QAIHC
Queensland Aboriginal and Islander Health Council

QAIHC SUBMISSION TO Queensland Health

SUBMISSION

Health Equity Strategies

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About the Queensland Aboriginal and Islander Health Council (QAIHC)

The Queensland Aboriginal and Islander Health Council (QAIHC) was established in 1990 by dedicated and committed Aboriginal and Torres Strait Islander leaders within the community-controlled health Sector (the Sector). From our first meeting 30 years ago, we have grown to become a national leader in Aboriginal and Torres Strait Islander health, and as a voice for our 26 members, the Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) in Queensland, two regional bodies and 14 Affiliate Members.

Like our ATSICCHOs, we embody self-determination; we are governed by an Aboriginal and Torres Strait Islander board that is elected by our Members.

QAIHC Members work tirelessly to provide culturally appropriate, comprehensive, primary health care services to local Aboriginal and Torres Strait Islander communities in Queensland. Collectively they have established more than 60 clinics across the State to service the population. Our two regional bodies – The Institute for Urban Indigenous Health (IUIH) and Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA) also provide support to our Members.

Our Members provide more than just holistic Primary Health Care models, they help the whole community and regional economies by encouraging whole of community wellbeing, thus creating local jobs and ensuring local design of services.

Nationally, we represent ATSICCHOs through our affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation (NACCHO) and are regarded as an expert in our field.

QAIHC, as the peak body for the ATSICCHO's of Queensland, wishes to express the collective views on behalf of our state-wide members in relation to the Queensland Government's proposal for Health Equity Strategies.

The purpose of this submission is to ensure the *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation* 2020 (the Regulation) incorporates the unique experiences of the ATSICCHO Sector. QAIHC would like to thank the Queensland Government for the opportunity to comment.

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1. Introduction

QAIHC believes that all Aboriginal and Torres Strait Islander peoples should have the same opportunity to be healthy and as well as other Australians, and deserve equitable access to the health system.

Unfortunately, we know that a health gap exists between Aboriginal and Torres Strait Islander peoples living in Queensland and other Australians. The Queensland Closing the Gap (CTG) Snapshot Report Card (2019) reports that the Aboriginal and Torres Strait Islander life expectancy gap for males and females was 7.8 years and 6.8 years respectively, the child mortality rate was 1.7 times that of non-Aboriginal and Torres Strait Islander peoples living in Queensland and that higher rates of hospitalisation for acute interventions lead to significant system costs and lower health outcomes.[1]

We also know that there are many factors which lead to health inequity, including barriers associated with Queensland's history of colonisation and assimilation policies, poor social determents and refusal or inappropriate access to services and treatment. Racism is a theme that underlies all of these factors. Racism can be interpersonal or institutionalised, but in all forms it affects health, wellbeing and access to health services. Racism makes people sick. The consequences of racism impacts the whole person and their wider community, with the long-term health impacts of racism being endless. They can include poor mental health, social and emotional distress, injury, harmful use of alcohol or other substances, self-harm, suicidality and exacerbated physical health conditions due to disengagement with the health system. This leads to poor and complex social determinants of health, for example poverty, unemployment and overrepresentation in youth detention and correctional centres.

There is evidence that interpersonal and institutional racism continues to be experienced by Aboriginal and Torres Strait Islander peoples with regard to healthcare, and there are important opportunities for the Hospital and Health Services (HHS) in Queensland to address these determents of health.[2]

QAIHC is encouraged by the commitment of the Queensland Government to support systemic change in its health service delivery structures in an effort to address institutional racism. The *Health Legislation Amendment Bill* 2019 (the Bill) and accompanying *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation* 2020 (the Regulation) provides an important milestone for Queensland to ensure health equity.

Failed attempts in the past to achieve health equity, including the relatively limited impact of the HHS CTG Action Plans, demonstrates the need for legislation to guarantee HHS commitment towards health equity outcomes. The Bill contains three components for change: Including as a guiding principle, a commitment to achieving health equity; requiring each HHS to have a strategy for achieving health equity with Aboriginal and Torres Strait Islander peoples; and requiring each HHS Board to have one or more Aboriginal and Torres Strait Islander persons as members. The Regulation must tie all three components of the Bill together, to ensure system integration, inclusion and accountability.

The second component of the Bill, the Health Equity Strategies (Strategies), requires each HHS to have a strategy for achieving health equity with Aboriginal and Torres Strait Islander peoples. Its purpose is to achieve health equity within the Queensland Government's health system primarily through eliminating interpersonal and institutional racism. The definition and intent of the Strategies need to be agreed.

The legislation must explicitly incorporate the purpose and intention of the Strategies, and mandate consistent reporting across the HHSs to ensure accountability within the HHS for meeting the outcomes. The Strategies and their outcomes must be contingent on sufficient government funding. The Strategies must also build on the Making Tracks Policy and Accountability Framework commitments; partnership, cultural respect, Indigenous health being everyone's business, recognising the ATSICCHO Sector, and accountability.

[1] Queensland Closing the Gap Snapshot Report Card 2019, DATSIP, https://www.datsip.qld.gov.au/resources/datsima/programs/closing-gap/ctg-snapshot-2019.pdf, page 3, 4.

[2] Addressing institutional barriers to health equity for Aboriginal and Torres Strait Islander people in Queensland's public hospital and health services, by Adrian Marrie (Bukal Consultancy Services Pty Ltd) https://www.qhrc.qld.gov.au/resources/reports/health-equity

QAIHC has delivered ten recommendations in the third section of this report. If implemented, the recommendations will transform the draft legislation into a useful and practical guide for HHSs to realise the purpose of the legislation: to ensure that all Aboriginal and Torres Strait Islander peoples have the same opportunity to be healthy and well as other Australians, and have equitable access to services. Further, more detailed responses to the consultation questions can be found in the fourth section of this response.

Health equity will not be achieved solely through legislative change to address interpersonal and institutional racism. Rather, strategies to address these determinants of health equity must be embedded within a range of health systems, therefore, wider reform is required. On the back of the recent COVID-19 pandemic and our experience of the response from the Queensland Government, in the fifth section of this response, QAIHC also provides 17 short-term and longer-term practical solutions that Queensland Health, in partnership with QAIHC and the ATSICCHO Sector, can implement to complement the Regulation and the legislation's intent.

2. Context

In attempting to eliminate institutional racism, governments tend to rely on two basic strategies: programs that increase the Aboriginal and Torres Strait Islander workforce; and the education and immersion of health staff into Aboriginal and Torres Strait Islander health issues and their cultures. There have been some positive improvements with increased Aboriginal and Torres Strait Islander representation on HHS Boards, an increase of senior executives within Queensland Health and HHSs, plus a general increase in clinical workforce including Aboriginal and Torres Strait Islander Health Workers/Practitioners (ATSIHW/Ps). These improvements must continue to grow and strengthen, but they are not enough to dismantle systemic barriers that influence access to quality health care.

What is required in our view is that Aboriginal and Torres Strait Islander peoples are legally supported to be included in decision-making roles that have influence over policy and program delivery, service design, workforce structure and, importantly, expenditure for every policy affecting Aboriginal and Torres Strait Islander peoples. When this happens, hopefully we can start to unpack some of the systems that have, essentially to date, excluded Aboriginal and Torres Strait Islander peoples' input into the delivery of their own healthcare.

The other vitally important strategy in breaking down systemic barriers is transparency and accountability. The proposed implementation of mandatory Strategies will ensure that HHS boards make Aboriginal and Torres Strait Islander health equity a priority, will encourage engagement and consultation with Aboriginal and Torres Strait Islander communities, and will ensure greater transparency of financial investment in health outcomes for that investment.

Since the Marrie and Marrie Matrix Audit was conducted, we have experienced some improvements in systems towards health equity. In our view the improvements have been the result of current stakeholder relationships, innovation, keen advocacy and organisational and political goodwill. We know that these are heavily dependent on the opinions and views of individuals. Many changes to health systems will require legislative levers to effect change so that the commitment can be sustained in the long run.

It is QAIHC's view that legislative changes, as we have seen with native title and human rights legislation, will enforce the dismantling of systemic barriers that currently exclude the perspectives of Aboriginal and Torres Strait Islander peoples. They will also support our people to exercise their right of self-determination, as designers of the health services that are there to protect and support their advancement.

To be effective the legislation needs to remove any confusion as to the purpose of a Strategy, the requirements set upon HHSs (such as partnerships), the process for establishing and funding Strategies, and the reporting and accountability framework that is associated with it. There must be no room for misinterpretation.

In order for the Strategies to be effective there needs to be genuine partnerships, funding, and accountability. While this legislation will require HHSs to produce Strategies, we believe the Strategies will not be effective unless there is a re-distribution of decision-making authority on matters that pertain to Aboriginal and Torres Strait Islander peoples. Decision making and resource allocations currently lie entirely within the HHSs with no transparency or requirement for HHSs to demonstrate that these decisions have the support or approval of Aboriginal peoples or their representative bodies, even though the matters directly impact on Aboriginal Torres Strait Islander peoples. These are systems that potentially perpetuate institutional racism. To truly create change, real partnerships are required to eradicate institutional racism within health systems in Queensland.

3. Recommendations for the Regulation

In order for the legislation to be effective in its aim of achieving health equity, QAIHC makes the following recommendations for the Regulation:

Area	Recommendation
The needs of the consumer	1. Maintain focus on the purpose behind this legislation at all times and **design the legislation so that HHSs deliver services and programs that demonstrably meet the needs of the consumer** (which are by definition 'patient-centred') within the broader context of ATSICCHOs delivering comprehensive and holistic care. Closing the Gap targets can only be met if the services are patient centred across the continuum of care.
Health Equity Strategy definition	2. **Partner with the ATSICCHO Sector** to refine and agree to the definition of health equity and include the definition in the Regulation. 3. Amend clause 8 (a) to include the **definition of Health Equity Strategies**.
State-wide consistency and co-design	4. Establish a **Health Equity Joint Advisory Committee** consisting of representatives from QAIHC and the ATSICCHO Sector and Queensland Health, including subject matter experts, to guide the amendment and implementation of this new legislation, to ensure overarching state-wide consistency and accountability.
Prescribed partnerships and consultation requirements	5. Amend clause 5 (11D (1 and 2)) prescribed persons for health equity strategies to include **every** ATSICCHO in a region, QAIHC and the new Health Equity Joint Advisory Committee.
Measurements and targets	6. Amend clause 8 (a) to include **SMART targets** which have been endorsed by the Health Equity Joint Advisory Committee.
Accountability and reporting	7. Amend clause 8 (b) to state the Strategy must include **core actions** as identified and agreed by **Health Equity Joint Advisory Committee** – perhaps to be published in a separate Queensland Health policy. Actions must be consistent across the state, designed by community and evaluation experts, and include principles of co-design, co-development, co-implementation and co-evaluation as well as CQI principles. 8. Include a new clause outlining **accountability requirements** for consultation, transparent decision-making and effective, sustainable services as identified in Making Tracks Policy and Accountability Framework, and include the need for formalised partnership agreements and audits.
Funding	9. Include a new clause outlining Health Equity Strategy funding responsibilities, with acknowledgement that funding is to be allocated for HHS and ATSICCHO Sector service delivery through formal partnerships.
National strategies	10. Amend clause 8 (c.) to include important national strategies such as the Close the Gap Framework, National Evaluation Strategy and National Workforce Strategy and maintain reference in clause 8(d) to other HHS strategies.

4. Response to Queensland Health's consultation areas

Queensland Health have provided a number of consultation documents which have been considered in this response:

- Consultation Paper – Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2020
- Confidential exposure draft – Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2020
- PowerPoint Presentation used to facilitate a consultation with the QAIHC Policy Network by Haylene Grogan, Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director General at Queensland Health on 4 June 2020.

QAIHC is also aware that Queensland Health have received a submission on the subject from the Institute for Urban Indigenous Health (IUIH), which QAIHC supports and recommends to the Department.

Please note, the responses below are ordered in line with Queensland Health's consultation paper questions.

Health Equity Strategies definition (Question 1)

The consultation paper proposes the definition for a Health Equity Strategy is:

> *"*In this context, a suggested definition for a health equity strategy for First Nations People in Queensland is … *a long term strategic direction for coordinated actions, plans and initiatives which drive a commitment to improved health outcomes by responding to discrimination and institutional racism; addressing social and cultural determinants of health inequities; ensuring cultural safety in the delivery of healthcare services; removing barriers to access and engaging Aboriginal and Torres Strait Islander people and communities to be an integral part of the design, delivery and implementation of culturally appropriate and responsive healthcare."*

Any definition will inform the reporting, accountability and evaluation methods and will ultimately impact the steps taken by HHSs towards health equity for Aboriginal and Torres Strait Islander peoples. If the definition is wholly focused on cultural barriers, then the evaluation will only focus on steps taken by HHSs to alleviate cultural barriers.

Given the foundational importance of this definition, QAIHC strongly recommends that further time is given to partnering with the ATSICCHO Sector, and that the agreed definition is included in the Regulation. In addition to this, to ensure that patient-centred care is at the forefront of design, QAIHC recommends the following are considered:

- **Be explicit about the aim**: it is to improve health outcomes *for Aboriginal and Torres Strait Islander peoples* through the provision of patient-centred healthcare services and the elimination of interpersonal and institutional racism, ensuring that clients have improved experiences and experience equitable outcomes from their interactions with the health system. This aim must be linked to the Council of Australian Governments (COAG) CTG targets and the language should be related to achieving results and not committing to results.
- **Include language around racism**: There is a risk that if the term 'institutional racism' is removed, or replaced with 'better relationship with First Nations people', sight will be lost of the actual issue that is being addressed. Whilst QAIHC acknowledge positive, strength-based language can be more inspiring and motivating to individuals than deficit language, and that reconciliation and partnerships are important, there is a major risk that excluding the term 'racism' in the definition will lessen parties' focus and drive to achieve change.

- **Include the full scope of international definitions of health equity**: The proposed definition has a reduced scope to the internationally recognised concepts of health equity. The definition needs to be specific in recognising that health inequities arise from factors that are unjust, unfair and preventable (The World Health Organisation uses the word 'remediable'). Adoption of this language will mean that if health equity is a goal, then inequity can be prevented altogether and not just 'fixed'.
- **Consider breaking down Strategy objectives into three levels to view health equity:** provider level, health service level, and health systems level. For example, "*… improved health outcomes by responding to unjust, unfair, or preventable healthcare provider, health service, and health system factors that can lead to health inequities between Aboriginal and Torres Strait Islander peoples and other Australians*."
- **Acknowledge the importance of self-determination**: Self-determination should be defined and explained within the purpose. Aboriginal and Torres Strait Islander leadership and ownership are central to self-determination.
- **Define what partnerships means**: Partnerships require the sharing of decision making, power, control, responsibility and accountability. In partnerships, partners build trust and have an agreed and shared purpose, vision and intent in working together in a supportive and transparent way. Partners design and review outcomes together and problem solve solutions. In other words, Strategies must include co-design, co-development, co-implementation and co-evaluation with Queensland Health, HHSs and the ATSICCHOs, and must be formalised through Agreements. We agree with the Deputy Premier's statement that the focus needs to be on the health of Queenslanders not Queensland Health and that releasing control and working with the community sector is crucial.
- **Acknowledge that the Strategies are not just for the HHSs**: The benefit cannot be limited to tertiary care as it will directly impact on the ATSICCHO Sector and the work of the ATSICCHOs. Moreover, some HHSs are also responsible for primary care services and the principles of the Strategy need to also extend to the delivery of these services as well as the tertiary healthcare sector.
- **Share accountability and responsibility**: This must be shared if self-determination has a role in the Strategies (noting the consequential requirement for power and resources to be shared).
- **Recognise the holistic nature of health**: Acknowledgement is needed in the definition of the holistic nature of health – health is not just medicine but must also be informed by culture, history and healing.
- **Focus on the client experience and patient centred services**: HHSs should have a legislated responsibility to ensure clients are satisfied and willing to engage with the HHS. Feedback from the ATSICCHO Sector indicates that HHSs often prioritise the system and clinicians in decision making rather than the patient.
- **Provide examples of unjust, unfair or preventable factors that lead to health inequalities**: For example;
    - Lack of access to patient centred care (i.e. care that does not address the patient's needs, their social determinants, etc.)
    - Reduced access to health services (e.g. lack of access to allied health, discharge against medical advice, poorer medication adherence, etc.)
    - Reduced access to social support services (e.g. Aboriginal community support, social support from other agencies, etc.).
    - Interpersonal and institutional racism (e.g. Aboriginal and Torres Strait Islander peoples and communities are not an integral part of the design, delivery and implementation of health services).

Recommendation 1: Maintain focus on the purpose behind this legislation at all times and design the legislation so that HHSs deliver services and programs that demonstrably meet the needs of the consumer (which are by definition 'patient-centred') within the broader context of ATSICCHOs delivering comprehensive and holistic care. Closing the Gap targets can only be met if services are patient centred across the continuum of care.

Recommendation 2: Partner with the ATSICCHO Sector to refine and agree the definition of health equity and include the definition in the Regulation.

Recommendation 3: Amend clause 8 (a) to include the definition of Health Equity Strategies.

Prescribed requirements (Question 2)

History demonstrates that the effectiveness and impact of a change may not be realised if the necessary requirements are not mandated in legislation. The CTG Action Plans exemplify this. The Regulation therefore needs to be explicit when describing the prescribed requirements, whilst allowing for local applicability.

In order to properly identify and develop the prescribed requirements, further consultation is required with the Sector and community. The Sector has had limited opportunity to consult on this Regulation due to COVID-19 and recognises the importance of *jointly* designing the prescribed requirements alongside Queensland Health.

Proposed solution: Establish a formal Partnership Agreement on health equity between Queensland Health and the ATSICCHO Sector

In March 2019, the Coalition of Peaks entered a historic formal Partnership Agreement on CTG with COAG. The agreement delineated shared decision making on CTG to enable true partnership between government and Aboriginal and Torres Strait Islander peoples. QAIHC suggest that a similar model is undertaken in Queensland for the development and accountability of Health Equity Strategies.

Through establishing a "Joint Health Equity Advisory Committee" and resourcing organisations appropriately for involvement, Queensland Health and the ATSICCHO Sector can ensure:

- the relevance and impact of the Strategies;
- community-driven decision making;
- high-level co-design of the Regulation's framework;
- Strategies are not HHS Strategies but community Strategies; and
- state-wide consistency, transparency and accountability for the implemented Strategies.

Establishment of such a committee will support Queensland Health's commitment to the guiding principles of partnership and community decision-making as identified in the Making Tracks Policy and Accountability Framework.

Recommendation 4: Establish a Health Equity Joint Advisory Committee consisting of representatives from QAIHC, the ATSICCHO Sector and Queensland Health, including subject matter experts to guide the amendment and implementation of this new legislation to ensure overarching state-wide consistency and accountability.

Initial feedback on the prescribed requirements are provided below, noting QAIHC's strong preference and recommendation for all suggested topics to be workshopped by a joint committee prior to finalising the Regulation. Given the timeframes associated with the Regulation, consideration could also be given to the joint committee developing policy guidelines which are referred to in the Regulation.

Question 2(a) Prescribed requirements: Proposed stakeholders

The ATSICCHO Sector are included in the list of development and implementation stakeholders, however there must be a requirement for a HHS to seek endorsement from all ATSICCHOs in their region, and not just one.

Aboriginal and Torres Strait Islander peoples in local communities are the foundation of ATSICCHOs. For an organisation to be 'Aboriginal and Torres Strait Islander Community Controlled', it must form a majority membership from the local Aboriginal and/or Torres Strait Islander community. The membership mandates the organisation to act in the interests of the members and their community. The Board of Directors are elected from the membership and, accordingly, community engagement mechanisms are inherently built into community controlled structures. Community elected Boards represent the ultimate expression of our self-determination.

To only seek involvement and endorsement from one ATSICCHO excludes other communities within a HHS region and does not reflect the Making Tracks' principles of partnership, self-determination and respect for the ATSICCHO Sector. The result would be that the Strategy will be ineffective and not a product of self-determination and partnership with the community.

Furthermore, there is a need to ensure state-wide consistency across the Strategies. It is recommended therefore that the proposed new Health Equity Joint Advisory Committee be engaged in reviewing Strategies.

Recommendation 5: Amend clause 5 (11D(1 and 2)) prescribed persons for health equity strategies to include every ATSICCHO in a region, QAIHC and the new Health Equity Joint Advisory Committee.

Question 2(b) - Prescribed requirements: Comment on Clause 5 regarding what must be contained in a Health Equity Strategy

(i) The Regulation must define the outcomes which the Strategy must address:

The Regulation (clause 5) refers to the following:

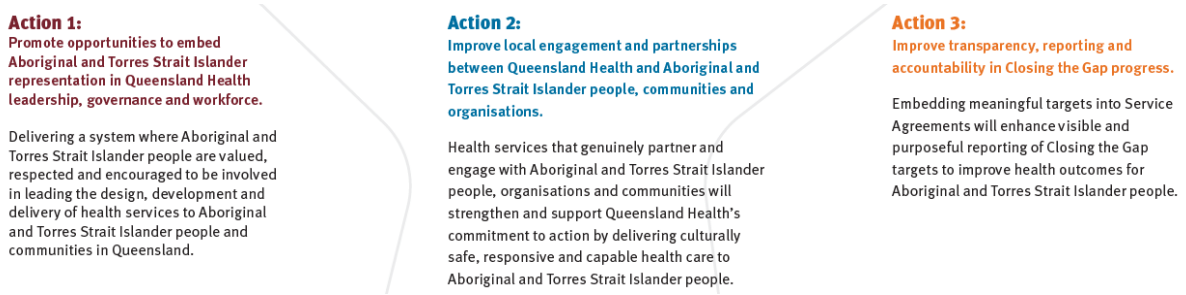
"*A Health Equity Strategy of a Service must set out the Services proposed actions to:*

(i) *ensure services are culturally and clinically responsive and appropriate for Aboriginal and Torres Strait Islander people; and*

(ii) *ensure a culturally capable workforce that supports and values Aboriginal and Torres Strait Islander employees; and*

(iii) *improve local engagement and partnerships between the Service and Aboriginal and Torres Strait Islander people, communities and organisations*."

The CTG Action Plans currently being reported by HHSs to Queensland Health have three key actions. These are: strengthening involvement of Aboriginal and Torres Strait Islander peoples in governance; participation in workforce and local engagement; and decision-making, as shown in the snapshot below:



Action 1:
Promote opportunities to embed Aboriginal and Torres Strait Islander representation in Queensland Health leadership, governance and workforce.

Delivering a system where Aboriginal and Torres Strait Islander people are valued, respected and encouraged to be involved in leading the design, development and delivery of health services to Aboriginal and Torres Strait Islander people and communities in Queensland.

Action 2:
Improve local engagement and partnerships between Queensland Health and Aboriginal and Torres Strait Islander people, communities and organisations.

Health services that genuinely partner and engage with Aboriginal and Torres Strait Islander people, organisations and communities will strengthen and support Queensland Health's commitment to action by delivering culturally safe, responsive and capable health care to Aboriginal and Torres Strait Islander people.

Action 3:
Improve transparency, reporting and accountability in Closing the Gap progress.

Embedding meaningful targets into Service Agreements will enhance visible and purposeful reporting of Closing the Gap targets to improve health outcomes for Aboriginal and Torres Strait Islander people.

In effect, Clause 5 is identical to what is currently being implemented and reported by HHSs as action areas in their CTG Health Plans. Thus, it is unclear how the Regulation will lead to any change in outputs and outcomes from HHSs given that HHSs are already reporting on these actions through CTG Health Plans.

For example, the North West HHS (NWHHS) reported in their Annual Report 2018-19 the following activities in line with the CTG Health Plans: recruitment strategies for Aboriginal and Torres Strait Islander staff; marking of cultural events of significance; development of protocols for communication with the Gangalidda, Garawa and Waanyi people; transition of primary health care programs to ATSICCHOs in Mount Isa and Mornington Island; the appointment of a Director of Aboriginal and Torres Strait Islander Health, and a list of CTG programs that have been running for several years (such as healthy skin programs). The NWHHS also reported on a few CTG indicators (e.g. 5.5% of hospitalised Aboriginal and Torres Strait Islander patients discharge against medical advice) although no benchmarks are listed in the Annual Report.

Without greater definition in the Regulation, it is unclear how the legislation will lead to any change in how HHSs are currently addressing health inequities.

Recommendation 6: Amend clause 8 (a) to include SMART targets which have been endorsed by the Health Equity Joint Advisory Committee.

(ii) The Regulation must define the process for designing and implementing Strategies:

Within a defined process for the design and implementation of the Strategies, the Regulation needs to stipulate *how* the HHSs will consult with ATSICCHOs and what endorsement looks like. Co-design, co-development, co-implementation and co-evaluation must be foundational principles.

Continuous Quality Improvement (CQI) principles, and formalised research projects where appropriate, also need to be embedded to ensure learnings are implemented to improve the Strategies.

QAIHC suggests that the Regulation needs to:

- have clear guidelines on how the Strategies will be implemented, who will be involved and what the consequences are for failure to meet defined deliverables and benchmarks
- include a method for complaint and its independent review if an activity is not being progressed
- describe how Strategies will be embedded, monitored and implemented with a CQI and/or research lens applied to ensure ongoing relevance and appropriate methodology
- describe clear accountability and transparency - reporting, monitoring and consequences such as performance management or funding cuts.

Recommendation 7: Amend clause 8 (b) to state the Strategy must include core actions as identified and agreed to by the Health Equity Joint Advisory Committee – perhaps to be published in a separate Queensland Health policy. Actions must be consistent across the state, designed by community and evaluation experts, and include principles of co-design, co-development, co-implementation and co-evaluation as well as CQI principles.

(iii) The Regulation must require formal partnership arrangements with ATSICCHOs:

Since the Marrie and Marrie Matrix Audit was conducted, we have experienced some improvement in health equity. In our view the improvements have been the result of current stakeholder relationships, innovation, keen advocacy and organisational and political goodwill. We know that these are heavily dependent on the opinions and views of individuals. Systemic change will require legal protection to ensure the commitment can be sustained in the long run.

ATSICCHOs lead the way in improving peoples' health yet they are still not recognised as the lead agencies. Until there is equity on all levels, change is unlikely.

ATSICCHOs' frequently experience engagement that can be considered tokenistic and with the intent of satisfying requirements to confirm they have consulted with an ATSICCHO for reporting purposes, rather than for genuine consultation and partnership. ATSICCHOs often undertake work that falls within the responsibility of the HHS for services that are not identified as necessary as Aboriginal and Torres Strait Islander health is not recognised as a priority. Many ATSICCHOs still do not have service level agreements (SLA) with HHSs regarding key services that the ATSICCHO support. QAIHC is aware of multiple occasions where ATSICCHOs have had meetings to discuss SLAs, with no action or offer produced by the HHSs.

There are some good examples of working relationships between ATSICCHOs and HHSs, and some examples which leave room for improvement:

- Carbal Medical Service has been working with Darling Downs HHS on a number of joint programs including the Maternity Services Integration Program (MSIP), a maternity education project to address poor attendance rates at antenatal HHS classes. HHS staff now run programs out of Carbal facilities resulting in dramatic improvements with client engagement. There has been a genuine effort for partnership from both parties however progress has been slow.
- Cairns and Hinterland HHS and Gurriny Yealamucka (Gurriny) have monthly CEO meetings. The relationship was initially established as a result of Gurriny demanding the HHS to meet, however this engagement is now mutually respected and effective. COVID-19 further necessitated the HHS to work in collaboration with Gurriny and the relationship has been positive. Gurriny hopes the regular communication and new working relationship will continue.
- Mackay Aboriginal and Torres Strait Islander Community Health Service (Mackay ATSICHS) have a mixed relationship with their HHS. There has been some excellent communication and care, but also some failures in communication. There is a perception that the HHS minimalises the situation of Aboriginal and Torres Strait Islander peoples in the region because they comprise a small proportion of the population.
- During the COVID-19 crisis, the Queensland Health HHS pathology laboratories appeared to have the best understanding of the need to prioritise Aboriginal and Torres Strait Islander peoples' tests over other HHS departments. The supportive response received from the pathology departments has been impressive. Queensland Health Pathology Department already has an identifier on the form (compared with other HHSs nationally who do not) which has enabled responsive prioritisation of cases. Many HHSs have a policy that the identifier must be completed, but some do not require it.
- The North West HHS has listed several CTG programs in its annual report, but it is unclear which (if any or all) of these programs have been co-designed, implemented with ATSICCHOs, and approved by ATSICCHOs. All HHSs should be required to report these important details according to pre-set reporting templates.

The Sector also has examples of how the HHS workforce structure does not ensure cultural safety or understanding:

- South West HHS has a progressive and supportive CEO, however, many middle managers and staff have failed to demonstrate cultural safety or understanding. In the ATSICCHOs experience, middle managers sometimes block change and ATSICCHOs do not see evidence of the HHS taking responsibility for staff who behave inappropriately.
- In a number of HHSs, the Indigenous Health Portfolio sits with a non-identified Executive Director role, to whom the identified Indigenous Health Manager role reports. The importance of Aboriginal and Torres Strait Islander Health becomes diluted. ATSICCHOs have seen Aboriginal and Torres Strait Islander health matters go from a two-page document to four lines in final reports. No matter how much advocacy the Indigenous Health Manager undertakes, unless the Executive Director and CEO support it, the Sector's experience is that change does not happen within HHSs.
- Since 2019, the relationship between the Darling Down HHS and one ATSICCHO has improved dramatically. The ATSICCHO is now consulted by senior managers, however the ATSICCHO has

seen that the HHS senior managers experience difficulties with staff when implementing the necessary changes within their own organisation. This has also been the experience for North Coast Aboriginal Community Controlled Health (NCACCH) when working with Sunshine Coast HHS' management. This can be frustrating for ATSICCHOs when trying to work with those staff to achieve and support the change.

The examples provided highlight the need for SMART targets that are communicated to all staff; a HHS may have a Strategy with genuine aspirations on paper, but effort will be required to ensure it is integrated throughout different departments in a complex hospital service with a constantly changing workforce.

Formal Partnership Agreements between every HHS and the ATSICCHOs in their region should be required to remove any risk of personal bias and ensure fairness to all ATSICCHOs. The Partnership Agreement must include processes for HHS and ATSICCHO co-design and 'sign off' on programs being developed for the Aboriginal and Torres Strait Islander community and, ideally, these processes should be consistent across the state. The Partnership Agreement could be developed as a template to support a nationally consistent document with flexibility for local variation.

Recommendation 8: Include a new clause outlining accountability requirements for consultation, transparent decision-making and effective, sustainable services as identified in Making Tracks Policy and Accountability Framework, and include the need for formalised partnership agreements and audits.

(iv) The Regulation must include information on how the Strategy will be funded:

It is clear that achieving health equity will reduce downstream costs in the long run, but will require upstream investment in the short-term. Upstream investment would involve funding parties to engage with the Strategies' co-design, co-development, co-implementation and co-evaluation, and through financing health equity projects to support the Strategies' co-implementation. Where the CTG Health Plans have worked well (e.g. Cape York region) the ATSICCHOs have received investment from the HHS. This process must not become a burden on the ATSICCHO Sector.

Recommendation 9: Include a new clause outlining Health Equity Strategy funding responsibilities, with acknowledgement that funding is to be allocated for HHS and ATSICCHO Sector service delivery through formal partnerships.

Question 2(c) - Prescribed requirements: Impact on other HHS Strategies e.g. Clinician Engagement Strategy; Consumer and Community Engagement Strategy or protocols with local primary healthcare organisations

All Strategies will need to be reviewed and updated to cross-reference and support each other. The Strategy needs to be integrated into all other Strategies.

Consideration needs to also be given to the need for legislative change to enable data sharing between ATSICCHO and HHSs. For example, around potentially preventable hospitalisation rates - the ATSICCHO Integrated Team Care team cannot easily share client data with HHS nurse navigators. ATSICCHOs could potentially assist with preventing hospitalisation but are not always aware that clients are being hospitalised.

Recommendation 10: Amend clause 8(c) to include important national strategies – such as the Close the Gap Framework, National Evaluation Strategy and National Workforce Strategy etc. and maintain reference in clause 8(d) to other HHS strategies.

Question 2(d) - Prescribed requirements: Board Meeting transparency

The consultation document asks "*Should Board discussions and decisions be shared with prescribed stakeholders?"*

QAIHC suggests that transparency of board discussions would improve partnerships and communication between the ATSICHCO Sector and the HHS. Where relevant to prescribed stakeholders, transparency of Board discussions and decisions would be beneficial. Consideration should also be given to the role of a Health Equity Joint Advisory Committee in ensuring accountability by HHS boards for health equity efforts.

HHS Boards must be able to govern effectively and to do so they need to be clear on what they are responsible and accountable for. Clearly defining the Strategies' purpose and intent, measurables and reporting requirements will assist board members to effectively govern.

A follow up question was asked by the Aboriginal and Torres Strait Islander Chief Health Officer: "*What does effective cultural competency training for HHS boards look like*"? *Please consider: delivery mode & personnel, content (including mandatory requirements), frequency & reviews, for example.*

QAIHC's members have the following comments regarding Board representation:

- Senior level representation is important, but a position alone is not enough. The individual can be isolated. This can be resolved by:
    - Appointing more than a single Aboriginal and Torres Strait Islander Board representative on HHS Boards;
    - Creating and facilitating a network of Identified Board members across HHSs;
    - Creating a local network between ATSICCHO Board members and the HHS Identified position;
    - Maintaining Aboriginal and Torres Strait Islander health as a standard agenda item.
- All existing and new Board members should be empowered to be effective, for example through access to the ATSICCHO Sector, and through the provision of additional support to enable the identified position(s) to be an advocate for the Sector on the board. All board members should receive training on governance requirements.
- All Board members should demonstrate that they have a working knowledge of Aboriginal and Torres Strait Islander health needs.
- HHS Boards should ensure that all areas, processes and systems of their HHS align, link and support the Strategies.
- HHS Boards must be briefed and exposed to the ATSICCHO Sector and its model of care, as well as health equity issues and how they can contribute to reform.
- By way of comparison, the New Zealand Health and Disability System Review Final Report Purongo Whakamutunga (March 2020) recommends that the New Zealand Health Board ensures equal representation of 50:50 Māori and Crown membership so that "the way the delivery system functions incorporates different world views".[3]

Question 2(e) - Prescribed requirements: Transition period

The consultation document asks "*What is a reasonable transition period to allow HHSs to consider implementation requirements after the passage of the Bill?*"

[3] Health and Disability System Review. 2020. Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington: HDSR. This report is available from www.systemreview.health.govt.nz/final-report, page 28

QAIHC is concerned that the Sector is not identified in the co-design and implementation. The timeframe must allow for genuine co-design, with QAIHC and the ATSICCHO Sector. QAIHC supports a 12-month transition period.

Question 3 (a) – Reporting requirements

The consultation document asks "*How regularly should HHSs be reporting? Will the matrix tool key indicators be sufficient for reporting or are new KPIs needed? Should all HHS activities aimed at closing the gap be considered under the umbrella of the overarching Strategy? How can current reporting be streamlined?*"

The Matrix provides a good starting point for reporting but could benefit from some alterations to better consider relationships and its practical application. QAIHC recommends criteria are discussed and agreed by the Health Equity Joint Advisory Committee to ensure appropriate thought and consideration is given to such an important question. This group would also have responsibility for keeping the HHSs accountable, similar to the New Zealand proposals for an independent Māori Health Authority with direct accountability to the Minister of Health for all advice, monitoring and reporting with respect to Māori health.[4]

Subject to authentic Sector consultation and co-design, QAIHC recommends that, as a minimum, additional points are considered for:

- practical ways of demonstrating connection and partnerships with the ATSICCHO(s);
- number of partnership agreements in place with ATSICCHO(s);
- endorsement of Strategy by all ATSICCHOs in the HHS region;
- preferred provider status for the ATSICCHOs in relation to any commissioning arrangement;
- number of projects delivered in genuine partnership with the ATSICCHO(s);
- number of projects and value of funding being transitioned to ATSICCHO(s);
- a transparent committed complaints process that captures, responds and improves systems in response to racism complaints (the Sector have suggested that a Ryan's Rule for Racism is created, providing independent oversight);
- structured linkages and coordination between roles and functions of ATSICCHOs and HHSs, community engagement committees / Clinical Networks / Community Advisory Networks and the Board / Board Aboriginal and Torres Strait Islander sub-committees;
- patient centred-analysis (e.g. social determents, health service function levels captured, patient journey including Patient Transport Subsidy Scheme);
- Number of focus groups held with consumers.

Strategies to address the determinants of health equity for Aboriginal peoples and Torres Strait Islander peoples, and appropriate performance indicators, can be embedded within a range of factors, such as those outlined in the table at Annex A. These strategies must be measurable and should be captured within the Health Equity Strategy even if they are already captured in another strategy or plan.

Question 3(b) - Reporting methods

The consultation document asks "*What strategies are effective for reporting on health equity strategies to consumers and communities?*

[4] Health and Disability System Review. 2020. Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington: HDSR. This report is available from www.systemreview.health.govt.nz/final-report, page 26-27.

Strategies for reporting must include:

- public visibility of results data (e.g. on HHS website including visual snapshot reports);
- regular information sharing with stakeholders (including ATSICCHOs) providing more in-depth analysis of performance and providing opportunity for continuous quality improvement;
- internal reporting to staff (maintaining investment and interest in achieving outcomes);
- internal accountability within personal development plans for staff (targets and centralised internal reporting on achievements against targets);
- annual reporting against targets by the Health Equity Joint Advisory Committee (strategic state-wide level report);
- annual Parliamentary report (public Ministerial accountability).

There must be strategies to ensure cross-regional consistency and sharing of best practice across HHSs. This could include:

- creating opportunity for Boards and CEOs to share best practice with each other;
- focused Board attention on Aboriginal and Torres Strait Islander health and opportunities for improvement;
- consistency across HHSs in their Health Equity Strategies (noting the existing CTG Action Plans contain vastly different information depending on the HHS);
- a role for the state-wide joint advisory committee;
- state-wide meetings including sharing of best practice and outcomes amongst HHSs;
- collaborative meetings between HHS and local ATSICCHO Boards;
- a state-wide consistent template and structure for all reports.

Question 3(c) – Reporting transparency

The consultation document asks "*What else needs to be considered in terms of transparency and reporting?"*

QAIHC recommends that a set of performance indicators that are measurable and to which senior managers can be held accountable are developed. The team developing these measures must have data experience and knowledge of valid and relevant indicators to develop such a framework.

In order to meet the need for accountability, QAIHC suggests that there is:

- **One reporting tool and standard proforma for all HHSs**. This will create state-wide consistency (with opportunity for additional local criteria to be added if desired by local community).
- **An independent audit body appraising performance** (similar to the RACGP standards but specific to health equity such as the Queensland Human Rights Commission analysis of the Matrix Tool and the Audit for Best practice in Chronic Disease management (ABCD) program). This formal audit process will be objective and provide reports summarising impact being achieved.
- **Quarterly Queensland Health HHS state-wide governance group meetings,** with public reporting available following the meeting. These could be chaired by the Deputy-Director General and Aboriginal and Torres Strait Islander Chief Health Officer with membership to include the Chairs of all HHS Boards and all Aboriginal and Torres Strait Islander Hospital and Health Board Directors. The report should include details of HHS progress towards Health Equity Strategies, achievements and challenges, sharing of best practice examples,

benchmark performance measures and cross-regional solutions. A public communique would be issued after each meeting.

- **Quarterly reporting to state wide Health Equity Joint Advisory Committee (new committee)** to invite state-wide objectivity and Sector involvement.
- **Reporting to community:** Regular public reporting (either annual or every 6 months), including reporting on board representation and partnership agreements with ATSICCHOs. Progress towards Strategy aims should be reported publicly through community dashboards and to the QAIHC CEO forum.
- **Reporting by the Premier to Parliament:** As part of the Closing the Gap Report, the Premier should report on HHS progress against Strategy objectives annually in Parliament.
- **Improved data availability** to support more accurate assessment and public scrutiny of the impact of Strategies, for example:
    - Burden of disease, cause of death and injury reporting for Aboriginal and Torres Strait Islander populations in Queensland should be updated regularly.
    - HHSs running primary health care facilities should report on national Key Performance Indicators, in line with their ATSICCHO counterparts.
- **Consequences for failure:** Health Equity Strategy implementation standards and measures incorporated into HHS CEO job description and performance targets. These expectations can be filtered down and across management and all staff so that everyone has accountability for meeting targets. There could also be impacts on budgets, for example through a model similar to the Queensland Weighted Activity Unit model.
- **Rewards for success:** Champion and celebrate milestone achievements. Focus on positive outcomes when they are achieved.

5. Recommendations for wider reform

To complement the intent of the legislation, QAIHC also recommend that Queensland Health work in partnership with QAIHC and the ATSICCHO Sector to implement wider health system reform in Queensland. This is particularly important following the health service delivery disruptions that resulted from the COVID-19 pandemic, which continue to be experienced.

A concerted effort is needed to ensure that COVID-19 does not disproportionately impact on the health and wellbeing of Aboriginal and Torres Strait Islander peoples. This is particularly pertinent during the current climate where there is already a substantial underspend on Aboriginal and Torres Strait Islander health. The health need is known to be 2.3 times greater than non-Aboriginal and Torres Strait Islander peoples and government health systems are known to lack cultural safety that is needed to provide health equity. This effort must go beyond the legislation and influence the very cultures of the HHSs.

The ATSICCHO Sector currently provide HHS-related services, such as dentistry services[5], maternity services support through the maternal journey from antenatal to postnatal support, surgical pathways such as the Institute for Urban Indigenous Health's Eye and Ear Surgical Services program, wraparound support services for renal patients and GP visits upon discharge of chronic disease patients. These programs provide examples of how the ATSICCHO and HHS health systems operate best for the patient when they work together.

Reform must start by understanding the patient experience and recognising the important and valuable role that different health providers can play in ensuring a streamlined and quality service. Focusing on the patient journey will realise efficiencies and downstream cost-reduction. With the right model, ATSICCHOs will be able to work with patients to keep them out of hospitals where a patient's health can be managed safely by the ATSICCHO, or to help keep patients in hospital where appropriate rather than discharging without medical advice.

An open mindset and cultural shift to the current approach will be required to see real reform. The Health Amendment Bill and Regulation will support this shift if it is implemented well and in true partnership with the ATSICCHO Sector. By co-designing, co-developing, co-implementing and co-evaluating services, with the community in control and supported by the Government, QAIHC believes that health equity can be achieved.

A deeper mindset shift is also required to address conscious or unconscious bias, attitudes, beliefs and assumptions about Aboriginal and Torres Strait Islander peoples, Aboriginal and Torres Strait Islander health and the ATSICCHO Sector. To achieve this, a joint and explicit effort is needed to raise awareness amongst all Australians of the reasons why health equity activities are necessary and how they can help. This includes the impact of:

- Queensland's assimilation policies and genocide practices which have led to significant past and ongoing trauma (stolen generation, slavery, massacres), the loss of cultural knowledge, practice, distress and conflict;
- the Deed of Grant in Trust (DOGIT) towns where many clans were forced to move off country and live together resulting in forced breaches of lore;
- over-representation of adults and children in correctional services that has resulted from the mismanagement and misidentification of health and healing issues, such as hearing loss, behaviour stemming from grief and loss, learning disabilities, experience of trauma (childhood and adult), racism, access barriers to education and resources, poverty, discrimination in schools, training authorities and employers, and potentially preventable trauma;

[5] See QAIHC's Oral Health Care Report 2020 - https://www.qaihc.com.au/media/37576/0069-qaihc-oral-health-care-in-queensland_v10_f.pdf

- the lack of culturally safe health services within correctional services;
- the lack of Aboriginal and Torres Strait Islander youth specific programs and strategies in Queensland, despite being a vulnerable target population.

With this in mind, QAIHC respectfully makes the following recommendations for short-term and longer-term health system reform and would welcome the opportunity to discuss them with Queensland Health further.

Area	Recommendation
Short-term solutions (immediate – 6 months)	
Acknowledge and raise public awareness of institutional racism	1. Recognise and publicly acknowledge that some Queensland government actions and decisions that have been taken, or lack of action and decisions taken, reflect an ongoing lack of awareness of institutional racism across all government systems (not just health) and the need for implicit reform. This includes in the response to COVID-19.
Retain the focus on culturally safe communication	2. Queensland Health consider embedding Aboriginal and Torres Strait Islander communications in their organisational structure OR entering into a fee-for-services arrangement with QAIHC and/or IUIH to develop regular Aboriginal and Torres Strait Islander communications material.
Reform the elective surgery wait-list process	3. The ATSICCHO Sector is willing and able to support the reduction of the waitlists for Aboriginal and Torres Strait Islander peoples through the funding of a Queensland ATSICCHO Surgical Pathways pilot. The ATSICCHO Sector currently has a strong example of an ATSICCHO led surgical pathway that has achieved excellent results for Aboriginal and Torres Strait Islander people receiving vision-saving cataract surgery in South East Queensland. The benefit of this model is coordinated, consistent, culturally safe care and the patient is truly at the centre. This model has demonstrated that is has broken down the barriers to participation for Aboriginal and Torres Strait Islander people. The ATSICCHO Sector has the capacity to replicate this model in other regions such as North and Far North Queensland or Central and South West Queensland where relationships between the HHS and ATSICCHO Sector are strong and the need is high across all elective surgery categories. This pilot would utilise the Sector's culturally safe holistic health model of care to provide wrap around support services for patients requiring elective surgery. This would include through specialist appointments, surgery and follow up care in the pilot area. Other outcomes from this project could include: a) Provide all patients with regular access to specialist support services, no matter where they live to ensure they are added to surgery waiting lists (e.g. optometrists, dentists, GPs who refer for elective surgeries etc.).

Area	Recommendation
	b) Aboriginal and Torres Strait Islander patients on elective surgery waiting lists are advanced and prioritised using the Sector's model which puts patient care at the centre of discussions. c) The health sector has greater transparency of elective surgery waiting list data and patient prioritisation processes. ATSICCHOs, who are likely to be able to indicate the extent to which the wait lists reflect the population need, can be utilised to identify gaps in wait lists early on. d) Eradicate institutional racism including the way clients are removed from waiting lists if they do not attend appointments, recognising this is happening because of a lack of understanding, discomfort, social or cultural obligations to leave or stress, and not because of a defiance for the health system. The language used to describe the patients who are unable to attend appointments also needs to change from "failure" to attend. The pilot gives Queensland Health the opportunity to witness the value of embedding ATSICCHO led surgical pathways in long-term HHS operations.
Improve data (pathology)	4. Build into policy a requirement that Aboriginal and Torres Strait Islander person status is collected on all pathology, fever clinic and notification forms.
Embed COVID-19 system improvement as business as usual	5. Systems improvements include: the partnerships developed between ATSICCHO and HHSs; provision of renal services on Country; fever-clinics; regular group meetings and consultation with community; and improvements to virtual and tele-medicine.
Respect the ATSICCHO Sector	6. Acknowledge QAIHC and the ATSICCHO Sector and understand their services to effectively integrate them into the health system. This must include addressing process oversights that fail to list QAIHC as the peak body for ATSICCHOs.
Housing solutions	7. Establish emergency accommodation options and longer-term housing solutions particularly for over-crowded and under-housed communities (such as Yarrabah) where an outbreak could still be devastating.
Longer-term solutions	
Establish the Aboriginal and Torres Strait Islander health voice through partnership	8. Establish a **Health Equity Joint Advisory Committee** consisting of representatives from QAIHC and the ATSICCHO Sector and Queensland Health including subject matter experts, to guide the amendment and implementation of this new legislation, ensuring overarching state-wide consistency and accountability.
Increase efficiency and fix	9. Redesign the funding model to keep our people out of hospitals and shift the focus to culturally safe, innovative and preventative primary care. This

Area	Recommendation
the funding model	will achieve value by reducing duplication and using resources more efficiently. Recognise the benefit the ATSICCHOs provide to patient journey experiences and health outcomes due to their unique skills, community-ownership and extensive experiences in delivering culturally safe holistic health care through the ATSICCHO Model of Care: a. Secure recurrent mainstream funding for the ATSICCHO Sector to support Queensland Health b. Develop funding models that support patients throughout their journey in the most culturally safe way (not providing activity-based funding weighted for vulnerable populations and allowing the funding to be spent on any HHS activity) c. Establish a structure and formalise partnerships: There needs to be a systemised approach to integration and collaboration for holistic health care which is not based on relationships (including patient information sharing, adequate and timely discharge summaries, staff following patients through the health journey such as maternity, Patient Transport Subsidy Scheme) d. Develop new models that consider ideal ATSICCHO partnerships with HHSs at the local, regional and state level.
Partnerships	10. Develop Regional Network Funding Agreements between HHSs and ATSICCHOs within their respective regions.
Accountability	11. Hold health system leadership to account for health inequity requiring boards to report against equity measures, Chief Executive Officers to have health equity built into their employment contracts and Health Equity Strategies reviewed, published and consistently reviewed for quality and effectiveness.
Improve clinical capability	12. Increase Aboriginal and Torres Strait Islander leadership and governance through workforce in HHSs. 13. Support Aboriginal and Torres Strait Islander Board members to network and meet regularly with each other and with the ATSICCHO Sector. 14. Support all Board members to develop a deep understanding of cultural safety and the ATSICCHO Sector. 15. Invest in developing new workforce rather than moving workforce between Sectors – there is a need to be cognisant of the impact an increase in HHS workforce targets will have on the ATSICCHO Sector workforce (as HHSs' higher salaries often attract workforce from the ATSICCHO Sector leaving the ATSICCHO Sector short staffed). Developing the workforce also includes empowering ATSIHW/Ps to perform to their full scope of practice within the HHS System.

Area	Recommendation
Provide healthcare closer to home	16. Work with the ATSICCHO Sector to develop how tertiary healthcare could be delivered from the home.
Apply pandemic-best practice principles to other health crises	17. Apply the same focus of prevention, coordination, attention, speed and investment on other emerging health crises such as communicable diseases (e.g. the sexual health epidemic) and non-communicable but highly preventable diseases (such as rheumatic heart disease, cancer, poor oral health and chronic diseases).

5. Conclusion

Health Equity is an enduring and active concern for QAIHC and our Members. Unfortunately, we know that interpersonal and institutional racism continues to be experienced by Aboriginal and Torres Strait Islander peoples. Creating an equitable health system will close existing health gaps and improve outcomes for current and future generations of Aboriginal and Torres Strait Islander peoples.

The *Health Legislation Amendment Bill* 2019 and accompanying *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation* 2020 represents an important milestone for Queensland in addressing health equity and it is important that the Regulation reflects the needs and preferences of clients and community.

The proposed Regulation sets out how HHSs will work with ATSICCHOs and community, but does not address fundamental principles of partnership including co-design, co-development, co-implementation, co-evaluation, investment and accountability. To address this, and to ensure state-wide consistency in application and accountability, QAIHC strongly recommends that Queensland Health establish a Health Equity Joint Advisory Committee with the Sector which sees power-sharing responsibilities for the Health Equity reforms.

Furthermore, to complement the intent of the legislation and ensure holistic and fully integrated solutions, QAIHC also recommends that Queensland Health work with the Sector to undertake a variety of wider health reforms to change the way Aboriginal and Torres Strait Islander peoples experience and access health care in Queensland. A range of short and long-term partnerships, funding and systems interventions are recommended which will address wider institutional racism and enable Queensland to capitalise from the recent learnings from COVID-19.

QAIHC is strongly committed to continuing to be part of the solution to reform the health system so that it meets the needs of Aboriginal and Torres Strait Islander peoples, but is limited without meaningful partnership with shared decision making, power, control, responsibility and accountability.

QAIHC would be happy to discuss this submission and any of its recommendations.

Annex A: Examples of potential performance indicators for HHSs to measure progress towards health equity.

The table below, developed by QAIHC's Public Health Medical Officer Dr Sophia Couzos, shows factors that influence health equity (influenced by Wagner's Chronic Disease Care Model[6,7]) and includes examples of potential indicators that HHSs could report on that have relevance to the steps that could be taken towards health equity.

This table is being shared to provide an example of the types of factors and measures that a Health Equity Joint Advisory Committee could explore and develop and not as a proposal for what should be measured.

FACTORS THAT INFLUENCE HEALTH EQUITY	**EXAMPLES OF POTENTIAL PERFORMANCE INDICATORS FOR HHS's TO MEASURE PROGRESS TOWARDS HEALTH EQUITY***
Healthcare provider factors	
Patient-centredness	Patient Reported Experience Measures (PREMs) *e.g. surveying patients if their agenda was met, if communication was clear, if there was shared decision-making, or measuring average waiting times to be consistent with standards*
	Patient reported outcome measures (PROMs) *e.g. measuring change in the severity of a patient's pain; measuring change in patient's self-assessed health status*
Cultural sensitivity of providers	Measures of the cultural sensitivity of staff *e.g. % of staff who have taken-up of training); number of complaints from patients*
Health service factors	
Organisational influences	Evidence of the employment of Aboriginal and Torres Strait Islander peoples for a workforce reflective of the population in the region
	Indicators of the cultural sensitivity of the health service e.g. Indicators to measure 'discharge against medical advice'
	Governance *e.g. the presence of Aboriginal and Torres Strait Islander members of the HHS Board*
Information systems	Measures of the quality of care (disaggregated for Aboriginal peoples and Torres Strait Islanders) to audit progress to meet equity targets
Delivery system	Evidence that flexible systems exist to support the delivery of opportunistic care *e.g. non-appointment-based services*
	Evidence that transport support (if provided) is being utilised by Aboriginal and Torres Strait Islander patients

[6] Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. Health Aff (Millwood) 2001. 20: 6: 64-78

[7] Wagner EH et al. Quality Improvement in Chronic Illness Care: A Collaborative Approach. Journal on Quality Improvement 2001 27(2):68 -18

	Evidence of streamlined referral pathways for patients
	Description of specific programs developed to Close the Gap *e.g. screening programs including co-design parameters*
Health literacy and self-management support	Evidence of educational resources developed for the target group; establishment of or referral to self-help groups, etc.
Community and other health linkages	Evidence that the health service partners with community organisations to support continuity of care, transfer of patient information, and patient follow-up *e.g. hospital discharge follow-up arrangements for every patient; arrangements for access to medications after discharge*
	Indicators to measure patient access to allied and/or specialist health services.
Health system factors	
Universal coverage	Indicators that health service operating hours are consistent with community demand; Indicators for patient access to allied health and specialist services
Access to primary health care	Communities have access to comprehensive primary health care (and not just primary medical care) such as through transitioning to Aboriginal community control. *e.g. existing indicators consistent with online services reporting (OSR) and nKPIs for ACCHSs; indicators of reduced reliance on emergency departments and increased patient attendance with PHC services*
Workforce innovation	Workforce measures that report on an expanded scope of practice for staff in rural and remote locations to provide more cost-effective services locally *e.g. non-dispensing pharmacist services; use of telehealth; Aboriginal and Torres Strait Islander practitioners*
Financial subsidies/incentives	Performance measures for staff to meet equity targets with associated incentives
Integration of health systems	Indicators of progress towards integrated information systems *e.g. shared electronic health records; satisfaction of PHC providers with discharge summaries and communication from specialists; other indicators of the degree of integrated health care*

This table has been informed by Wagner's Chronic Disease Care Model and principles of integrated care.

*This list includes a mixture of lead and lag indicators. Lead indicators are indicators that precede an outcome and are about input. They are hard to measure but easy to change. For example, number of staff trained in cultural safety. Lag indicators are about measuring output or outcomes. They are easy to measure but are hard to change, such as the number of patients who discharge against medical advice.

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