Consultation Report

Torres and Cape regional consultation

17 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: Torres and Cape regional 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**

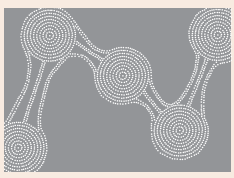
An electronic version of this document is available at **health.qld.gov.au** and **qaihc.com.au**

Disclaimer

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 Torres and Cape consultation workshop was undertaken on 15 April 2021 at the Novotel, Cairns. The consultation had 13 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. 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 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:

- regular experiences of racism and discrimination experienced by Torres and Cape mob when accessing care
- the substantial access barriers in the region due to remoteness and having limited to no choice in healthcare providers—the HHS is the primary provider across most of Cape York and the current outreach service arrangements require ongoing improvement
- the need to strengthen and grow the local Aboriginal and Torres Strait Islander workforce by supporting existing staff members to work to their full scope of practice (both clinical and community/patient advocacy) and building a pathway and pipeline to build the future health workforce
- addressing the institutional racism experienced by local HHS employees not having access to the same employment benefits as non-local workers recruited to the region
- effective governance, accountability and change management being tied to the HES
- cultural safety and cultural security needing to be embedded across every point of care and within accreditation standards.

Top five health reforms

considered a priority for this region by the participants

1. **Establish a First Nations Health Board**
8. **Establish regional coordinated care hubs**
11. **Embed cultural capability into Clinical Services Capability Framework**
13. **Undertake annual independent institutional racism audits**
18. **Establish pilot 'Marmot city regions' across Queensland**

Key discussion points

The discussion from the Torres and Cape consultation will be incorporated into the overall state consultation report, which 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 Torres and Cape consultation region.

Principle 1: First Nations leadership	
Systems	• The HES needs to be accessible to everyone—the language and actions need to be clearly communicated (no jargon; clear and concise language). • The HESs provide an opportunity to rebuild, reframe, re-empower and reinvent community engagement and community empowerment. • The community needs to sit at the heart of the health system and determine the best way the health system can respond to their needs and priorities. • Community needs to discuss the priorities and actions that need to be included in the new HES—there are concerns this will not happen because this level and type of engagement has never happened before. • HES can't be one plan—localised actions are needed. Thirty-five communities are in the Torres and Cape region. Effective engagement needs to occur with each of the 35 communities to sit and discuss local actions.
Culture	• Cultural governance needs to overlay health system governance. • Torres Strait Islander representation is needed on various governance structures at local, regional, state and national levels. • Community can encourage community people to apply for board positions on HHSs when they become available.

Principle 2: Local and regional decision making	
Systems	• Genuine partnerships are based on trust, and historically, there's been a lack trust between community and ATSICCHOs towards Queensland Health—this needs to be acknowledged. • Improvements are needed to current partnership and governance arrangements across the Torres and Cape. • The HES must be accompanied by an accountability and governance framework—currently policies and frameworks are not implemented and no-one is accountable when they're not delivered/actioned. This needs to change to ensure the new HES does not become another dusty document that sits on the shelf. • Need to co-design place-based community indicators to reflect the needs, interests and priorities from a community point of view. • Geographical differences in health care access, experiences and outcomes need to be recognised across the state. • Existing MOUs are not strong enough because there's no legal accountability. • Need to learn from current partnership arrangements—they don't deliver because they need stronger accountability and governance arrangements to the HHS Board and community.

Principle 3: Reorienting local health systems	
Systems	• The Torres region has one of the largest life expectancy gaps compared to other regions across the state—need to take into consideration that regional variances exist between regions and HHSs. • The HES provides us with a platform for health system change and accountability—need to make the most of this opportunity. • Need to overhaul current health system complaints process—currently the complaints process is burdensome for patients and staff. • A change management strategy needs to accompany the development and implementation of the new HES. • Need to strengthen accreditation standards across the health system—current accreditation standards (how they are monitored and evaluated) are still failing communities. • Revise the current transport assistance system—Patient Transport Support Scheme (PTSS) to make it effective and suitable for remote communities. • HESs need to prioritise social and emotional wellbeing. • Data-sharing needs to become common practice.
Workforce	• Need to support current Aboriginal and Torres Strait Islander health workers (ATSIHWs) to continue their career pathway and explore other health career opportunities—a gap exists in current upskilling pathways. • Need to undertake integrated workforce planning across the health system (between HHS/ATSICCHO/PHNs) to determine service gaps.

Principle 4: Cultural capability	
Systems	• Cultural safety has many different aspects—it's about an individual and what they experience in the health system, but it's also about community governance.
Care	• Cultural security and cultural safety need to be provided throughout every point of the patient journey—this is currently not the case.
Workforce	• Need more Aboriginal and Torres Strait Islander navigators, care coordinators and trainee roles throughout HHS. • One example of institutional racism is the different employment incentives and benefits provided to non-local people recruited to work and live in the Torres and Cape. The same level and type of incentives need to be provided to local people from the Torres and Cape.
Culture	• Because people experience racism in the hospital, their healthcare and health outcomes are jeopardised. Cape and Torres Strait Islander mob regularly report experiencing racism in Cairns hospital. • Cultural safety and cultural security need to be built/embedded into the foundations of clinical safety guidelines and models of care. Lofty statements and policy documents exist about cultural capability but they are not genuinely embedded into how healthcare services are developed and delivered. • Human rights and cultural respect principles don't go far enough because they don't change or challenge the institutional privilege where a government or system can choose not to listen.

Principle 5: Social determinants	
Systems	• Integrated approaches to funding and planning are needed in remote communities to maximise investment from all sources (Queensland and Australian Governments). • Health plays a strong leadership role in the community—the sector can drive local change because it plays a huge part in the community. • Health system improvements need to support broader reforms across communities—effective governance structures need to be established that look at the whole picture (health, social and economic priorities) in a community.
Funding	• Lack of affordable housing in the Torres Strait.

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

Attendee's comments/views/input

General discussion

HEALTH EQUITY DEFINITION

- New Zealand definition (page 10) is strong because it recognises different people have different levels of advantage and disadvantage and require tailored support. The Cape and Torres Strait are very disadvantaged in regards to accessing resources and funding which has a direct impact on achieving equitable health outcomes. The Cape and Torres will experience significant barriers in achieving health equity with the current level of resourcing.
- An agreed definition is needed for people to understand what health equity does and does not entail—people will then develop their own personal understanding of equity based on the common definition. Service providers need to see themselves in the definition and what their role/responsibilities are in achieving health equity.
- Need to ensure the definition references the social determinants of health because poorer health is caused by social and economic factors. NZ definition takes this into consideration and does not focus solely on the health system.
- Health differences are 'avoidable'—need to ensure the agreed definition of health equity makes reference to this.
- Patient choice needs to be factored into the definition—currently mob in the Torres and Cape don't have a choice to second opinions, specialists or different providers.
- The definition needs to emphasise urgency—the journey has been a long one for Aboriginal peoples and Torres Strait Islanders, and substantial health inequities are still the reality for many people. The life expectancy gap for people in the Cape and Torres Strait Islands is much greater than the state average of 7.3 years. Geographical differences in healthcare access, experiences and outcomes need to be recognised across the state. More innovative thinking is needed to co-design solutions in the Torres and Cape because the health inequities and barriers are greater than other parts of Queensland.
- Need to settle on a definition that can withstand the test of time—needs to be still relevant in ten years (2031).
- The definition and principles need to describe a health system that can provide 'the healthcare I need, where I need it, when I need it and how I need it'.

HEALTH EQUITY PRINCIPLES

- The principles need to be flexible enough for each region to tailor resourcing, service models and workforce strategies to create an integrated local health system that responds to the health needs and priorities of communities.
- The NPA is made up of five communities but it is often amalgamated into one region with the same health needs. Health differences exist between and within the five communities—the principles need to reflect that place-based (or local) responses are needed for each community, in addition to regional actions that include common actions.
- Self-determination means different things for individuals, the community-controlled health sector and communities themselves. For communities, self-determination means having the authority to determine their own future. For individuals, it could mean deciding to work for a government department. The definition has many applications—each is valid and need to co-exist.
- The principles—and new HES—need to hold people accountable.
- The principles—and the new HES—need get ATSICCHOs and HHSs to the table to both co-design and implement new integrated approaches to healthcare.

Attendee's comments/views/input

- Accountability must be referenced in the principles and the HES, accompanied by an accountability and governance framework (which is operationalised through a reporting, monitoring and evaluation framework)—currently polices and frameworks are not implemented and no-one is accountable when they're not delivered/actioned. This needs to change to ensure the new HES does not become another dusty document that sits on the shelf.
- Communities need to control the health system by governing the system and have accountability back to them. One Aboriginal or Torres Strait Islander board member on a HHS Board isn't enough.
- Cultural safety has many different aspects—it's about an individual and what they experience in the health system but it's also about community governance. Cultural safety = self-determination. The community needs to sit at the heart of everything and determine the best way the health system can respond to their needs and priorities.
- Cultural governance needs to overlay health system governance.
- Human rights and cultural respect principles don't go far enough because they don't change or challenge the institutional privilege where a government or system can choose not to listen. Local health decision-makers—such as a Director of Nursing (DoN)—decide how and when they will consult, engage or partner with local communities, and if they don't want to work with the community, it doesn't happen.
- The HES (and regulation) now require community organisations to be involved in local health system planning—this is the first time it is a legislative requirement.
- The HES needs to be accessible to everyone—the language and actions need to be clearly communicated (no jargon; clear and concise language) so a community member can easily read it and understand what each health provider is responsible for and how they work together as one health system.
- Meaningful actions need to be included in the HES that can be implemented—existing leadership groups (for example, the Health Action Group) can be overwhelmed by the list of actions because so many priorities and issues exist that need to be addressed. The HES cannot be more of the same—it is an opportunity to reset and focus attention over the short, medium and long-term about improvements and reforms that can be introduced over the next ten years (starting with the first three-year HES).
- Health system improvements need to support broader reforms across communities. Effective governance structures need to be established that look at the whole picture (health, social and economic priorities) in a community.
- Local councils are important stakeholders because they are responsible for a range of municipal functions, including managing housing stock and land allocation.
- Need more than one Aboriginal or Torres Strait Islander voice at a table—five or six voices translates into a large representational voice.
- Improvements are needed to current partnership and governance arrangements across the Torres and Cape.
- The HES provides us with a platform for health system change and accountability—need to make the most of this opportunity.
- Existing MOUs are not strong enough because there's no legal accountability. And even HHS directives have their limitations because sometimes they are not implemented by local decision-makers (for example, some DoNs may not implement directives because they are not monitored).
- Community needs to discuss the priorities and actions that need to be included in the new HES—there are concerns that this will not happen even though it is a requirement in the regulation because this level and type of engagement has never happened before.
- Genuine partnerships are based on trust, and historically, there's been a lack of trust between community and ATSICCHOs towards QH. This history needs to be recognised and the HHS needs to work out how they will build and demonstrate trust with community and ATSICCHOs in the development and implementation of the new HES.

Attendee's comments/views/input

- The HESs provide an opportunity to rebuild, reframe, re-empower and reinvent community engagement and community empowerment. The health sector needs to engage across the community and with as many other organisations/services as possible because the health sector can't do it by itself. Need to focus on the long-term (ten-year horizon) and determine what can be achieved in each three-year plan.
- Health plays a strong leadership role in the community—the Sector can drive local change because it plays a huge part in the community.
- Community can encourage community people to apply for board positions on HHSs when they become available. Need more than one person, and for cultural reasons, at least two people (a male and a female) need to be represented, with one person being Aboriginal person and one Torres Strait Islander person.
- Aboriginal and Torres Strait Islander people must be represented and employed across all parts and levels of an organisation—not only identified positions but in every occupational stream.

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 and opportunities		
Torres region has one of the largest life expectancy gaps compared to other regions across the state—need to take into consideration that regional variances exist between regions and HHSs. Greater health inequities exist in some regions. When looking at the equity graphic on page nine, 'the Torres and Cape HHS is already five boxes behind other HHSs. We need five additional boxes before we can even start thinking about healthcare like other HHS regions'.	• Degree of health inequities varies across Queensland – Torres and Cape experience substantial challenges.	P2: Local and regional decision making. P3: Reorientating local health systems.
Torres Strait Islander representation is needed on various governance structures at local, regional, state and national levels. Torres Strait Islander people do not want someone from SEQ speaking or making decisions on their behalf. Torres Strait Islander cultural representation is often missing on governance bodies and groups. Aboriginal peoples and Torres Strait Islander peoples are two different peoples—cultural needs are different.	• Torres Strait Islander representation.	P1: First Nations leadership.
HES governance bodies and engagement bodies need to have cultural representation from people who live and work in a particular region; they don't know what is happening.	• Torres Strait Islander representation.	P1: First Nations leadership.
Power imbalance exists between HHSs and community organisations and members—HHSs have the power.	• Health system integration.	P2: Local and regional decision making. P3: Reorientating local health systems.
Concerns exist for some people denied access to healthcare. There was a case recently where the renal team did not want to readmit a patient because there were a number of complaints against this person. The patient was in significant pain and was not provided with appropriate pain medication and is now in palliative care.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
Because people experience racism in the hospital, their healthcare and health outcomes are jeopardised. Cape and Torres Strait Islander mob report experiencing racism in Cairns hospital.	• Racism and discrimination.	P4: Cultural capability.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
HHSs currently do not support or empower Aboriginal and Torres Strait Islander health workers (ATSIHW) to practice their clinical skills and advocate for mob within HHSs. Historically, ATSIHWs were employed as cultural brokers to support Aboriginal and Torres Strait Islander people navigating the health system. They were then upskilled to provide clinical services but ATSIHW are not supported or empowered to practice their skills.	• Build and strengthen local Aboriginal and Torres Strait Islander health workforce.	P1: First Nations leadership. P4: Cultural capability.
Under the former Government (LNP), local Aboriginal and Torres Strait Islander people in leadership positions were pushed out of the HHS, and white nurses and doctors given the authority to make decisions. For example, for the PTSS, nurses (or DoN) makes the decision about whether a patient can have an escort to attend outpatient or specialist care in Cairns, Townsville or Brisbane. Because they aren't part of the community, they don't fully understand the level and type of support patients need. The previous leadership role of Aboriginal and Torres Strait Islander people in the health system was lost.	• Enhance/ expand existing models of care—cultural safety and security.	P1: First Nations leadership. P4: Cultural capability.
Cultural security and cultural safety need to be provided throughout every point of the patient journey – this is currently not the case. Previously, nurses and DoNs reported to a local Indigenous leader. This no longer happens, resulting in local Aboriginal and Torres Strait Islander people losing the power to ensure services are being delivered appropriately. ATSIHWs' authority needs to be respected and listened to when advocating for clients' rights.	• Enhance/ expand existing models of care—cultural safety and security.	P4: Cultural capability.
APHRA cultural security needs to be a critical tool in the HES toolkit. APHRA has mapped out the localised points throughout the patient journey to ensure cultural safety/security. Every community and staff member needs to have an Aphra-registered cultural safety sign-off person.	• Enhance/ expand existing models of care—cultural safety and security.	P4: Cultural capability.
Need to strengthen accreditation standards across the health system—current accreditation standards (how they are monitored and evaluated) are still failing communities. The majority of ATSICCHOs are accredited through RACGP and HHSs have different accreditation standards. Consideration needs to be given to creating (nationally, state-wide or locally) an agreed accreditation framework across the health system that prioritises cultural safety and values the voice/ experiences of consumers. RACGP 5th standards are starting to introduce changes by assessing/monitoring clinical governance.	• Local health system improvements.	P4: Cultural capability.
Improvements needed to existing care planning—discharge care plans are often missing even though they are a critical point in the transition of care from hospital to community. But HHS are not held to account when they fail to provide clients with discharge care plans. The current legislative environment doesn't not hold HHSs to account. There needs to be better/more targeted consequences for failures—currently none exist.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Strengthen referral pathways (access) to specialist care—it is unfair to encourage and promote health checks without providing a range of options for patients to access care. Getting access to specialist health services is vital but travelling away from home numerous times throughout the year is hard for people. Need to ensure there's a range of options throughout the patient's cycle of care—travelling away to specialist care, accessing regular outreach services and providing access to telehealth/virtual healthcare.	• Local health system improvements.	P3: Reorientating local health systems.
Revise the current transport assistance system (PTSS) to make it effective and suitable for remote communities. Many experiences of patients and their escorts encountering racism, culturally inappropriate services (for example, expecting patients and escorts to share a room which may be against cultural protocols) and poor standard/quality accommodation (dirty/unhygienic rooms or booking a room for an Elder in a three-storey building without an elevator)—the needs of mob travelling are not understood or respected. This has been reported numerous times to QH but no changes/improvements have been made. Remote areas also need a fully costed patient transport service—not a subsidised service where patients are expected to pay some of the costs. Sometimes accommodation providers require patients to pay a deposit and they don't have the money.	• Local health system improvements.	P3: Reorientating local health systems.
Improve access to primary and specialist care: • Sometimes patients have to wait 14 days to get a flight booking to attend an appointment, regardless of the seriousness of the condition. There was one example of a NPA community member who died while waiting to get a flight booking. • Breast screening has not been conducted in the NPA for the last six years. Breast screening was being conducted on Thursday Island but no travel assistance was provided for women from NPA to attend the screening. Need to improve and strengthen the level and type of primary healthcare provided in remote locations, including family planning and family case conferencing. • Mob in community need a relational approach where people feel comfortable going to specialist appointments, rather than getting on a plane and someone unknown meeting them. This experience is scary for many people. Priority has to be given to supporting a person connect to the location/specialist service they are attending—this will result in better outcomes.	• Local health system improvements.	P3: Reorientating local health systems.
Need to overhaul current health system complaints process—currently the complaints process is burdensome for patients. For example, it requires individuals to make complaints and not family members or advocates. There was an example in the NPA where another person tried to make a complaint about the experience of a brain-injured patient who had a seizure on the plane due to not receiving the correct medication, and the compliant was not able to proceed.	• Local health system improvements.	P3: Reorientating local health systems.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Forge genuine partnerships between local healthcare providers to listen to one another and develop local solutions to the problems identified. The new HESs have to support these local partnership/governance relationships and ensure funding is allocated to respond to locally identified health system gaps.	• Local health system improvements.	P3: Reorientating local health systems.
Learn from existing successful health services and empower Aboriginal and Torres Strait Islander health staff to advocate on behalf of patients. More Aboriginal and Torres Strait Islander people need to work across the entire health system—nurse navigators have improved the coordination of care within hospitals but they don't know people from the community or understand the concerns or challenges people face from the community.	• Build and strengthen local Aboriginal and Torres Strait Islander health workforce.	P3: Reorientating local health systems.
Current referral system to outreach services needs improvements—referrals often get lost for patients needing access to outreach specialist outreach services and communication/process breakdowns exist about referring a patient to the waitlist. Clinical staff and community members sometimes talk about the barriers preventing outreach services being delivered in smaller communities—for example, paediatrics clinic is available in Weipa but not Mapoon.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
Support current ATSIHWs to continue their career pathway and explore other health career opportunities (for example, nursing or allied health). A gap exists in current upskilling pathways. It is important local communities are supported to develop these skills.	• Build and strengthen local Aboriginal and Torres Strait Islander health workforce.	P3: Reorientating local health systems.
Need to encourage younger people to pursue a career in health and find creative ways to get young people interested so they aspire to a be a health worker, doctor or nurse. Many opportunities exist for young people to complete Certificate II/IIIs at boarding schools, which can be used when they return to the community (including work experience) or start them on the pathway of becoming a nurse or doctor in the future. Current education standards in the Torres and Cape are not good enough yet—need to partner with schools to find creative ways to support and inspire young people.	• Build and strengthen local Aboriginal and Torres Strait Islander health workforce—future workforce.	P3: Reorientating local health systems.
Increased access to maternal and child health. Access to healthcare in the early years (first five years of life) needs to be ramped up. Very limited access to allied health and specialist developmental assessments, including NDIS.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
ATSIHWs are being underutilised. The role is not all clinical. There are clinical CNCs based in hospitals and that are navigators not clinicians—they refer to the clinical specialists. Need to do things smarter. Explore opportunities to create Aboriginal and Torres Strait Islander navigator roles within HHSs (similar to nurse navigator roles but to extend care beyond the HHS like the care coordinators employed in the ATSICCHO Sector who support a patient throughout their journey). Current nurse navigator funding is not flexible and can only be used for qualified nurses.	• Build and strengthen local Aboriginal and Torres Strait Islander health workforce.	P3: Reorientating local health systems.
Ensure all ATSIHWs are AHPRA-registered and can work to their full scope of practice.	• Build and strengthen local Aboriginal and Torres Strait Islander health workforce.	P3: Reorientating local health systems.
Concerns about current the revisions to the ATSIHW Cert IV—support is needed to create a pathway and pipeline to support more Aboriginal and Torres Strait Islander people obtain health qualifications and work in the health system. Need to employ more health workers who live and work in our communities, 'who walk our talk and support the client from home, to the hospital and then back home again—this is how we'll get the change we need in terms of economic development and changing local behaviours'. Need more Indigenous people working in the health system to change many parts of the health system that are still racist.	• Build and strengthen local Aboriginal and Torres Strait Islander health workforce.	P3: Reorientating local health systems.
Need more ATSIHW and practitioners working across the health system—this will enable, encourage and support greater access to care for Aboriginal and Torres Strait Islander peoples. Also need to encourage more men to pursue careers in healthcare.	• Build and strengthen local Aboriginal and Torres Strait Islander health workforce.	P3: Reorientating local health systems.
Need more Aboriginal and Torres Strait Islander trainee positions in HHSs. The HHS is committed to increasing the number of trainees—a key challenge is the non-recurrent nature of funding to employ trainees.	• Build and strengthen local Aboriginal and Torres Strait Islander health workforce.	P3: Reorientating local health systems.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Need to undertake integrated workforce planning across the health system (between HHS/ATSICCHO/PHNs) to determine where additional positions are needed. Because of funding constraints, need to spend funding and allocate resources (positions) where they will provide the most benefit. Need to partner and work with Primary Health Networks (PHNs) to influence the needs assessment to ensure any additional Commonwealth funding commissioned by PHNs is based on disease profile/Burden of Disease (BoD). All health system partners need to come together and work collaboratively is maximise the funding allocated from the Commonwealth for primary health care and where possible, reinvest and modify funding to change community behaviours.	• Local health system improvements.	P2: Local and regional decision making.
Need more administration support staff because they work closely with communities (do a lot of chasing up because they know where people live). They currently work in a team with nurse navigators.	• Build and strengthen local Aboriginal and Torres Strait Islander health workforce.	P3: Reorientating local health systems.
Explore opportunities to improve and streamline current state (Queensland Health) and Australian Government funding arrangements to ATSICCHOs.	• Improved funding arrangements.	P3: Reorientating local health systems.
NQPHN needs to invest in existing local community organisations and providers on the ground rather than funding mainland providers to establish small offices with limited staff—efficiencies can be produced by NQPHN working closely with existing providers on the group to deliver and/or purchase services, and integrate healthcare with other social support/assistance (re social determinants of health).	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
HESs need to prioritise social and emotional wellbeing—this is currently missing. Additional resources/funding/services are needed across the region to improve SEWB (Social and Emotional Wellbeing) and mental health—including building resilience within families and communities to reduce suicides. Current service coverage of SEWB/mental health services is patchy across the Torres and Cape.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
Confusion exists about the difference between SEWB and mental health services—both are needed but significant differences between the two. In the HHS, the SEWB team is now part of Mental Health—this has resulted in some central components of the SEWB model becoming absorbed/replaced by a clinical mental health lens. Need to reconsider the benefits of rebuilding the SEWB program/team and creating the necessary links between both services/models of care. There is a common perception by some people that the HHS prefers to label communities as having mental health problems (and needing medication) rather than understanding the complex and intergenerational nature of trauma due to the impact of previous government policies (re former missions and reserves), including the impact of the stolen generations on families and communities.	• Enhance/ expand existing models of care.	P4: Cultural capability.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Increase delivery of holistic models—currently fewer holistic models of care are being delivered with an increased focus on delivering clinical services. Will reduce suicides in communities by implementing more holistic primary healthcare and reinvesting in SEWB services and support. SEWB models adopt a holistic approach to health and wellbeing, including advocating and supporting families access other services.	• Enhance/ expand existing models of care.	P3: Reorientating local health systems.
Cultural safety and cultural security need to be built/embedded into the foundations of clinical safety guidelines and models of care. Lofty statements and policy documents exist about cultural capability, but they are not genuinely embedded into how healthcare services are developed and delivered. Western clinical governance models are given priority and dominate the design/delivery of models of care. If cultural safety and cultural security existed, health equity would be achieved, and we wouldn't be having these conversations.	• Enhance/ expand existing models of care—cultural safety.	P4: Cultural capability.
Integrated approaches to funding and planning are needed in remote communities to maximise investment from all sources (Queensland and Australian Government). For example, training for future health workers could come from other Australian Government sources (re CDP or economic development funding streams, and cashing out Medicare funding). A key barrier to improving health outcomes is having a local workforce with the necessary skills. The new HESs could be used as a partnership mechanism to get buy-in from other agencies and portfolios by integrating planning and investment.	• Improved funding arrangements.	P5: Social determinants.
Critical infrastructure upgrades are needed to support service delivery—the current 12-bed facility in NPA is in desperate need of an upgrade. Across remote communities, critical infrastructure updates are needed to ensure access to basic services, including reliable and safe water.	• Local health system improvements.	P5: Social determinants.
Lack of affordable housing in the Torres Strait: • Rent is high on Thursday Island and housing on the outer islands is often of poor quality. Rental costs are not commensurate with wages that locals get (compared to non-local people), and there's not enough housing on the outer islands for the workforce with five or six generations sometimes living in one house. The housing shortage results in some QH staff choosing to not accept leadership development positions in other locations because they will lose their current housing. Some families spent generations in the same house. • Need to bring down current rental prices in Thursday Island—caps could be placed on existing Queensland Government rental subsidies. • Suggestion to build a government hub on Horn Island because it has more land and move people off the outer islands—this would free up available housing stock and provide local residents with better quality housing.	• Infrastructure constraints—housing.	P5: Social determinants.

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Encourage local home ownership. Rather than providing housing allowances for QH staff, expand option to provide mortgage allowances to enable people to own their own home. Indigenous Business Australia (IBA) is one provider who currently provides loans in the Torres Strait.	• Infrastructure constraints—housing.	P5: Social determinants.
One example of institutional racism is the different employment incentives and benefits provided to non-local people recruited to work and live in the Torres and Cape. The same level and type of incentives need to be provided to local people recruited from the Torres and Cape. Non-local people receive 17 months free rent then pay $17 week for rent—local people do not receive the same benefit. This creates a disincentive to growing a local health workforce.	• Improve conditions and benefits to grow a local health workforce.	P4: Cultural capability.
Accommodation is a barrier for sustainable healthcare delivery—existing levels of housing stock and infrastructure prevent people staying and living in the communities. This creates a dependency on FIFO workforce.	• Improve conditions and benefits to grow a local health workforce.	P5: Social determinants.
Transition to community control to provide culturally safe health services—more healthcare services need to transition from HHSs to ATSICCHOs. Three established ATSICCHOs operate across region and opportunities exist for primary healthcare to be transitioned to ATSICCHOs. When cultural safety is put at the centre, changes and improvements start to happen because healthcare models are not solely dominated by a clinical lens. Aboriginal and Torres Strait Islander peoples and cultures are not seen as the 'other' in ATSICCHOs—we are part of the way things are done in the Sector.	• Transition primary healthcare to community-controlled health sector.	P3: Reorientating local health systems.
Need more Aboriginal and Torres Strait Islander navigators, care coordinators and trainee roles throughout HHS—the value add of level three nurse navigators is questioned if not they do not provide culturally safe care. In the past, 21 Aboriginal and Torres Strait Islander allied health assistants were trained but no positions were created for them to transition into employment with the HHS or ATSICCHOs.		P3: Reorientating local health systems.
HHS Board members to be held accountable for delivery of the HES and receive cultural safety /capability training.		P2: Local and regional decision making.
Need to conduct cultural impact assessments as regularly as other types of impact assessments are conducted to ensure services and programs are culturally safe and culturally secure.		P4: Cultural capability.

Attendee's comments/views/input

Other comments—ideas

- **Strengthen partnerships between HHS and ATSICCHOs** to deliver and monitor health services—need to walk together:
  - ensure relationship is open and transparent, with public reporting on agreed actions
  - deliver actions agreed at meetings
  - local KPIs developed and agreed together
  - determine which is the best placed organisation to deliver services/programs to reduce duplication, respond to service gaps and maximise efficiencies.
- **Co-design place-based community indicators to reflect the needs, interests and priorities** from a community point of view and assess what effectiveness looks like for the community. Improvements needs to measurable and reported back to the community regularly (i.e. every three years).
- **HES can't be one plan**—localised actions are needed. Thirty-five communities are in the Torres and Cape region. Effective engagement needs to occur with each of the 35 communities to sit and discuss local actions.
- **Service providers need to stop competing for funding and pool resources.** For example, Mookai Rosie could lead the delivery of the Commonwealth-funded Australian Nurse Family Partnership (ANFP) because they are registered and the local ATSICCHO aren't able to deliver. Often program budgets are not fully expended because service providers are not meeting to work out which organisation has the capacity/capability to deliver a program.
- **ATSICCHOs need to be adequately funded to provide universal primary health care services**—need to understand what that means in practice across the region and conduct an assessment/audit to identify service gaps where there currently isn't access to universal primary healthcare. Ongoing lobbying and advocacy is needed with the Australian Government to increase funding into universal primary healthcare. It will take time to move money out of the hospital system and redirect it towards primary healthcare. Commonwealth needs to increase investment in ATSICCHOs.
- **Data-sharing needs to become common practice**—data-sharing arrangements (or protocols) boil down to obtaining consent because data belongs to the patient. Provisions to secure patient's consent to share data needs to be factored into policy and funding arrangements. There are unlikely to be many concerns about sharing de-identified data in the Torres and Cape region because community members want to see integrated healthcare service delivery.
- Data needs to be better used with families, communities and other service providers, including councils, so they understand how powerful it is—sharing information about the BoD in communities. Some Cape communities are only transferring to electronic systems with the transition from paper to digital systems still happening.
- F**urther information is needed about the new 'care coordination hub'** and how it will be able to support the development and implementation of actions in the new HES. The hub will play a key role in supporting patients' journeys across the continuum of care and linking patients to other social assistance and support.
- **A change management strategy needs to accompany the development and implementation of the new HES**—sometimes middle management can act as gatekeepers and maintain the status quo rather than adopting new approaches. There might be high-level support and community-level buy-in, but middle management need to operationalise and drive new approaches and commitments, otherwise they don't become embedded in everyday practices.

Attendee's comments/views/input

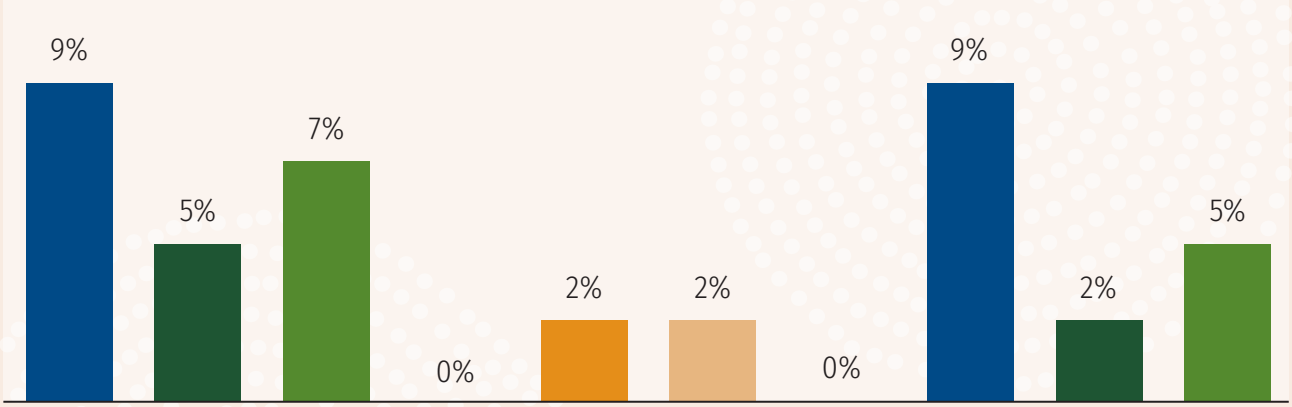
- **Need to learn from current partnership arrangements—they don't deliver because they need stronger accountability and governance arrangements to the HHS Board and community.** For example, the NPA has an MOU with QH about the delivery of different health services. What is experienced on the ground (operationally) is very different to what is detailed in the MOU. And whenever complaints are made, there is no follow-up action and nothing happens. There need to be multiple governance arrangements that involve the Board and community members who can provide both guidance (what is needed) and confidential feedback (what is and isn't working). In NPA, QH is the one-stop shop for community, so there's no choice—and if something's not working well, local people suffer.
- **Feedback has to be bilateral (two ways) and not unilateral—mechanisms need to be created as part of the HES that require Queensland Health to enter into a two-way dialogue about priorities raised by community.** This needs to be part of a governance and accountability framework.
- **HES KPIs need to include both process and outcome KPIs** tailored for each community, based on identified priorities and health needs.

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

Future ideas for discussion

Torres and Cape 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

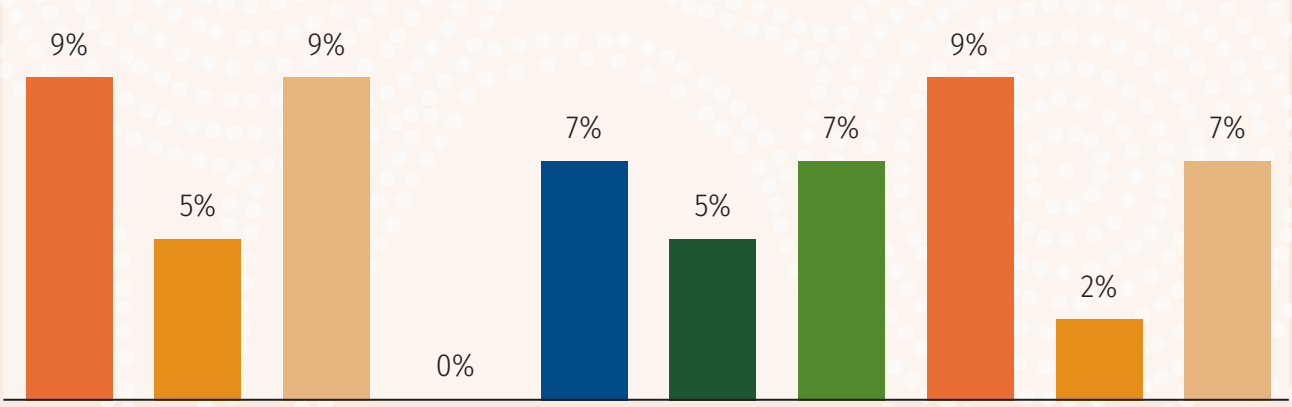
Reform Idea 6 Introduce First Nations employment measures

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
Patricia Yusia	NPA Family and Community Services
Nick Loukas	PHN Board Chair
Bevan Ah Kee	QAIHC
Cleveland Fagan	QAIHC
Jenny Gillett	QAIHC
Karen Thompson	QAIHC Consultant
Yasmin Muller	Queensland Health
Noeleen Mulley	Torres and Cape Hospital and Health Service
Joselyn Tully	Torres and Cape Hospital and Health Service
Elthies Kris	Torres And Cape Hospital and Health Service
Karen Dini-Paul	Torres and Cape Hospital and Health Service
Rhonda Shibasaki	Torres and Cape Hospital and Health Service
Paula Arnol	Torres Health Indigenous Corporation

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
BoD	Burden of Disease
CATSIHO	Chief Aboriginal and Torres Strait Islander Health Officer
CE	Chief Executive
CTG	Closing the Gap
DAMA	Discharge Against Medical Advice
DoN	Director of Nursing
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
HWQ	Health and Wellbeing Queensland
IUIH	Institute for Urban Indigenous Health
KPIs	Key performance Indicators
LANA	Local area needs analysis
MHAOD	Mental Health and Other Drugs
OH&S	Occupation Health and Safety
PHC	Primary health care
PHN	Primary Health Network
PTSS	Patient Travel Subsidy Scheme
QAIHC	Queensland Aboriginal and Islander Health Council
QH	Queensland Health
RN	Registered Nurse
SDoH	Social determinants of health
SEWB	Social and Emotional Wellbeing (also ESWB)
WHO	World Health Organization

QAIHC
Queensland Aboriginal and Islander Health Council

Queensland Government