Consultation Report

Mackay consultation

31 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: Mackay consultation

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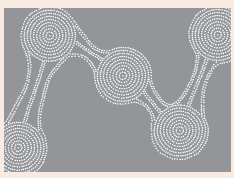
Acknowledgement of Country

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.

Contents

Introduction

The Mackay consultation workshop was undertaken on 31 May 2021 at Quest on Gordon, Mackay. The consultation had 15 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

Participants at the regional workshop discussed the effectiveness of many well-designed health services and programs in the region but spoke frankly about the lack of integrated planning and service delivery between all healthcare providers (HHS, ATSICCHOs, Primary Health Network (PHN) and private GPs). Relationships between some providers are strong but some working relationships have a long history of distrust that need to be repaired.

All health providers are aware of the need to work together and are committed to improving local service delivery, planning, and governance and have recently committed to establishing a First Nations (FN) leadership table and are conducting a Local Area Needs Assessment (LANA) between the HHS and PHN. A priority for all health providers is maximising the healthcare available in Mackay and only transferring patients outside of the region (to Townsville or Brisbane) for specialist care.

Key discussions included:

- ongoing experiences of racism and discrimination that stop people accessing care when they need it
- the importance of educating people about equity and iterating different approaches do not equate to preferential treatment
- cultural governance being valued equally with clinical governance in the design and implementation of models of care
- the need to grow the Aboriginal and Torres Strait Islander health workforce across the region and various healthcare providers, including private GPs
- the opportunity to build upon and enhance existing effective programs in the region, such as the Kutta Mulla Gorinna Special Assistance School
- current barriers to healthcare access for some population groups, including children in out-of-home care (OOHC) and young people disengaged from the education system
- the importance of two-way accountability back to the community.

Top five health reforms

considered a priority for this region by the participants.

18	Establish pilot 'Marmot city regions' across Queensland
8	Establish regional coordinated care hubs
3	Legislate the responsibilities of the Chief Aboriginal and Torres Strait Islander Health Officer
7	Create capability pipeline for HHS Board members
17	Utilise the Health Equity Strategies as future health investment plans

Key discussion points

The discussion from the Mackay 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 Mackay region.

Principle 1: First Nations leadership	
Systems	• A First Nations leadership table is currently under development for the region. • Stronger accountability needs to go back to Aboriginal and Torres Strait Islander communities about health (outcomes, access, and experiences)—both quantitative and qualitative.
Care	• Need to develop both clinical and cultural governance models of care.
Workforce	• Need to build cultural capability within HHSs by increasing the Aboriginal and Torres Strait Islander workforce. • More Aboriginal health practitioners need to be employed by the HHS to deliver Aboriginal and Torres Strait Islander-led models of care, and existing health workers and practitioners supported to work to full scope of practice.
Culture	• Many types of mechanisms for community engagement are needed to build confidence and trust across communities about the new HES.

Principle 2: Local and regional decision making	
Systems	• Better coordination and integration are needed between state and federal health funding and service delivery—ATSICHS Mackay and the Mackay HHS both deliver great services, but they aren't connected or integrated and operate in silos. • All healthcare providers in the region need to work effectively together and integrate healthcare planning, investment and delivery. • HHS and PHN are currently conducting joint health needs analysis through LANA. • The HES could be used as an overarching health service plan for the region.
Culture	• Need to build upon and strengthen existing programs working effectively in the region—for example, the Kutta Mulla Gorinna Special Assistance School. • Need to improve the relationship between the HHS and the Aboriginal and Torres Strait Islander community-controlled health service in Mackay.

Principle 3: Reorienting local health systems	
Systems	• Increased accountability is needed across the health system and at all levels—change needs to be driven across the public health system, and leaders and managers held to account. • Need to integrate existing data sets between all healthcare providers to identify local and regional health needs.
Care	• The size of the Aboriginal and Torres Strait Islander population who don't access any healthcare is unknown but exists. • Want to maximise local healthcare delivery in the Mackay region and only transfer patients to Brisbane or Townsville for specialist care. Ongoing patient care and management, including wrap-around supports, needs to be provided locally to be effective. • A priority needs to be given to young people with complex needs. • Need to bring healthcare to the people because opportunistic care connects people, who don't regularly access care, to a service. • Need to address the blockages and barriers experienced by young people in OOHC in accessing primary healthcare.
Workforce	• Need more Aboriginal and Torres Strait Islander people working across the health system but there isn't an untapped pool of Aboriginal and Torres Strait Islander healthcare workers waiting for employment—investment and local strategies are needed to build a future workforce. • Building and recruiting a local health workforce is a key priority. • Need to invest in multi-disciplinary teams that support and integrate care across the health system and enable the Aboriginal and Torres Strait Islander workforce to work across settings.

Principle 4: Cultural capability	
Systems	• The HHS needs to change how it engages and communicates with Aboriginal and Torres Strait Islander peoples.
Workforce	• It is time for the non-Indigenous health workforce to educate themselves and take greater responsibility. • The value of Aboriginal health workers, practitioners, and liaison officers in building safe and trusting relationships with mob is not understood or respected across the HHS and broader health system.
Culture	• Racism and discrimination stop people from accessing care when and where they need it—mob need to feel safe to come to a service. • A lack of understanding exists about unconscious bias and white privilege—a lot of non-Aboriginal and Torres Strait Islander people do not understand the many faces of racism or that equitable treatment is not the same as preferential treatment.

Principle 5: Social determinants	
Systems	• Need to make health equity a priority for other Queensland Government departments—the Mackay Senior Officers group could be used as the mechanism to get buy-in and support from other Queensland Government agencies in the region. • Need to bring together many other stakeholders outside of the health system to develop and implement the new HES.

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

Attendee's comments/vViews/input
General discussion
• **Increased accountability is needed across the health system and at all levels**—the Minister, Director-General and Chief Executives need to drive changes across the public health system and hold leaders and managers to account. Accountability also needs to be given back to community—feedback loops need to travel to both the Minister and Director-General but also back to community members and consumers. • **Further discussions and education are needed to explain what health equity is**—whatever the agreed upon definition is. People don't understand that equity requires different approaches, depending on what people need. Positive discrimination is not well understood.

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		
Better coordination and integration are needed between state and federal health funding and service delivery—the health system needs to operate as an integrated system. Limited crossover exists in the planning and delivery of health services, and the level and extent of patient coordination (re clinical handovers) varies. Health programs and services are not integrated and coordinated between HHS, PHN and CCHS. AICHS Mackay and HHS are both doing great work and delivering great services, but they are not connected or integrated. They operate as silos. This creates inefficiencies, duplication (re. two Deadly Choices programs being delivered by the HHS and AICHS Mackay) and affects effectiveness. Need to align and integrate Commonwealth Health and federally funded programs/investment and planning with HHSs' HESs.	• Improved funding arrangements. • Local health system improvements.	P3: Reorientating local health systems
Need to integrate existing data sets between all healthcare providers (HHSs, AICHS Mackay and private GPs/PHNs) to identify local and regional health needs (PHN has MOUs in place with private GPs to use/access data for service planning).	• Local health system improvements.	P2: Local and regional decision making
There's a history of AICHS Mackay not engaging in joined up planning and service design with the HHS. All healthcare providers need to come together strongly—AICHS Mackay works well with the PHN but not the HHS. The increased separation between primary healthcare and HHSs can be traced back to 2012 with the LNP Government—need to rectify this and increase the presence of primary healthcare workforce in HHSs.	• Local health system improvements.	P2: Local and regional decision making
Need to improve and strengthen the local health system processes and structure so it's not who you know, or personality based—the system needs to work for everyone.	• Local health system improvements.	P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Racism and discrimination stop people from accessing care when and where they need it. Many Aboriginal and Torres Strait Islander people have had bad experiences in the hospital and accessing care from private GPs. Mob need to feel safe to come to a service—but it can't just be symbolic (Aboriginal art on the wall). A health service needs to be genuinely culturally capable/competent. It doesn't take much for a FN person to leave a hospital or health service—it can be a look or a negative encounter/experience. Aboriginal and Torres Strait Islander people are 'always on' (the red zone) and ready to respond to or withstand racism. The only time they truly relax (the green zone) is when they are at home. Everyday experiences—in the workforce and broader society—are tiring.	• Racism and discrimination.	P4: Cultural capability
A lack of understanding exists about unconscious bias/white privilege—a lot of non-Aboriginal or Torres Strait Islander people do not understand the many faces of racism or that treating people equitably (and differently) is not the same as preferential treatment. The link between health equity and patient-centred care needs to be explained through a communications and marketing campaign.	• Cultural capability.	P4: Cultural capability
FN peoples are the most 'researched' people—it is time for the non-Indigenous workforce to educate themselves and take greater responsibility.	• Cultural capability.	P4: Cultural capability
Need to build cultural capability within HHSs by increasing the Aboriginal and Torres Strait Islander workforce—some skills can't be taught to non-Indigenous people; people have to see it being done/modelled by an Aboriginal and Torres Strait Islander workforce to understand.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P1: First Nations leadership
Current Aboriginal and Torres Strait Islander workforce (Indigenous Health Liaison Officers and Aboriginal health workers/practitioners) are overwhelmed and overworked—need more Aboriginal and Torres Strait Islander people working across the health system but there isn't an untapped pool of Aboriginal and Torres Strait Islander healthcare professionals with qualifications waiting for employment. Investment and local strategies are needed to build a future workforce.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
The value of Aboriginal Health Workers and Indigenous Health Liaison Officers in building safe and trusting relationships with mob is not understood or respected across the HHS and broader health system. Aboriginal health workers are everything for some patients but sometimes don't feel valued by other professional streams.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P4: Cultural capability
The HHS needs to change how it engages/communicates with Aboriginal and Torres Strait Islander peoples: 'inclusion is not a painting or a black person at the front desk'. It can't only be symbolic—it needs to be practical delivery.	• Local health system improvements.	P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Large proportion of young people in youth justice, (OOHC; around 400) and not attending school or accessing primary healthcare. PHN tried to commission bulk-billed primary healthcare services for children in OOHC through private GPs but it was blocked by the Department of Communities. OOHC young people cannot receive primary healthcare unless approved by the Department and taken to receive care by a Departmental youth worker.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems
Need to reduce/stop Aboriginal and Torres Strait Islander people only going to hospital when very sick. The first presentation to the healthcare system should not be for hospital-based care because an Aboriginal and Torres Strait Islander person is really sick and hasn't accessed primary healthcare because a GP doesn't bulk bill.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems
Substantial rigidity of existing QH funding mechanisms/parameters—for example, little flexibility exists in using Making Tracks program funding because concerns exist the funding will be used for other purposes.	• Improve funding arrangements.	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.	P3: Reorientating local health systems
The size of the Aboriginal and Torres Strait Islander population who don't access any healthcare—unless through ED or through ambulance services—is unknown but exists. Some people do not access healthcare until they are really sick. Fifty percent of Aboriginal and Torres Strait Islander people do not access care through AICHS Mackay and go to private GPs (three in region).	• Enhance/ expand existing models of care.	P3: Reorientating local health systems
Building and recruiting a local health workforce is a key priority. Need to support a fluid and flexible workforce across the health system (not just QH or AICHS Mackay) because barriers exist for both providers.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
Need for all healthcare providers in the region to work effectively together and integrate healthcare planning, investment and delivery. Regional and local coordination/integration processes and structures can't be people dependent—they must endure and continue after certain people have left.	• Local health system improvements.	P2: Local and regional decision making
Existing PHN contractual arrangements in the region. PHNs currently have head contracts with most providers until 2022—after this time, there will be more flexibility with Australian Government funding managed/commissioned by PHNs (who gets funding and what they have to deliver/achieve).	• Local health system improvements.	P2: Local and regional decision making

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Need to make health equity a priority for other Queensland Government agencies (education, housing, justice, child safety). Most of the other Queensland Government agencies' decision-makers (Regional Directors) are based in either Rockhampton or Townsville (Regional Managers Coordination Network) which means there is a lack of authority in the region. Mackay has a Senior Officers Network, and they could be used to drive local action. Need to bring together other stakeholders outside of the health system to develop and implement the HES.	• Social determinants.	P5: Social determinants
Stronger accountability is needed back to Aboriginal and Torres Strait Islander communities about health (outcomes, access and experiences)—both qualitative and quantitative data. Trusting and respectful relationships are needed to do this.	• Local health system improvements.	P1: First Nations leadership
Enablers		
Build and strengthen existing programs working effectively in the region—for example, Kutta Mulla Gorinna Special Assistance School (KMG) is an alternative school model in its second year of operation, funded by the PHN, that provides services and support to 56 young people between 12 to 17 years and their families. KMG and other programs could be used to increase access to care (including SEWB and mental health, NDIS) and provide greater support to families to address the SDoH (re other economic and social barriers).	• Enhance/ expand existing models of care.	P2: Local and regional decision making
FN leadership table for the region—currently under development.	• Local leadership.	P1: First Nations leadership
PHN has identified FN health equity and mental health as key priorities in the region. PHN has existing clinical council (and just released an EOI for a First Nations representative) and the HHS board already has an Aboriginal and Torres Strait Islander representative.	• Local health system improvements.	P3: Reorientating local health systems
HHS works well with private GPs in region—no GPs bulk bill in region; three private GPs deliver most of the primary healthcare to Aboriginal and Torres Strait Islander people in the region.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems
Want to maximise local healthcare delivery in the Mackay region and only transfer patients to Townsville or Brisbane for specialist care (coordinated care hubs). Currently only 5% of patients are transferred to Townsville or Brisbane—don't want that to increase. Ongoing patient care and management, including wrap-around support, needs to be provided locally to be effective. Can deliver a lot in Mackay and don't want to lose local partnerships and relationships.	• Enhance/ expand existing models of care.	P2: Local and regional decision making
HHS and PHN currently conducting joint health needs analysis through LANA.	• Local health system improvements.	P2: Local and regional decision making

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Need to bring in as many local/regional stakeholders as possible to develop and implement the HES—all local healthcare providers need to partner and work together. A strong commitment and buy-in exists for local place-based approaches by key service partners/stakeholders in the region.	• Local health system improvements.	P2: Local and regional decision making P5: Social determinants
The greatest impact (return on investment) on health outcomes will be prioritising primary health care and health care managed/monitored in the home. More investment is needed in personal health technology for people to manage/monitor their health at home.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems
Need more training/understanding about unconscious bias/white privilege. PHN has delivered unconscious bias/white privilege training—the team found it highly beneficial and confronting. Great training resources exist—need to increase uptake/access to training, have more conversations about racism, discrimination and equity; and embed new practices and processes across the health system.	• Cultural capability.	P4: Cultural capability
HHS governance mechanisms need to have a cultural lens over the care delivered and ensure accountability is two way and goes back to Aboriginal and Torres Strait Islander community members and Elders.	• Cultural capability.	P1: First Nations leadership
Deliver more services/education in schools—currently one provider delivers health education at schools (Life Education Queensland) but this does not include clinical services. Schools need to agree for external healthcare providers to deliver services/programs in schools (with parental consent).	• Enhance/ expand existing models of care.	P3: Reorientating local health systems
A priority focus needs to be given to young people with high/complex needs to provide comprehensive primary healthcare and other family/ carer support. A new workforce/team could be created to provide support to families and carers to the top 10% of Aboriginal and Torres Strait young people in youth justice/OOHC with complex needs. Most Aboriginal and Torres Strait Islander families will not allow or be comfortable for government agencies or providers coming to their homes but this type of support could be provided by Aboriginal and Torres Strait Islander community organisations.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
Improve/change language and communication throughout the patient journey.	• Enhance/ expand existing models of care.	P4: Cultural capability
Need to build the capability and support the existing Aboriginal and Torres Strait Islander workforce while building the pipeline for a future workforce.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P1: First Nations leadership

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Invest and support peer education and advocacy to increase community access—a previous successful program involved increasing breast screening rates for Torres Strait Islander women. Need to revisit previous successful programs and modernise them (re. potential tech).	• Enhance/ expand existing models of care.	P3: Reorientating local health systems
Need to bring healthcare to the people—in shopping centres, schools, workplaces, home visiting teams. Opportunistic care can connect people to a service if they do not regularly access regular healthcare. This was done in the past but these programs have not continued.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems
Need to address the blockages/barriers experienced by OOHC young people to receive primary healthcare.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems
Employ more Aboriginal and Torres Strait Islander health advocates to walk alongside patients.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P1: First Nations leadership
The Senior Officers Network (government agencies) in Mackay could be used as a mechanism to get buy-in and support from other Queensland Government agencies in the region to deliver coordinated and integrated responses to address the SDoH. The Senior Officer's Network is effective and works well, and because the Department of Premiers and Cabinet is based in Mackay, could (potentially) support driving this work across other portfolios/departments. They 'are a group looking to drive change and do something'.	• Local health system improvements.	P2: Local and regional decision making P5: Social determinants
State-wide (executive and Ministerial level) discussions are needed with other Queensland Government agencies to get behind and support the regional Health Equity Strategies. Other departments need to prioritise this work (re from their executives/Minister), give the authority for their regional offices to support the development and implementation of the HESs, and to partner with each other to address the SDoH.	• System-wide leadership.	P3: Reorientating local health systems P5: Social determinants
HS/PHN/community-controlled health sector can drive change within and across the health system (what they can directly control) and then partner and influence other departments and portfolios at both a regional and state-wide level. Need to work out what the health system can do locally to address the social and economic challenges experienced by FN peoples coming into contact with the health system, and then influence other departments and portfolios at a local, regional and state level. More wrap-around support needs to be tied to the care provided to individuals and families.	• Local health system improvements.	P1: First Nations leadership P2: Local and regional decision making P5: Social determinants

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Develop local recruitment campaigns across the health system (HHS, AICHS Mackay and PHNs/private providers) and where/if possible, recruit for some positions to work in multiple settings (HHS, AICHS Mackay and private GPs).	• Local health system improvements.	P2: Local and regional decision making P3: Reorientating local health systems
Use the HES as an overarching health service plan for the region.	• 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
Share learnings between HHSs (regions) about what works well/effectively—learn from each other.	• Local health system improvements.	P2: Local and regional decision making
Establish effective clinical and cultural governance of models of care for local and regional service delivery (healthcare and links to broader social/cultural supports)—these models need to be patient and community centric.	• Local health system improvements.	P1: First Nations leadership P2: Local and regional decision making P3: Reorientating local health systems P4: Cultural capability
Need more Aboriginal health workers and practitioners working to full scope of practice across the health system, including with private GPs. This includes AHWs working in acute setting (clinical skills) but also providing advocacy, support and education. AHWs have the relationships and trust with local communities—this needs to be valued and respected across the health system. Without a respectful and trusting relationship, some people won't access healthcare when they need to.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P1: First Nations leadership
Provide skills training/development to staff to be able to integrate/coordinate service delivery between providers.	• Local health system improvements.	P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Ensure Aboriginal and Torres Strait Islander staff are not funded from program funding—they need to be funded as part of core/base funding. For example, some Aboriginal and Torres Strait Islander staff members are funded through three year Making Tracks funding.	• Improved funding arrangements.	P3: Reorientating local health systems
Need lots of Aboriginal health practitioner roles in Mackay to deliver Aboriginal and Torres Strait Islander-led models of care—currently AHW in the region do not deliver clinical services. Multi-disciplinary cultural teams are needed in communities to support people accessing care before presenting to hospital with a preventable condition and to walk alongside people throughout their health journey. Having the right person from the start of the patient journey is critical.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P1: First Nations leadership P3: Reorientating local health systems
Need to invest in multi-disciplinary teams that support and integrate care across the health system and enable Aboriginal and Torres Strait Islander workforce to work across settings in the local health system. The practice of primary healthcare workers stopping at the hospital door needs to stop.	• Build and strengthen the local Aboriginal and Torres Strait Islander workforce.	P3: Reorientating local health systems
Need many types/mechanisms for community engagement to build confidence and trust across the community about the HES—can't just have one body but need to use many mechanisms and avenues for engagement. The current language and communication mechanisms need to be redesigned and improved.	• Local leadership.	P1: First Nations leadership P2: Local and regional decision making

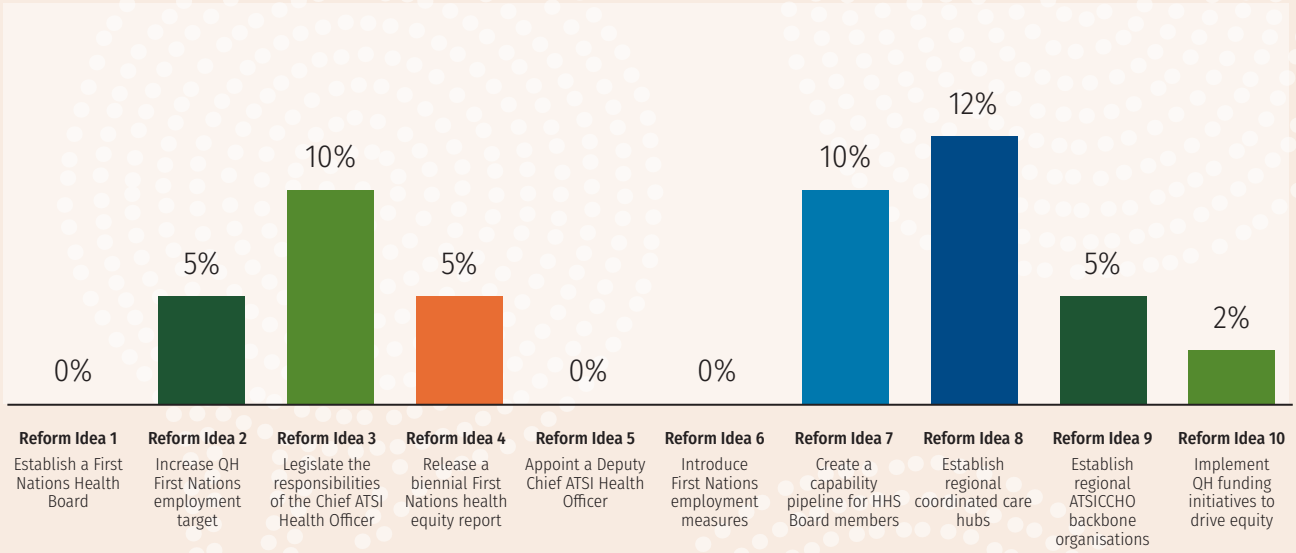
Attendee's comments/views/input
Other comments—Ideas
• The toolkit needs to outline state-wide whole-of-government governance structures for the HESs that can address policy or legislative barriers experienced at local/regional levels when the health system is trying to improve/redesign local service systems to influence the SDoH. A two-way accountability mechanism needs to exist between regions and state-level governance structure. • Templates are needed for MOUs/joint service plans. • Templates are needed for the HES.

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

Future ideas for discussion

Mackay 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

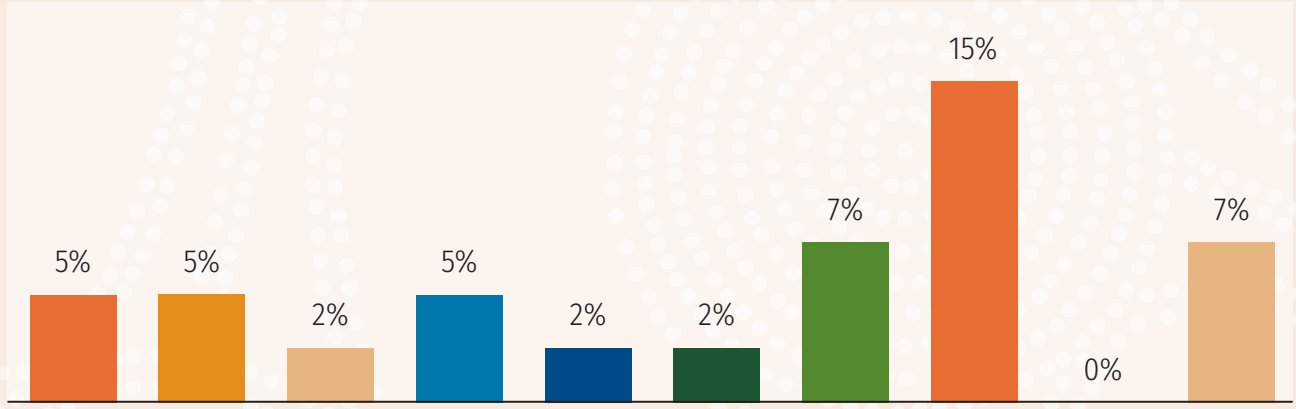
Reform Idea 6 Introduce First Nations employment measures

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
Julie O'Brien	Mackay Hospital and Health Service
Lisa Davies Jones	Mackay Hospital and Health Service
Matilda Christian	Mackay Hospital and Health Service
Philip Kemp	Mackay Hospital and Health Service
Karin Barron	NQPHN
Bevan Ah Kee	QAIHC
Cleveland Fagan	QAIHC
Graham Kissell	QAIHC
Jason Fagan	QAIHC
Karen Thompson	QAIHC Consultant
Lauren Trask	QAIHC
Tiana Lea	QAIHC
Adrienne Barnett	Queensland Health
Giovanna Castellani	Queensland Health
Kiel Weigel	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
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
OOHC	Out-of-home care
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 Wellbeing (also ESWB)
WHO	World Health Organization

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government