

# Consultation Report

## *Bundaberg consultation*

28 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**

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

Consultation report: Bundaberg consultation

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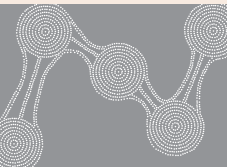
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Acknowledgement of Country

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



Making Tracks artwork produced by Gilimbaa for Queensland Health.



Sharing Knowledge artwork produced by Casey Coolwell for QAIHC.

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## Introduction

*The Bundaberg consultations were undertaken on 28 April 2021 at the Generator in Bundaberg. The consultation had 23 participants and was conducted over a five-hour period.*

## Workshop purpose

The regional workshops were held statewide to:

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

## Workshop structure

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

### Section 1

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

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

### Section 2

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

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

### Section 3

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

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





# Report structure

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

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

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

- systems
- care
- funding
- workforce
- culture.

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

# Executive summary

*The Bundaberg region does not have a good history of a health system working collaboratively. It is evident that there has been a breakdown in working relationships between parties in this region and that attaining the outcomes of health equity will be challenging if this is not resolved. There has been a change in personnel in the recent past, and it is hoped that along with the health equity reforms, this will add impetus to achieving a more integrated way of moving forward.*

Major issues of racism, disadvantage brought about from the Social Determinants of Health (SDoH), and distrust of the system impact strongly on the health outcomes for First Nations peoples in this area. Workforce issues, as with many other areas, cause major constraints on the system to provide culturally appropriate care. In turn, the lack of a cohesive working relationship between First Nations providers and the HHS means many First Nations peoples avoid any interaction with the health system until they have a serious health issue.

Models of care appropriate to the local community must be considered along with funding reform. There needs to be a more streamlined service for patients with wrap-around care from the patient leaving home to returning. This will require genuine partnership and trust between providers. Outside-hours care is an area of great concern, with many First Nations peoples not accessing the system because there is no one culturally appropriate available or self-discharging because, again, there is no one culturally appropriate to explain why they should remain.

A baseline audit needs to be undertaken of institutional racism, and ongoing training and support must be provided to staff to ensure their cultural competence. Consideration could be given to a program such as Courageous Conversations currently in use on the Gold Coast.

## Top five health reforms considered a priority for this region by the participants.

- 10 Implement funding incentives to address specific First Nations equity issues
- 4 Release a biennial First Nations health equity report tabled at Parliament by Chief Aboriginal and Torres Strait Islander Health Officer
- 2 Increase Queensland Health's First Nations employment targets commensurate to local population or hospital presentation and user rates (whichever is greater)
- 13 Undertake annual independent institutional racism assessments across Queensland Health
- 3 Legislate the responsibilities of the Chief Aboriginal and Torres Strait Islander Officer in the Hospital and Health Boards Act 2011

# Key discussion points

The discussion points from the Bundaberg 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 comments have been mapped against the components of the health equity design principles so that we can start to use the comments to guide what needs to be done to design a health system that meets the needs of people in the Bundaberg region.

Principle 1: First Nations leadership	
Care	<ul style="list-style-type: none"><li>● Need to work together.</li><li>● Need to start from a positive perspective and NOT a negative one.</li><li>● Explore the causal factors of poor health—social determinants.</li><li>● Need leadership of key positions in the health system and pathways to build the next generation of leaders.</li><li>● Need our children to have education to move into leadership positions within health.</li></ul>

Principle 2: Local and regional decision making	
Systems	<ul style="list-style-type: none"><li>● Need leadership of key positions in the health system and pathways to build the next generation of leaders.</li><li>● Need a flexible approach and to evaluate and change as needed.</li><li>● Understand the needs and gaps.</li><li>● Learnings from areas where success has been achieved.</li><li>● There are issues between health providers which need to be addressed and effective partnerships need to be forged moving forward.</li><li>● Community asking key providers to work together.</li><li>● Basis of health equity is co-design and HHS and community control working together.</li></ul>
Care	<ul style="list-style-type: none"><li>● Need models that meet the local need for our region.</li><li>● Need to focus on what is needed within the region.</li><li>● Lived experience relates to what the model of care should look like and how it's delivered.</li><li>● Collective leadership and common understanding of each other's role in model of care.</li><li>● The model of care should be needs based, identify workforce and other support structures, and be fully costed against current health investment into the region.</li><li>● Need to have the right infrastructure to service the model of care.</li></ul>

Principle 2: Local and regional decision making	
Funding	<ul style="list-style-type: none"><li>● Need to understand what investment is needed to implement the model of care that will bring health gains.</li><li>● Need to identify and agree where funding will go.</li><li>● Refer to above comments.</li><li>● Need to include the PHN to ensure that Commonwealth funding is included.</li><li>● Equity of funding for regional areas should be based on need.</li></ul>
Workforce	<ul style="list-style-type: none"><li>● Need our children to have education to move into leadership positions within health.</li><li>● Need to develop the workforce needed for all parts of the health system.</li><li>● Benefits of using a health worker vs nurse for navigator positions.</li><li>● Question whether this was best use of a nurse's position, doing something that a health worker would be better placed to do.</li><li>● Need to analyse what is needed and what position is best used to achieve that outcome.</li><li>● This should be addressed as part of the model of care and the supporting workforce needed to deliver.</li></ul>
Culture	<ul style="list-style-type: none"><li>● Greater First Nations voice within the HHS.</li><li>● Aspects of cultural capability.</li><li>● Need to have the right regional governance, with the right organisations/members making informed decisions.</li><li>● Not having this brings confidentiality and 'shame' issues which results in non-attendance.</li></ul>

Principle 3: Reorienting local health systems	
Care	<ul style="list-style-type: none"><li>● Need models that meet the local need for our region.</li><li>● Need to review and reflect on what has worked, what has not worked and why to be able to map forward journey.</li><li>● Better access to services.</li><li>● Need to consider alternative models of care—like outreach.</li></ul>
Workforce	<ul style="list-style-type: none"><li>● Need to develop the workforce needed for all parts of the health sector.</li><li>● Benefits of using a health worker vs nurse for navigator positions.</li><li>● Question whether this was best use of a nurse's position, doing something that a health worker would be better placed to do.</li><li>● Need to analyse what is needed and what position is best used to achieve that outcome.</li><li>● This should be addressed as part of the model of care and the supporting workforce which is needed to support that model.</li><li>● Identify partners who can work with the health providers.</li><li>● Greater First Nations' voice within the HHS.</li><li>● Aspects of cultural capability.</li></ul>

# 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.*

Principle 4: Cultural capability	
Care	<ul style="list-style-type: none"><li>● Examples of culturally appropriate services.</li><li>● Need community to understand the health system regardless of education or understanding level and to feel comfortable and confident to engage.</li><li>● Need to make after-hours and weekend care in HHS facilities culturally safe.</li></ul>

Principle 5: Social determinants	
Systems	<ul style="list-style-type: none"><li>● Need to include social determinants in how to improve health care.</li><li>● Need models that meet the local need for our region.</li><li>● Identify the risks of not impacting the health issues.</li></ul>

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
<b>Health Equity definition</b>		
If everyone is moving forward together, then success will take care of itself. We don't need to do more matrixes, data or frameworks. Let's not do a measure of where we are at, we know where we're at.	● Need to work together.	P1: First Nations leadership
Let's understand the grey areas and the gaps. Coming together is the beginning, staying together and working together is the success. No more matrixes, as we have sufficient data.	● Understand the need and gaps.	P2: Local and regional decision making
Agree it needs to be flexible and a different approach—listen more and modify things that don't go well. Collaboration is missing.	● Need a flexible approach and to evaluate and change as needed.	P2: Local and regional decision making
Current models are mainstream and designed to tick boxes. We need to be able to re-educate staff.	● Need models that meet the local need for our region.	P2: Local and regional decision making
The current definition of health equity has negative focus—the positive frame and lenses that are required will see balanced outcomes. A story is shared of the Maori people in New Zealand and the inequalities experienced by Maori people.	● Need to start from a positive perspective and NOT a negative one.	P1: First Nations leadership
We need to understand, and have a commitment to change, a western system does not work for Aboriginal and Torres Strait Islander peoples.	● Need models that meet the local need for our region.	P3: Reorienting local health systems
We need flexibility in the system, it has to be fluid to respond to the change, some models are not responsive enough to meet the needs or the social determinants of health. It is not a one size fits all model.	● Need models that meet the local need for our region.	P2: Local and regional decision making NEW: Social determinants
We need to go back to bare bones. For me in healthcare typically, people think they do one thing for Aboriginal and Torres Strait Islander people and that will resolve the issue. Mainstream have their own views, most times they don't consider the community in need. It is a western/ mainstream model not taking into account the needs of community. Go back to the start to find where the issue is and educate. Putting the blame on Aboriginal and Torres Strait Islander peoples needs to stop.	● Need models that meet the local need for our region.	P2: Local and regional decision making



Attendee's comments/views/input	Learnings	Health Equity Design Principles*
We need to have the connectedness with each other, being agile, being flexible. We need to listen and learn. We need to do things differently to have a responsive system. For the definition we need to understand what excellence looks like and that everyone has different views. We can't do what we have always done, or we will end up in the same position.	<ul style="list-style-type: none"> <li>Need to review and reflect on what has worked, what hasn't worked, and why to be able to map forward journey.</li> </ul>	P3: Reorientating local health systems
Regional focus, not state-wide, include examples of excellence and what equity looks like.	<ul style="list-style-type: none"> <li>Need to focus on what is needed within the region.</li> <li>Learnings from areas where success has been achieved.</li> </ul>	P2: Local and regional decision making
Indigenous Wellbeing Centre (IWC) – Discussed what is happening at IWC and how they educate Aboriginal and Torres Strait Islander patients in a culturally appropriate way that meets their patients' needs.	<ul style="list-style-type: none"> <li>Examples of cultural appropriate services.</li> </ul>	P4: Cultural Capability
<b>Principles</b>		
Look at downstream also and whole value chain.	<ul style="list-style-type: none"> <li>Identify the risks of not impacting the health issues.</li> </ul>	NEW: Social determinants
Vertical integration—train people already in the system e.g. mentoring.	<ul style="list-style-type: none"> <li>Need to develop the workforce needed for all parts of the health system.</li> </ul>	P2: Local and regional decision making P3: Reorienting local health systems
*Equity picture needs a 4th picture that shows a member of the family playing in the ring—an image of success.		
Role of lived experience and gap in Aboriginal and Torres Strait Islander peoples represented in this.	<ul style="list-style-type: none"> <li>Lived experience relates to what the model of care should look like and how it's delivered.</li> </ul>	
Education and traineeships are vital to introduce and support opportunity—need to be pathways that are supported.	<ul style="list-style-type: none"> <li>Need to develop the workforce needed for all parts of the health system.</li> </ul>	P2: Local and regional decision making
Equity means we can look and see people who look like us. Young people need to see black doctors and CEOs.	<ul style="list-style-type: none"> <li>Need leadership of key positions in the health system and pathways to build the next generation of leaders.</li> </ul>	P1: First Nations leadership P2: Local and regional decision making

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Reiterated role of lived experience and there is an opportunity for workforce development.	<ul style="list-style-type: none"> <li>Lived experience relates to what the model of care should look like and how it's delivered.</li> </ul>	P2: Local and regional decision making
For Principle 3: Reorienting local health systems, we need to shine a light on whole value chain. There is also downstream; there are collaborators.	<ul style="list-style-type: none"> <li>Identify partners who can work with the health providers.</li> </ul>	P3: Reorientating local health systems
We can strive for all these wonderful things and tell our kids to go to school to conform to all these systems, but we need health. If we don't have health, we don't have nothing. We need to look at upskilling Aboriginal and Torres Strait Islander peoples. If we see people like us, that is equitable change. True equity is having family play in the baseball field.	<ul style="list-style-type: none"> <li>Need our children to have education to move into leadership positions within health.</li> </ul>	P1: First Nations leadership P2: Local and regional decision making
We need to have opportunities for our kids to work for the systems. We need to introduce these opportunities and we know other regions have trainees, e.g. FNQ, but be careful using the examples. It's different for each region. We had ten trainees. The criteria excluded people from participating.	<ul style="list-style-type: none"> <li>Need our children to have education to move into leadership positions within health.</li> </ul>	P1: First Nations leadership P2: Local and regional decision making
Very supportive of school kids, Wide Bay HHS (Wide Bay HHS) are currently working with Maryborough school to encourage Aboriginal and Torres Strait Islander children to consider working in the health sector.	<ul style="list-style-type: none"> <li>Need our children to have education to move into leadership positions within health.</li> </ul>	P1: First Nations leadership P2: Local and regional decision making
These opportunities filter down to the families and can create changes.		NEW: Social determinants
Discussed the work in schools; talks of Logan and the traineeships with Mater.	<ul style="list-style-type: none"> <li>Need our children to have education to move into leadership positions within health.</li> </ul>	P1: First Nations leadership P2: Local and regional decision making
Discussed that it needs to be localised and a priority.		P2: Local and regional decision making
Discussed the needs of young people, young person finishing year 12 and wants to be in health; we can't just rely on these traineeships.	<ul style="list-style-type: none"> <li>Need our children to have education to move into leadership positions within health.</li> </ul>	P1: First Nations leadership P2: Local and regional decision making
The problem we see training and opportunities exist in cities, and young ones don't want to leave country. Changing that western view.	<ul style="list-style-type: none"> <li>Need our children to have education to move into leadership positions within health but do this across all geographic regions.</li> </ul>	P1: First Nations leadership P2: Local and regional decision making

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

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

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

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
<b>Challenges</b>		
Community perspective needs to demystify the health system—some people bury their heads in sand as they don't know what to expect. Encourage people to participate and put information at a community level and in language. For people not educated in that space, it is too heavy going and people need to know how they can be involved and what that will look like and mean.	<ul style="list-style-type: none"><li>● Need community to understand the health system, regardless of education or understanding level, and to feel comfortable and confident to engage.</li></ul>	P4: Cultural capability
'Intuition compliance is committing to something but knowing how they will' Saying it to get people off their back.		
IWC – We are the ATSICCHO in the region. Wouldn't call HHS meeting the needs (challenged the HHS comment that nurse navigators being a positive experience).	<ul style="list-style-type: none"><li>● There are issues between health providers which need to be addressed and effective partnerships going forward.</li></ul>	P2: Local and regional decision making
Nurse navigator position—thought it would have been Aboriginal and Torres Strait Islander HW—having an RN which wipes out a lot of the potential Aboriginal and Torres Strait Islanders to employ in the rest of the system. 'What a waste of a RN driving someone around and not doing clinical work.' Why aren't local people being trained up and used as health workers and they don't want to be RNs. 'Change Nurse Navigators to Health Navigators.' 'It's not just us, other people are saying that.' Nurse navigators are a good concept but there are flaws. You do not need a RN to be in this role. Aboriginal health workers should be employed. It is a waste of a resource if you have nurses in these positions. Workforce issues and education issues that impact on bread-winner's issues with self-funding—other AMS are saying the same thing.	<ul style="list-style-type: none"><li>● Benefits of using a health worker vs nurse for navigator positions.</li><li>● Question whether this was best use of a nurse's position, doing something that a health worker would be better placed to do.</li><li>● Need to analyse what is needed and what position is best used to achieve that outcome.</li><li>● This should be addressed as part of the model of care and the supporting workforce needed to deliver.</li></ul>	P2: Local and regional decision making P3: Reorientating local health systems

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
Question to IWC and HHS 'When are you mob going to come together to talk and leave whatever in the past behind as we are losing people?' IWC – we were working together, we are on the verge of working together—we have drifted apart but initial discussions have been had but there have been blockages. Community – 'You guys are leaders in our community and I will walk away from this meeting feeling a whole lot better after hearing that.' We look to your services, I leave knowing these discussions will begin.	<ul style="list-style-type: none"><li>● Community asking key providers to work together.</li><li>● Basis of health equity is co-design and HHS and community control working together.</li><li>● Collective leadership and common understanding of each's role in model of care.</li></ul>	P2: Local and regional decision making
You can't make decisions with 2 or 3 people at the table	<ul style="list-style-type: none"><li>● Need to have the right regional governance, with the right organisations/members making informed decisions.</li></ul>	P2: Local and regional decision making
Over the last 18 months, we have had group activities, and recently established an Aboriginal and Torres Strait Islander advisory group, HHS feeds reports back to the board, cultural awards individuals and team, artwork from local, meeting regularly with community around COVID-19.	<ul style="list-style-type: none"><li>● Greater FN voice within the HHS.</li><li>● Aspects of cultural capability.</li></ul>	P3: Reorienting the local health systems
No one gets invited around the table, a collective is required.	<ul style="list-style-type: none"><li>● Need to have the right regional governance, with the right organisations/members making informed decisions.</li></ul>	P2: Local and regional decision making
Communication and workforce are important. We need community, the Aboriginal and Torres Strait Islander community, at the table. Issues with workforce, health workers are at capacity. Funding should be on a need's basis rather than a submission basis. We are working the system and challenging internally.	<ul style="list-style-type: none"><li>● Need to analyse what is needed and what position is best used to achieve that outcome.</li><li>● This should be addressed as part of the model of care and the supporting workforce needed to deliver.</li></ul>	P2: Local and regional decision making



Attendee's comments/views/input	Learnings	Health Equity Design Principles*
<p>The HES need targeted funding. Funding needs to be flexible to respond. We need to ensure what we develop we need to match with funding, resources are scarce, staff at capacity. Have a trust relationship with Galangoor and other services took time to establish. We need decentralised policies and procedures—we still die earlier. The change in the last 20 years has not been mammoth. We need to be funded; other regions such as Mackay have more funding/resources but we have a similar population. If we are going to revisit the change needed, we need flexible and agile, responsive funding.</p> <p>We can do all these things but if you don't have the funding then nothing can be done.</p>	<ul style="list-style-type: none"> <li>Need to understand what investment is needed to implement the model of care that will bring health gains.</li> <li>The model of care should be needs based, identify workforce and other support structures, and fully costed against current health investment into the region.</li> <li>Need to identify and agree where funding to go.</li> </ul>	P2: Local and regional decision making
<p>IWC – we are sick of money going to management, were PHNs invited? We are not impressed by PHNs. The PHNs have nothing to do with the community. We get about 1% of the Aboriginal and Torres Strait Islander funding available—while the population is small, Aboriginal and Torres Strait Islander peoples have the highest need in the system.</p>	<ul style="list-style-type: none"> <li>Refer to above comments.</li> <li>Need to include the PHN to ensure that Commonwealth funding is included.</li> <li>Equity of funding for regional areas should be based on need.</li> </ul>	P2: Local and regional decision making
<p>WBHHS – acknowledges the challenges with funding—local, needs, population, local needs assessment needs to be done. We are working with PHN. A commitment is required.</p>	<ul style="list-style-type: none"> <li>Refer to above comments.</li> </ul>	P2: Local and regional decision making
<p>IWC – never had an AMS; our closest is Galangoor. Other ATSICCHOs have been running for years and have had the chance to establish workforce.</p>		P1: First Nations leadership
<p>Discussion with Dr Mark Wenitong SDoH recognised 40% in the nation. We need to revisit our needs.</p>	<ul style="list-style-type: none"> <li>Need to include social determinants in how to improve health.</li> </ul>	NEW: Social determinants
<p>Trust for the system does not exist. The system needs different ways of working e.g. different rooms people are ashamed. WBHHS—we may need to outsource to safe spaces.</p>	<ul style="list-style-type: none"> <li>Need to have the right infrastructure to service the model of care.</li> <li>Not having this brings confidentiality and 'shame' issues which results in non-attendance.</li> </ul>	P2: Local and regional decision making

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
<p>Workforce, issues with attendance to ER on weekends, no Aboriginal and Torres Strait Islander staff available. Mental health changes are required for Aboriginal and Torres Strait Islander peoples—shares grandsons' story, medical jargon issues not accessible to community to understand. It's about educating families in a culturally appropriate manner.</p>	<ul style="list-style-type: none"> <li>Need to make after hours and weekend care in HHS facilities culturally safe.</li> </ul>	P4: Cultural capability
<b>Enablers</b>		
<p>Nurse Navigators – 2 positions have received good feedback. Need to help people navigate the system and avoid people getting 'lost' and feel safe in the ED and in the system e.g. making sure people don't leave the ED, but get the help required. Note: IWC did not agree.</p>	<ul style="list-style-type: none"> <li>Previous discussions on health navigator vs nurse navigator and dependent on what the outcome is and what technical skills needed.</li> </ul>	P2: Local and regional decision making
<p>Pathways need to be appropriate to support the holistic needs of Aboriginal and Torres Strait Islander peoples. We need culturally safe pathway that addresses needs of mob.</p>	<ul style="list-style-type: none"> <li>Referral pathways between primary and secondary/ tertiary needs to be culturally safe for community.</li> </ul>	P2: Local and regional decision making
<p>Lived experience is a model is needed around that can walk along—workforce development and pathways are key to this.</p>	<ul style="list-style-type: none"> <li>Lived experience relates to what the model of care should look like and how it's delivered.</li> </ul>	P2: Local and regional decision making
<p>It is about demystifying the system to encourage people to be engaged in the system, ensuring health literacy access for community based, accessible, ensuring people understand what happens rather than just agreeing.</p>	<ul style="list-style-type: none"> <li>Making sure that people understand the health system and their journey to address their health issues and where this doesn't happen, then the providers are able to explain for understanding.</li> </ul>	P3: Reorientating local health systems
<p>It's about listening and understanding to the needs and understand SDoH e.g. nutrition.</p>	<ul style="list-style-type: none"> <li>Need to include social determinants in how to improve health.</li> <li>Need to understand the causal factors of health.</li> </ul>	NEW: Social determinants

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
<b>Other comments</b>		
HHS – we are at saturation point for what we can offer. Our health workers are working at capacity. The historical funding models of QH limits what we can do. We need to revisit our funding and it is on a needs basis and not just the loudest voice. We are working and challenging our own systems internally and our biggest challenge is getting in broached <b>on a needs base not an historical base.</b>	<ul style="list-style-type: none"> <li>Need to review the model of care and the workforce and funding needed to deliver to achieve outcomes.</li> <li>The funding should then be aligned to the model of care costings.</li> </ul>	P2: Local and regional decision making
Hub works well and taken years to build the trust e.g. great nurse navigator relationship with Galangoor.	<ul style="list-style-type: none"> <li>Good example of HHS and community control working together.</li> </ul>	P3: Reorientating the local health system
Want to see decentralised policies and procedures so we can have the ability to do it locally. State Health needs to consider that funding needs to be on a needs basis to meet the differential.	<ul style="list-style-type: none"> <li>Need to review the model of care and the workforce and funding needed to deliver to achieve outcomes.</li> <li>The funding should then be aligned to the model of care costings.</li> <li>This should also include having the right state legislative framework to support the region.</li> </ul>	P2: Local and regional decision making
Wide Bay never had an AMS—for the last 12 years and we can't be compared with other regions that have had well-established ATSICCHOs (and the implications of this for historical funding).		P1: First Nations leadership
Mob always had to go to Rockhampton my whole life (IWC have no black faces there). Very upsetting to hear these funding issues re historical footprint. Institutionalised racism comes in many shapes and forms, and this sounds like that to me re funding.	<ul style="list-style-type: none"> <li>The model of care needs to identify what can be delivered locally vs in Rockhampton.</li> <li>Need to deal with institutional racism.</li> </ul>	P4: Cultural capability
IWC—poor relationship with PHN. There is too much money going to keep people in jobs that have nothing to do with Indigenous health.	<ul style="list-style-type: none"> <li>Need to have a process for distribution of funding to where it's needed.</li> </ul>	P2: Local and regional decision making
Local representation is 3 per cent but need up to 10 per cent.		

Attendee's comments/views/input	Learnings	Health Equity Design Principles*
HHS—funding always an issue. Growth income hard to come by, especially after COVID-19. LANA are something we are now moving to and am supportive of populations needs funding decision making moving forward, and we need to do this in partnership with PHN.	<ul style="list-style-type: none"> <li>Need to be able to discuss and agree on collaboration amongst the health providers.</li> </ul>	P2: Local and regional decision making
Mental health—having clinicians talking in jargon and medical terms and need for Aboriginal and Torres Strait Islander workforce to help with safe discharge planning.	<ul style="list-style-type: none"> <li>Need to have the health system be safe for community and continuity of care across each section of the health system.</li> </ul>	P2: Local and regional decision making
The need for choice in discharge—if there is no other choice, people will end up back in hospital. Dollars means education to me e.g. helping people better shopping/food choices for diabetes care.	<ul style="list-style-type: none"> <li>Refer above.</li> </ul>	P3: Reorientating local health systems
Get rid of DATSIP.		P2: Local and regional decision making



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

## Future ideas for discussion

### 1. First Nations Health Board

- Governance increases the Aboriginal and Torres Strait Islander local HHS board. Create sub-committees.
- Council CEO sits on that board. The chair also comes along and one Aboriginal and Torres Strait Islander representative—do feed into the board, reports are made.
- Ensuring a voice straight up because there have been points that it hasn't.
- Indigenous Health network, it has a process it going through execs, CEO and it can be tracked.
- Increase current representative for Aboriginal and Torres Strait Islander (e.g. male/female).
- Local representative from across the region e.g. Bundaberg, Hervey Bay.
- A concept that can be taken back to the board.
- Concerns that money not going to grassroots activities. Money not sitting at frontline.
- Need to sort out regional mandate and representation—issue about how to get everyone to agree.

### 2. Increase Queensland Health's First Nations employment target—state and regional

- The 2% target should be increased.
- Sit beside funding.
- Other mechanisms e.g. scholarships.
- Active marketing exists in other HHS regions not this region.
- We need Indigenous employment HR; some exist in other regions.
- There is a draft for the HR strategy HHS.
- Increase the employment.
- Pathways to get people there.

### 3. Legislate the responsibilities of CATSIHO state

- YES—confusion as people thought it already was.

### 4. Release of biennial FN health equity report state/regional

- Making tracks reports done 6 months by HHS.
- This is a state level so yes it needs to be done.

### 5. Appoint a deputy CATSIHO State

- Yes, ambivalent.

### 6. Introduce First Nations employment measure

- Yes—local responsibility.
- Ensuring Indigenous people are on interviewing panels.
- Role descriptions—previously Indigenous people had to be on the interview panel but has changed.
- Identification of identity on resumes—our mob can fear identifying themselves.
- Included in job advertisements should be 'we encourage Indigenous'.
- Indigenous person/s should have final say in who is employed.
- Consideration how the Indigenous representatives on panels are given true respect.
- Consider how this looks to non-indigenous staff.
- Would it be a percentage or a rate?

### 7. Create capability pipeline for HHS Board members

- Some HHS have employed Indigenous executives which creates a pipeline higher up.
- A board pipeline needs to occur.
- A workforce pipeline needs to occur.
- Train people up to be HHS Board Members.
- Aboriginal unit is under an Allied health; it used to sit under CEO. Looking at where units sit with the HHS.
- Important to establish the HHS.
- Currently inequity exists.
- Agreed that the HHS needs an Indigenous HHS executive position.

### 8. Establish regional coordinator care hubs

- Already talked about. Not everyone uses ATSIChOs so regional hubs could work.

### 9. Establish regional ATSIChO backbone organisations

- This was proposed to QAIHC, federally Medicare local wanted to make an Indigenous regional body, so Institute for Urban Indigenous Health (IUIH) who IUIH represents has just been lost.

### 10. Implement Queensland Health funding incentives to drive equity

- QUIP?? funding for Indigenous units to meet criteria to improve low birth weights—it needs to be tiered funding—being able to locate funding rather than be lost. It needs to be tiered.
- Recognition and understanding of regional need.
- Remove relevance of funding source and focus on patient and community outcomes. Make conversation.

### 11. Embed cultural capability into Clinical Services Capability Framework

- Yes, it is happening but needs to continue to happen, need to specialised programs.

### 12. Refresh Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033

- YES, badly! Driven by state and HHS should conform.

### 13. Undertake annual independent institutional racism audits

- YES!! Needs to happen and the Henrietta matrix is great. Can't be done by HHS needs to be independent.

### 14. Amend birth notifications to acknowledge birth parent's cultural connection to country

- Yes, change needs to occur, especially for parents giving birth in other HHS regions (National—BDM), looking at the time of birth registration should occur at birth to ensure Indigenous babies are registered.
- Could be project on its own.
- IWC suggested that it sits outside health equity.
- Who is making the call on identity? Are DATSIP and linkup doing things on it.

- What if the birth certificate stated Country of birth or Country from where they are from?
- Has potential to assist with MHAOD due to helping link with identity.
- Single parent etc.
- We have oral history and now we are moving back to white man's way of identification on paper.

### 15. Strengthen the functions of other health statutory authorities to drive health equity

- Yes state.

### 16. Factor equity into existing Queensland Health funding models

- Yes, but based on needs.

### 17. Utilise the health equity strategies as future health investment plans

- Yeah, not so much of a priority.

### 18. Establish pilot Marmot city regions across Queensland

- Lower priority for the region.
- Apprehension about how it would map onto Queensland Health system which is different to NHS.

### 19. Set Queensland Health procurement targets

- Not a high priority.

### 20. Drive an anti-racism campaign

- Would be a higher level of priority in the future.
- Questions about Cultural Capability and how this links with 4-hour mandatory training and Courageous Conversations (adopted by the HHS).
- How do we measure it?
- There seems to be a disconnect between explicit racism and cultural capability courses.
- Embed cultural capability into framework.

#### Overall Comments

- Understanding and promoting ethics of why people work—to look after mob not the pay.
- What community need, not what Canberra need—that's healing.
- Blue card issues and being knocked back from historical issues.
- Target 1—Establish a First Nations Health Board.



# Appendix 4— Attendee list

Name	Organisation
Steven Ober	QAIHC Board Member
Norelle Watson	River Nations
Raelene Baker	Wide Bay HHS
Clare Kelly	Wide Bay HHS
Robyn Bradley	Wide Bay HHS
Peter Wood	Wide Bay HHS
Debbie Carrol	Wide Bay HHS
Melissa Lees	Wide Bay HHS
Consuela Morrice	Wide Bay HHS
Stephen Bell	Wide Bay HHS
Clarissa Schmierer	Wide Bay HHS
Ara Harathunian	IWC
Wayne Mulvany	IWC
Stirling Eggmolesse	IWC
Jenny Springham	IWC
Geteno George	Queensland Health
Maxine Thompson	Council Member
Karla Thompson	Carer
Jermaine Isua	Queensland Health
Yasmin Muller	Queensland Health
Rachel Doolan	QAIHC
Kelly Dingli	QAIHC
Karen Thompson	QAIHC Consultant

# Appendix 5— Agenda

Proposed times	Agenda item
10:00–10:30am	Welcome to Country, Housekeeping, Introductions
10:30–11:00am	The Health Equity Project— <ul style="list-style-type: none"><li>Who is on the Project Team?</li><li>What will the project do?</li><li>How will it bring better health for me and my family in the future?</li></ul>
11:00am–12:00pm	Discuss Section 1: The journey so far... (page 6–23)
12:00–12:30pm	LUNCH
12:30–1:30pm	Discuss Section 2: Embedding health equity in local health systems... (page 24–31)
12:30–1:30pm	Discuss Section 3: Driving health equity across the health system and addressing the social and cultural detirminants of health... (page 32–43)
2:30–3:00pm	Wrap up and close the meeting

# Appendix 6—Glossary

Abbreviation	Meaning
AIHW	Aboriginal and Island Health Worker
AMS	Aboriginal Medical Service
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
CATSIHO	Chief Aboriginal & Torres Strait Islander Health Officer
CE	Chief Executive
CTG	Closing the Gap
DAMA	Discharge Against Medical Advice
DATSIP	Dept of Aboriginal and Torres Islander Partnerships
ED	Emergency Department
FN	First Nations
FNQ	Far North Queensland
HHS	Hospital and Health Service
HR	Human Resources
IUIH	Institute for Urban Indigenous Health
IWC	Indigenous Wellbeing Centre
KPIs	Key performance Indicators
LANA	Local area needs analysis
MHAOD	Mental Health and Other Drugs
OH&S	Occupation Health and Safety
PHC	Primary health care
PHN	Primary Health Network
QAIHC	Queensland Aboriginal and Islander Health Council
QH	Queensland Health
RN	Registered Nurse
SDoH	Social determinants of health
SEWB	Social and Emotional Well Being (also ESWB)
WHO	World Health Organization

