Consultation Report

Cairns consultation

14 MAY 2021

Making Tracks towards health equity with Aboriginal and Torres Strait Islander peoples—working together to achieve life expectancy parity by 2031

Discussion Paper

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government

Making Tracks towards health equity with Aboriginal and Torres Strait Islander peoples—working together to achieve life expectancy parity by 2031

Consultation report: Cairns consultation

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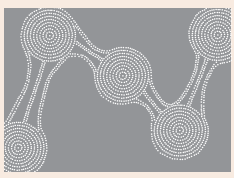
Acknowledgement of Country

Queensland Health and the Queensland Aboriginal and Islander Health Council (QAIHC), the peak body representing Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) in Queensland, acknowledge the Traditional and Cultural Custodians of the lands, waters and seas across Queensland, pay our respects to Elders past and present, and recognise the role of current and emerging leaders in shaping a better health system. We recognise the First Nations peoples in Queensland are both Aboriginal peoples and Torres Strait Islander peoples, and support the cultural knowledge, determination and commitment of Aboriginal and Torres Strait Islander communities in caring for the health and wellbeing of our peoples for millennia.

Making Tracks artwork produced by Gilimbaa for Queensland Health.



Sharing Knowledge artwork produced by Casey Coolwell for QAIHC.

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Introduction

The Cairns regional consultation was undertaken on 14 May 2021 at Novotel, Cairns. The consultation had 25 participants and was conducted over a five-hour period.

Workshop purpose

The regional workshops were held statewide to:

- **increase the understanding of the Health Equity agenda**
- **explore how the Health Equity Regulation will change the health landscape in Queensland**
- **discuss what this means for Hospital and Health Services (HHSs) and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) in delivering health services**
- **explore the implications and associated challenges for HHSs in meeting their requirement to prepare their Health Equity Strategy (HES) within 12 months of the regulation being passed**
- **identify any tools that would assist HHSs to develop their HES**
- **socialise other potential health reforms (outlined in section 3 of the Discussion Paper) to identify the ones that have the greatest support and to identify any other important reform items.**

Workshop structure

The workshop was broken into three parts to correspond to the three sections of the Discussion Paper. Each section was discussed and explored through key questions and subsequent discussion with the groups. Scribes from Queensland Aboriginal and Islander Health Council (QAIHC) and the Department of Health took notes to capture the essence of the discussions and the thoughts and opinions of the participants.

Section 1

Discussed the journey that Aboriginal and Torres Strait Islander peoples have taken to improve health outcomes in Australia and Queensland since 1971.

This included the services undertaken by the Aboriginal and Torres Strait Islander community-controlled sector and Queensland Health. While there have been some health gains, the current pace of reform and activities is not enough to meet the Close the Gap (CTG) targets by 2031.

Section 2

Discussed the health equity journey since 2017, including the current tranche of reforms being introduced in Queensland through the new Health Equity Strategy Regulation. There are going to be additional accountability requirements on HHSs to demonstrate co-design and working in partnership with ATSICCHOs.

Explored the current issues with the local health system and what will need to be done to build a health system that better meets the needs of community and where all providers are working collaboratively towards improved health outcomes.

Section 3

Discussed the 20 proposed ideas to drive further system reforms to supplement the new HESs.

These 'ideas' are not limited to 20 as others could be identified, but it is important to have an idea of what could be relevant to this region and its priority. Details of the ideas are provided in Appendix 3.

Report structure

During the consultative process across the state, there was overall agreement that the health equity design principles (page 23 of the Discussion Paper) should include cultural capability and social determinants of health. Accordingly, the health equity design principles used for this report are:

- First Nations leadership
- local and regional decision making
- reorienting local health systems
- cultural capability (this could be changed to cultural safety)
- social determinants of health.

Further, five key themes have emerged from the workshops. These are:

- systems
- care
- funding
- workforce
- culture.

This report drills down further to map the principles to the key themes. There is often overlap in the learnings and how they have been attributed to the principles, so you may see some comments in multiple places as they are applicable to a variety of areas.

Executive summary

Many of the discussions focused on the opportunity provided by the new HES to strengthen the local health system by building upon the strong foundations and regional partnerships that already exist across the region. The next step is creating the necessary checks and balances across the health system to become a 'collective health system', accountable to each other and community. The ongoing experience of racism and discrimination in all its forms; from institutional racism to direct experiences of racism, was discussed frankly with the observation made that many non-Indgenous remain blind to their own personal or institutional biases, with the 'the fiction of terra nullius still the unconscious driver for many'.

Other key themes included:

- The need to invest in the supply pipeline for a local Aboriginal and Torres Strait Islander health workforce by creating supportive pathways for young people.
- 'Cultural standards of care' needing to become embedded as the norm across the health system because mob don't feel culturally safe.
- Other portfolios needing to increase their understanding and commitment to addressing the social determinants of health because the health sector does not create the conditions for people to live healthy lives.
- Integrated health service planning being dependent on regular data sharing between healthcare partners, including private GPs.
- The requirement for co-authorised power-sharing arrangements between the HHS and the ATSICCHO sector for the new HES to genuinely redesign and 'shift' the local health system to place patients at the centre.

Top five health reforms

considered a priority for this region by the participants.

3 **Legislate the responsibilities of the Chief ATSI Health Officer**

16 **Factor equity into existing QH funding models**

1 **Establish a First Nations Health Board**

2 **Increase QH First Nations employment target**

20 **Drive an anti-racism strategy across the health system**

Key discussion points

The discussion from the Cairns consultation will be incorporated into the overall state consultation report, which will be used to develop the guide and toolkit that HHS will use to develop their health equity strategies over the next 11 months.

The ideas discussed during the workshop have been mapped against the health equity design principles and can be used to have further conversations about what actions need to be undertaken to redesign the local health system to better meet the needs of people in the Cairns region.

Principle 1: First Nations leadership	
Systems	• More support, training and mentoring/professional development is needed to build the capability of ATSICCHO boards and the wider community—need to support 'home grown leaders' and encourage more community members to take on leadership roles. • A reputational risk exists for ATSICCHOs because they alone cannot achieve health equity for Aboriginal and Torres Strait Islander peoples—QH cannot shift the entire responsibility for health equity to the sector. • The new HES will require working with Aboriginal and Torres Strait Islander peoples, community and organisations to design, deliver and monitor a renewed local health system.
Workforce	• Need to build a skilled local workforce in community and encourage resource sharing (re positions working across primary and acute care settings)—local supply pathways need to skill young people for clinical and non-clinical positions across the health system.
Culture	• Need to be guided by frontline Aboriginal and Torres Strait Islander staff about experiences of systemic racism—to identify what's happening and what improvements are needed to address the barriers.

Principle 2: Local and regional decision making	
Systems	• Strong regional health partnerships exist in the Cairns region to develop the new HES and drive broader system-wide reforms. • The new HESs need to be co-authorised, with both parties having the same level of authority and decision making at the table—this will make 'co-design', 'co-ownership' and 'co-implementation' real. • Substantial improvements can be made across the health system—need to focus on what health partners can do locally, as well as state and national (federal) level reforms. Realistic actions and performance measures (process, output and outcomes) need to be included in the HES. • Improvements are needed to share data across healthcare providers and other key providers. • The Aboriginal and Torres Strait Islander regional health plan (*Stronger Mob, Living Longer*) are releasing an annual public report card to strengthen accountability back to community. • Timely (monthly/quarterly) local/regional data needs to be shared between healthcare providers and with community to enable integrated service planning and to track progress.

Principle 2: Local and regional decision making	
Care	• Queensland Health and the HHSs need to shift how they work re partnerships and supporting First Nations-led models of care.

Principle 3: Reorienting local health systems	
Systems	• Need to maximise and make the most of Health and Wellbeing Queensland (HWQ) and the statutory role it plays in health promotion and driving health equity because they are an implementation partner in the new HESs. • The new HES will need to look at ways to improve the patient journey/flow between Cairns, Cape, Torres and NPA. • Stronger relationships/partnerships are needed with private GPs because some Aboriginal and Torres Strait Islander peoples choose to access private primary healthcare.
Care	• Examples of good practice exist where healthcare is provided outside of hospital—for example, Wuchopperen provides some out-of-hospital cardiac rehab services, and Gurriny Yealamucka Health Service provides dialysis. More of these models are needed because mob prefers to attend local services rather than the hospital. • Maximising quality of life needs to be an integral part of models of care—for example, people undergoing dialysis and older people can't be tied to a dialysis chair or their rooms. • Holistic care requires integrated care across the patient journey—primary health needs to sit alongside both secondary (hospital) and tertiary (specialist) care. • More investment is needed to ensure clinical governance places client outcomes (consumers/patients/community) front and centre. • Need to strengthen models of care that proactively support people with chronic disease before they experience acute conditions.
Funding	• Current funding arrangements need to change—time-limited funding (for programs/services) does not support effective strategic planning to design and deliver effective, sustainable care.
Workforce	• Greater investment and effort are needed to build the supply and pipeline for more Aboriginal and Torres Strait Islander people in the health sector (clinical and non-clinical roles). Workforce targets aren't enough—need the target and new incentivised pathways to increase the supply. • Innovative workforce models are needed to make the most of multidisciplinary skillsets. • Opportunities exist through the new Health Equity Strategy and broader health equity reforms for HHSs to develop new models of care that could outsourced to ATSICCHOs.
Culture	• Cultural standards of care need to be part of the core curriculum for all healthcare professionals and regulated as part of scopes of practice. This can't be achieved through a few lectures—a substantial revision is required to the health curriculum to ensure every person who graduates has certified modules.

Principle 4: Cultural capability	
Systems	• 'Did not attend' indicates mob are not coming or engaging with the HHS—these occurrences (and trends—growing or decreasing) mean existing practices and processes need to change for mob to feel comfortable. • Re-running the institutional racism matrix audit across the local health system (for the Cairns and Hinterland HHSs and other health providers) could be another way for local healthcare providers to develop a plan for improvements and increasing accountability by linking it to accreditation. • Patient Reporting Experience Measure (PREMs) (patient voice) data needs to be better used to improve the experience of consumers when accessing hospital-based care.
Culture	• Cultural standards of care need to become embedded as part of standard practice/patient safety for our mob—daily processes and practices need to recognise cultural needs. • Need to identify and address institutional racism across the health system—this will involve challenging entrenched values, beliefs and mindsets held about Aboriginal and Torres Strait Islander peoples. • The health system and broader society still do not understand they continue to operate unconsciously from the premise of terra nullius (= institutional racism). • Direct racism is still prevalent across the health system—it is not only institutional racism that needs to be addressed. Direct experiences of racism (re racist abuse) point towards values/mindsets that are difficult to change.

Principle 5: Social determinants	
Systems	• Accountability measures need to be created for other non-health portfolios to drive change and support the HESs. • Holistic care needs to be factored in to address the social determinants of health because a person's life determines their health—this requires community/client engagement models to understand family health ('see health in the wider context') via home or household/family outreach (re home audits). • Need to recognise that achieving life expectancy parity (by 2031) is a composite target that requires both health and non-health solutions (for example, housing, employment education). • A key challenge is breaking down silos between government departments and portfolios—a lack of understanding exists about the new agreement (*National Agreement on Closing the Gap*) and the responsibilities of departments/portfolios to drive changes and implement agreed actions/initiatives. • Formalised processes/arrangements (re MOUs) are needed between the local health sector (HHSs and primary health care) and other portfolios about the social determinants of health.

Appendix 1—Section 1: The journey so far...

Attendee's comments/views/input
General discussion
• The current working definition (p22) uses deficit language—it is more important to look forward than look backwards ... ' ... don't want to look in the rear-view mirror'.
• Support for elements of the WHO, New Zealand and Victoria definitions (refer page 10 in the Discussion Paper).
• The current working definition needs to reflect the following ideas—equal access, equity voice, right to say no, informed consent and acknowledge the importance of place, country and local belief/knowledge systems.
• The new HESs need to be co-authorised, with both parties having the same level of authority and decision making at the table—this will make 'co-design', 'co-ownership' and 'co-implementation' real.
• 'Cultural standards of care' need to become embedded as part of standard practice/patient safety for our mob—daily processes and practices need to recognise cultural needs.
• 'Cultural standards of care' need to be part of the core curriculum for all healthcare professionals and regulated as part of scopes of practice. This can't be achieved through a few lectures—a substantial revision of the health curriculum is required to ensure every person who graduates has certified modules. The ATSICCHO sector does not have the resources to build these skills—it needs to be the responsibility of education providers.
• More clinical placements are needed for doctors and nurses in the ATSICCHO sector or in geographical locations with a high proportion of Aboriginal and Torres Strait Islander peoples.
• Cultural onboarding processes need to occur before health professionals commence—this is not currently part of AHPRA skill requirement. Regional ATSICCHO peaks could potentially take on this role and provide onboard cultural training before health professionals commence with ATSICCHO members.
• Examples of good practice exist where healthcare is provided outside of hospital—for example, Wuchopperen provides some out-of-hospital cardiac rehab services, and Gurriny Yealamucka Health Service provides dialysis. More of these models are needed because mob prefers to attend local services rather than the hospital. A dialysis chair in every ATSICCHO would result in improved health outcomes because care would be culturally safe.
• Maximising quality of life needs to be an integral part of models of care—for example, people undergoing dialysis and older people can't be tied to a dialysis chair or their rooms. Additional assistance is needed to support people to engage with life, move around and stay socially connected.
• Holistic care requires integrated care across the patient journey—primary health needs to sit alongside both secondary (hospital) and tertiary (specialist) care.
• Further consumer education needs to be provided for patients/community members to have information about services available, what they should expect as the standard/level of care, and how to complain if they don't receive this level of care.
• Holistic care needs to be factored in to address the social determinants of health (SDoH) because a person's life determines their health—this requires community/client engagement models to understand family health ('see health in the wider context') via home or household/family outreach (re home audits). Understanding home health or family health requires a proactive approach—this used to be part of the ATSICCHO model of care but it shifted due to legislative requirements (re where people can work). Reintroducing these models will be challenging because of the cost and the need to have a multidisciplinary team with health and Social and Emotional Wellbeing (SEWB) workers to make the connection between health needs, cultural norms and social support/assistance.
• New patient-monitored technology can help drive health equity and improve healthcare—needs to be innovative and bold.
• More support, training and mentoring/professional development is needed to build the capability of ATSICCHO boards and the wider community—need to support 'home grown leaders' and encourage more community members to take on leadership roles.

Appendix 2—Section 2: Embedding health equity into local health...

Placing First Nations peoples and voices at the centre of healthcare service delivery

**Have aligned comments to the health equity principles as a guide to move from concept/ideas/comments to action.*

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Challenges		
Need to recognise that achieving life expectancy parity (by 2031) is a composite target that requires both health and non-health solutions (for example, housing, employment, education). Two-thirds of the life expectancy gap is attributed to the social determinants and the new HES can't achieve all these improvements in the first three year plan—the expectation is unrealistic. But over the course of three HESs (three years each), measurable improvements can be made. This needs to be communicated to community and other health and non-health stakeholders.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems P5: Social determinants
Accountability measures need to be created for other non-health portfolios to drive change and support the HESs. As part of the implementation of the *National Agreement on Closing the Gap* (2020), governance and accountability measures are being created across the Queensland Government to ensure joined up effort across portfolios to achieve the 16 Closing the Gap targets.	• Social determinants.	P2: Local and regional decision making P5: Social determinants
Substantial improvements can be made across the health system—need to focus on what health partners can do locally, as well as state and national (federal) level reforms. Realistic actions and performance measures (process, output and outcomes) need to be included in the HES so the impact/change can be measured over three years.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
A reputational risk exists for ATSICCHOs because they alone cannot achieve health equity for Aboriginal and Torres Strait Islander peoples—QH cannot shift the entire responsibility for health equity to the sector. QH and the HHSs need to shift how they work re partnerships and supporting First Nations-led models of care. QH and HHSs have substantial levers they can use to change the health system landscape—they need to shoulder their responsibility to change how they develop and deliver policies and services.	• Local health system improvements.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
A key challenge is breaking down silos between government departments and portfolios—a lack of understanding exists about the new agreement (National Agreement on Closing the Gap) and the responsibili-ties of departments/portfolios to drive changes and implement agreed actions/initiatives. The time taken for governments to adopt, fund and allocate resources for new initiatives is substantial—the ATSICCHO sector continues to advocate for change.	• Social determinants.	P5: Social determinants
Need to identify and address institutional racism across the health system—this will involve challenging entrenched values, beliefs and mindsets held about Aboriginal and Torres Strait Islander peoples; increasing the number and level of identified positions across the health system—because most mainstream organisations are not culturally safe, it is difficult for Aboriginal and Torres Strait Islander individuals to be the only identified position; supporting mentorship arrangements; creating more leadership opportunities for Aboriginal and Torres Strait Islander people with different skillsets—leadership is not only for Aboriginal and Torres Strait Islander people with advanced degrees.	• Racism and discrimination.	P1: First Nations leadership P4: Cultural capability
The health system and broader society still do not understand they continue to operate unconsciously from the premise of terra nullius (= institutional racism). While this legal fiction was overturned through the Mabo decision, many non-Aboriginal and Torres Strait Islander people do not understand that institutional racism exists across society because this fact remains largely ignored in principle and practice. More conversations and discussions are needed about institutional racism, why it exists and how it can be challenged.	• Racism and discrimination.	P1: First Nations leadership P4: Cultural capability
'Did not attend' or no shows indicates mob are not coming or engaging with the HHS—these occurrences (and trends—growing or decreasing) mean existing practices and processes need to change for mob to feel comfortable. New approaches may include education (re health literacy) and putting in place new/redesigned cultural mechanisms for people to feel safe.	• Racism and discrimination.	P3: Reorientating local health systems P4: Cultural capability
Co-evaluation needs to become the norm—health services/models of care need to be evaluated by consumers and partners.	• Enhance/ expand existing models of care.	P1: First Nations leadership P2: Local and regional decision making
Direct racism is still prevalent across the health system—it is not only institutional racism that needs to be addressed. Direct experiences of racism (re racist abuse) point towards values/mindsets that are difficult to change—sometimes these ideas can be altered if the person has the right attitude (open) but it's a long process and challenging for all parties.	• Racism.	P4: Cultural capability

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Aboriginal and Torres Strait Islander Health Workers (ATSIHW) are not allowed to practice to same degree as other states—this is an example of institutional racism in practice that needs to be fixed.	• Racism.	P3: Reorientating local health systems P4: Cultural capability
More investment is needed to ensure clinical governance places client outcomes (consumers/patients/community) front and centre. Continuous quality improvement processes need to be properly resourced to support genuine engagement with consumers/patients/community.	• Enhance/expand existing models of care.	P3: Reorientating local health systems
Need to strengthen models of care that proactively support people with chronic disease before they experience acute conditions (re heart attack). This may involve HHSs partnering with ATSICCHOs to identify the top 20% of patients with complex needs (via re-admissions/PPH data) for ATSICCHOs to provide intensive follow-up primary healthcare to reduce hospital re-admissions.	• Enhance/expand existing models of care.	P3: Reorientating local health systems
Formalised processes/arrangements (re MOUs) are needed between the local health sector (HHSs and primary health care) and other portfolios about the SDoH. Some portfolios require further education to understand the relationship between their portfolio (for example, housing) and the direct impact it has on health. Housing is a big issue in the region—the Department has been demolishing houses but not replacing them, resulting in substantial overcrowding (18 people per household in Kuranda and nine in Mareeba). A community housing organisation is now managing housing stock (the Department of Housing transferred management to a community organisation) but more housing (new stock) is needed. A regional forum could be organised to identify other stakeholders to bring to the table to support the new HES.	• Social determinants.	P5: Social determinants
The South Cairns Collective is a local community initiative being facilitated by James Cook University to facilitate improvements about education, law and order, and community safety. The health sector is part of the collective and part of the process for change but not leading it—many examples exist where the health sector is partnering with other portfolios to influence the SDoH.	• Social determinants.	P5: Social determinants

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Need to maximise and make the most of HWQ and the statutory role they play in health prevention and driving health equity because they are an implementation partner in the new HESs. Health promotion, prevention and early intervention make up the 'primary' in primary healthcare and a better relationship is needed with HWQ to support the ATSICCHO sector (for example, life modification programs). HWQ could potentially partner with the ATSICCHO sector to assess the effectiveness of current SEWB models of care and manage a wellbeing data hub. The original intent of the SEWB models has been lost in the health system and reduced to a very limited service scope that falls under 'mental health' rather than 'wellness'. The community wellbeing aspect of SEWB models needs to be prioritised and the scope expanded to focus on what makes our community well.	• Reorienting local health systems.	P3: Reorientating local health systems
Improvements are needed to share data across health care providers and other key providers (for example, housing and education) to better respond to identified health needs and priorities in the region.	• Reorienting local health systems.	P2: Local and regional decision making P3: Reorientating local health systems
Public Health Unit (PHU) has both a local remit and statewide remit (for rheumatic heart disease and environmental health) and are very keen to support the development of the new HES. PHU has the data and the public health level expertise that can support the community's voice.	• Reorienting local health systems.	P2: Local and regional decision making P3: Reorientating local health systems
The new HES will need to look at ways to improve the patient journey/flow between Cairns, Cape, Torres and NPA—and address some of the current challenges with patient transport and accommodation for patients accessing care at the Cairns hospital.	• Local health system improvements.	P3: Reorientating local health systems
Some current models of care need to be redesigned—for example, some patients undergoing cardiac rehabilitation are expected to return to community where the workforce and community services are not available to provide them with the support they need. Liability is transferred back to community without the resources (re workforce). A tailored approach is needed that takes into account the needs of patients and capacity of community—in the case of cardiac rehab and dialysis, it would be better for some patients to be provided with accommodation for six weeks with easy access to the hospital, with additional wrap-around support as needed (re transport, meals, social support).	• Enhance/expand existing models of care.	P3: Reorientating local health systems P5: Social determinants

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Current funding arrangements need to change—time-limited funding (for programs/services) does not support effective strategic planning to design and deliver effective sustainable care. Better funding certainty and a budget allocation is needed to design/redesign new models of care, including a flexible regional funding pool for innovation models. All health partners could contribute towards an innovative fund and develop the criteria for it to be used for local initiatives/projects.	• Improved funding arrangements.	P2: Local and regional decision making P3: Reorientating local health systems
The new HES will require working with Aboriginal and Torres Strait Islander peoples, community and organisations to design, deliver and monitor a renewed local health system. A collective understanding and agreement will be required between all partners about what is needed (priorities) and how these priorities will translate into on-the-ground actions. A starting point could be looking at the patient journey and responding to identified barriers/challenges/gaps in care to improve effectiveness (re referral pathway). The new regional hub will focus on this—re. the connection between primary health care and secondary/tertiary care.	• Local health system improvements.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems P4: Cultural capability P5: Social determinants
HHS Chairs and CEs have a pivotal role in driving health equity reforms across the HHSs and health systems—their leadership needs to be visible. All executives/Divisions within HHSs need to be driving changes and allocating budgets towards redesigning their care—it cannot be driven and funded by the Aboriginal and Torres Strait Islander health areas alone because one division cannot be responsible for redesigning the whole health system. HHS Board Chairs and CEs have a role in ensuring all parts of the HHS are committed to the health equity agenda.	• System leadership.	P2: Local and regional decision making P3: Reorientating local health systems
Stronger relationships/partnerships are needed with private GPs because some Aboriginal and Torres Strait Islander peoples choose to access private primary healthcare. Private GPs are often the missing partner in healthcare planning conversations—need to work with PHNs to develop ways to engage with private GPs and share data.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
Enablers		
The National Agreement on Closing the Gap (2020) is the mechanism for other government departments/portfolios to support health equity. Strong leadership is needed by the Department of Premier and Cabinet to ensure all departments and portfolios support the implementation of the agreement at statewide, regional and local levels. The HESs will be the local mechanisms for the health sector to collaborate and partner with other departments/portfolios.	• System leadership.	P2: Local and regional decision making P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Greater investment and effort are needed to build the supply and pipeline for more Aboriginal and Torres Strait Islander people in the health sector (clinical and non-clinical roles). Workforce targets aren't enough—need the target and new incentivised pathways to increase the supply. Aboriginal and Torres Strait Islander peoples in the health system are a limited resource and do not want to normalise a landscape where QH/HHS and ATSICCHO are poaching staff from each other.	• Build and strengthen local Aboriginal and Torres Strait Islander workforce.	P1: First Nations leadership P3: Reorientating local health systems
Cultural safety is not done well for Aboriginal and Torres Strait Islander people—improvements are needed across the health system for mob to feel safe.	• Cultural capability.	P1: First Nations leadership P3: Reorientating local health systems P4: Cultural capability
Need to be guided by frontline Aboriginal and Torres Strait Islander staff about experiences of systemic racism—to identify what's happening and what improvements are needed to address the barriers. Many times examples of systemic racism are identified when frontline staff experience barriers to care for mob—for example, outreach care is needed but the existing model of care is clinic-based; outreach clinic times are changed without any notice or consideration of the impact on family and community; Patient Transport Support Service have not considered the time taken to organise family care for a patient out of community.	• Local health system improvements.	P3: Reorientating local health systems P4: Cultural capability
Current Aboriginal and Torres Strait Islander regional health plan (*Stronger Mob, Living Longer*) are releasing an annual public report card to strengthen accountability back to community. Cairns and Hinterland HHS are currently designing a reporting dashboard to provide regular data about health system performance for Aboriginal and Torres Strait Islander peoples.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
Re-running the institutional racism matrix audit across the local health system (for the Cairns and Hinterland HHSs and other health providers) could be another way for local healthcare providers to develop a plan for improvements and increasing accountability by linking it to accreditation. The Cairns and Hinterland HHS currently undertakes an annual leadership self-survey about health equity using a modified American tool for executives and leaders to assess HE in practice (culturally, structurally and programmatically). If an area has a rating of 3 out of 5, they need to identify actions to improve their health equity rating. The tool is not focused solely on Aboriginal and Torres Strait Islander health equity but a general 'equity' assessment for the public health system leaders to be accountable for continuous institutional improvements by assessing the system (re corporate, leadership, complaints, patient outcomes, workforce).	• Racism and discrimination.	P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
PREMs (patient voice) data needs to be better used to improve the experience of consumers when accessing hospital-based care. PREMs can be used as an outcome measure because it collects data on patient experiences. Existing PREMs data needs to be disaggregated/analysed for Aboriginal and Torres Strait Islander people to guide how services can be delivered differently. Targeted questions about cultural safety and racism/discrimination need to be captured through PREMs data.	• Local health system improvements.	P1: First Nations leadership P3: Reorientating local health systems P4: Cultural capability
Feedback (including complaints) needs to be directly captured from Aboriginal and Torres Strait Islander peoples about their experiences when accessing care.	• Local health system improvements.	P3: Reorientating local health systems P4: Cultural capability
Need to build a skilled local workforce in community and encourage resource sharing (re positions working across primary and acute care settings)—local supply pathways need to skill young people for clinical and non-clinical positions across the health system (not only ATSIHW). Integrated workforce models will result in a cross-pollination of culturally safe practices across sectors and address discrimination and racism. HR and corporate flexibility is needed to shift people and resources to where they are needed the most.	• Build and strengthen the local health workforce.	P1: First Nations leadership P3: Reorientating local health systems P4: Cultural capability
Secondments need to be formalised between health care providers/settings/sectors to enrich cultural safety for patients. The skill base needs to be shared across sectors/settings/providers rather than competing for limited resources (including GPs and allied health staff). Practices and processes are more likely to be improved and streamlined when team members are working across multiple settings—duplications/inefficiencies will be reduced.	• Build and strengthen the local health workforce.	P3: Reorientating local health systems P4: Cultural capability
Innovative workforce models are needed to make the most of multidisciplinary skillsets—for example, there's only a limited supply of Aboriginal and Torres Strait Islander doctors. Need to think about health differently and employ a mix of clinicians and non-clinicians such as health educators, lifestyle coaches and mentors/role models who can help people with chronic diseases manage and navigate their own health journey.	• Build and strengthen the local health workforce.	P3: Reorientating local health systems P4: Cultural capability
Timely (monthly/quarterly) local/regional data needs to be shared between healthcare providers and with community to enable integrated service planning and to track progress. Examples of the types of local health data needed include access (are people accessing the care they need when they need it?), the proportion of people accessing care, number of health checks, potentially preventable hospitalisations, discharge against medical advice, inappropriate medications.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Need to tie funding (commissioning) to agreed needs assessment, data and regional priorities via an agreed commissioning tool developed between regional health partners that is based on integrated health service planning data (re burden of disease).	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
Strong regional health partnerships exist in the Cairns region to develop the new HES and drive broader system-wide reforms. Need to build on the partnerships for providers to see themselves as part of the broader health system (part of a collective), with checks and balances occurring across the health system (not only HHSs). The immediate focus needs to be on defining local and regional priorities—heat maps could be created to identify service access based on population (*this analysis has been previously done for Edmonton). Potential geographical regions include Kuranda, Mantaka, Mona Mona, Mooroobool, Manundra, Yarrabah, Ravenshore and Mt Garnet.	• Local health system improvements.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems
Opportunities exist through the new HES and broader health equity reforms for HHSs to develop new models of care that could outsourced to ATSICCHOs re additional wrap-around support; at-the-elbow support throughout the patient journey to and from home to the hospital/ specialist care.	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems P4: Cultural capability

Attendee's comments/views/input

Other comments—Ideas

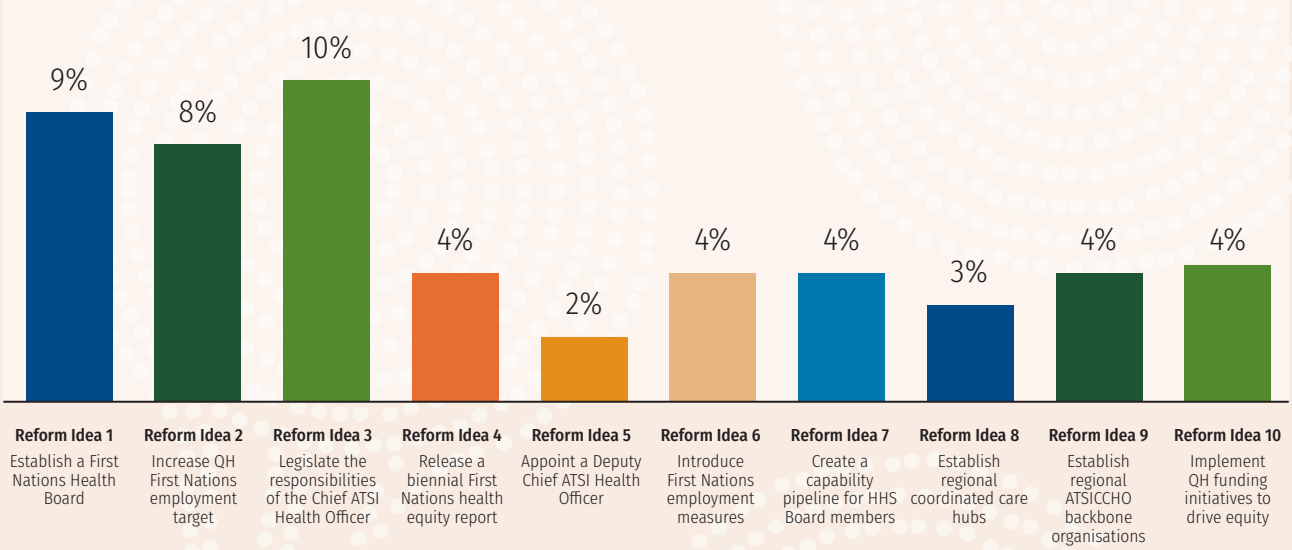
- Cairns and Hinterland HHS has had a HES for the entire HHS since 2018, which includes suite of procedures and audit processes to monitor and track how they are progressing.
- Cairns and Hinterland HHS current strategic plan runs until 2022—the Board decided to ex-tend it for 12 months. The new strategic plan will prioritise health equity and ensure Aboriginal and Torres Strait Islander representation on all community consultation committees.
- Improvements are needed to existing HHS workforce data—about 40% of EEO data is not completed. The local estimate is that about 5% of staff in the Cairns and Hinterland HHS are Aboriginal or Torres Strait Islander.
- Formal partnerships exist between the HHS and all five ATSICCHOs in the region—strong re-lationships exist between health providers.
- Existing QH cultural practice program requires revision.
- Cairns and Hinterland HHS have made a number of important improvements in delivering healthcare/existing models of care in the region—some are small but all have improved the patient journey and contributed towards better outcomes:
  - changed the way medications dispensed on discharge to ensure Aboriginal and Torres Strait Islander people don't pay on discharge
  - PTSS—based on individual patient and traveller, come to new arrangements where community-based organisation looks at patient eligibility as part of other services
  - phone no-caller ID number for palliative care changed so that mob would take the call.
- A new approach to public sector recruitment is needed to encourage more Aboriginal and Torres Strait Islander people to join the Queensland public sector and QH. A partnership needs to be brokered with the Public Service Commissioner to promote preferential recruit-ment options and direct appointments for First Nations peoples who meet the selection criteria.
- Need to support pathways for Aboriginal and Torres Strait Islanders to participate in executive training programs.
- Tools for a toolkit—checklists on what might someone need to think about as a health service:
  - stakeholder lists
  - key contact details
  - initial letter out saying what about to embark on
  - key messages, communications, stakeholder analysis
  - everything you need to top and tail cut paste, to make process as easy as possible
  - local level input
  - here are some suggestions of what you can do:
  - we're in this together, done some good work, not done enough
  - senior and chair co-host alongside ATSICCHO first community forum
  - definitions—clear understanding of key words.

Appendix 3—Section 3: Driving health equity across the health system and addressing the social and cultural determinants of health...

Future ideas for discussion

Cairns Health Equity Consultation Workshop

Voting on the 20 health reform ideas in Section 3 of the Health Equity Discussion Paper



Reform Idea 1 Establish a First Nations Health Board

Reform Idea 2 Increase QH First Nations employment target

Reform Idea 3 Legislate the responsibilities of the Chief ATSI Health Officer

Reform Idea 4 Release a biennial First Nations health equity report

Reform Idea 5 Appoint a Deputy Chief ATSI Health Officer

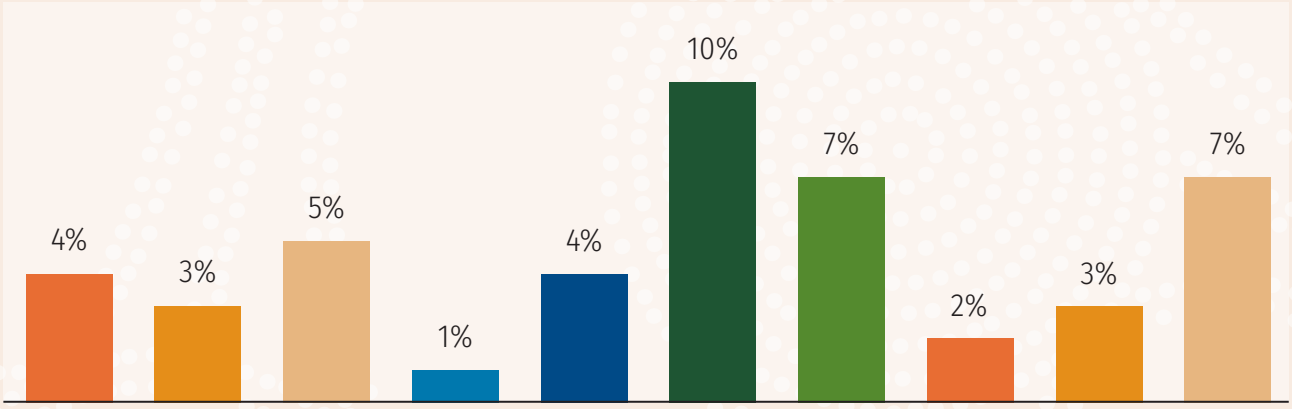
Reform Idea 6 Introduce First Nations employment measures

Reform Idea 7 Create a capability pipeline for HHS Board members

Reform Idea 8 Establish regional coordinated care hubs

Reform Idea 9 Establish regional ATSICCHO backbone organisations

Reform Idea 10 Implement QH funding initiatives to drive equity



Reform Idea 11 Embed capability into *Clinical Services Capability Framework*

Reform Idea 12 Refresh *QHATSI Cultural Capability Frameworks 2010–2033*

Reform Idea 13 Undertake annual independent institutional racism audits

Reform Idea 14 Amend birth notification to acknowledge birth parents cultural connection to Country

Reform Idea 15 Strengthen functions of other health statutory authorities to drive health equity

Reform Idea 16 Factor equity into existing QH funding models

Reform Idea 17 Utilise the Health Equity Strategies as future health investment plans

Reform Idea 18 Establish pilot Marmot city regions across Queensland

Reform Idea 19 Set statewide and regional QH procurement targets to purchase from ATSI-owned businesses

Reform Idea 20 Drive an anti-racism strategy across the health system

Appendix 4—Attendee list

Name	Organisation
Adelina Stanley	Mamu Health Service Limited
Amie Armstrong	Cairns and Hinterland Hospital and Health Service
Bevan Ah Kee	QAIHC
Cleveland Fagan	QAIHC
Dallas Hure-Little	Northern Aboriginal and Torres Strait Islander Health Alliance
Dania Ahwang	Wuchopperen Health Service Limited
Donnella Mills	Wuchopperen Health Service Limited
Gail Wason	Mulungu Aboriginal Corporation Primary Health Care Service
Graham Kissell	QAIHC
Jason Fagan	QAIHC
Jermain Isua	Queensland Health
Joy Savage	Cairns and Hinterland Hospital And Health Service
Karen Thompson	QAIHC Consultant
Loretta Rigby	Northern Queensland Primary Health Network
Maria Mene	Cairns and Hinterland Hospital and Health Service
Marie Kelly	Cairns and Hinterland Hospital and Health Service
Michelle Rothwell	Cairns and Hinterland Hospital and Health Service
Oscar Whitehead	Tropical Public Health Service
Paula Arnol	Torres Health
Robin Whyte	Northern Queensland Primary Health Network
Sandra Levers	Wuchopperen Health Service Limited
Theresa Simpson	Mookai Rosie Bi-Bayan
Tiana Lea	QAIHC
Tina Chinery	Cairns and Hinterland Hospital and Health Service
Yasmin Muller	Queensland Health

Appendix 5— Agenda

Proposed times	Agenda item
10:00–10:30am	Welcome to Country, Housekeeping, Introductions
10:30–11:00am	The Health Equity Project— • Who is on the Project Team? • What will the project do? • How will it bring better health for me and my family in the future?
11:00am–12:00pm	Discuss Section 1: The journey so far... (page 6–23)
12:00–12:30pm	LUNCH
12:30–1:30pm	Discuss Section 2: Embedding health equity in local health systems... (page 24–31)
12:30–1:30pm	Discuss Section 3: Driving health equity across the health system and addressing the social and cultural detirminants of health... (page 32–43)
2:30–3:00pm	Wrap up and close the meeting

Appendix 6—Glossary

Abbreviation	Meaning
AIHW	Aboriginal and Islander Health Worker
ATSIHW	Aboriginal and Torres Strait Islander Health Workers
AMS	Aboriginal Medical Service
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
CATSIHO	Chief Aboriginal and Torres Strait Islander Health Officer
CE	Chief Executive
CTG	Closing the Gap
DAMA	Discharge Against Medical Advice
DATSIP	Department of Aboriginal and Torres Islander Partnerships
ED	Emergency Department
FN	First Nations
FNQ	Far North Queensland
HES	Health Equity Strategy
HHS	Hospital and Health Service

Abbreviation	Meaning
HR	Human Resources
HWQ	Health and Wellbeing Queensland
IUIH	Institute for Urban Indigenous Health
KPIs	Key performance Indicators
LANA	Local area needs analysis
MHAOD	Mental Health and Other Drugs
OH&S	Occupation Health and Safety
PHC	Primary health care
PHN	Primary Health Network
PTSS	Patient Travel Subsidy Scheme
QAIHC	Queensland Aboriginal and Islander Health Council
QH	Queensland Health
RN	Registered Nurse
SDoH	Social determinants of health
SEWB	Social and Emotional Wellbeing (also ESWB)
WHO	World Health Organization

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government