Consultation Report

Hervey Bay consultation

15 APRIL 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

AUDAX AT FIDELIS
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: Hervey Bay consultation

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For more information contact

Aboriginal and Torres Strait Islander Health Division
Department of Health
GPO Box 48
Brisbane QLD 4001

Phone **07 3708 5557**

An electronic version of this document is available at **health.qld.gov.au** and **qaihc.com.au**

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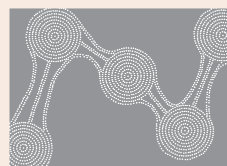
Acknowledgement of Country

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 Hervey Bay consultation workshop was undertaken on 15 April 2021 at the Oaks, Hervey Bay. The consultation had nine 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 Queensland Health (QH) 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 health 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, it's 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

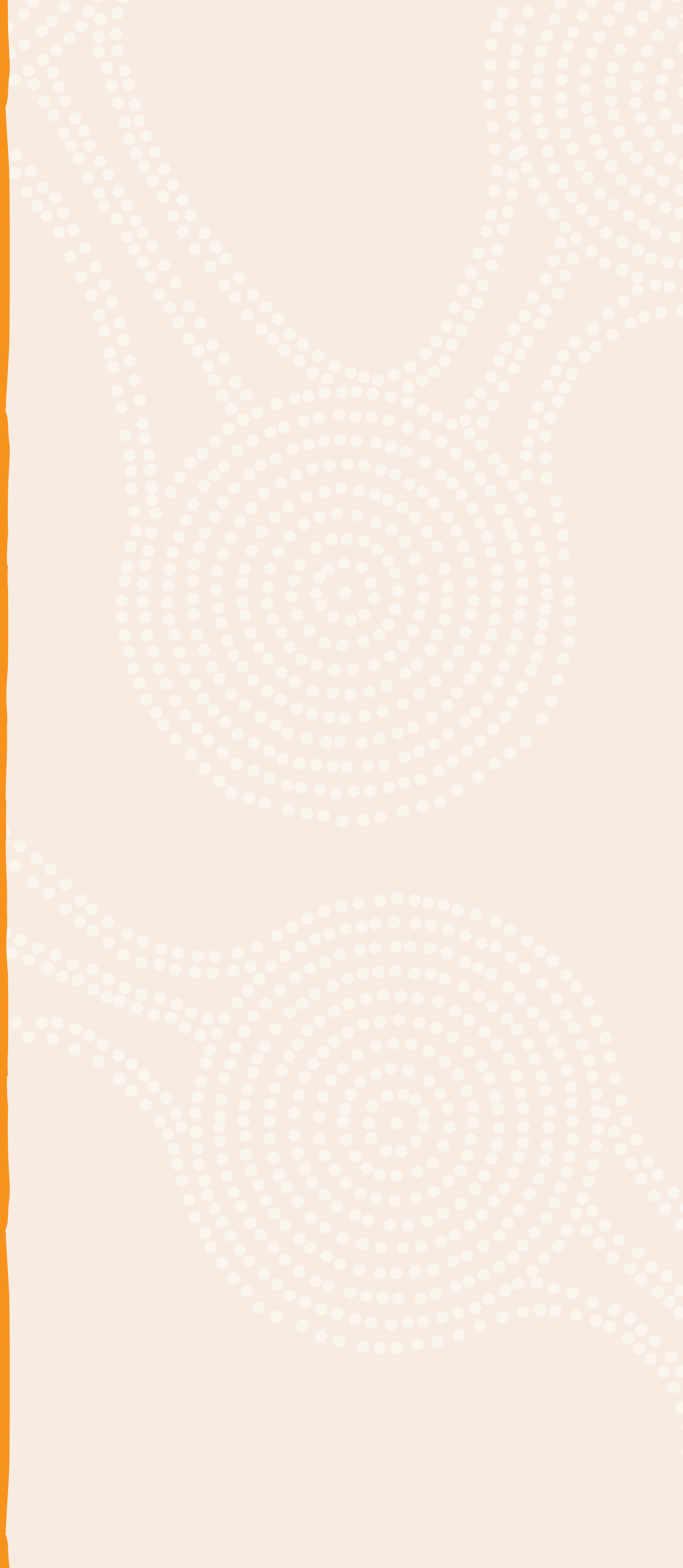
During the consultative process across the state, there was overall agreement that the health equity design principles (page 23 of the Discussion Paper) should include cultural capability and social determinants of health. Accordingly, the health equity design principles used for this report are:

- 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

The workshop generated robust discussions about the need for local health system change and reform. A lot of specific (real-life) examples were discussed about the experiences of Aboriginal and Torres Strait Islander community members, which is often vastly different to the commitments made in numerous state and national policy documents. Participants welcomed the opportunity presented by the new Health Equity Strategy to reset the local health system but were realistic about the challenges because previous attempts over the years had not resulted in sustained or substantive improvements.

Key themes discussed included:

- Resource allocation needs to be appropriate to need and to ensure that service delivery in being delivered in partnership and not duplicating effort.
- Recognition of the past needs to occur but a forward-looking plan is required. This plan needs to look at what has worked in the past and what has not. CTG outcomes have not been achieved and future investment needs to make sure they are.
- Community consultation needs to occur at a broader level and there needs to be accountability mechanisms built into future strategies.
- Models of care need to be developed that meet the communities' needs and outreach and in-reach services.
- A workforce strategy needs to be implemented to ensure a long-term pipeline of culturally appropriate health service professionals.
- An audit into racism and anti-racism strategies needs to be implemented to provide a culturally safe space for Aboriginal and Torres Strait Islander people within the health system.

Top five health reforms

considered a priority for this region by the participants

- **2** — **Increase Queensland Health's First Nations employment target**
- **8** — **Establish regional coordinated care hubs**
- **9** — **Establish regional ATSICCHO backbone organisations**
- **11** — **Embed cultural capability into Clinical Services Capability Framework**
- **4** — **Release a biennial First Nations health equity report**

Key discussion points

The discussion from the Hervey Bay consultation will be incorporated into the overall state consultation report. This will be used to develop the guide and toolkit that the 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 Hervey Bay region.

Principle 1: First Nations leadership	
Systems	• Need to have partnerships and clear definitions about roles of each service within the system.
Funding	• Need to ensure that funds are allocated to areas best positioned to provide that service. • Need to consider best use of limited resources and ensure systems are not duplicating effort.

Principle 2: Local and regional decision making	
Systems	• Need to ensure effective partnerships are in place. • Need accountability. • Need to have partnerships and clear definitions about roles of each service within the system. • Need to consider best use of limited resources and ensure systems are not duplicating effort. • Need to have partnerships and clear definitions about roles of each service within the system.
Care	• Need to identify the needs and the how to align service. • Need to identify what is working and what is not to develop new agenda.

Principle 3: Reorienting local health systems	
Systems	• Need to establish partnerships and have accountability. • Need Memorandums of Understanding (MOUs). • Need partnership agreements.
Care	• Need to consider models of care such as local access to specialists. • Need to acknowledge past but focus forward. • Need to identify the needs and the how to align services. • Need to look at models of care and design to meet needs.
Funding	• Need to ensure that funds are allocated to areas best positioned to provide that service. • Need to ensure adequate funding.

Principle 4: Cultural capability	
Workforce	• Need to have a workforce strategy to address current shortage of culturally appropriate workforce.
Culture	• Need to involve community in the design. • Need to undertake regional community consultation. • Need to address unconscious bias and institutional racism.

Principle 5: Social Determinants
• Nil

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

**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*
General discussion		
HE is about ATSICCHO and HHS working together to serve the community. Need access to funding that the HHS holds onto, not just Indigenous funding.	• Need to ensure that funds are allocated to areas best positioned to provide that service.	P1: First Nations leadership P3: Reorienting local health systems
Operational on ground, I think service when I think of HE due to many factors including SDoH. Children who go undiagnosed because they can't access paediatricians. People who have the resources may be able to attend Brisbane. From an operational perspective, access is central.	• Need to consider models of care such as local access to specialists.	P3: Reorienting local health systems
I think it's great that it is embedded in legislation otherwise it would be pointless having the conversation. There is an important focus on HE and I want to know more about the barriers.	• Need to ensure that funds are allocated to areas best positioned to provide that service.	P1: First Nations leadership
You have services for people to achieve a better outcome for people in one part of the HHS. How do we ensure that Indigenous people have access to all HHS? HHS and ATSICCHOs may have different views on HE. We need to work out our core business. ATSICCHO is primary health care focus but what is the HHS core business? Is it acute primary health care? What is the scope of business for each stakeholder?	• Need to have partnerships and clear definitions about roles of each service within the system.	P1: First Nations leadership P2: Local and regional decision making
Funding—primary health care funding has decreased—we need to look at how funding translates to Mob in community. What do they get from funding and the impact it has?	• Need to consider best use of limited resources and ensure systems are not duplicating effort.	P1: First Nations leadership P2: Local and regional decision making

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		
What if there is an organisation that does not play fair?	• Need to ensure effective partnerships are in place. • Need accountability.	P1: First Nations leadership. P2: Local and regional decision making.
Some challenges I see will be the intrinsic and historical factors. It is about changing people's mindsets. This is our chance for reset to meet the needs of everyone. How do we come in with a HES to grow Wide Bay region?	• Need to acknowledge past but focus forward. • Need to identify the needs and the how to align services.	P1: First Nations leadership. P3: Reorientating local health systems.
This strategy for Wide Bay—we need to align with the HES—we are all one.	• Need to identify the needs and the how to align service.	P2: Local and regional decision making. P3: Reorientating local health systems.
Looking at the historical CTG has not met the needs of Aboriginal and Torres Strait Islander people.	• Need to identify what is working and what is not to develop new agenda.	P2: Local and regional decision making. P3: Reorientating local health systems.
Need to get language and terminology correct to show Mob.	• Need to ensure we bring the community on the journey by ensuring language is understood.	P1: First Nations leadership.
What are the easy wins?	• Need to identify some potential early gains.	P2: Local and regional decision making.
Easy wins include the advisory council. We may need to go to HHS/ATSICCHOs together out to community to discuss this with grass roots people. And ask them directly what community wants. To plan a regional consultation.	• Greater First Nations voice within the HHS. • Aspects of cultural capability.	P1: First Nations leadership. P4: Cultural Capability.
Change the way things are done historically—it's about working together.	• Need to acknowledge past but focus forward. • Need to identify the needs and the how to align services.	P1: First Nations leadership. P3: Reorientating local health systems.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Funding—is this group funded? (Is ATSICCHO funded?)	• Need to ensure adequate funding.	P3: Reorientating local health systems
It's about using funding smartly, making HHS and ATSICCHOs funding equal. My issue is the federal government—shares and example about having to look at projecting the population of the region which creates barriers.	• Need to get Federal buy in.	P1: First Nations leadership
Enablers		
It has to be localised, that we walk with our mob, we co-chair and co-design with government. It's about how we drive this. How do we increase HE together? We need to co-chair on HHS council; we need to do this together. We already do this ad hoc but we don't do this continuously. For principle 2, us as First Nations people, we have done all of this with nothing to come from it. How do we bring all of us together to drive HE to be a part of the decision-making process? How we think differently? How we do differently and how we do it smarter to effect change that is not tokenistic?	• Need to establish partnerships and have accountability. • Need MOUs. • Need partnership agreements.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems
It is about the patient's journey; it should be seamless. If aunty can't get to the ATSICCHO, how do we get health care to her?	• Need to look at models of care and design to meet needs.	P3: Reorientating local health systems
It's about having choice if I don't use one service but knowing a service is available.	• Need to have all services culturally appropriate and accessible.	P2: Local and regional decision making
How do you become a blank service rather than having a service of family?	• Need to ensure that services are meeting client's needs.	P1: First Nations leadership
It's about proof of service, we are happy to advocate. It's not about family. We are happy to assist the navigation of the health system.	• Need to have identified pathways for service provision. • Need accountability for service provision.	P1: First Nations leadership P2: Local and regional decision making
Agree cultural capability—my view is that most people don't understand what is, and also that people don't understand what racism is. Most of the people our staff will say they are not racist, but these hard/difficult conversations need to occur.	• Need to address unconscious bias and institutional racism.	P4: Cultural Capability
I think it should be building workforce capacity and working together. Creating pathways. ATSICCHOs have to compete with each other. Workforce is the issue; it's not the target.	• Need to have a workforce strategy to address current shortage of culturally appropriate workforce.	P1: First Nations leadership P4: Cultural Capability

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

Future ideas for discussion

Discussion about Section 3:

1. **Establish a First Nations Board** *(of interest)*
   It would be ok, the people on it need to be appropriate. Can't be tokenistic need to have power have some teeth with it. Think of it as a standalone type of commission. An independent body. An oversight type of model. It would need to be shaped and worked dependent on people.

2. **Increase Queensland Health's First Nations employment targets commensurate to local population or hospital presentation and user rates**
   I think it should be building workforce capacity and working together. We are not even reaching them now due to the workforce which needs to be upskilled. We could do it better. Keep target as it is. Unpack what's behind it to support to aim for the current goal. Creating pathways. ATSICCHOs have to compete with each other. Workforce is the issue; it's not the target. Biggest issue is someone coming from NGO to government and not understanding the language and stumbling across the position description. Aging workforce, not succession plan. Identified positions as social workers. Attraction to the region. Region workforce attraction is difficult.

3. **Legislate the responsibilities of the CATSIHO in the *Hospital and Health Boards Act 2011***
   Absolutely.

4. **Release biennial reports**
   Concerns around having a report for the sake of having a report, not setting people up for failure. If we fail looking for the solution. Understanding that realistic goals must be used.

5. **Appoint a Deputy CATSIHO**
   YES, but if it would be a doctor, yes. Or it could be medical e.g. medical practitioner. These clinicians could influence/challenge change with AMA, RACGP and workforce etc. As long as a clinical framework does not override a governance framework.

6. **Introduce First Nations special measures for priority consideration and preference selection in Public Health sector recruitment**
   Yes, group agreed. Taking a weighting for cultural expertise. Informing gatekeepers about the Racial Discrimination Act.

7. **Create capability pipeline for future First Nations HHS board members**
   Yes, but there should be a male and a female—funding needs to be attached with it. Training provided, how board members are elected is the issue/understanding the selection process. We don't mentor very well, it's understanding how to do this—12 months of mentorship at HHS, at ATSICCHOs. Embed within strategies and regions and develop them—looking at the QAIHC youth strategy.

8. **Establish regional coordinated care hubs and integrated care pathways** *(has potential)*
   Yes – good opportunity for Indigenous business growth E.g. getting a bus.

9. **Establish regional Aboriginal and Torres Strait Islander community-controlled health organisations** *(potential) (to include Wide Bay and CQ)*
   Yes, but needs to be thought out—AMS did not want to compete for one bucket of money. If we were going to look at it, we would need to look at CQ to make the effectiveness work. How do we adapt it to include the four community-controlled services?

10. **Implement funding incentives to address specific First Nations equity issues**
    It needs to be looked at strategic funding—people don't want to be burdened with reporting funds every 6 months. Barriers include predicting populations for funding. Not at the expense of burdening. Services may just do it for incentive but not for real reason.

11. **Embed cultural capability into *Clinical Services Capability Framework***
    Yes, be interested to see how it works out.

12. **Refresh *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033***
    Yes, agree.

13. **Undertake annual independent institutional racism assessments across Queensland Health**
    Yes—needs to be an independent body. Aboriginal and Torres Strait Islander people must have oversight—it may be a First Nations board in Principle 1. It would need to be shaped and worked. You would have to do it initially to get a baseline across the state to find out where the service is at.

14. **Amend birth notifications to acknowledge birth parent's cultural connection to Country**
    CoA needs to stay with Aboriginal and Torres Strait Islander organisations. Unsure but would really need to be worked out. It is passed down by family—an option should be offered.

15. **Strengthen the functions of other health statutory authorities to drive health equity**
    Health Workforce Qld, PHN—it would be yes as they need to be a part of it. Are PHN sitting at tables?

16. **Factor equity into existing Queensland Health funding models**
    Yes, but changes need to happen with the gatekeepers who don't have cultural capability to understand. Perhaps it needs to be legislated in HHS, an Indigenous director to have oversight over the funding. Legislating Haylene's role as an oversight to funding for Indigenous people.

17. **Utilise the health equity strategies as future health investment plans**
    Yes.

18. **Establish pilot Marmot city regions across Queensland**
    We need more information on Marmot—workforce attraction due to no availability of housing.

19. **Set state-wide regional Queensland Health procurement targets to purchase goods and services from Aboriginal and Torres Strait Islander owned and operated businesses**
    It must be in contract/tender that local places First Nations need to be used.

20. **Drive an anti-racism strategy across the health system**
    Coincide with the roll out of strategies. Yes, hand in hand. Align with cultural significance dates—getting systems out meeting with community. More financial support for education showing up not with your stall be present.

Appendix 4—Attendee list

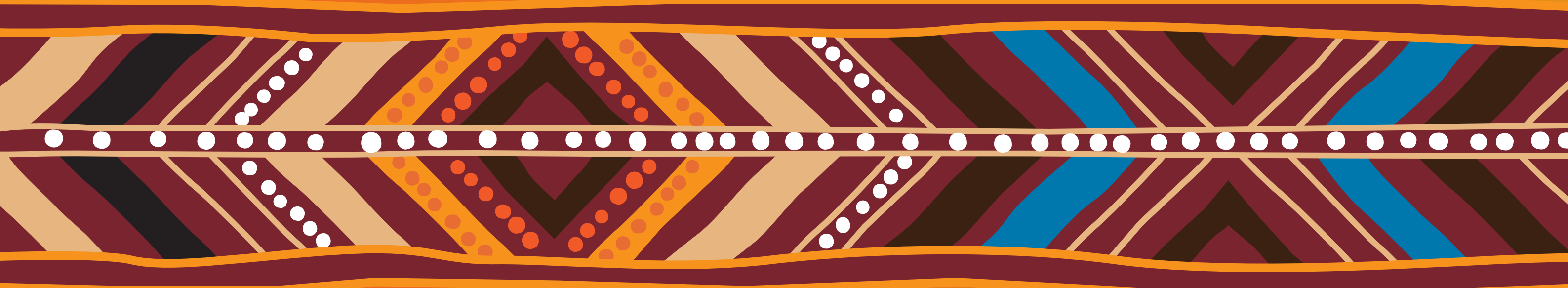
Name	Organisation
Nina Walker	Wide Bay HHS
Steven Bell	Wide Bay HHS
Leon Nehow	Wide Bay HHS Board
Graham Douglas	Chair of Galangoor
Anne Woolcock	Senior primary
Steven Ober	CEO Galangoor and Director on QAIHC Board
Jermaine Isua	Queensland Health
Yasmin Muller	Queensland Health
Karen Thompson	QAIHC Consultant
Tiana Lea	QAIHC

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 Island Health Worker
AMS	Aboriginal Medical Service
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
CATSIHO	Chief Aboriginal & Torres Strait Islander Health Officer
CE	Chief Executive
CTG	Closing the Gap
DAMA	Discharge Against Medical Advice
DATSIP	Dept of Aboriginal and Torres Islander Partnerships
ED	Emergency Department
FN	First Nations
FNQ	Far North Queensland
HHS	Hospital and Health Service
HR	Human Resources
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
QAIHC	Queensland Aboriginal and Islander Health Council
QH	Queensland Health
RN	Registered Nurse
SDoH	Social determinants of health
SEWB	Social and Emotional Well Being (also ESWB)
WHO	World Health Organization



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