Consultation Report

Toowoomba consultation

19 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

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: Toowoomba consultation

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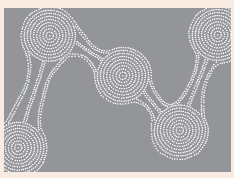
An electronic version of this document is available at **health.qld.gov.au** and **qaihc.com.au**

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 Toowoomba consultation workshop was undertaken on 19 April 2021 at Picnic Point, Toowoomba. 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 Queensland 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.

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. Many specific, real-life examples were discussed about the experiences of Aboriginal and Torres Strait Islander community members, which were often vastly different to the commitments made in numerous state and national policy documents. Participants welcomed the opportunity presented by the new HES 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:

- The Darling Downs Hospital and Health Service (DDHHS) catchment includes many clients of the Goolburri Aboriginal Health Advancement Co Ltd, Goondir Health Service, Cherbourg Regional Aboriginal and Islander Community Controlled Health Service and Carbal Medical Service. The current mechanisms for co-design in healthcare and a collaborative approach to shared clients vary greatly between the DDHHS and the ATSICCHOs.
- Models of care and the issues that occur given the remote location need to be addressed. The current model of care and the issues of distance continue to be barriers to good health outcomes for First Nations peoples. The journey through the health system is complex for Aboriginal and Torres Strait Islander peoples and needs to be simplified with consideration given to at-home and e-health options.
- There needs to be accountability for each client along the whole patient journey, with a better and more streamlined system that ensures culturally safe ongoing care at each stage from home and back to home. Models of care need to be developed to let clients receive treatment locally, rather than sending them away to major cities. Technology and e-health can play major roles in place-based care, thus streamlining care and minimising the need for further interventions.
- Having a more coordinated approach to client care, along with more culturally appropriate secondary and tertiary care, are vital to improve health outcomes in this area.
- As with most rural and remote areas, it is difficult to attract and retain a skilled workforce. This is particularly true for this area regarding skilled Aboriginal and Torres Strait Islander health professionals. This shortfall exacerbates the health issues faced by the local community. A pipeline is needed with a longer-term ability to grow its own workforce and to offer training locally.
- Racism needs to be addressed; audits need to occur with the findings addressed. More training and support need to be available to hospital staff, and complaint mechanisms streamlined to allow Aboriginal and Torres Strait Islander people to feel comfortable using the system. Current complaint mechanisms are too cumbersome, and many patients feel there is no accountability when complaints are made. The education system was listed as a major concern in contributing to poor wellbeing and thereby contributing to a lack of growth of a local workforce. Truant children are suspended, escalating the cycle of poor education outcomes and trauma.
- Social determinants such as education and housing are not integrated into the health and wellbeing of Darling Downs First Nations peoples. Family is paramount; consideration of social determinants in this inter-connectedness and in the long-term welfare of Aboriginal and Torres Strait Islander peoples is desperately needed.

Key discussion points

The discussion from the Toowoomba 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 Toowoomba region.

Principle 1: First Nations leadership	
Systems	• Need to streamline how the agencies responsible for SDoH can partner together to achieve good health outcomes. • Health literacy programs are needed in the community. • Health education and support is necessary for individuals to be able to take care of themselves. • Need to ensure processes are in place to address requirements of regulation. • Need the HE framework to outline parameters, consultation and sign-off processes. • Need to get buy-in from Commonwealth and get primary health network (PHN) to the table. • Need different areas of the health system to collaborate on patient outcomes. • Need to have Commonwealth at the table. • Consultation and collaboration must occur to ensure patient welfare. • HES needs high-level participation from all local health providers (HHS, ATSICCHOs, QAIHC).
Care	• Models of care need to allow for both outreach and inreach to ensure wholistic care is provided. • Need to have concierge services to assist patient navigate from home, through the health system and back again. • Need to understand that health equity is about wellbeing. • The patient needs to be the centre focus of all health activity.
Funding	• Need ongoing funding to meet long-term need. • Models of care need to be appropriately funded through needs-based funding. • Funding must be needs-based. • Funding reform to allow for flexible models of care is required. • Need funding for training.
Workforce	• Need a long-term workforce strategy to attract and retain First Nations staff at all levels. • Need to address disparity in wages. • Referee checking prior to engagements is paramount. • Need to consider staff rotation and secondments, mentoring and other development options.
Culture	• Consultation and collaboration must occur to ensure patent welfare. • HES needs to be flexible.

Principle 2: Local and regional decision making	
Systems	• Need to ensure that all stakeholders are included. • Need to manage appointments to allow for transport issues. • Need to establish good transport options for community. • Need to develop processes which allow for easy patient transition between jurisdictions. • There needs to be flexibility in the system that allows community to access care regardless of the financial situation. • Need more service provision for early intervention and prevention. • Need different areas of the health system to collaborate on patient outcomes. • Priorities for health need to be decided at a local level with the involvement of service providers. • Models of care need to allow for both outreach and in reach to ensure wholistic care is provided. • Need to find innovative solutions for patient transports.
Care	• Need to have concierge services to assist patient navigate from home, through the health system and back again. • Need to ensure patient-centred care. • Acknowledge strengths and work together to build upon them. • Need to ensure that patients are given everything they need for ongoing care after discharge until they see their regular care provider.
Workforce	• Need to consider staff rotation and secondments, mentoring and other development options. • Referee checking prior to engagements is paramount.
Culture	• The HHS needs to utilise the expertise in the ATSICCHOs. • Need a long-term workforce strategy to attract and retain First Nations staff at all levels. • Need funding for training.

Principle 3: Reorienting local health systems	
Systems	• Need to streamline how the agencies responsible for SDoH can partner together to achieve good health outcomes. • Need to keep improving access. • Health education and support are necessary for individuals to be able to take care of themselves. • Health literacy programs are needed in the community. • Need different areas of the health system to collaborate on patient outcomes. • Need strategies to reach vulnerable sections of community. • Need all parts of the health system to work in a collaborative relationship to identify and address health needs. • Transport issues are stopping patients from being able to access services and attend scheduled appointments. • Without access to all data, practitioners are not seeing whole health story of patient.
Care	• Need to provide safe pathways for mob to access services such as First Nations Hospital Liaison Officers (HLOs). • Need to have concierge services to assist patient navigate from home, through the health system and back again. • Different models of care need to be established. • Need to run health promotion and education programs about preventive care. • Models of care need to allow for both outreach and inreach to ensure wholistic care is provided. • Flexible service delivery models are needed. • The system needs to put the patient at the centre of care. • Need different areas of the health system to collaborate on patient outcomes. • Need to ensure patient-centred care. • Need to have more services provided at local venues. • Need opportunistic screening when specialists are available. • Need to find innovative solutions for patient transports. • Need to ensure that patients are given everything they need for ongoing care after discharge until they see their regular care provider.
Workforce	• Need to look at local models of care to meet patients' needs. • Look at outreach and in-reach. • Need First Nations staff in all areas of the health system.
Funding	• Funding reform to allow for flexible models of care is required.
Culture	• Patients need to feel comfortable accessing services wherever they are provided.

Principle 4: Cultural capability	
Systems	• Need to have systems in which all racism is called out and dealt with when it occurs.
Care	• HHS could consider providing services at the ATSICHHO or other outreach location.
Workforce	• Need a long-term workforce strategy to attract and retain First Nations staff at all levels. • Need to address disparity in wages between HHS and ATSICCHOs. • Ensure cultural safety training is run regularly and is mandatory for all workers in the health system at every level (cleaners through to Chief Executive (CE)).
Culture	• Need to address cultural safety in health provision. • Patients need to feel comfortable accessing services wherever they are provided. • All areas of health system need to be culturally safe so patients have a choice of provider. • Embed cultural safety into all aspect of health provision and make cultural safety the backbone of profession service delivery.

Principle 5: Social determinants	
Systems	• Other factors such as SDoH affect outcomes in health. • Patients need to follow through with treatment. • Need to streamline how the agencies responsible for SDoH can partner together to achieve good health outcomes. • Need to provide safe pathways for mob to access services such as First Nations HLOs.

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		
Challenge—Equity of access is key but doesn't necessarily equate to equity in health.	• Other factors such as SDoH affect health outcomes. • Patients need to follow through with treatment.	NEW: Social determinants of health.
Key focus area—Equitable access is something the health system can control. But health equity is affected by many factors that the health system doesn't have influence over such as housing, education etc. This is an area which is not done well at the moment and could be a focus of the HHS's HES. The questions are: • How to link into those sectors/services? • How to build capacity (at an individual/family level)? • How to ensure there are points of entry that people feel comfortable to access? • How to advocate for their health, that is, by having Indigenous HLOs who can be accessed and are safe contacts?	• Need to streamline how the agencies responsible for SDoH can work together to achieve good health outcomes. • Need to provide safe pathways for mob to access services such as First Nations HLOs.	NEW: Social determinants of health. P3: Reorientating local health systems.
Definition—Get the health care you need, when you need it and from whom you choose.		
Other non-health-related departments that have a role in health—how are they engaged? How do they take responsibility?	• Need to streamline how the agencies responsible for SDoH can work together to achieve good health outcomes.	P1: First Nations leadership NEW: Social determinants of health.
Access = models of care—Aboriginal and Torres Strait Islander-led. For example, a mental health patient is more likely to share if there is an Aboriginal and Torres Strait Islander staff member. This creates better access.	• Need to look at local models of care to meet patients' needs. • Look at outreach and in-reach. • Need First Nations staff in all areas of the health system.	P3: Reorientating local health systems.
The ATSICCHOs have 'easier/stronger' pathways into those other systems to improve the SDoHs and suggest greater investment in the ATSICCHO under HESs. Getting the models can help influence.	• The HHS needs to recognise and make use of the expertise in the ATSICCHOs.	P2: Local and regional decision making.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Partnerships and referral pathways are improved and working well, but access remains a challenge. Service delivery could be improved.	• Need to keep improving access.	P3: Reorientating local health systems.
Local governance arrangements—regular meetings between the health providers—are currently not occurring in a structured, strategic way.	• Need a long-term workforce strategy to attract and retain First Nations staff at all levels.	P1: First Nations leadership.
Priorities are defined by others, rather than the local service providers. They are defined by evidence and developed externally, and without the service providers.	• Priorities for health must be decided at a local level, involving service providers.	P2: Local and regional decision making.
Short-term time-limited funding affects the effectiveness and sustainability of service delivery and employment/workforce. It does not support effective systems, responses or a local, sustainable workforce.	• Need ongoing funding to meet long-term requirements.	P1: First Nations leadership.
Ideal model: every individual having the capacity to undertake responsibility for their own health, including knowledge about it, and then having access to whatever they need to make this happen. Health literacy = empowerment.	• Health education and support is necessary so individuals can take care of themselves. • Health-literacy programs are required in the community.	P1: First Nations leadership P3: Reorientating local health systems.
Workforce—recruitment and retention of GPs—incentives and competition between providers—capacity to offer more attractive salaries/packages. Note the challenges around disparity in packages between HHS and ATSICCHOs and challenges this creates.	• Need a long-term workforce strategy to attract and retain FN staff at all levels. • Need to address disparity in wages between HHS and ATSICHHOs.	P4: Cultural capability.
Complexities around sign-off by all Traditional Owners noting 26 individual communities.		
How do you get sign-off from all bodies?	• Need to ensure processes are in place to meet the requirements of the Regulation.	P1: First Nations leadership.
Clarify the sign-off process: who is involved; what this looks like; the difference between consultation/engagement and sign-off (local and then by key partners); how it can be included in the co-design process from the beginning.	• Need the health equity framework to outline parameters, consultation and sign-off processes.	P1: First Nations leadership.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Commonwealth/PHN engagement in the process.	• Need to get buy-in from Commonwealth and get PHN to the table.	P1: First Nations leadership.
Role of the sector in informing the regulations; engagement in the process and understanding of the regulations promotion.	• Need the health equity framework to outline parameters, consultation and sign-off processes.	P1: First Nations leadership.
Health equity for Aboriginal and Torres Strait Islander peoples includes enabling access to healthcare that prioritises a whole-of-person approach, considering and addressing their individual social determinants and providing supports to navigate the health system to meet health needs. It requires equitable funding for ATSICCHOs at the state and federal level; funding based on need, rather than population. This must be supported by building a strong, permanent ATSICCHO workforce, having reliable visiting specialist schedules, better partnerships and true consultation between government organisations and ATSICCHOs to ensure the focus meets the healthcare needs of each person in a holistic way that prioritises continuity of care.	• Need everyone to understand health is about wellbeing. • Models of care must be appropriately funded through needs-based funding. • They must also allow for both outreach and in reach to ensure wholistic care is provided.	P1: First Nations leadership.
Health equity needs to work for everyone, not just people familiar with the system or who have connections. Assistance and access to meet serious health needs are currently happening through connections, 'who you know', because it's just too difficult for the average person. Navigating the health system is so difficult that people give up. Building capacity in individuals and staff in getting patients' health needs met is important and requires working together to meet patient needs in the local area wherever possible, or bigger HHS where needed.	• Need concierge services to assist patients navigate from home, through the health system and back again. • Need different areas of the health system to collaborate on patient outcomes.	P1: First Nations leadership. P3: Reorientating local health systems.
Health equity has to include providing access to doctors and specialists in HHS and ATSICCHOs.	• Different models of care need to be established.	P3: Reorientating local health systems.
Equity of access means meeting all the needs, including social determinants, that is, a whole-health-preventative approach. We can focus on providing equitable access to health care, but that is still only 20 per cent of solution. Causal factors outside health include housing, education etc.	• Need to streamline how the agencies responsible for SDoH can work together to achieve good health outcomes.	NEW: Social determinants of health.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
ATSICHHOs: Patients come in and we do referrals for all needs, not just health. We need more inclusive pathways that include social determinants as influences on health. How do we link with other government agencies? How do we get/have power over inputs that add to health outcomes (that is, social determinants plus cultural issues like cyber-bullying)? Focus must be on meeting the need and better outcomes for the person.	• Need to streamline how the agencies responsible for SDoH can work together to achieve good health outcomes.	NEW: Social determinants of health
Health equity for Aboriginal and Torres Strait Islander peoples includes enabling access to healthcare that prioritises a whole-of-person approach, considering and addressing their individual social determinants and providing supports to navigate the health system. It requires equitable funding for ATSICCHOs at state and federal level, based on need rather than population. This needs to be supported by building a strong, permanent ATSICCHO workforce, having reliable visiting specialist schedules, and better partnerships and true consultation between government organisations and ATSICCHOs to focus on meeting the healthcare needs of each person in a holistic way in a way which prioritises continuity of care.	• Need to understand that health equity is about wellbeing. • Funding must be needs-based. • Need a long-term workforce strategy to attract and retain First Nations staff at all levels.	P1: First Nations leadership

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		
Encompassing all key stakeholders.	• Need to ensure all stakeholders are included.	P2: Local and regional decision making.
Accessing podiatry, for example, as part of CTG. The impact of the demand exceeding the need. Capacity to undertake preventative services.	• Need to run health promotion and education programs about preventative care.	P1: First Nations leadership P3: Reorientating local health systems.
Funding doesn't cover all the needs.	• Funding needs to be flexible.	P1: First Nations leadership.
Workforce challenges—podiatry is a particular challenge.	• Need a long-term workforce strategy to attract and retain First Nations staff at all levels.	P4: Cultural capability.
How do you engage hard-to-reach groups (for example, older men)?	• Need strategies to reach vulnerable sections of community.	P3: Reorientating local health systems.
Workforce—men seeing female GPs as an example. Workforce recruitment and retention (HHS pays higher). Workforce model engaging junior doctors who are supervised by a senior doctor (rebates around to cover costs).	• Need a long-term workforce strategy to attract and retain First Nations staff at all levels • Need to include cultural safety in health provision.	P4: Cultural capability.
Transport—transport to be able to get transition out, arranging out of hours, how to take advantage of appointments as they come up; Patient Travel Subsidy Scheme (PTSS) limitations.	• Need to manage appointments to allow for transport issues. • Need to establish good transport options for community.	P2: Local and regional decision making.
Inter-border challenges—relationships between NSW Health and QH—originally the flow was the same, but it seems there are now more coming into the DDHHS region.	• Need to develop processes that allow for easy patient transition between jurisdictions.	P2: Local and regional decision making.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Relationships to be developed before the region can identify what's needed to meet the local health needs/priorities.	• Need all parts of the health system to work collaboratively to identify and meet health needs.	P1: First Nations leadership. P3: Reorientating local health systems.
Patients being changed out-of-pocket fees. If the balance isn't paid, they cannot access services, so people cannot access services.	• There needs to be flexibility in the system that allows community to access care, regardless of the financial situation.	P2: Local and regional decision making.
How do you bring services to places where they aren't normally provided?	• Models of care need to allow for both outreach and in reach to provide wholistic care.	P3: Reorientating local health systems.
Current base funding arrangements.	• Funding reform to allow for flexible models of care is required.	P3: Reorientating local health systems.
Getting the right people to the table; note: this should not stop things from progressing.	• Need to ensure that all stakeholders are included.	P2: Local and regional decision making.
Access: Meeting primary health need to avoid patients progressing to tertiary need. That is, patients needing services but not qualifying for services – only those at high-risk. Low-risk screening needed for preventative care, for example, podiatry.	• Need more services for early intervention and prevention.	P2: Local and regional decision making.
Some services not available in ATSICCHOs, for example, ENT, audiology, fracture clinic.	• Patients need to feel comfortable accessing services wherever they are provided. • HHS could consider providing services at the ATSICCHO or other outreach location.	P3: Reorientating local health systems. P4: Cultural capability.
Workforce: Staff not available to provide healthcare at outer locations. Salary differential between QH and ATSICCHOs. Not enough doctors.	• Need a long-term workforce strategy to attract and retain First Nations staff at all levels. • Need to include cultural safety in health provision.	P1: First Nations leadership. P4: Cultural capability.
Transport and accommodation: No public transport to South Burnett. Patient transport outside hours. Little notice of surgery openings in major centres. Patients coming from over the border. Relationships between QH and NSW Health—funding between states. Where patient can't make appointment for whatever reason (usually transport), patient can't afford the $25 Did Not Attend fee, so gives up on health needs.	• Transport problems are stopping patients from accessing services and attending scheduled appointments.	P3: Reorientating local health systems.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Regional gatekeepers, territory-guarding, stonewalling. May be unwilling to work with others to implement practical solutions or evidence-based strategies.	• Need all parts of the health system to work collaboratively to identify and deal with health needs.	P1: First Nations leadership.
Medical information-sharing.	• Need improved systems for data-sharing.	P1: First Nations leadership.
Medical records—tell story once.	• Without access to all data, practitioners are not seeing a patient's whole health story.	P3: Reorientating local health systems.
Lack of continuity of care; no handover; no discharge summaries.	• Need to have concierge services to assist patient navigate from home, through the health system and back again. • Need different areas of the health system to collaborate on patient outcomes.	P2: Local and regional decision making. P3: Reorientating local health systems.
Lack of provider choice for patients—HHS/GP/community control.	• All areas of health system must be culturally safe so patients have a choice of provider.	P4: Cultural capability.
Enablers		
Agile strategy—living, breathing document.	• HES needs to be flexible.	P1: First Nations leadership.
Home visits—can services be delivered in a different way?	• Models of care need to allow for both outreach and inreach to provide wholistic care.	P2: Local and regional decision making. P3: Reorientating local health systems.
Services not delivered in locations where people don't access them—how do you take services out of the traditional settings?	• Flexible service delivery models are needed.	P3: Reorientating local health systems.
Workforce—joint employment/location of staff across multiple sites organisations—options for professional development—staff referee checks so HHS don't employ staff terminated by the ATSICCHO.	• Need to consider staff rotation and secondments, mentoring and other development options. • Referee-checking prior to engagement is paramount.	P2: Local and regional decision making. P4: Cultural capability.
Patient-centred approaches.	• The system must put the patient at the centre of care.	P3: Reorientating local health systems.
Collaboration between providers. Division between divisions, resulting in looking after 'our' own budgets and interests without putting clients at the centre.	• Need different areas of the health system to collaborate on patient outcomes. • Need to ensure patient-centred care.	P2: Local and regional decision making. P3: Reorientating local health systems.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Workforce development—provide Aboriginal health practitioners with development and opportunities—opportunities to operate within scope of practice and professional development of staff to enable them to access at full scope of practice.	• Need a long-term strategy to attract and retain First Nations staff at all levels. • Need to consider staff rotation and secondments, mentoring and other development options.	P1: First Nations leadership.
Allocation, especially of funding, based upon need, not population.	• Funding must be needs-based.	P1: First Nations leadership.
Engagement with the Commonwealth and Commonwealth funding.	• Must have Commonwealth at the table.	P1: First Nations leadership.
Flexible approach.	• Funding reform needed to allow for flexible models of care.	P1: First Nations leadership. P3: Reorientating local health systems.
Build upon things that already work well.	• Acknowledge strengths and work together to build upon them.	P2: Local and regional decision making.
Workforce: QH policy not to poach employees from ATSICCHOs. Check references to ensure staff not leaving ATSICCHO for bad reasons and then being employed by QH.	• Need to rectify disparity in wages. • Referee-checking prior to engagements is paramount.	P1: First Nations leadership.
Health: • Positive cross-employment between HHS and ATSICCHOs. • Employ more trainee doctors under senior doctors. • Training Certificate IV holders to be health practitioners (fund for training and time off work).	• Need a long-term workforce strategy to attract and retain First Nations staff at all levels. • Need to consider staff rotation and secondments, mentoring and other development options. • Need funding for training.	P1: First Nations leadership. P2: Local and regional decision making.
Access: • Take services out to the people in the locations needed. • Screen low-risk patients when visiting if specialists are not busy.	• Need to have more services provided at local venues. • Need opportunistic screening when specialists are available.	P3: Reorientating local health systems.
Transport—no answers. PTSS not funded but still done. Previously had an understanding with local car dealer, PHN fund staff/maintenance and fuel by ATSICCHO.	• Need to find innovative solutions for patient transports.	P2: Local and regional decision making. P3: Reorientating local health systems.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
How to get past regional gatekeepers and prioritise patients? Genuine consultation and discussion meeting to achieve a meaningful plan for the group to come to the table without agendas, to identify strengths and prioritise patient care—getting the job done and moving forward together.	• The patient must be the central focus of all health activity. • Consultation and collaboration must occur to ensure patient welfare.	P1: First Nations leadership.
Calling out racist assumptions/profiling whenever they happen.	• Need to have systems in which all racism is called out and dealt with when it occurs.	P4: Cultural capability.
Use existing cultural safety-training modules that work for medical professionals, not just doctors but all staff.	• Embed cultural safety into all aspects of health provision and make it the backbone of professional service delivery.	P4: Cultural capability.
Make cultural safety training mandatory, using existing models. A participant from a health service talked about their **Aboriginal-led** cultural training model and facilitation program for building cultural capacity towards improving cultural safety.	• Ensure cultural safety training is run regularly, and is mandatory for all workers in the health system at every level from cleaners to CEs.	P4: Cultural capability.
Mandatory discharge planning to enable continuity of care needs to include: • recording of patient preferences re outpatient at HHS/mainstream/ATSICCHO • mandatory discharge summary to preferred provider • ensuring medications lasts until patient can see outpatient provider • medication list.	• Need to ensure patients get everything they need for ongoing care after discharge until they see their regular care provider. • Provide a concierge service to ensure patients navigate through and out of the system.	P2: Local and regional decision making. P3: Reorientating local health systems.

Attendee's Comments/Views/Input

Other comments - Ideas

- Regional ATSICCHOs—question why a sector issue is included in an HHS document?
- Several issues are statewide so may not be relevant to a local HHS.
- ATSICCHOs mostly rely on Medicare, so more equity is needed in funding distribution. It must be needs-based rather than population-based. That is, ATSICCHOs must build provider-patient relationships, provide mental health services to patients and refer them on with a focus on meeting needs, above all. Services are provided, but they are underfunded or not funded. Need better investment to provide a holistic approach. More continual funding for priority needs OF THE COMMUNITY. Projects must not be started and then just dropped, regardless of results, because they only have one-off project funding. This causes instability in staffing and in meeting patient needs.
- Good partnerships and true consultation. Need to ask for what WE need: that is, partnership is improving pathways to service delivery. More focus needed on partnerships. Regular results focused meetings between HHS and ATSICCHOs.
- Better partnership with government organisations.
- Strong workforce—ATSICCHOs currently compete with QH for doctors and other professionals.
- We need funding and the will to meet these needs through the enablers or other flexible solutions.
- Value of Rica Lacey's/leadership role—creating access and relationships between the HHS and ATSICCHOs. Initial focus is upon relationship-building.
- Make cultural safety training mandatory, using existing models. A health service participant talked about their Aboriginal-led cultural training model, and a facilitation program for building cultural capacity towards improving cultural safety.
- DDHHS suggest that HHS First Nations representatives are given the opportunity to provide feedback and suggestions on ATSICCHO models of care as part of the Health Equity reform to ensure patient care is streamlined and the health sector are working together to achieve health equity. This would achieve true patient centred co-design, co-ownership and co-implementation across the health system and support health system reform.

Appendix 3—Attendee list

Name	Organisation
Reece Griffin	Carbal Medical Centre
Anne Neilson	Darling Downs Hospital and Health Service
Bede Wilson	Darling Downs Hospital and Health Service
Charlie Waters	Darling Downs Hospital and Health Service
Greg Neilson	Darling Downs Hospital and Health Service
Hope McMillan	Darling Downs Hospital and Health Service
Peter Gillies	Darling Downs Hospital and Health Service
Rica Lacey	Darling Downs Hospital and Health Service
Shayne Stenhouse	Darling Downs Hospital and Health Service
Shirley-Anne Gardiner	Darling Downs Hospital and Health Service
Trish Leddington-Hill	Darling Downs Hospital and Health Service
Candice Renouf	Darling Downs Hospital and Health Service
Anna Moffitt	Darling Downs Hospital and Health Service
Lizzie Adams	Goolburri Aborignal Health Advancement Co Ltd
Raylene Baker	Goolburri Aborignal Health Advancement Co Ltd
Diana Weribone	Goondir Health Services
Don Gorman	Goondir Health Services
Floyd Leedie	Goondir Health Services
Gary White	Goondir Health Services
John Walker	Goondir Health Services
Cleveland Fagan	QAIHC
Tiana Lea	QAIHC
Warren Waters	Queensland Health
Randall Taylor	Queensland Health
Megan O'Shannessy	Rural Medical Education Australia Ltd

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
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
DDHHS	Darling Downs Hospital and Health Service
ED	Emergency Department
FN	First Nations
FNQ	Far North Queensland
HES	Health Equity Strategy
HHS	Hospital and Health Service
HLO	Hospital Liaison Officers

Abbreviation	Meaning
HR	Human Resources
IUIH	Institute for Urban Indigenous Health
KPIs	Key performance Indicators
LANA	Local area needs analysis
MHAOD	Mental Health and Other Drugs
NCACCH	North Coast Aboriginal Corporation for Community Health
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