children and adults are all much more likely to have a fatal transport-related injury than their non-Indigenous Australian peers.

Indigenous people are two to three times as likely to have a transport-related fatal injury and 30% more likely to have a transport-related serious injury than non-Indigenous Australians. Seventy-five per cent of these injuries are in regional and remote areas; although even in urban locations Indigenous people have 2.3 times higher transport-related fatal injury. Indigenous people are 10 times as likely to die as a pedestrian compared to non-Indigenous Australians (35% vs. 13% of all transport-related fatalities, respectively).[2] The impacts of road injury are significant, including emotional stress and psychological impact on individuals, families and close-knit communities; reduced quality of life for carers; and the financial burden of the lost ability to work.

Indigenous people have generally not experienced the reduction in road fatalities in the non-Indigenous Australian population caused by effective road safety interventions. Our understanding of why this is the case is limited by suboptimal data collection, especially in remote areas, and insufficient evaluation of new interventions. Research is urgently needed to better understand Indigenous road injury, to work out why mainstream interventions have not been successful, and to tailor and evaluate new programs.

RACS supports the measures outlined in the Australian National Road Safety Strategy 2011-20. Some states and territories have had better compliance with this strategy than others, and the Australian Automobile Association's quarterly benchmarking reports provide good insight into progress.

RACS also supports:

- the use of point to point speed enforcement where available;
- technological advancements;
- safe speeds;
- the separation of bicycles from other road users;
- real-time data on serious pedestrian injuries;
- education about road user distraction (mobile phone usage) and fatigue;
- mandatory helmet legislation;
- national consistency on assessment and enforcement of fitness to drive; and
- mandatory first aid training for all learner drivers.

Cancer

Cancer death rates for Indigenous Australians increased by 11% between 2006 and 2012, while rates for non-Indigenous Australians declined by 5%.[3] Strategy 5A within the Implementation Plan, '*Aboriginal and Torres Strait Islander adults have access to primary prevention services for screening, early detection and treatment of major diseases*' is therefore critically important.

RACS commends the recent publication of the National Aboriginal and Torres Strait Islander Cancer Framework. The framework thoroughly addresses key issues such as awareness, accessibility to health services, remoteness, cultural sensitivities and environmental issues (exposure to smoking, low HPV vaccination rates); all critical factors in the increased burden of cancer related disease in Aboriginal and Torres Strait Islander communities. These preventative measures are critically important to achieving Strategy 1C: '*Whole-of-life cycle health interventions are accessible and have a strong focus on prevention and early intervention to prevent mental health conditions and illness, chronic health conditions and injuries from occurring, including disability.'*

Through improving the accessibility of health services, particularly screening and specialist services for remote and rural indigenous people, and the cultural safety of major hospital services and staff we can ensure that Aboriginal and Torres Strait people with cancer symptoms present earlier for treatment and that they are supported to obtain ongoing treatment. An increased focus in the implementation plan on cancer services will benefit patients suffering from a wide variety of cancers and improve their prospects for recovery.

RACS is particularly concerned about the rates of head and neck cancer within Aboriginal and Torres Strait Islander communities, where it ranks as the second most common cancer in Aboriginal and Torres Strait Islander populations after lung cancer - further implicating higher rates of cigarette smoking as the key causal factor. Head and neck cancers are treatable, especially if detected early, and together with increased HPV vaccination rates and reduced rates of smoking, effective treatment can contribute to closing the gap in outcomes.

SUBMISSION

WHICH ISSUES NEED MORE OR DIFFERENT DATA INDICATORS TO MEASURE SUCCESS OR IMPROVEMENT?

In relation to both trauma related harm and cancer RACS highlights the importance in achieving Strategy 7A of the plan, 'Enhance data systems to inform better outcomes'. The current lack of reliable national data on the diagnosis, prevalence and risk factors for Aboriginal and Torres Strait Islander Australians is of concern to RACS and its Fellows. While all state and territory cancer registries collect information on Indigenous status, in some jurisdictions the quality of Indigenous status data is insufficient for analyses. For example, the latest information on how many cases of head and neck cancer in the indigenous population are diagnosed, as well as geographical analysis, treatment and survival rates would allow a better understanding of the size of the issue.

Quantification of road injury in the Indigenous population has previously been difficult because of poor reporting of crashes and the complexity of ensuring the identification of Indigenous people in the data collection.[4] The inadequate identification of Aboriginal and Torres Strait Islander (ATSI) status in the deaths registration systems and in hospital inpatient data collection means that the published data severely underestimates the burden of injury in ATSI people.[5]

The benefits to improving data collection are seen in RACS own audit of surgical mortality reports where the Northern Territory Audit of Surgical Mortality recorded no differences in clinical management issues between Aboriginal and Torres Strait Islander persons and non-Aboriginal and Torres Strait Islander persons. However, the report highlighted that Aboriginal and Torres Strait Islander persons presented for surgery with a significantly increased severity of disease prior to undergoing surgery and that they were younger in age compared with non-Indigenous people who presented with similar underlying conditions.[6]

HOW CAN THE IMPLEMENTATION PLAN BE DESIGNED TO HIGHLIGHT THE INVOLVEMENT AND LEADERSHIP OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE?

Workforce

RACS is committed to increasing the number of Aboriginal and Torres Strait Islander people involved in healthcare delivery. The ongoing dissemination of the National Aboriginal and Torres Strait Islander Cancer Framework, accessible information and training of Aboriginal Liaison Officers (ALO), who are part of the multidisciplinary cancer team in hospitals is important and the promotion of effective programs in place for smoking cessation, and HPV vaccination is taking place through school programs. RACS also affirms that consideration of increases to funding and training for ALOs should be prioritised. Many ALOs operate across a range of areas and services at hospitals, strategically there would be merit, in some locations, to attaching ALOs to specific surgical services and teams. This could be addressed within Strategy 1E '*Support, grow and increase the capability of the workforce…to meet current and future Aboriginal and Torres Strait Islander health needs*.'

WHICH OF THE CURRENT 2013 PLANNED DELIVERABLES NEED TO BE REVISITED TO REFLECT CHANGED PRIORITIES, REVISED TARGETS OR NEW EVIDENCE?

The current Implementation Plan links to more than 60 other strategies, frameworks and programmes, which may make it difficult for the government to monitor progress and prioritise activities. In this submission RACS

has sought to draw attention to two key areas of Aboriginal and Torres Strait Islander morbidity and mortality that we believe need to be better prioritised in the next iteration of the Implementation Plan.

Recognition of the prevalence and costs associated with trauma in Aboriginal and Torres Strait Islander communities will lead to more awareness, better data collection and prevention and minimise the negative economic and social impacts that may result if unaddressed. This may be best targeted within the Adolescent and Youth Health domain of the Implementation Plan. Through an increased focus on prevention and early intervention in cancer diagnosis and treatment RACS believes that cancer mortality in Aboriginal and Torres Strait Islanders can be significantly reduced. This may be best targeted within the Health Systems Effectiveness domain of the Implementation Plan.

References

[1] Caring for the Severely Injured in Australia: Inaugural Report of the Australian Trauma Registry. Melbourne, Victoria: Alfred Health; 2014.

[2] Australian Institute of Health and Welfare: Harrison JE & Berry JG. Injury of Aboriginal and Torres Strait Islander people due to transport, 2001–02 to 2005–06. Injury research and statistics series number 46. Cat. no. INJCAT 120. Adelaide: AIHW 2008.

[3] Department of Prime Minister and Cabinet. Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report. Canberra: Australian Health Ministers' Advisory Council; 2015.

[4] Macaulay T ea. Australian Indigenous road safety: contract report Vermont South, Victoria: ARRB Transport Research; 2003.

[5] Harrison J ME, Weeramanthri T, Wakerman J, Barnes T. Information sources for injury prevention among Indigenous Australians: status and prospects for improvements. Canberra: Australian Institute of Health and Welfare; 2001.

[6] Royal Australasian College of Surgeons, Northern Territory Audit of Surgical Mortality; 2016.