Making Tracks

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

Discussion paper: a shared conversation

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

Discussion paper: a shared conversation

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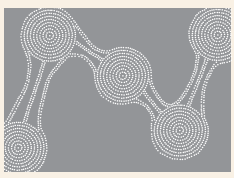
Acknowledgement of Country

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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Foreword

Ministerial Statement

The Palaszczuk Government is committed to safeguarding all Queenslanders' health—throughout the global COVID-19 pandemic and into the future. Central to this is our commitment to improving Aboriginal and Torres Strait Islander health. The health inequities that placed First Nations peoples at greater risk from the pandemic is the legacy of our colonial history. Whilst this is our past—and we need to be honest and brave in our truth telling—our future is one of healing and righting the wrongs of our history by supporting First Nations peoples attain their full health potential.

The Honourable Yvette D'ath,
Minister for Health and Ambulance Services

Generations of Aboriginal and Torres Strait Islander peoples have worked hard to address the legacy of institutional racism in the public health system and the broader society. Health improvements have been made and in Queensland, Aboriginal and Torres Strait Islander peoples have the smallest life expectancy gap compared to any of the other States and Territories. This shows our collective efforts have resulted in health gains but more needs to be done and will be done under the Palaszczuk Government. It will also be great when we see First Nations people across our health system, with a voice in the system, supported by a coordinated system.

This discussion paper is an important piece of work to put the voices of our First Nations peoples and communities at the forefront and guide this important work—in partnership.

The inaugural Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General was appointed in 2019 to empower First Nations voices and drive a renewed health equity agenda across the health system. This discussion paper outlines what has been achieved to date but more importantly, it is seeking your ideas about building on these foundations and creating a better and healthier future with First Nations peoples.

The Palaszczuk Government is committed to listening, learning and partnering with First Nations peoples. I encourage you to put forward your ideas and join us on our shared journey towards health equity.

Joint Chairperson and Chief Executive Officer Statement

The health equity discussion paper collaboration between QAIHC and Queensland Health represents an important milestone in the health equity journey. Systemic and sustainable health equity reform can only be achieved through the genuine inclusion of, and partnership with, Aboriginal and Torres Strait Islander peoples at every stage. QAIHC acknowledges the important role co-design with Queensland Health has played in the development of this discussion paper.

Matthew Cooke,
Chairperson, Queensland Aboriginal and Islander Health Council

Cleveland Fagan,
Chief Executive Officer, Queensland Aboriginal and Islander Health Council

The reform needed to achieve health equity is bold and cannot exist in isolation. ATSICCHOs are a living expression of more than 45 years of Aboriginal and Torres Strait Islander rights to self-determination. The strengths and successes of ATSICCHOs are about more than Aboriginal and Torres Strait Islander governance, leadership and culturally safe primary healthcare—they are an integral part of the health system architecture in Queensland. ATSICCHOs are the largest provider of primary healthcare and preventative health services outside of government for Aboriginal and Torres Strait Islander peoples and communities.

The ATSICCHO model of care is unique and was developed to consider the broader social determinants of health as well as service integration. These holistic elements are essential for achieving health equity, and outcomes at every level can be enhanced when the patient journey is coordinated and led by Aboriginal and Torres Strait Islander peoples. For health equity to be realised and entrenched, Aboriginal and Torres Strait Islander peoples of all ages need to be engaged. The road to health equity must be built on a foundation of shared decision making that is inclusive of urban, regional and remote communities across the state.

We are pleased to be partnering with Queensland Health on the co-design of this health equity discussion paper and consultation process, and look forward to the action it will stimulate to bring about lasting change to the Queensland healthcare system for improving the health and wellbeing outcomes for our people and communities.

Foreword

Joint Director-General and Chief Aboriginal and Torres Strait Islander Health Officer Statement

We are pleased to deliver this health equity discussion paper in partnership with our colleagues from QAIHC, to guide statewide discussions on current and future reforms to achieve health equity with Aboriginal peoples and Torres Strait Islander peoples.

Dr John Wakefield, *Director-General, Queensland Health*

The discussion paper, co-designed with QAIHC, is an important step in our ongoing journey towards health equity with First Nations peoples. It is important that First Nations voices inform this journey—whether you are a health consumer, a health worker, or a health advocate, we encourage you to get involved. We particularly encourage young people, our leaders of tomorrow, to participate in the process and share your perspectives. Your voice matters.

Three key reforms are needed to drive a health equity agenda across the health system in Queensland: we must see our First Nations peoples across the system; have our First Nations voices in the system; and design a better coordinated system for First Nations peoples.

We encourage you to engage and participate in this process so First Nations voices are front and centre in proactively achieving health equity for and with First Nations peoples.

Haylene Grogan, *Yalanji and Tagalaka woman, Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General, Aboriginal and Torres Strait Islander Health Division, Queensland Department of Health*

Terminology

Terminology Explanation: Throughout the discussion paper, the terms 'Aboriginal and Torres Strait Islander peoples', 'First Nations peoples' and 'Aboriginal peoples and Torres Strait Islander peoples' are used interchangeably rather than 'Indigenous'. Whilst 'Indigenous' is commonly used in many national and international contexts, Queensland Health's preferred terminology is 'Aboriginal and Torres Strait Islander peoples', 'Aboriginal peoples and Torres Strait Islander peoples' or 'First Nations peoples'. QAIHC's preferred terminology is 'Aboriginal and Torres Strait Islander peoples'.

The terminology 'First Nations peoples' refers to the Aboriginal peoples and Torres Strait Islander peoples, their nations, societies, and language groups that have occupied these lands since time immemorial. The term describes the vast network of independent yet interdependent sovereign First Nations (and affiliated tribal units or confederation of clans) that existed, and continue to exist today, which have distinct geographic boundaries and complex systems of government, laws (lores), languages, cultures and traditions. The word 'peoples' recognises individual and collective dimensions to their lives as affirmed by the *United Nations Declaration on the Rights of Indigenous Peoples* (2007).

Acknowledging First Nations peoples' right to self-determination, Queensland Health and QAIHC recognise the choice of Aboriginal and Torres Strait Islander peoples to describe their own cultural identity, which may include the terms explained above or particular sovereign First Nations peoples (for example, *Mununjali*, *Yidinji*, *Turrbal*) and traditional place names (for example, *Meanjin* Brisbane).

In all contexts, whether written or verbal, the preferred terminology is the one decided by the peoples being referenced, discussed or described.

Concept definitions—glossary of terms

A list of conceptual definitions has been included to assist readers understand the various ideas outlined in the discussion paper. The definitions have been prepared by QAIHC and have been included for the audience to understand the perspective and values of the ATSICCHO Sector. Queensland Health acknowledges and respects that these concepts guide the vision, philosophy and practices of the ATSICCHO Sector. ***Everyone is encouraged to read the conceptual definitions before the main sections of the discussion paper.***

Partnerships and co-design

The term 'co-design' reflects shared decision-making authority through genuine partnerships. Partnerships require the sharing of decision-making, power, control, resources, responsibility and accountability. In partnerships, trust is built and there is an agreed and shared purpose, vision and intent in working together in a supportive and transparent way. Partners design and review outcomes together and problem solve solutions. In other words, strategies must include co-design, co-development, co-implementation and co-evaluation with Queensland Health, Hospital and Health Services (HHSs) and ATSICCHOs, which are formalised through agreements.

Terminology

Self-determination

Self-determination is a principle preserved in international law. According to law, all peoples have the right of self-determination and "by virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development"[1]. Similarly, according to the *United Nations Declaration on the Rights of Indigenous Peoples,* "Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions". [2]

For Aboriginal and Torres Strait Islander peoples in Australia, the right to self-determination has and continues to be of fundamental importance in improving health and wellbeing outcomes.[3]

ATSICCHOs are practical expressions of Aboriginal and Torres Strait Islander self-determination.

Aboriginal and Torres Strait Islander community-driven solutions

When Aboriginal and Torres Strait Islander peoples take charge of developing their own strategies, they better reflect their interests, values, vision and concerns, increasing ownership and accountability.[4]

A community-driven approach to health policies and programs is the true reflection of self-determination in health, which will significantly contribute to reducing disparity in health outcomes experienced by Aboriginal and Torres Strait Islander peoples.

Upholding a self-determined approach to health provides Aboriginal and Torres Strait Islander peoples with complete control of the design and the provision of programs and initiatives appropriate to meet their community needs.

Place-based solutions

Place-based approaches empower community to participate, lead and own the initiatives that are important to meet their community needs. The approach is also helpful to break down fear and stigma by engaging community, family and children in their own environment to take charge of their own health and wellbeing. QAIHC's Members, the ATSICCHOs, exemplify the important role place-based approaches have in improving overall health outcomes of Aboriginal and Torres Strait Islander peoples; and are best positioned to facilitate the process at the local level. Recognising the different needs of people through place-based solutions creates better results.

Aboriginal and Torres Strait Islander Community-Controlled Health Organisations (ATSICCHOs)

For an organisation to be 'Aboriginal and Torres Strait Islander Community-Controlled' it must form a majority membership from the local Aboriginal and/or Torres Strait Islander community. The membership mandates the organisation to act in the interests of the members and their community. A Board of Directors is elected from the membership, thereby ensuring community engagement mechanisms are inherently built into Aboriginal and Torres Strait Islander community-controlled structures. Community-elected Boards represent the ultimate expression of Aboriginal and Torres Strait Islander peoples self-determination.

In addition to the standard governance responsibilities of financial and legal responsibilities, ATSICCHO Boards have the added responsibility of representing community needs, beliefs and values. This essential element of the ATSICCHO Model of Care is a contributor to its success as it represents ultimate consumer engagement.

ATSICCHO Model of Care and cultural safety, community engagement and development

The ATSICCHO Model of Care,[6] developed with respect and understanding of local historical context and cultural values, ensures that Aboriginal and Torres Strait Islander families feel culturally safe and free from institutional racism when presenting for holistic and comprehensive quality primary health care.

Cultural safety is distinguished from cultural 'awareness' as it relates to embedding culturally sound practices into all elements of delivery, rather than merely recognising that cultural differences exist. The values and perspectives of local communities shape the design of the delivery of services, evaluation, cultural policies, engagement mechanisms and the physical attributes of our organisations.

Racism and the law

Racism is the belief of one's ethnic superiority over other ethnic groups.[7] It is experienced through interpersonal (relationships, behaviours, words) and institutional (structural, systemic, organisational) racism. Freedom from discrimination (which includes racism) is a fundamental human right enshrined in the *Racial Discrimination Act 1975* (Cwth) and in the *Human Rights Act 2019* (Qld).

Holistic concept of health

The Aboriginal and Torres Strait Islander concept of health is holistic, incorporating the physical, social, emotional, and cultural wellbeing of individuals and their whole communities. For Aboriginal and Torres Strait Islander peoples, health is seen in terms of the whole-life-view.[8]

The holistic concept also acknowledges the greater influences of social determinants of health and wellbeing including homelessness; education; unemployment; problems resulting from intergenerational trauma; grief and loss; abuse, violence; removal from family and cultural dislocation; substance misuse; racism and discrimination and social disadvantage.[9]

Profound intergenerational impacts of trauma inflicted by racist policies, state sponsored discrimination and violence, forced institutionalisation of individuals by government medical officers, the removal of children from families and social marginalisation are visible within the prevalence of mental illness such as depression, violence and self-harm, substance misuse, imprisonment, and inharmonious family relationships.[10] The resulting grief and trauma have been culturally devastating and is inextricable from the identity of present-day Aboriginal and Torres Strait Islander peoples.

Introduction

The case for change and purpose of the discussion paper

*This discussion paper is about exploring how our healthcare system—and broader society—can and **will** achieve health equity with Aboriginal peoples and Torres Strait Islander peoples. **We have a profound opportunity.** The target to achieve life expectancy parity with First Nations peoples by 2031 was set in 2008 and Queensland has 10 years to accelerate effort to achieve it.*

In the spirit of our renewed partnership approach, including the *National Agreement on Closing the Gap* (2020), this paper has been co-designed and co-written in partnership between Queensland Health and QAIHC on behalf of the Aboriginal and Torres Strait Islander Community-Controlled Health Sector. It's the first time a discussion paper has been developed by Aboriginal and Torres Strait Islander health leaders from Queensland Health and across the health system.

Some ideas and perspectives in the discussion paper are challenging but robust conversations are needed to address the current misalignment between **demand** (what Aboriginal and Torres Strait Islander peoples need and want) and **supplier capabilities** (what is currently being delivered across the health system).

The purpose of this document is to **create a shared understanding about the health equity agenda to drive change across the health system.** Critically, other ideas beyond the ones described in this paper are being sought to guide future health system reforms and improvements. The paper acknowledges the health gains made over the last 30 years but also challenges the health system to consider ways to strengthen partnerships between service providers, better understand the patient journey, make links between health and wider social issues, better utilise health investment, share responsibility for effective health care across providers, measure success using collective measures, and drive other systemic changes. Different and new approaches based on the needs of Aboriginal and Torres Strait Islander peoples—*determined by Aboriginal and Torres Strait Islander peoples*—are explored and explained in this discussion paper.

A commitment to health equity requires reform, change and improvement across the entire health system—it can't be a continuation of the status quo or business as usual. Now is the time to be bold and brave because all parts of the health system ***need, can and should do better*** including the Department of Health, Hospital and Health Services (HHSs), the Aboriginal and Torres Strait Islander Community-Controlled Health Sector, Primary Health Networks, General Practitioners and other healthcare providers. **Only by working together as an integrated and connected health system, can Aboriginal and Torres Strait Islander peoples exercise user choice and access the care they want and need.** Local health systems need to be strengthened, redesigned and reoriented to better listen and support First Nations peoples. And at a state level, policies need to champion systemic changes that enable local healthcare providers to implement needed changes and reform. **This is our call to action.**

Discussion paper structure

The paper is comprehensive and divided into three sections. Feedback questions are included in each section to prompt responses. A summary leaflet and fact sheets also accompany the discussion paper.

SECTION 1:

The journey so far...

building on our foundations in the past and now (pages 6 to 23)

Section 1 provides the context and explains the who, what, why and how. It sets the scene and explains the reason health equity is driving current and future health system reforms.

Key components

- WHY? Our First Nations peoples set the foundation
- WHO and HOW? Co-design is integral
- WHAT? What does health equity mean for us in Queensland?
- WHY? Why is health equity currently being embedded into the health system?
- WHAT works? The lessons so far from COVID-19—health equity in action:
  - Different (inequitable) starting points
  - Aboriginal and Torres Strait Islander leadership is essential
  - Better together
- HOW? Reframing the relationship with Aboriginal and Torres Strait Islander peoples—First Nations leadership at the centre of decision-making
- WHAT? What do these changes mean for the health system in Queensland?
  - First Nations Health Equity—a working definition
  - Health Equity Design Principles—moving from ideas to practical health system, service and practice improvements.

Feedback questions

1. Is the rationale (the 'why') for a renewed health equity agenda across the health system understood?
2. Is the urgency for change, improvement and new approaches understood?
3. First Nations health equity working definition: does it make sense? How can it be improved?
4. First Nations health equity design principles: do you support the principles? How can these principles be applied in practice to drive health system, service and practice improvements across the health system?

Introduction

SECTION 2:

Embedding health equity into local health systems... *placing First Nations peoples and voices at the centre of healthcare service delivery* (pages 24 to 31)

Section 2 focuses on the legislative reforms being introduced following the passage of the *Health Legislation Amendment Act 2020* in August 2020. The Act includes amendments to the *Hospital and Health Boards Act 2011* requiring each HHS to develop a Health Equity Strategy. This section explains the proposed legislative requirements for the Health Equity Strategies and asks questions about the types of support required for the Health Equity Strategies to be successful. The ideas from this section will inform the Health Equity Framework that will be released in July 2021.

Key components

- Timeline: Development history of the Health Equity Strategies
- Co-designing the Health Equity Strategies Regulation
- Key components of the Health Equity Strategies
  - Developing and implementing Health Equity Strategies
  - How will the Health Equity Strategies build upon existing plans and activities?
  - Relationship between the Health Equity Strategies and other prescribed strategies and protocols
  - Monitoring and evaluation.

Feedback questions

1. The new Health Equity Strategies will build on existing effort over the last three years. What changes or initiatives in your region have had a positive impact and increased the representation of Aboriginal and Torres Strait Islander peoples in the design and delivery of local health services? How can a co-designed, co-owned and co-implemented Health Equity Strategy be fostered or enhanced in your service area and across other regions?
2. What challenges, barriers and resistance exist to develop and implement the Health Equity Strategies? And how can they be managed?
3. How can the ideas and voices of First Nations peoples of all ages and abilities be incorporated into the design and implementation of the Health Equity Strategies?
4. What type of guidance needs to be provided in the Health Equity Framework to support the development and implementation of the Health Equity Strategies?
5. What other policy tools and resources would be beneficial at a local and regional level?

SECTION 3:

Driving health equity across the health system and addressing the social and cultural determinants of health... *future ideas for discussion*

(pages 32 to 43)

Section 3 explores opportunities to build on the current health equity agenda underway, including practical ways for the health system to influence the broader social and economic determinants of health. The questions in this section are seeking other innovative and progressive ideas to support First Nations peoples achieve life expectancy parity by 2031.

Key components

This section is about other potential changes needed across the health system and society more broadly to achieve the shared vision we want for the future. Twenty proposals and ideas are outlined under the following six themes:

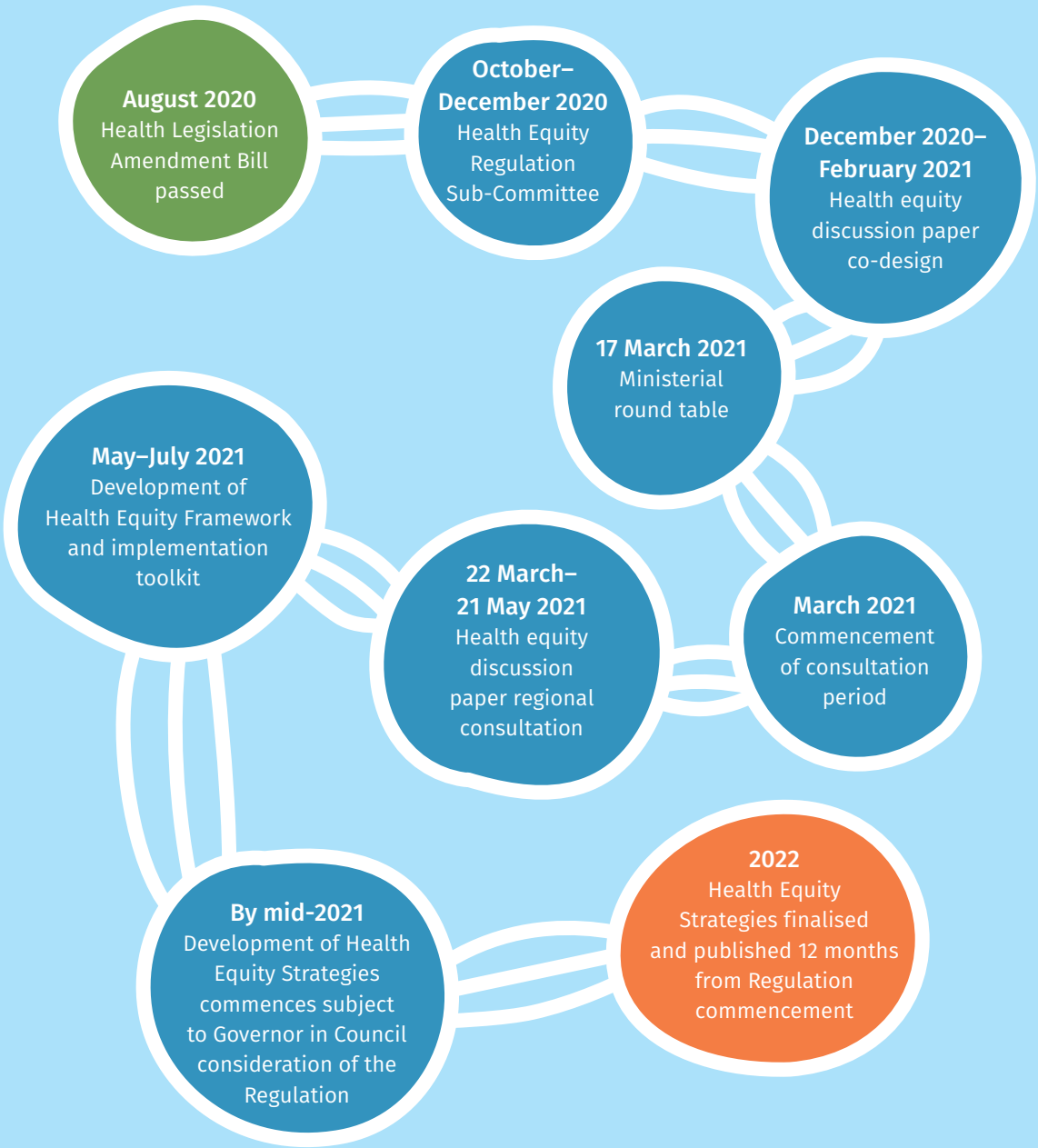
- Representation and Voice
- Building First Nations health system leadership and workforce
- Implementing integrated healthcare models and pathways to improve the patient journey and decrease demand on hospitals
- Embedding cultural determinants into patient safety and quality
- Driving state and national health funding reforms
- Addressing the social determinants of health and eliminating racism.

Feedback questions

1. What are the top three changes, improvements or reforms that could contribute to improving the broader social determinants of health and achieving health equity?
2. What other health system changes, improvements and reforms are needed to achieve health equity with First Nations peoples?
3. How can the health system take a local leadership role in improving the broader social determinants of health?
4. Are 'Marmot city regions' a feasible approach for local communities to tackle long-term economic and social inequities, and improve the social determinants of health?

Introduction

Health equity timeline—where we're heading



SECTION 1:

The journey so far...

building on our foundations in the past and now

Feedback Questions

1. Is the **rationale (the 'why')** for a renewed health equity agenda across the health system understood?
2. **Is the urgency for change, improvement and new approaches** understood?
3. **First Nations Health Equity working definition:** does it make sense? How can it be improved?
4. **First Nations Health Equity Design Principles:** do you support the principles? How can these principles be applied in practice to drive health system, service and practice improvements across the health system?

SECTION 1:

The journey so far... *building on our foundations in the past and now*

WHY?

Our First Nations peoples set the foundation

Health is interwoven into the essence of the world's oldest continuous cultures. For millennia, Aboriginal peoples and Torres Strait Islander peoples have been doctors, nurses, pharmacists, midwives, counsellors and paramedics—we are the first healers of these lands.

Caring for self, kin, community and country, was and continues to be, a central aspect of Aboriginal and Torres Strait Islander knowing, being and belonging. 'Health' is not restricted to the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole community in which each individual can achieve their full potential and bring about the total wellbeing of their community.[11]

Recognition of the central place of health and wellbeing in Aboriginal and Torres Strait Islander cultures is essential for understanding the past, responding to current challenges and opportunities, and charting a path for the future. This journey is thousands of years old and continues because of the cultural strength, resilience and determination of Aboriginal peoples and Torres Strait Islander peoples.

> *Our mob have been advocating for health equity for generations. We didn't call it that but that's what we've been saying, 'work with us to deliver the type of health care services we need and want'. And this is the first time it is genuinely happening—the whole health system partnering with us and working together for our mob.*
>
> *Cleveland Fagan, QAIHC*

WHO and HOW?

Co-design is integral

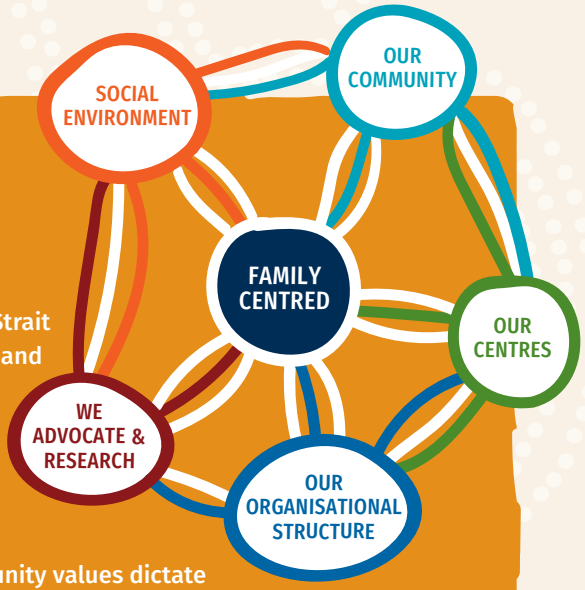
The commitment to achieve health equity is a shared one grounded in genuine partnerships with Aboriginal and Torres Strait Islander peoples to achieve this long overdue human right.

Partners on this journey include Aboriginal and Torres Strait Islander community members and consumers, Queensland Health, Aboriginal and Torres Strait Islander health leaders and clinicians from across the public health system, the ATSICCHO sector and their representative peak body QAIHC. This new way of working together is how all healthcare policies, programs and services will be designed and implemented in the future through collaboration and shared decision-making. First Nations health leaders across the health system are driving this agenda. See Diagram 1 for an overview of the health system in Queensland.

The ultimate success of this shared journey will be measured by achieving the 16 socio-economic targets agreed in the *National Agreement on Closing the Gap* (2020), including eliminating the current life expectancy gap that exists between Aboriginal and Torres Strait Islander peoples and other Queenslanders by 2031; currently estimated at around 7.3 years (6.7 years for women and 7.8 years for men).[12] Progress has been made in reducing the health disparities that contribute to the life expectancy gap over the last 10 years **but more can be done and done differently to build on these health gains**.

A commitment to health equity—which involves dual efforts to strengthen and improve the health system, and implementing practical measures to address the social determinants of health and eliminate racism—is the roadmap to achieve life expectancy parity by 2031. Some health system adjustments will be experienced as more resources (funding) and effort are directed towards **addressing greatest need rather than greatest demand** but doing 'business as usual' will result in the continuation of the same modest but slow improvements. The current pace *will not* achieve the goal of life expectancy parity by 2031.

Health equity: a key part of the Aboriginal and Torres Strait Islander Community-Controlled Model of Care



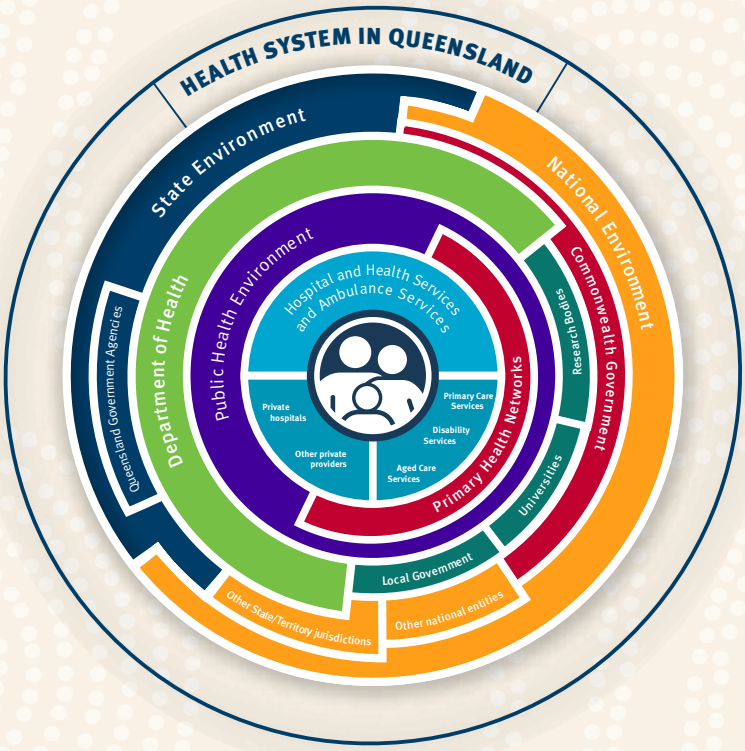
Health equity has always been part of the Aboriginal and Torres Strait Islander Community-Controlled concept of healthcare, wellbeing and expression of self-determination by delivering primary health care for our people, by our people. ATSICCHOs are a culturally informed and consumer-led model of care that empowers Aboriginal and Torres Strait Islander peoples to take charge of their own health.

Because Aboriginal and Torres Strait Islander cultural and community values dictate the delivery of care by an ATSICCHO, healthcare services and practices are culturally safe, cost-effective and responsive to addressing the needs of most relevance to the community. The values and perspectives of local communities shape the design of the delivery of services, evaluation, cultural policies, engagement mechanisms and physical attributes of our organisations.

Source: Queensland Aboriginal and Islander Health Council, Queensland Aboriginal and Torres Strait Islander Community Controlled Health Organisations' Model of Care, 2019, accessed 4/01/21, https://www.qaihc.com.au/media/37570/modelofcare_19082019_hr.pdf

Diagram 1—Health system overview

All parts of the health system need to work effectively to achieve health equity with Aboriginal and Torres Strait Islander peoples—it cannot be achieved in isolation. This diagram illustrates the shared responsibility and roles of multiple service providers and funders for healthcare and wellbeing in Queensland. HHSs and ATSICCHOs are part of the inner light blue circle of the Queensland health system.



All of us have to work together to achieve health equity with First Nations peoples—it is a shared commitment.

Keiran Keys, Health Service Chief Executive, Townsville Hospital and Health Service

WHAT?
What does health equity mean for us in Queensland?

Health equity is a well known and multi-dimensional concept used in the healthcare sector and economic and social development fields more broadly. The World Health Organization (WHO) adopted health equity as its guiding ideology more than 70 years ago, using the concept to explain the unfair and inequitable causes of health disparities—the social determinants of health—and the requirement to adopt tailored approaches to remedy health differences between groups of people.[13]

In short, health inequities arise because of inequities in the conditions of daily life (such as housing, education, employment) and the fundamental drivers that give rise to them: namely differential access to power, money and resources.[14] These fundamental drivers are further compounded and amplified by race and racism. When the causal factors for health disparities are addressed—the 'causes of the causes'—people's health improves.[15]

Critically, health equity adopts a **social justice and human rights-based approach to health and healthcare access** by responding to differences between groups of people that takes into account what people need to attain their full health potential. The health system plays a pivotal role in addressing health equity but every segment of society underpins health through the economic and social conditions in which people grow, live, work and age. Society as a whole, and not the health system alone, creates the foundations for good health.[16]

A First Nations health equity approach is being adopted to galvanise a renewed and shared agenda to improve Aboriginal and Torres Strait Islander people's health outcomes, experiences and access to care across the health system. This agenda aims to build on the foundations of the past to reshape the health system by placing 'health equity' at its centre. To be successful, it must be underpinned by representation, leadership and shared decision-making with Aboriginal peoples and Torres Strait Islander peoples to change the current power balance and create a health system free from racism and discrimination.

Fast Fact 1: The difference between equality and equity

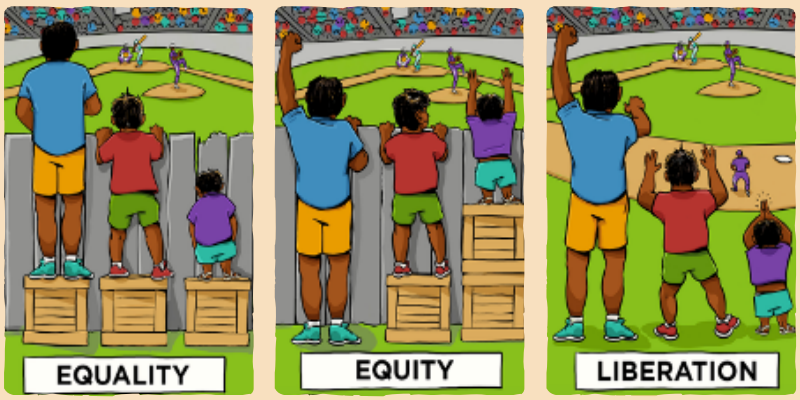
Both equity and equality are principles of fairness. Equity is a principle of fairness that treats people differently dependent on need. Equality is a principle of fairness that treats everyone the same regardless of need. Equality aims to promote fairness but it only works if everyone starts from the same place and has the same needs.

Differences between equality and equity

In the first image, it is assumed everyone will benefit from the same supports. They are being treated equally.

In the second image, individuals are given different supports to make it possible for them to have equal access to the game. They are being treated equitably.

In the third image, the cause of inequity has been addressed and all three see the game without any supports or accommodations. The systemic barrier has been removed.



Source: *www.storybasedstrategy.org*

Fast Fact 2: Definitions of health equity

World Health Organization (WHO)	Equity is the absence of avoidable, unfair and remediable differences among groups of people (whether defined socially, economically, demographically, geographically or other means of stratification). 'Health equity' or 'equity in health' implies that everyone should have a fair opportunity to attain their full health potential and that no-one should be disadvantaged from achieving this potential.
New Zealand Health	In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.
VicHealth (Victorian Health Department)	Health equity is the notion that everyone should have a fair opportunity to attain their full health potential and no-one should be disadvantaged from achieving this potential if it can be avoided. Health inequalities are differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair.

Source: www.who.int/topics/health_equity/en/; www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity; www.vichealth.vic.gov.au/our-work/health-equity-health-inequalities-health-inequities# (accessed 03/01/21)

WHY?

Why is health equity currently being embedded into the health system?

In addition to the numerous national and state reports about the health status of Aboriginal and Torres Strait Islander peoples dating back to the landmark *National Aboriginal Health Strategy* in 1989, the release of the 2017 report *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander people in Queensland's Public Hospital and Health Services*, shone a light on the ongoing challenges and barriers experienced by Aboriginal and Torres Strait Islander peoples in the public health system in Queensland.[17] The report was commissioned by the then Queensland Anti-Discrimination Commission (now Queensland Human Rights Commission) and QAIHC. The report found the *Hospital and Health Boards Act 2011* effectively rendered Aboriginal and Torres Strait Islander peoples 'legally invisible' by only having a single reference to Aboriginal and Torres Strait Islander health.[18] The report concluded that the *Hospital and Health Board Act 2011* failed to give the necessary legislative force for the public health system to 'close the gap' with Aboriginal and Torres Strait Islander peoples thereby creating the structural conditions for institutional racism and health inequality.

Queensland Health's response to the report in 2017 signaled the beginning of a health equity reform agenda. Since then, a number of substantial reforms have occurred to embed health equity across the health system and address the legacy of institutional racism described in the report. **Placing Aboriginal and Torres Strait Islander leadership at the heart of decision-making within Queensland Health and empowering First Nations health leaders across the health system, have guided much of this activity over the last three years.**

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Health equity reforms have gathered pace since 2017 and include many inaugural and substantive changes for Queensland Health:

2017 Release of Queensland Health's *Statement of Action towards Closing the Gap in health outcomes* in response to the Queensland Anti-Discrimination Commission (now Queensland Health Rights Commission) and QAIHC report on institutional racism in the public health sector.

2018 Appointment of Aboriginal and Torres Strait Islander health executives across many HHSs.

Introduction of annual HHS reporting against two key performance indicators—proportion of low birthweight babies and First Nations workforce representation.

Development of Closing the Gap Action Plans and Aboriginal and Torres Strait Islander Workforce Action Plans by each HHS.

2019 Appointment of the inaugural Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General in October 2019 to achieve health equity for Aboriginal and Torres Strait Islander peoples by embedding cultural perspectives across the public health sector, addressing institutional racism and driving improvements across the health system in Queensland. This position serves as a member of the Executive Leadership Team and Queensland Health Leadership Advisory Board.

Establishment of the Aboriginal and Torres Strait Islander Health Division to support the Chief Aboriginal and Torres Strait Islander Health Officer by advocating, supporting and monitoring Queensland Health's commitment to a culturally safe, equitable and responsive health system to meet the needs identified by First Nations peoples in Queensland.

2020 Requirement for all Department of Health governance bodies to have a minimum of one First Nations person as a representative from July 2020 onwards.

Certification of the inaugural *Aboriginal and Torres Strait Islander Health Workforce (Queensland Health) Certified Agreement 2019 (No.1)* in August 2020 creating a specific workforce classification and remuneration stream for Aboriginal and Torres Strait Islander health practitioners, health workers, mental health workers and hospital liaison officers.

Passage of the *Health Legislation Amendment Act 2020* in August 2020, requiring each HHS to have a Health Equity Strategy and to appoint one or more Aboriginal persons or Torres Strait Islander persons as members on each Hospital and Health Board.

Creation of the inaugural First Nations Health Improvement Advisory Committee within the Department of Health in September 2020 to advise the Chief Aboriginal and Torres Strait Islander Health Officer about the reforms needed to drive a health equity agenda. The committee is co-chaired with QAIHC and the Terms of Reference require 50 per cent non-government representation and a minimum of 50 per cent Aboriginal and Torres Strait Islander representation.

Commitment to establish a First Nations Clinical Network to develop, drive and implement clinical quality standards, ensure statewide equity and plan for sustainable service and healthcare improvements. An Establishment Reference Group was formed in December 2020 to standup the network and a launch date for the clinical network is on track for mid-2021.

Inclusion of a First Nations specific Key Performance Indicator (KPI) measuring potentially preventable hospitalisations in HHS Service Agreements (to take effect from 2020–21).

2020 election commitment to develop a First Nations Health Workforce Plan to support the implementation of the *Aboriginal and Torres Strait Islander Health Workforce (Queensland Health) Certified Agreement 2019 (No.1).*

2020 election commitment to release a Health Equity Framework in July 2021 and re-affirmed the Government's commitment for each HHS to develop and implement a Health Equity Strategy.

WHAT works?

The lessons so far from COVID-19—health equity in action

More recently, the lessons from the global pandemic and evolving national and state policy objectives to reframe the government's relationship with Aboriginal and Torres Strait Islander peoples, have amplified the need to drive a health equity agenda across the health system.

The lessons so far from COVID-19

Queensland's response to the global pandemic demonstrated several things:

- COVID-19 exacerbates underlying health inequities and increases the risks experienced by First Nations peoples and communities
- The effectiveness of responses to manage the risk of COVID-19 in Aboriginal and Torres Strait Islander communities across urban, regional, rural and remote areas is dependent on the leadership of Aboriginal and Torres Strait Islander peoples working in partnership with governments, and
- Local health systems have demonstrated their flexibility and ability to innovate by working differently, together and ultimately better, by tailoring and delivering the healthcare services needed by people during the pandemic.

We would like to commend the Aboriginal and Torres Strait Islander Mayors and leaders from the Aboriginal and Torres Strait Islander Community Controlled Health Sector who have worked with us to keep our communities safe during this pandemic. As a result of our collective efforts, there's been no positive COVID-19 cases in rural or remote First Nations communities and only 11 First Nations cases in Queensland. Importantly, no First Nations person has lost their life to COVID-19.

Dr Jeannette Young, Chief Health Officer and Haylene Grogan, Chief Aboriginal and Torres Strait Islander Health Officer, Queensland Department of Health – 4 February 2021

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> ***COVID-19 has created a 'muscle memory' for us to be more responsive and reset how we deliver healthcare in the future. The pandemic amplified the challenges that existed before COVID-19 but it also showed us that the health system can pivot, adjust and be agile as needed.***
>
> *Joy Savage, Cairns and Hinterland Hospital and Health Service*

Different (inequitable) starting points: Very few countries have been spared loss of life (mortality) or morbidity from COVID-19 but many Aboriginal and Torres Strait Islander peoples and communities are at increased risk from the disease because of the complex health needs and underlying social and economic inequities still experienced by many First Nations peoples before the pandemic disrupted our lives. Aboriginal and Torres Strait Islander peoples were identified as an at-risk group when the global pandemic was declared in March 2020, resulting in restricted access to designated Aboriginal and Torres Strait Islander communities in rural and remote areas to limit the risk of the disease entering and spreading.[19] Concerns about Aboriginal and Torres Strait Islander peoples living in urban and regional areas—which is approximately 80 per cent of the Aboriginal and Torres Strait Islander population—also exist due to the social, economic and health inequities and poorer health outcomes experienced in urban and regional areas.

Aboriginal and Torres Strait Islander leadership is essential: First Nations leaders have responded swiftly and effectively because of the increased risk of mortality from COVID-19 for people with existing chronic conditions. State and federal governments have partnered with Aboriginal and Torres Strait Islander leaders in urban, regional and remote locations because it is the only way to ensure the pandemic response will work.[20] During the first lockdown in Queensland, Mayors of rural and remote Aboriginal and Torres Strait Islander communities held regular meetings with state Ministers and senior public servants to plan their local responses to the pandemic in conjunction with Public Health Units and provided advice to the Chief Health Officer to inform the public health response.

Across urban, regional and rural areas, ATSICCHOs are at the forefront of implementing targeted public health campaigns, setting up testing clinics and educating community members about the risks of the disease and how to manage it. QAIHC, the Institute for Urban Indigenous Health (IUIH) and Apunipima Cape York Health Council developed communication materials for the ATSICCHO Sector to ensure access to relevant advice and culturally appropriate resources designed specifically for and with Aboriginal and Torres Strait Islander peoples.

> ***COVID-19 has given us an opportunity to re-energise, improve and fix the health system. All of us working in the health system can do better. We can't waste this opportunity.***
>
> *Cleveland Fagan, QAIHC*

Better together: Local health systems—encompassing all healthcare providers from primary through to acute and tertiary hospital based care—are being innovative, creative and agile in finding ways to support patients throughout the pandemic and provide ongoing care for patients with multiple and complex health needs. HHSs, ATSICCHOs and other providers have strengthened existing partnerships and worked across organisational boundaries to respond to the many challenges caused by the pandemic. Efforts are coordinated to provide care to vulnerable patients with complex health needs, satellite renal clinics established outside of hospitals in community settings and telehealth has become the new norm. New services were established to respond to demand, including a dedicated Aboriginal and Torres Strait Islander Teletriage Service in 13HEALTH staffed by a First Nations nursing team, and additional wrap around and transitional support for young people at Brisbane Youth Detention Centre and their families via a partnership between IUIH and the Queensland Government.

COVID-19 required the deployment of swift and innovative models of care to be delivered in ways not previously done either systematically or so far-reaching. It 'unleashed the potential' of models, pathways and partnerships across the health system, highlighting what can be done when effort, resources and leadership are focused and channeled. Unprecedented levels of collaboration has occurred between the primary and hospital based acute care sectors not previously experienced prior to the pandemic.

This same level of leadership, focus and commitment demonstrated by the COVID-19 public health response is required to eliminate the avoidable, unfair and unjust health disparities and racism that has placed Aboriginal and Torres Strait Islander peoples at a greater risk of mortality from COVID-19 in the first place.

COVID-19 has created a moment in history where Queensland's health system doesn't have to revert to how things were pre-COVID. Our 'new normal' provides the health system with an opportunity to apply the lessons from responding to the global pandemic and create a better and more equitable health system for the future.

HOW?

Reframing the relationship with Aboriginal and Torres Strait Islander peoples—First Nations leadership at the centre of decision-making

State and national government policy approaches have substantially changed over the last 10 years in response to broader societal changes. This has resulted in increased recognition of the distinct rights and interests of Aboriginal and Torres Strait Islander peoples and the importance of listening, valuing and respecting the lived experiences of First Nations peoples.

The Queensland Government has committed to historic policy and legislative reforms as Queensland journeys towards negotiating a Treaty with First Nations peoples and devolving decision-making to Aboriginal and Torres Strait Islander communities through the Local Thriving Communities (LTC) reforms. The *Tracks to Treaty Statement of Commitment* (2019) outlines how the Queensland Government is reframing its relationship with Aboriginal and Torres Strait Islander peoples by developing and implementing policies and services in accordance with eight key principles. Building on this, in 2020 the Queensland Government released the *Treaty Statement of Commitment* (2020) and accepted or accepted-in-principle all eight recommendations from *the Path to Treaty* report (2020).

Fast Fact 3: *Statement of Commitment to reframe the relationship between Aboriginal and Torres Strait Islander peoples and the Queensland Government (2019)*

The eight principles are:

1. **Recognition of Aboriginal and Torres Strait Islander peoples as the First Peoples of Queensland**
2. **Self-determination**
3. **Respect for Aboriginal and Torres Strait Islander cultures**
4. **Locally led decision-making**
5. **Shared commitment, shared responsibility and shared accountability**
6. **Empowerment**
7. **Free, prior and informed consent**
8. **A strengths-based approach to working with Aboriginal and Torres Strait Islander peoples to support thriving communities.**

The key to achieving a sustained improvement is to enable Aboriginal and Torres Strait Islander communities to develop solutions for themselves.

Queensland Productivity Commission, Final Report: Service Delivery in remote and discrete Aboriginal and Torres Strait Islander Communities

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The passage of the *Queensland Human Rights Act 2019* further enshrines the rights of First Nations peoples by explicitly protecting the cultural rights of Aboriginal peoples and Torres Strait Islander peoples (Section 28). As outlined in the preamble:

> ***"... although human rights belong to all individuals, human rights have a special importance for the Aboriginal peoples and Torres Strait Islander peoples of Queensland as Australia's first people, with their distinctive and diverse spiritual, material and economic relationship with the lands, territories, waters, coastal seas and other resources with which they have a connection under Aboriginal tradition and Ailan Kastom. Of particular significance to Aboriginal peoples and Torres Strait Islander peoples of Queensland is the right to self-determination."***

A list of other significant Queensland Government policies and frameworks aimed at driving change and working with Aboriginal peoples and Torres Strait Islander peoples to improve the social determinants of health and wellbeing, is summarised on page 45 (Appendix 1).

Fast Fact 4: *Human Rights Act 2019*

Queensland's *Human Rights Act 2019* protects 23 human rights in law and requires the Queensland public sector to act and make decisions which are compatible with the rights it protects.

Section 28 relates to the cultural rights of Aboriginal and Torres Strait Islander peoples: *Aboriginal and Torres Strait Islander peoples in Queensland hold distinct cultural rights. They include the rights to practice their beliefs and teachings, use their language, protect and develop their kinship ties and maintain their relationship with the lands, seas and waterways.*

Section 37 relates to the right to health services: *Every person has the right to access health services without discrimination. A person must not be refused emergency treatment that is immediately necessary to save the person's life or prevent serious impairment to the person.*

Closing the Gap

Queensland's approach to reframing the relationship with Aboriginal and Torres Strait Islander peoples is aligned with broader national efforts. Nationally, the 'Closing the Gap' agenda is Australia's approach to improving life outcomes for Aboriginal and Torres Strait Islander peoples and addressing the social determinants of health by taking a multi-sector and whole-of-life approach to improving the foundations of economic, social and cultural wellbeing. The release of the new *National Agreement on Closing the Gap* (2020) includes 16 socio-economic indicators of wellbeing and marks a substantial shift in how governments across Australia are required to partner with Aboriginal and Torres Strait Islander peoples and their representative organisations. The new agreement was developed and negotiated with the Coalition of Peaks. This is a historical first and the only example of a National Cabinet (former Council of Australian Governments or COAG) agreement negotiated with an external non-government body. The Coalition of Peaks, consisting of approximately 50 Aboriginal and Torres Strait Islander community-controlled organisations representing a variety of interests across Australia, negotiated the details of the agreement, including the 16 socio-economic targets, four priority reforms and five outcomes.

Central to the agreement is **sharing decision-making authority between governments and Aboriginal and Torres Strait Islander peoples through their representative bodies in the design and delivery of policies and services**. Polices, programs and services can no longer be developed without First Nations peoples, perspectives and interests at the centre.

When considering the Aboriginal and Torres Strait Islander holistic concept of health, no individual socio-economic target exists in isolation. However, the new *National Agreement on Closing the Gap* includes three specific health targets that Governments and the Aboriginal and Torres Strait Islander Community-Controlled Health Sector **have committed to achieve together**. The overarching commitment to closing the life expectancy gap by 2031 has been retained in addition to two new national health targets about healthy birthweight and suicide reduction.

Fast Fact 5: Overview of the *National Agreement on Closing the Gap*

Five outcomes	• Shared decision-making • Building the community controlled sector • Improving mainstream institutions • Aboriginal and Torres Strait Islander led data • Improving socio-economic outcomes
Four priority reforms	• Formal partnerships and shared decision-making • Building the community-controlled sector • Transforming government organisations • Shared access to data and information at a regional level
16 socio-economic targets* **four additional targets will be developed for family violence, access to information, community infrastructure and inland waters*	• Everyone enjoys long and healthy lives • Children are born healthy and strong • Early childhood education is high quality and culturally appropriate • Children thrive in their early years • Students achieve their full learning potential • Students reach further education pathways • Youth are engaged in education or employment • Strong economic participation and development • People can secure appropriate and afforable housing • Adults are not overrepresented in the criminal justice system • Young people are not overrepresented in the criminal justice system • Children are not overrepresented in the child protection system • Families and households are safe • Social and emotional wellbeing • People maintain distinctive relationships with their land and waters • Cultures and languages are strong

*Refer **www.closingthegap.gov.au** for further information.*

Fast Fact 6: ***National Agreement on Closing the Gap*** **health targets**

1. Close the gap in life expectancy within a generation by 2031
2. By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91%.
3. Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander peoples towards zero.

These significant state and national government policy developments have occurred alongside broader public advocacy and community campaigning about First Nations sovereignty and addressing the inequities, discrimination and racism still experienced by many Aboriginal and Torres Strait Islander peoples. The release of the *Uluru Statement from the Heart* (2017) and the international Black Lives Matter movement that originated in the United States and became a beacon for addressing the systemic injustices experienced by black, brown and Indigenous peoples globally, has increased public support across Australia to address the ongoing economic and social injustices still affecting many Aboriginal and Torres Strait Islander peoples today, including recognising First Nations peoples in Australia's Constitution. The development of a national Voice to Parliament and local and regional decision-making structures, remain national priorities that are substantially changing how governments and the wider public are finding ways to right the wrongs of Australia's colonial history and work together to create a just future.

Together, these legislative and policy reforms are significant structural changes aimed at changing how governments share decision-making with Aboriginal and Torres Strait Islander peoples to address historical and ongoing economic and social injustices, and recognise First Nations sovereignty and right to self-determination.

Until recently, most of the conversation in the health sector has focused on equality rather than equity. Treating everyone the same by providing the same support and approaches doesn't result in the same health outcomes. People need different approaches. There is a cultural bias in the design of the public health system because it serves the majority and often ignores the needs of the minority.

Joy Savage, Cairns and Hinterland Hospital and Health Service

The health system will improve for all Queenslanders if you get it right for First Nations peoples—start there because the need is greatest but once it's working well, the health system will work better for everyone. The health system needs to be designed for the patient and not the clinician. And because every patient is different, the system needs to have the capability to cater for differences.

Mick Gooda, Former Aboriginal and Torres Strait Islander Social Justice Commissioner

There needs to be an urgency to improve Aboriginal and Torres Strait Islander health—we can't continue to 'kick the can along the road' anymore. Increased effort and new approaches are needed to achieve life expectancy parity by 2031.

Adrian Carson, Chief Executive Officer, Institute for Urban Indigenous Health

WHAT?

What do these changes mean for the health system in Queensland?

For over 30 years, Queensland Health has delivered various policies, programs and healthcare services aimed at supporting First Nations peoples achieve their health aspirations. Longer still, the ATSICCHO Sector has nearly 50 years of delivering comprehensive primary health care services and empowering Aboriginal peoples and Torres Strait Islander peoples to gain greater control over the decisions affecting their health and lives. The Aboriginal and Torres Strait Islander Community Health Service Brisbane (ATSICHS Brisbane) and Townsville Aboriginal and Torres Strait Islander Corporation for Health Services (TAIHS) were the first ATSICCHOs established in Queensland in 1973 and 1974 respectively, with more ATSICCHOs forming shortly afterwards in Cairns and Mackay. Whilst recognising the long history of healthcare aimed at supporting and empowering First Nations peoples, it is acknowledged much more needs to be done across the health system to achieve health equity. A chronology of key health system milestones in Queensland over the last 50 years is detailed on page 19.

In 2010, Queensland Health released two groundbreaking policies that remain the guiding policy frameworks for the public health system: *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Policy and Accountability Framework (Making Tracks)* and the *Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033 (Cultural Capability Framework)*. Together these two companion policies outline the health system improvements needed to eliminate health disparities, achieve parity and the priority areas for investment (*Making Tracks*), and the actions needed by the public health system to eliminate institutional and personal experiences of racism by providing culturally safe, respectful and responsive care (*Cultural Capability Framework*). Together they form, and continue to serve as, the generational roadmaps for the public health system.

> ***Statistics aren't numbers—they are our families, our stories, our experiences. They are our Elders, mothers and fathers, uncles and aunties, our future generations.***
>
> *Erikka Dunning, Queensland Department of Health*

These policy frameworks continue to guide Queensland Health and over the last 10 years there's been growing recognition about the need to strengthen the implementation of these policy frameworks to overcome barriers and challenges. Chief among these areas for improvement are building the size, capacity and capability of First Nations leadership across the public health system, addressing resourcing (funding) restraints and strengthening partnerships with the ATSICCHO Sector to integrate and coordinate healthcare across the patient journey. These limitations do not deny or overshadow the many achievements of Aboriginal and Torres Strait Islander health leaders in the public health sector or First Nations led models of care that continue to deliver improved health outcomes but many of these successes have been dependent on Aboriginal and Torres Strait Islander leadership, workforce representation and involvement in decision-making which has fluctuated across Queensland Health over the last 30 years.

Many examples of good practice exist across the health system (see page 20 for some case studies) but good practice is not yet common practice across the public health sector. Both policy frameworks continue to serve as the generational roadmaps for the public health sector, however, improvements are needed to strengthen, renew and reinvigorate their implementation by driving a health equity agenda with the voices of Aboriginal peoples and Torres Strait Islander peoples at the centre of decision-making.

SECTION 1:

The journey so far... *building on our foundations in the past and now*

Aboriginal and Torres Strait Islander health: timeline of key events and policies in Queensland

1971
First Aboriginal Medical Service established in Redfern, NSW

1973
First national *Ten Year Plan for Aboriginal Health* released

1973–1980s
First Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) established in Brisbane, Townsville, Mackay and Cairns

1989
A *National Aboriginal Health Strategy* released by an Aboriginal and Torres Strait Islander led working group

1990
Queensland Aboriginal and Islander Health Forum (QAIHF) established in Mackay by seven ATSICCHOs across Queensland

1991
Royal Commission into *Aboriginal Deaths in Custody* final report

1992
Aboriginal Primary Health Care Project led by QAIHF FNQ Member Services

Binang Goonj Bridging Cultures in Aboriginal Health

1994
Queensland Health's *Aboriginal and Torres Strait Islander health policy*

Evaluation of the *National Aboriginal Health Strategy*

1995
ATSIC transferred health portfolio back to the Australian Government under the *National Aboriginal and Torres Strait Islander Health Framework Agreement*

Aboriginal and Torres Strait Islander Cultural Awareness released by the Cairns Rural Health Training Unit

1996
Queensland Aboriginal and Torres Strait Islander Health Framework Agreement, supporting Aboriginal and Torres Strait Islander community-controlled health services (updated 2002 and 2005)

1997
National Aboriginal and Torres Strait Islander Health Performance Indicators and targets endorsed by Health Ministers

Queensland Health's *Aboriginal and Torres Strait Islander Cultural Capability Minimum Standards*

Royal Australian College of General Practitioners Aboriginal and Torres Strait Islander mandatory training for General Practice registrars

The Australian College of Rural and Remote Medicine incorporated

1998
Queensland Health review of health worker competency

Queensland Health *Aboriginal and Torres Strait Islander Cross-Cultural Awareness Minimum Standards*

1999
Our Jobs, Our Health, Our Future—Queensland Health Indigenous Workforce Management Strategy 1999-2002

2002
Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework

2003
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013

2004
Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009

2006
Aboriginal and Torres Strait Islander Health Performance Framework

2008
Making Queenslanders Australia's healthiest people—advancing health action: a commitment to close the gap in health status between Indigenous and non-Indigenous Queenslanders

National Indigenous Reform Agreement—target to close the gap in life expectancy by 2031

2009
Institute for Urban Indigenous Health established

Queensland Premier signed the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*

2010
Queensland Government *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033*

Queensland Health *Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033*

Department of Health Closing the Gap programs commenced for Aboriginal and Torres Strait Islander peoples

2011
Queensland Health launched the Aboriginal and Torres Strait Islander Cultural Practice Program and established a funding model to implement the *Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033* within HHSs

Creation of Cultural Practice Program Coordinator positions throughout all HHSs

2013
National Aboriginal and Torres Strait Islander Health Plan 2013–2023

2014
Recruitment of a Torres Strait Islander Cultural Advisor to the Department of Health

2016
Refreshed *Queensland Health Statement of Commitment to Reconciliation*

Launch of Queensland Health's *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026*

Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health—a national approach to building a culturally respectful health system

National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023

2017
The Queensland Anti-Discrimination Commission in partnership with QAIHC released *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services* (institutional racism) report

Royal Commission into National Safety and Quality in Health Care Standards released by the Australian Commission on Safety and Quality in Health Care

Final *Royal Commission into Institutional Responses to Child Sexual Abuse* report

The *Statement of Action towards Closing the Gap in health outcomes* agreed to by all HHS Board Chairs in response to the 2017 institutional racism report

2018
Release of the *Queensland Government Reconciliation Action Plan 2018–2021*

2019
Appointment of Queensland's first Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General

2020
First *Aboriginal and Torres Strait Islander Health Workforce (Queensland Health) Certified Agreement (No.1)*

Royal Assent of the *Health Legislation Amendment Act 2020*

National Agreement on Closing the Gap—16 socio-economic targets agreed between all governments and the Coalition of Peaks

2021
Proposed *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021*

Aboriginal and/or Torres Strait Islander persons mandated to sit on HHS Boards

Aboriginal and Torres Strait Islander models of care: building upon existing good practice

Driving local change—Cairns and Hinterland Hospital and Health Service Health Equity Policy

The Cairns and Hinterland Hospital and Health Service (CHHHS) is committed to creating systems and processes to facilitate health equity for Aboriginal and Torres Strait Islander patients. The CHHHS *Health Equity for Aboriginal and Torres Strait Islander Patients Policy* aims to minimise avoidable disparities in health through inclusion and narrowing gaps in the operating environment. This policy captures the expectations across the CHHHS from the Board room to the front-line and management of service delivery, and outlines a set of core principles to ensure the highest quality preventative or therapeutic health care to Aboriginal and Torres Strait Islander peoples. Health equity within an organisational context is measured in collaboration with each Directorate annually using a Health Equity Self-Assessment Tool developed by the Institute for Healthcare Improvement.

Courageous Conversations About Race Beyond Diversity Program

The Gold Coast Hospital and Health Service (GCHHS) is the first organisation in Australia and within the health field to be awarded the prestigious 2019 International Leadership in Racial Equity Award in addition to the Highly Commended Department of Health and Queensland Health Excellence Awards in 2019 for its Courageous Conversations™ About Race (CCAR) Beyond Diversity program. To date approximately 350 GCHHS staff members, including Board members, the executive and community members, have participated in the CCAR Beyond Diversity program.

CCAR is an internationally recognised and award winning protocol for effectively engaging, sustaining and deepening interracial dialogue. The GCHHS worked in partnership with with the Courageous Conversation South Pacific Institute to context the CCAR Beyond Diversity program to our Aboriginal and Torres Strait Islander peoples, healthcare system and Australia. The GCHHS is currently one of only two organisations within Australia delivering the program and training staff to become licensed facilitators. CCAR operates on the principle that an organisation cannot achieve cultural responsiveness and inclusion in professional practice until they can explicitly talk about race and racism. The CCAR protocol provides an opportunity for healthcare professionals to enhance their practice in working with Aboriginal and Torres Strait Islander peoples by reorienting clinicians and other health staff towards a practice that acknowledges the impact of race and racism in healthcare. Through the program, the GCHHS has created a space for all staff to have conversations that transforms beliefs and behaviours so staff of all races can achieve at their highest levels and live their most empowered lives.

Sunshine Coast flu vaccination model of care

During the COVID-19 pandemic, existing healthcare services had to adjust to new infection control protocols to ensure the safety of vulnerable populations. In response to these changes the Sunshine Coast Hospital and Health Service (SCHHS) revised the influenza vaccination model and created three new clinics across three locations. The SCHHS created specific Aboriginal and Torres Strait Islander procedures to ensure care during these times was culturally safe and met the needs of the community. As a result of the new practices and procedures, the SCHHS saw an uptake in influenza vaccinations and the community feedback was overwhelmingly positive, with patients reporting feeling safe and supported at the clinics.

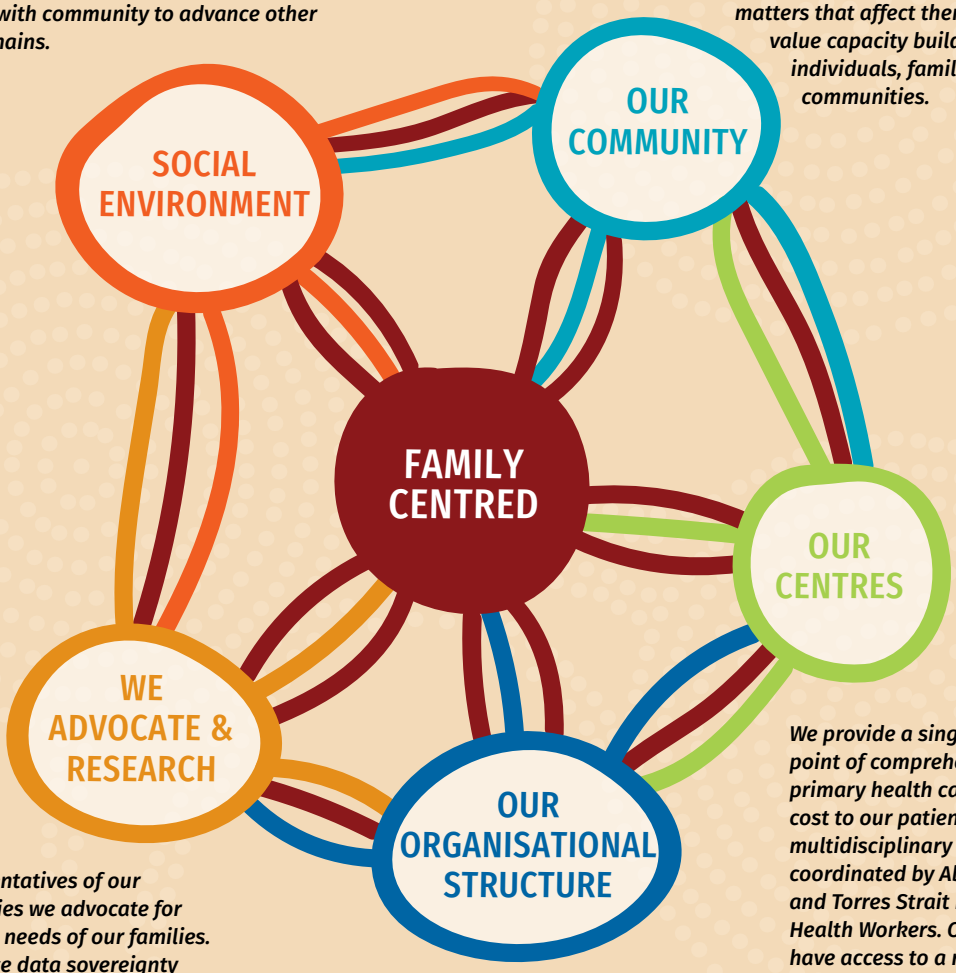
Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care

Starting as a small GP clinic in 1995 under the leadership of Wakka Wakka and Kalkadoon man Dr Noel Hayman, and nurse Nola White, descendent of the Ghungalu clan, the then Inala Indigenous Health clinic has grown from a small clinic to a multi-disciplinary team of 50 staff members providing clinical, specialist and allied health support to over 6,000 patients attending 20,000 consultations. The purpose built Southern Queensland Centre of Excellence opened in 2013 and it has a strong focus on preventative health, with the centre completing over 1000 health checks each year. Since the child health program commenced in 2006, the Southern Queensland Centre of Excellence has been responsible for 10 per cent of all Aboriginal and Torres Strait Islander child health checks done in urban Australia. In addition to primary healthcare services, the centre delivers a range of community outreach programs, manages an extensive research program and is a teaching centre for students and the next generation of doctors, nurses, dentists and allied health professions.

ATSICCHO model of care—*we are built from self-determination, governed by and answerable to our communities*

We understand that our people are only as strong as their communities. We acknowledge the impact of social determinants on our health and work with community to advance other social domains.

Our service delivery is guided by our cultural values. We provide a care environment that is culturally safe and engage our communities and consult on matters that affect them. We value capacity building of individuals, families and communities.



As representatives of our communities we advocate for the health needs of our families. We practice data sovereignty and build partnerships with key stakeholders to enhance our evidence base.

We provide a single-point of comprehensive primary health care at no cost to our patients. Our multidisciplinary team is coordinated by Aboriginal and Torres Strait Islander Health Workers. Our patients have access to a range of clinicians on site.

We have a highly skilled Aboriginal and Torres Strait Islander workforce committed to Continuous Quality Improvement. We provide assistance to our patients to reduce practical barriers and actively practice clinical excellence.

First Nations Health Equity—a working definition

The First Nations health equity journey in Queensland has only commenced but pivotal to building and strengthening this agenda is defining what health equity means to First Nations peoples and operationalising health equity in practice.

Two concepts have been developed to guide these ongoing reforms: **a working definition** of First Nations health equity and three **health equity design principles** to guide further health system improvements. Many definitions of health equity exist but no definition has been created by and with First Nations peoples in Australia.

It's important 'health equity' is ***defined by and not for* Aboriginal peoples and Torres Strait Islander peoples.** Profound and intergenerational impacts of colonisation, dispossession, settlement and cumulative discriminatory acts and policies of colonial and state governments on First Nations peoples have caused health disparities. The historical injustices tied to present day social and economic inequities are often overlooked and decontextualised, resulting in a narrative of 'disadvantage'. This discourse has pervaded discussions about Aboriginal and Torres Strait Islander health and often conflates First Nations peoples themselves with 'disadvantage' and 'deficit'—or most damagingly—places First Nations peoples as the source of the problem themselves. The resilience of First Nations peoples to survive successive discriminatory government acts and policies since the commencement of colonisation must be acknowledged. Being dispossessed of land and resources, outlawing of language and cultural practices, and social and economic exclusion from Australian society has directly impacted the health of First Nations peoples over generations.[21] To effectively remedy past injustices and inequities, **Aboriginal peoples and Torres Strait Islander peoples who hold knowledge of these experiences must drive, guide and lead a truly effective First Nations health equity agenda.**

A working definition has been developed to start conversations with First Nations peoples about the **meaning of health equity in principle and practice**. The goal is to create a definition that is easily understood and can be applied in practice. Once finalised, this definition will be used by Queensland Health to guide the delivery of healthcare services across the health system.

Working definition:

Achieving First Nations health equity requires eliminating the avoidable, unjust and unfair health differences experienced by Aboriginal and Torres Strait Islander peoples by addressing social and economic inequalities, historical injustices, racism and discrimination that lead to poorer health.

Strategies to achieve health equity include:

- **prioritising effort, strengthening accountability and redirecting investment across the health system**
- **valuing our First Nations leadership and cultural strength**
- **adopting and investing in different approaches**
- **delivering culturally safe, responsive and capable healthcare services that First Nations peoples want and need to create healthier futures**
- **eliminating racism and discrimination.**

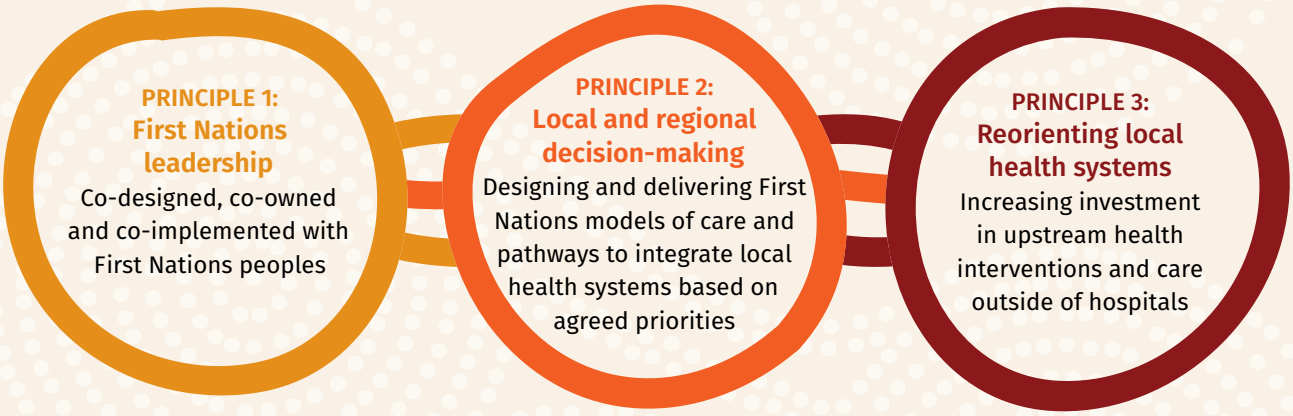
Health Equity Design Principles—moving from ideas to practical health system, service and practice improvements

Ideas and concepts are important but they must be implemented in practice to have any real and measurable impact.

Three initial design principles—underpinned by cultural capability—have been developed by Queensland Health to supplement the working definition and **guide future reforms across the health system** whilst the Health Equity Strategies and Health Equity Framework are being developed (more about this in Section 2).

These principles will be further developed based on the feedback from consultation and finalised in partnership with QAIHC and the broader ATSICCHO Sector to ensure health equity can be applied in practice.

All healthcare providers will be encouraged to apply these principles in the design, implementation, review, monitoring and evaluation of healthcare policies, programs and services.



Underpinning these principles is **cultural capability** as demonstrated by cultural respect, cultural competency, cultural safety and the broader Queensland Government commitment to **reframe the relationship with First Nations peoples**

Fast Fact 7: Difference between upstream and downstream health interventions

Upstream or population health approaches to health services focus on entire populations by eradicating the sources of problems.

Downstream approaches focus on individuals by providing care and treatments for those who are sick or injured using a biodmedical approach to care.

Self-determination is evident in the representation of First Nations peoples at the highest governance structures within Queensland Health—it is a monumental shift.

Matthew Cooke, QAIHC Chairperson

SECTION 2:

Embedding health equity into local health systems...

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

Feedback Questions

1. The new Health Equity Strategies will build on existing effort over the last three years. What changes or initiatives in your region have had a positive impact and increased the representation of Aboriginal and Torres Strait Islander peoples in the design and delivery of local health services? How can a co-designed, co-owned and co-implemented Health Equity Strategy be fostered or enhanced in your service area and across other regions?
2. What challenges, barriers and resistance exist to develop and implement the Health Equity Strategies? And how can they be managed?
3. How can the ideas and voices of First Nations peoples of all ages and abilities be incorporated into the design and implementation of the Health Equity Strategies?
4. What type of guidance needs to be provided in the Health Equity Framework to support the development and implementation of the Health Equity Strategies?
5. What other policy tools and resources would be beneficial at a local and regional level?

SECTION 2:

Embedding health equity into local health systems...

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

A cornerstone of the health equity agenda is the legislative requirement passed by the Queensland Parliament in August 2020 for HHSs to develop and implement Health Equity Strategies.[22] For the first time, a commitment to improving Aboriginal and Torres Strait Islander health outcomes and achieving health equity is firmly embedded in the legal framework guiding the public health system in Queensland.

The requirement to develop and implement Health Equity Strategies is a substantive legislative reform that aims to build on the activities undertaken since the release of the *Statement of Action towards Closing the Gap in health outcomes* (2017) by creating uniform good practice standards and processes across the public health system.

A timeline of the activities leading up to the development of the Health Equity Strategies is outlined below and on pages 11–12 and 19.

We know we're not doing enough because health disparities exist. It's that simple. Once there's no difference in health data and people tell us their healthcare experiences hit the mark, that's when we'll know we've achieved health equity.

Dr Jillann Farmer, Deputy Director-General, Queensland Department of Health

Timeline: Development history of the Health Equity Strategies

March 2017
The Queensland Anti-Discrimination Commission and QAIHC release the *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander people in Queensland's Public Hospital and Health Services* report (Health Equity report).

December 2017
In response to the Health Equity report, Queensland Health implements a number of strategies to address institutional racism in the health system and releases the *Statement of Action towards Closing the Gap in health outcomes.*

November 2018
Queensland Health publishes a formal response to the Health Equity report outlining efforts across each HHS including:

- implementing Closing the Gap Health Plans
- reporting against two new Aboriginal and Torres Strait Islander-specific key performance indicators to improve transparency and accountability
- developing Aboriginal and Torres Strait Islander Workforce Action Plans.

June 2019
The Minister for Health and Minister for Ambulance Services establishes an expert panel which recommends amendments to the *Hospital and Health Boards Act 2011* to embed the Queensland Government's commitment to closing the gap and improving health outcomes with Aboriginal and Torres Strait Islander peoples.[23]

What is institutional racism?

For the purpose of the proposed Regulation, institutional racism is defined as ways in which racist beliefs, attitudes or values have arisen within or are built into the operations, legislation and/or policies of an institution in such a way that discriminates against, controls or oppresses, directly or indirectly, a certain group of people to limit their rights; causing and/or contributing to inherited disadvantage.

November 2019
The Minister for Health and Minister for Ambulance Services introduces the *Health Legislation Amendment Bill 2019* to the Queensland Parliament.

March 2020
Queensland Health commences statewide consultation on the draft *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021*.[24]

August 2020
The *Health Legislation Amendment Act 2020* receives Royal Assent.[25] The Act contains amendments to the *Hospital and Health Boards Act 2011* requiring each HHS to develop and implement a Health Equity Strategy and have First Nations representation on Hospital and Health Boards.

October 2020
The First Nations Health Improvement Advisory Committee forms a subcommittee to co-design the drafting instructions for the *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021* following feedback from statewide consultation between March and June 2020.

November 2020
The Palaszczuk Government's election commitment reaffirms each HHS developing and implementing a Health Equity Strategy and the release of a Health Equity Framework to guide development.

Co-designing the Health Equity Strategies Regulation

When commenced, the amendments to the *Hospital and Health Boards Act 2011*, made by the *Health Legislation Amendment Act 2020*, will require HHSs to develop and implement a Health Equity Strategy, and enable a regulation to be made to prescribe the minimum legislative requirements to develop and implement the Health Equity Strategies.

Queensland Health has undertaken an extensive participatory process to co-design the proposed Health Equity Strategies Regulation (the Regulation) that will guide the development and implementation of Health Equity Strategies to ensure they address the issues identified in the 2017 report on institutional racism in the public health sector, and respond to the needs, aspirations and interests of Aboriginal and Torres Strait Islander peoples, their institutions and other key health service providers. Once finalised, the Regulation will prescribe the minimum legislative requirements for each HHS to develop and implement a Health Equity Strategy for their respective health service areas and to ensure consistency and continuity of the patient journey across different health service areas.

Representatives and stakeholders from across the health system participated in the Regulation consultative design process, including Hospital and Health Board members, Health Service Chief Executives and Aboriginal and Torres Strait Islander staff members, QAIHC, the ATSICCHO Sector, Primary Health Networks, independent health statutory agencies and Aboriginal and Torres Strait Islander health consumers.

An extensive 10 month consultative legislative development process was undertaken to ensure the Regulation was fit-for-purpose and to maximise commitment across the health system. The development and design process included:

- Statewide public consultation between March and June 2020, resulting in written feedback from 34 stakeholders on the draft Regulation—key findings are summarised in Box 1 (page 28)
- Engagement process (presentations and Q&A sessions) with QAIHC's policy network
- A co-design process undertaken between October and December 2020 with a dedicated subcommittee of key stakeholders to refine the drafting of the Regulation based on the feedback received from the statewide public consultation
- Consultation with Health Service Chief Executives, Hospital and Health Board members and Aboriginal and Torres Strait Islander health leaders across the public health system on the draft Regulation throughout January 2021
- Consideration of the draft Regulation by the First Nations Health Improvement Advisory Committee in February 2021.

The development process for the Regulation was completed in February 2021.

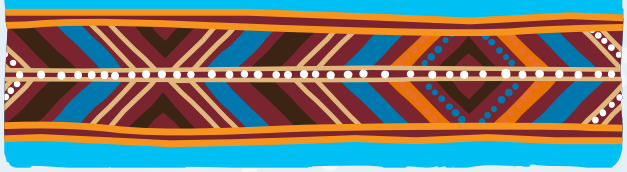
Queensland Health has recently introduced a number of ground-breaking reforms including the appointment of the Chief Aboriginal and Torres Strait Islander Health Officer position and the amendments to the Hospital and Health Boards Act 2011. These important reforms have been the result of genuine co-design and partnership between Queensland Health, QAIHC and the Aboriginal and Torres Strait Islander Community Controlled Health Sector.

Angela Young, QAIHC

Box 1: Feedback summary from statewide public consultation

Feedback to improve the draft Regulation can be summarised under five key themes:

- Refining the definition of health equity
- Strengthening accountability and reporting requirements for the Heath Equity Strategies including independent oversight mechanisms—for example, a statutory body
- Expanding the prescribed stakeholders who need to be involved in the development and implementation of the Health Equity Strategies
- Utilising the principles from the Queensland Government *Statement of Commitment to reframe the relationship (2019)* to design and implement the Health Equity Strategies, and
- Linking funding and formalised partnership responsibilities to the Health Equity Strategies.



The new and improved Health Equity Strategies Regulation from the statewide public consultations and working group process directly reflects voices and ideas from our multitudinous stakeholders and partners. The process was co-designed with this in mind from beginning to end.

Kiel Weigel, Queensland Department of Health

Key components of Health Equity Strategies

Subject to Governor in Council consideration of the Regulation, HHSs will have 12 months from the date the Regulation commences to co-design and release a Health Equity Strategy as prescribed by the Regulation. Critically, the new provisions in the *Hospital and Health Board Act 2011* and the Regulation will require Health Equity Strategies to be **co-designed, co-owned and co-implemented in partnership** with prescribed stakeholders to share decision-making and accountability to improve local health outcomes. To provide guidance to HHSs and regional stakeholders about the requirements relating to the development and implementation of the Health Equity Strategies, a Health Equity Framework will be released in July 2021.

The proposed minimum requirements for the Health Equity Strategies are detailed on the following page.

The regulation needs to find the right balance between driving local solutions and acting as a compliance process. All levels across the public health system—from Board members and executives to clinicians and support staff—need to champion health equity. We all need to challenge how we think and what we do to work towards health equity.

Dallas Leon, Townsville Hospital and Health Service

Table: *Proposed minimum requirements for the Health Equity Strategies*

Key priority areas	**Objectives and key performance measures** will be required for the following priorities in the Regulation: • Improve health and wellbeing outcomes for Aboriginal peoples and Torres Strait Islander peoples • Actively eliminate racial discrimination and institutional racism • Increase access to healthcare services • Influence the social, cultural and economic determinants of health • Deliver sustainable, culturally safe and responsive healthcare services • Work with Aboriginal peoples and Torres Strait Islander peoples, communities and organisations to design, deliver, monitor and review health services.
Prescribed stakeholders	Provisions in the Regulation will outline **who must be involved in the development and implementation** of the Health Equity Strategies, including: **Development stakeholders:** • Aboriginal and Torres Strait Islander staff members • Aboriginal and Torres Strait Islander health consumers • Aboriginal and Torres Strait Islander community members • Traditional Custodians and native title holders of lands and seas • All implementation stakeholders (see below) **Implementation stakeholders:** • Queensland Aboriginal and Islander Health Council • Chief Aboriginal and Torres Strait Islander Health Officer • Health and Wellbeing Queensland • All service delivery stakeholders (see below) **Service delivery stakeholders:** • Aboriginal and Torres Strait Islander Community Controlled Health Organisations • Local primary healthcare organisations Three types of prescribed stakeholders (development, implementation and service delivery) have been identified to distinguish the responsibilities and functions of the various parties in the development and implementation of the Health Equity Strategies.
Actions to achieve health equity	Hospital and Health Services will be required to outline actions it will take to: • Achieve the strategy's key performance measures including through agreements established with stakeholders • **Partner with stakeholders** to ensure greater collaboration, shared ownership and decision-making • Improve the **integration of health service delivery** between providers • Provide **inclusive mechanisms** to support Aboriginal and Torres Strait Islander peoples of all needs and abilities to engage with and provide feedback to Hospital and Health Services • Increase **workforce representation** of Aboriginal and Torres Strait Islander peoples across all levels of health professions and employment streams to levels at least commensurate with local population.

The new Health Equity Strategies will amplify the voices of local Aboriginal and Torres Strait Islander communities and consumers. It will strengthen accountability back to consumers.

Jo Smethurst, Health Consumers Queensland

Developing and implementing Health Equity Strategies

A Health Equity Framework will be released in July 2021 outlining the strategic and operational requirements for the Health Equity Strategies. This will include:

- Principles for co-design, shared decision-making and shared ownership with Aboriginal peoples and Torres Strait Islander peoples to design and deliver the Health Equity Strategies
- Engagement processes, protocols and timeframes, including minimum notification periods for prescribed stakeholders
- Public reporting requirements including frequency
- Mediation and conflict resolution, including the role of the Chief Aboriginal and Torres Strait Islander Health Officer in mediating disagreements or disputes between parties, and
- Monitoring and evaluation.

Health Equity Strategies will be the mechanism to redesign and reorientate local health systems to better listen to and support First Nations peoples.

Where relevant, some operational requirements for the Health Equity Strategies will be outlined in Health Service Directives and Service Agreements with HHSs.

How will the Health Equity Strategies build upon existing plans and activities?

The Health Equity Strategies will replace the existing Closing the Gap Health Plans. Additionally, HHSs have a number of other plans and strategies aimed at improving Aboriginal and Torres Strait Islander health outcomes. This includes (but not limited to) Aboriginal and Torres Strait Islander health workforce action plans, Aboriginal and Torres Strait Islander health workforce action plans, Aboriginal and Torres Strait Islander Cultural Capability Action Plans and Reconciliation Action Plans. Wherever feasible and practicable, **the aim is to bring together and integrate all existing Aboriginal and Torres Strait Islander health plans under the new Health Equity Strategy**. This will reduce duplication, streamline reporting and refocus efforts on the key priorities and specified actions outlined in the Regulation. However, in accordance with the principle of subsidiarity[26], the decision to keep existing plans and strategies in addition to developing a new Health Equity Strategy, will be made in partnership by each HHS with their prescribed development stakeholders.

Queensland Health is genuinely working with Aboriginal and Torres Strait Islander peoples across the health system—our voices are being heard. We have an opportunity to push the boundaries, shake things up and make a real difference. The new regulation provides an opportunity for genuine innovation but its effectiveness will be measured when the 'rubber hits the road' and Hospital and Health Services start developing the strategies.

Donna Burns, Healing Foundation

Relationship between the Health Equity Strategies and other prescribed strategies and protocols

Once the legislative reforms for the Health Equity Strategy commences, each HHS will be required to have three prescribed strategies and a protocol:

- Health Equity Strategy
- Consumer and community engagement strategy
- Clinician engagement strategy
- Protocol with local primary healthcare providers.

The *Hospital and Health Boards Act 2011*, once amended, will require these strategies to align with each other, maximise opportunities for collaboration, be publicly available and be reviewed within three years of the strategy's release.

Monitoring and evaluation

To supplement the reporting requirements under the new *National Agreement on Closing the Gap* (2020) and *Making Tracks* (2010), a statewide First Nations Health Equity monitoring and evaluation framework will be developed to measure the effectiveness of the Health Equity Strategies and support continuous quality and service improvements across HHSs. In accordance with the *National Agreement on Closing the Gap* (2020), the monitoring and evaluation framework will be co-designed in partnership with the Aboriginal and Torres Strait Islander Community-Controlled Health Sector and First Nations health leaders across the public health system. This will ensure the monitoring and evaluation framework is culturally appropriate and adheres to the principle of Aboriginal and Torres Strait Islander data sovereignty by ensuring the narrative reflects the voices and experiences of Aboriginal and Torres Strait Islander peoples.[27]

Common and tailored KPIs will be developed for each of the priority areas listed in the draft Regulation, and a regular statewide report produced by the Chief Aboriginal and Torres Strait Islander Health Officer about progress made and ongoing implementation barriers.[28] This approach will maximise transparency and accountability of the public health system in achieving health equity (as per the legislative requirements outlined in the Regulation) and actions taken to remedy the legacy of institutional racism.

SECTION 3:

Driving health equity across the health system

and addressing the social and cultural determinants of health—future ideas for discussion

Feedback Questions

1. What are the top three changes, improvements or reforms that could contribute to improving the broader social determinants of health and achieving health equity?
2. What other health system changes, improvements and reforms are needed to achieve health equity with First Nations peoples?
3. How can the health system take a local leadership role in improving the broader social determinants of health?
4. Are 'Marmot city regions' a feasible approach for local communities to tackle long-term economic and social inequities, and improve the social determinants of health?

SECTION 3:

Driving health equity across the health system *and addressing the social and cultural determinants of health—future ideas for discussion*

***Sections 1 and 2** outlined the reasons for the renewed health equity agenda and the current legislative reforms underway across the health system to achieve health equity in practice. **Section 3** is focused on 'big picture thinking' and explores other ideas to achieve health equity with Aboriginal peoples and Torres Strait Islander peoples, address the social and cultural determinants of health, and eliminate racism. The following proposals are not government policy but a collection of ideas for discussion and debate.*

Similar to the 16 socio-economic targets agreed in the *National Agreement on Closing the Gap* (2020), some of these reforms extend beyond the traditional remit of the health system and demonstrate how the public health sector can take a leadership role in influencing the broader economic and social conditions that affect health and wellbeing.

The ideas and proposals outlined in this section have come from many different sources including Aboriginal and Torres Strait Islander health leaders in the public health sector and the Aboriginal and Torres Strait Islander Community Controlled Health Sector, various committees and governance groups within Queensland Health including the First Nations Health Improvement Advisory Committee, commissioned research and insights shared during regional visits conducted by the Chief Aboriginal and Torres Strait Islander Health Officer before COVID-19 (see Box 2, page 34 for a summary of the findings). **They are not government policy.**

The ideas and proposals described in this section are aimed at either improving the health system or addressing the social and cultural determinants of health. Both are interconnected and necessary because a well functioning health system is not sufficient for improving the health of First Nations peoples—it is a whole of society approach.

The various reform proposals have been grouped into six themes and directly link to the **First Nations health equity working definition** and the **First Nations health equity design principles** described in Section 1.

The six themes are:

1. **Representation and Voice**
2. **Building First Nations health system leadership and workforce**
3. **Implementing integrated healthcare models and pathways to improve the patient journey and decrease demand on hospitals**
4. **Embedding cultural determinants into patient safety and quality**
5. **Driving state and national health funding reforms, and**
6. **Addressing the social determinants of health and eliminating racism.**

The six themes and 20 proposals are ideas to start a conversation about their relevancy and appropriateness, and to inspire other bold, innovative and progressive ideas about practical steps that can be undertaken to reform the health system and address the social determinants of health to achieve health equity. The proposals range from systemic level reforms and whole-of-government activity to service improvements and practice changes, and everything in-between.

Box 2: Findings from the Chief Aboriginal and Torres Strait Islander Health Officer regional visits

2019	OCTOBER	14	• Metro North HHS
		22-23	• North West HHS • Gidgee Healing • QAS
		23-25	• Central Queensland HHS • Bidgerdii • Local Elders
		29-31	• Torres and Cape HHS • QAS • Hope Vale Aboriginal Shire Council
	NOVEMBER	5	• Sunshine Coast HHS
		6-7	• Cairns and Hinterland HHS • Yarrabah (HHS and ATSICCHOs) • Mamu Health Service
		20	• South West HHS
		22	• Darling Downs HHS • ATSICCHOs discussion (Carbal Medical Centre and Goondir)
		26-27	• Central West HHS • QAS
	DECEMBER	13	• West Moreton HHS • Local Elders
		17	• Metro North HHS
2020	FEBRUARY	3-4	• Townsville HHS
		12	• Wide Bay HHS • Community Council
	MARCH	5	• Children's Health Queensland HHS

13 Hospital and Health Services (HHSs)

3 Queensland Ambulance Service (QAS)

4 Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHO)

Successes and Strengths

- Some HHSs have developed strong community **relationships**, referral and discharge pathways, and in-reach and outpatient services with ATSICCHOs.
- Strong Hospital and Health Board and executive **leadership** to improve First Nations health outcomes.
- Most Hospital and Health Boards have Aboriginal and Torres Strait Islander **membership**.
- Many First Nations **advisory groups** operational across Queensland.

Identified Priorities

HEALTH CONDITIONS

- **Mental health** is a growing concern across urban, regional and remote areas.
- **Maternal and child health**—some regions have high rates of Discharge Against Medical Advice after birthing.
- **Young people** and healthy transitions to adulthood.
- **Oral health**
- **Renal health and diabetes**
- **Rheumatic heart disease and cardiac health**
- **Sexual health**
- **Alcohol and other drugs**, including concern over increased ice usage in some regions.

COMMUNITY IDEAS

- Further embed **cultural practices and perspectives** into HHS operations.
- Promote the beneficial impact of **culture and cultural identity** on health.
- Strengthen **engagement with young people** in the design and delivery of services.

WORKFORCE

- Improve **clinical scope, classification and career structure** of First Nations workforce (liaison officers, health workers and practitioners).
- **Recruitment challenges**—need to build supply pipeline with *RTOs, schools and universities. **some local QAS stations have RTO status*
- Increase **training and professional development** opportunities for First Nations health workforce.
- Concerns about **temporary positions** funded from *Making Tracks* investment.
- Enhance **cultural competency** of non-First Nations staff.
- **Grow First Nations health workforce**, including midwives and nurses.
- Expansion of **First Nations health workforce-led models of care**.
- Some ATSICCHOs are **losing staff** to HHSs.
- Opportunity for **HHSs to partner with ATSICCHOs** to provide registrar/GP training.

HEALTH SYSTEM PERFORMANCE

- Strengthen **collaboration and integration*** between HHSs, Primary Health Networks and ATSICCHOs to improve the effectiveness, efficiency and reduce duplication. **including data sharing*
- Strengthen **partnerships** between some HHSs and QAS.
- Opportunity for the new **Health Equity strategies** to take a holistic approach and extend beyond *Making Tracks* investment.
- **Transition primary and preventative health services** from HHSs to ATSICCHOs.
- Increase **long-term investment** in ATSICCHOs to deliver primary and preventative public health care, including community education.
- Improve *Making Tracks* **funding processes**, communication and timeframes to apply for funds.
- Increase **funding opportunities** outside of *Making Tracks* to deliver new services and models of care—activity-based funding is restrictive.
- Challenges with **short-term QH funding arrangements**, including *Making Tracks*.
- Organisation of statewide Aboriginal and Torres Strait Islander **QH staff forums**.
- Support a **leadership pipeline** for Aboriginal and Torres Strait Islander HHS board members.
- Critical role of **Aboriginal and Torres Strait Islander advisory councils and committees** in the planning, design and delivery of care.
- Provision of **transport** assistance to reduce Failure to Attend for outpatient and elective surgery appointments in urban areas.
- Increase **virtual care/telehealth** to improve care provided to First Nations.
- Improve **prison health service referral** processes and pathways.
- Improve Aboriginal and Torres Strait Islander **identification rates**.
- Improve **reporting to inform health planning and share** with the local community.
- Better **access to data** to inform health care planning and delivery.

Rural and Remote Challenges

- **Local recruitment, retention and empowerment** of First Nations health workforce.
- Strengthen **environment health services** and build partnerships with public health units.
- Improve the delivery of the **Patient Travel Subsidy Scheme**.
- Need for **innovative employment models** such as joint positions between HHSs and ATSICCHOs.
- Growing demand for **birthing closer to home and on Country**.
- Limited access to **high quality accredited training and development**.
- Provision of **appropriate housing** in remote communities for staff and residents.
- Lack of uptake of and restrictions to **MBS accessibility** for Royal Flying Doctors Service and some HHSs.
- Growing demand for **aged care services** in the Torres Strait and Cape York region.
- Strengthen the **continuity of care** between outreach services and local health services.
- Deliver more care **closer to home (on Country)**, including palliative care.
- Critical **role of Aboriginal and Torres Strait Islander Shire Councils** in priority setting.
- Strengthen **patient journey** between HHSs when accessing specialist care.

SECTION 3:

Driving health equity across the health system *and addressing the social and cultural determinants of health—future ideas for discussion*

THEME 1:
Representation and Voice

1. **Establish a First Nations Health Board:**
   The ATSICCHO Sector has advocated for the creation of an Aboriginal and Torres Strait Islander Health Board as an independent statutory authority or body to strengthen accountability about addressing institutional racism across the public health system, monitor health outcomes for Aboriginal peoples and Torres Strait Islander peoples, and advise the Queensland Health Minister on how to redress inequities in the health system. No other First Nations health statutory body exists in Australia but a few examples exist internationally—Canada has an authority operational in British Columbia and Aotearoa New Zealand is currently considering the merits of establishing an independent Māori Health Authority to sit alongside a new health authority (Health NZ) and the Ministry of Health.[29]

   If government approves the establishment of a new statutory authority or body, substantial development work would be required to establish and define its roles and responsibilities compared to those already held by the Chief Aboriginal and Torres Strait Islander Health Officer, Hospital and Health Boards and other health statutory bodies. Consideration would also be given to the relationship between any new statutory authority or body, and other local and regional decision-making and governance bodies being established through the national Indigenous Voice co-design process and the LTC reform agenda in rural and remote areas. If this proposal has merit, the lead-up time for the statutory authority or body to become operational is likely to be substantial (up to five years).

> *The equity challenges that Māori face demand more than a clearer mandate for Māori policy development, more than the simple identification of strategy execution failures, and more than the identification of the systematic disadvantaging of Māori and Kaupapa providers by contracting arrangements. Similarly, the equity challenges demand more than a partnership role for Māori in the commissioning process because, in the worst-case scenario, this would mean that Māori have little more than an advisory role.*
>
> *Heather Simpson, New Zealand Health and Disability System Review Final Report 2020*

THEME 2:

Building First Nations health system leadership and workforce

Growing the size, capacity and capability of the Aboriginal and Torres Strait Islander public health sector workforce across every employment stream and occupational level will improve the cultural safety of the health system and help address the social determinants of health. Outside the delivery of direct healthcare provision, increasing employment and economic development opportunities are two practical ways the public health system can influence the social determinants of health.

2. **Increase Queensland Health's First Nations employment targets commensurate to local population or hospital presentation and user rates (whichever is greater):**
   Queensland Health has a 3 per cent Aboriginal and Torres Strait Islander health workforce target by 2022 and is currently achieving 2.14 per cent (2,294 headcount) as at November 2020.[30] Some HHSs, statutory bodies and agencies that comprise Queensland Health are already exceeding the three per cent target[31] but some parts of the organisation continue to struggle to recruit, retain and develop a workforce that reflects the population they serve, especially in rural and remote areas. The proposal to tailor employment targets to local population and user rates would enable HHSs and different areas within Queensland Health to develop targeted recruitment, retention and career development programs to ensure they have a representative, diverse and culturally safe workforce. This would include implementing local 'grow your own' workforce approaches to create employment pathways from schools, the vocational education and training (VET) and higher education sectors into local health services, including cadetships and apprenticeships. Tailored employment targets would require HHSs and other areas within Queensland Health to develop innovative and creative partnerships with education and training providers to support labour market development and build the size, capacity and capability of the future health workforce. The attributes of the inaugural *Aboriginal and Torres Strait Islander Health Workforce (Queensland Health) Certified Agreement 2019 (No. 1)* would also be leveraged to maximise career structure pathways, learning and development opportunities, and advancement.

3. **Legislate the responsibilities of the Chief Aboriginal and Torres Strait Islander Officer in the *Hospital and Health Boards Act 2011*:**
   The appointment of the inaugural Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General in 2019 was a substantive reform designed to ensure First Nations leadership was part of the highest decision-making structures across Queensland Health. The creation of the position and a standalone Aboriginal and Torres Strait Islander Health Division has elevated the needs, interests and voices of First Nations peoples across the public health sector but more can be done. The proposal to strengthen the authority, stature and defined functions of the Chief Aboriginal and Torres Strait Islander Health Officer role within the *Hospital and Health Boards Act 2011* would provide the position with legislative responsibilities comparable to to other positions with legislative functions (for example, the Chief Health Officer). Legislating the roles and responsibilities of the Chief Aboriginal and Torres Strait Islander Health Officer would also require the position to be a legislated identified position filled by either an Aboriginal person or a Torres Strait Islander person.

4. **Release a biennial First Nations health equity report tabled at Parliament by the Chief Aboriginal and Torres Strait Islander Health Officer:**
The release of a biennial report similar to the Chief Health Officer's *Health of Queenslanders Report* would strengthen the accountability of the health system to achieve the three health targets agreed to in the *National Agreement on Closing the Gap* (2020) and provide a public mechanism to report on the effectiveness of the Health Equity Strategies. An agreed reporting cycle would be established between the Chief Health Officer and the Chief Aboriginal and Torres Strait Islander Health Officer, and the report would be co-designed in partnership with the Aboriginal and Torres Strait Islander Community-Controlled Health Sector and health leaders across the public health sector. Critically, the report would focus on the effectiveness of the entire Queensland health system in supporting First Nations peoples achieve their health goals, not only Queensland Health.

5. **Appoint a Deputy Chief Aboriginal and Torres Strait Islander Health Officer:**
The identified position would be a medical officer and provide expertise about clinical and cultural safety for First Nations peoples. The position would work closely with Clinical Excellence Queensland, and together with the Chief Aboriginal and Torres Strait Islander Health Officer and First Nations Clinical Network, ensure the highest standards of clinical and cultural safety in the design and delivery of healthcare for First Nations peoples.

6. **Introduce First Nations special measures for priority consideration and preference selection in public health sector recruitment:**
This proposal aims to increase the recruitment of suitable Aboriginal and Torres Strait Islander applicants by giving priority consideration to First Nations applicants and preferencing applicants in selection if they meet all essential criteria and are deemed suitable at level. Similar recruitment practices are in place in the Northern Territory Public Service and have resulted in improvements in the representation of Aboriginal and Torres Strait Islander peoples in the public service.[32] By building on the existing provisions under the *Anti-Discrimination Act 1991* (Part 5 General exemptions for discrimination), this proposed approach would increase opportunities for First Nations peoples and expand Aboriginal and Torres Strait Islander representation in senior leadership roles across Queensland Health in the medium to long term.

7. **Create a capability pipeline for future First Nations Hospital and Health Service board members:**
A dedicated executive leadership and capability program would be developed for Aboriginal peoples and Torres Strait Islander peoples interested in competing for future Hospital and Health Board positions. The program would provide structured training, mentoring and professional development opportunities about the leadership and governance skills required to participate on HHS governance boards. If this proposal has merit, opportunities to tailor existing Board Director training programs through third-party corporate providers would be explored.

> ***As one of the largest employers in the state, Queensland Health can be a leader in addressing the social determinants of health by increasing employment and economic development opportunities for First Nations peoples by employing gardeners to surgeons, and awarding contracts for caterers to graphic designers. Economic advantage leads to social advantage.***
>
> *Haylene Grogan, Chief Aboriginal and Torres Strait Islander Health Officer, Queensland Department of Health*

THEME 3:

Implementing integrated healthcare models and pathways to improve the patient journey and decrease the demand on hospitals

8. **Establish regional coordination care hubs and integrated care pathways:**
Initial planning has commenced between the Department of Health and the ATSICCHO Sector to design, fund and implement coordination care hubs to support the patient journey between the primary and acute care sectors. These hubs would function as navigation and care coordination centres providing 'at the elbow' support when Aboriginal and Torres Strait Islander patients access care across the care continuum to improve efficiency, reduce duplication and increase the overall effectiveness of the healthcare system. The navigation and coordination hubs would network and interface with all healthcare providers in a region to ensure the patient journey is culturally safe and responsive, and where needed, source additional non-clinical social support. A pilot model is proposed for Cairns to service Far North Queensland and other hubs will be considered depending on the outcomes from the pilot and the capacity and readiness of local healthcare providers in other urban, rural, regional and remote areas.

   These and other types of models to integrate care between the primary and acute care sectors—under the leadership of First Nations peoples—are proposed as a means to reshape healthcare demand and supply by developing alternate care pathways designed *by First Nations peoples for First Nations peoples.*

9. **Establish regional Aboriginal and Torres Strait Islander Community Controlled Health Organisations:**
Additional capacity is required for ATSICCHOs to coordinate and integrate primary healthcare at a regional level by establishing regional networks of primary healthcare and social support providers. This approach has been established in south-east Queensland with the IUIH, a regional Aboriginal and Torres Strait Islander Community-Controlled Health backbone organisation operating across eight local government areas (Brisbane, Gold Coast, Redlands, Moreton Bay, Ipswich, Lockyer Valley, Somerset and the Scenic Rim).

   IUIH was established in 2009 and over the last 12 years, has built an integrated regional health ecosystem—the IUIH *System of Care*—that coordinates and integrates primary and preventative care across five primary health care services and 20 clinics, intersects with the broader public hospital system and addresses the social determinants of health by supporting clients to access other social assistance and wrap-around support through a 'no wrong door approach'.[33] Substantial health gains have been achieved in south-east Queensland, with an independent

review in 2019 finding the IUIH System of Care has achieved significant client outcomes, including improvements in Health Adjusted Life Expectancy (HALE) of 0.4 years, increased service reach from 8,000 regular clients to 35,000, increased access to health assessments from 550 to 21,000, and its performance against the national Key Performance Indicators (nKPI) exceeding the national median of other urban based Aboriginal and Torres Strait Islander Community-Controlled Health Services across Australia.[34]

QAIHC has been advocating for this reform since 2011[35] and any proposal to invest in the establishment of regional Aboriginal and Torres Strait Islander Community-Controlled 'backbone' Health Organisations would be negotiated with QAIHC and the Commonwealth Government as part of potential future reforms under the *National Health Reform Agreement*.

10. **Implement funding incentives to address specific First Nations equity issues:**
The Department of Health has designed various funding instruments in the past to incentivise HHSs and other healthcare providers to strengthen and enhance existing models of care and patient pathways in partnership with ATSICCHOs and other local healthcare providers. Most recently, the Department of Health introduced two Quality Improvement Payments in 2018–19 to reduce smoking and increase access to antenatal care, and meet workforce growth targets. Further consideration will be given to designing and developing other funding incentives aimed to improve healthcare access and address the social and cultural determinants of health.

THEME 4:
Embedding Aboriginal and Torres Strait Islander cultural determinants into patient safety and quality

FIRST NATIONS HEALTH EQUITY DESIGN PRINCIPLES 1,2

11. **Embed cultural capability into the Clinical Services Capability Framework:**
Currently limited reference to cultural capability exists in the Clinical Services Capability Framework (CSCF). Various iterations of the planning documents and guidelines that make up the CSCF have been released since 1994 but limited consideration has been given to the interrelationship between cultural capability (as demonstrated by cultural respect, cultural competency and cultural safety) and clinical capability and outcomes. Any proposed revisions to the CSCF would be led by the First Nations Clinical Network to ensure cultural safety is a key component and embedded within clinical safety.

IDEAS FOR DISCUSSION
NOT GOVERNMENT POLICY

12. **Refresh the Queensland Health *Aboriginal and Torres Strait Islander Cultural Capability Framework:***
Refreshing the policy framework would build on the achievements from the last 10 years by embedding cultural capability—as demonstrated by cultural respect, cultural competency and cultural safety—into standardised patient safety and quality practices across the public health sector. The refreshed framework would respond to the recommendations from the independent 2017 review of the framework[36] and the findings from the 2017 report on institutional racism within the public health sector.[37] The revised cultural capability framework would include a suite of supporting tools and resources for Queensland Health employees to support their cultural capability journey across the continuum from cultural awareness through to cultural competency. This would include understanding the impact of unconscious bias and how a colour-blind approach to healthcare provision can impede health equity rather than enable it.

13. **Undertake annual independent institutional racism assessments across Queensland Health:**
Since the release of the 2017 report into institutional racism in the public health sector[38], a readiness and maturity has grown across the public health system to address the legacy of institutional racism.

Under this proposal, independent annual assessments would be conducted using a revised assessment tool (based on the original matrix used in the 2017 report) to assess progress and identify areas for ongoing improvement. A selection of HHSs, Department of Health divisions and QAS locations would be assessed each year as part of a rolling cycle of assessments across the health system and the findings reported in the biennial Chief Aboriginal and Torres Strait Islander Health Officer report.

14. **Amend birth notifications to acknowledge birth parents' connection to country or language groups:**
Substantial efforts are underway from the Queensland Government to improve birth registration rates for Aboriginal and Torres Strait Islander peoples in Queensland. Currently, many Aboriginal and Torres Strait Islander women from remote areas are unable to give birth on country and travel to regional tertiary hospitals for birthing, resulting in the location of the child's birth reflecting the location of the hospital. The inclusion of language groups and/or country or place of origin of parents on a child's birth certificate would acknowledge the importance of Aboriginal and Torres Strait Islander culture, language and country as a critical foundation for a healthy life.

15. **Strengthen the functions of other health statutory authorities to drive First Nations health equity:**
Queensland Health consists of numerous independent non-departmental government entities (statutory authorities) that support the effectiveness of the public health system in Queensland. Many of these statutory bodies prioritise Aboriginal and Torres Strait Islander health but legislative amendments would strengthen their existing functions to adopt a stronger equity agenda across the health system. Proposed legislative amendments could be considered for the functions and responsibilities of the Queensland Health Ombudsman (*Health Ombudsman Act 2013*), Health and Wellbeing Queensland (*Health and Wellbeing Queensland Act 2019*) and the Queensland Mental Health Commission (*Queensland Mental Health Commission Act 2013*).

THEME 5:

Driving state and national health funding reforms

16. Factor equity into existing Queensland Health funding models:

Substantial investment has been directed towards First Nations health under the three year *Making Tracks* investment strategies since the policy was released in 2010 (over $270 million per three year strategy) but this only represents a small proportion (between 1 to 2 per cent) of a growing annual health budget (ranging from $9 billion in 2010–11 to $21.8 billion in 2020–21). Aboriginal and Torres Strait Islander health leaders across the health system have advocated for a greater proportion of the mainstream (or baseline) funding to be directed towards Aboriginal and Torres Strait Islander services and programs rather than relying solely on Aboriginal and Torres Strait Islander funding sources. A substantial proportion of the triennial *Making Tracks* investment strategies is allocated for ongoing Aboriginal and Torres Strait Islander programs and healthcare services, leaving only a small proportion of unallocated funds for new programs and initiatives every three years.

We need to stop thinking in terms of 'mainstream and Making Tracks' dollars—it's ALL health dollars. Our discussions, our funding models and investment decisions need to focus on using the totality of the health budget to address areas of greatest need. When funding is tight, we need a funding model that helps incentivise care towards those that need it the most.

Nick Steele, Deputy Director-General, Queensland Department of Health

Queensland Health will look to proactively explore and implement changes to its funding models and incentives, and develop funding approaches to ensure a more equitable distribution of total funding, including a focus on First Nations health equity. Australia's healthcare funding arrangements are complex with responsibilities split between the Commonwealth and the States and Territories but general consensus exists that funding arrangements need to reorient more investment upstream to prevent and reduce the demand on hospital-based care, and wherever appropriate and feasible, for healthcare to be delivered in settings closer to home and outside of hospitals. Funding for Aboriginal and Torres Strait Islander health is a shared priority between the Commonwealth and State governments and further reforms are needed to achieve health equity for First Nations peoples across the health sector, including the ATSICCHO Sector.

17. **Utilise the Health Equity Strategies as future health investment plans:**
This proposal would result in the future Health Equity Strategies (as described in Section 2) becoming the basis for future investment plans for each HHS service area using planning data from the Local Area Needs Assessment (LANA) and Queensland Geographic Needs Index (QGNI). Based on the data from LANA and QGNI, the activities in the Health Equity Strategies would be costed and Queensland Health investment tied to their delivery. The merits of this proposal would be considered after the first tranche of Health Equity Strategies have been released by April 2022. This proposal would also include negotiations with the Commonwealth Government to work towards a long-term approach for all State and Commonwealth funding sources being tied to the local priorities in the Health Equity Strategies.

This proposal aligns with the long-term health reforms in the new *National Health Reform Agreement* signed by all Australian governments in May 2020, which encourages States and Territories to trial new funding modes and models of care focused on how different components of the health system interact.[39]

THEME 6:
Addressing the social determinants of health and eliminating racism

18. **Establish pilot 'Marmot city regions' across Queensland:**
'Marmot city regions' is the term used for cities and regions that have applied the research findings from Sir Professor Marmot, the renowned global advocate on the social determinants of health. Based on 40 years of research and leading international and national reviews for the WHO and the UK Government, Professor Marmot advocates that health is dependent on the conditions that enable people to live the lives they would choose to live, with inequalities in health arising from inequalities in society.[40] Marmot city regions involve local and regional authorities implementing six principles in the planning and delivery of services aimed at reducing inequities. Greater Manchester is the first Marmot city region in the United Kingdom that has adopted the recommendations from the Marmot review by gearing all their policies, approaches and resources towards creating a fairer and equal society.[41]

The proposal to establish pilot Marmot city regions would involve negotiating interest from all levels of government (federal, state and local), the ATSICCHO Sector and wider community to implement a social determinants framework using the Marmot city region framework and the priority areas from the *National Agreement on Closing the Gap* (2020). Importantly, the framework would be adapted and contextualised to be a First Nations led model

and incorporate cultural considerations. Early discussions with Professor Marmot have confirmed his interest to support Queensland's First Nations health equity agenda, including sharing his insights about establishing potential Marmot city regions.

19. Set statewide and regional Queensland Health procurement targets to purchase goods and services from Aboriginal and Torres Strait Islander owned and operated businesses:

The Queensland Government has a target to purchase goods and services from Aboriginal and Torres Strait Islander owned and operated businesses to 3% of the value of government procurement contracts by 2022.[42] To strengthen the accountability measures across Queensland Health against the target, under this proposal each HHS and the Department of Health would be required to annually report on the number and value of procurement contracts as part of mandatory reporting requirements, including major projects (above $5 million). Where HHSs are meeting or exceeding the 3% target, annual stretch targets above 3% will be set to progressively increase the number and value of procurement contracts awarded to Aboriginal and Torres Strait Islander owned and operated businesses.

20. Drive an anti-racism strategy across the health system:

Queensland Health's response to the 2017 institutional racism report and the *Queensland Government's Path to Treaty Statement of Commitment* (2020) have demonstrated the commitment and readiness for truth telling and accepting the uncomfortable and discriminatory aspects of our shared history. The delivery of a targeted anti-racism strategy would strengthen the cultural capability and health equity journey by renewing the health system's commitment to eliminating racism, advocating for racial equality and responding effectively when racism occurs. The negative impact of racism on health and wellbeing through implicit and explicit biases, institutional structures and interpersonal relationships is well-known and extensively researched.[43] The strategy would focus on eliminating racism and discrimination at the individual and institutional levels within and across the health system by delivering training, providing support and developing local campaigns to unlearn implicit bias, identify white privilege and address lateral violence. If this proposal is supported, the strategy would be developed in partnership with leading Aboriginal and Torres Strait Islander researchers and practitioners, the Australian Human Rights Commission and other relevant national and global organisations.

Next Steps...

what happens after the discussion paper?

The discussion paper is an important step in the health equity journey. It's a call to action to generate wider discussions, mobilise effort and build collective support across the health system and society more broadly for a renewed and focused agenda centred on First Nations health equity. This agenda aims to:

- **Introduce broader changes and improvements within and across the health system, and**
- **Influence wider changes and improvements to the economic and social conditions in which Aboriginal and Torres Strait Islander peoples live their lives.**

A nine week regional consultation process between March to May 2021 will involve Queensland Health and the ATSICCHO Sector discussing the health equity agenda and seeking other suggestions to drive this agenda forward and improve the social determinants of health.

Written responses to the discussion paper can also be submitted to the following email, online and mailing addresses:

Online Survey:
www.surveymonkey.com/r/health-equity-consultation

Email address:
Health.Equity_Consultation@health.qld.gov.au

Postal address:
Aboriginal and Torres Strait Islander Health Division
Department of Health
GPO Box 48
Brisbane Qld 4001

A public report will be prepared outlining the responses to the public consultation process and a **Health Equity Framework** released in July 2021 to guide the development and implementation of the Health Equity Strategies. Similar to this discussion paper, the **Health Equity Framework** will be co-designed in partnership between Queensland Health, HHSs and QAIHC on behalf of the ATSICCHO Sector.

The ideas generated from the regional engagement and consultation process will be used to inform the First Nations health equity agenda over the next 10 years as Queensland's health system partners with First Nations peoples to achieve health parity by 2031 and improve the social and cultural determinants of health.

Appendices

Appendix 1: Queensland Government policies, strategies and frameworks

The following policies, strategies and frameworks, released over the last five years, demonstrate the Queensland Government's commitment to improving the social determinants of health and wellbeing with First Nations peoples. Many of these policies, strategies and frameworks are centred on working in partnership with Aboriginal peoples and Torres Strait Islander peoples and signal a significant shift in the Queensland Government's approach to designing and implementing policies and services with—and not for—First Nations peoples.

The list is not exhaustive and other Queensland Government policies, strategies and frameworks have been released or are in development:

- *Queensland Government Statement of Commitment and Response to recommendations of the Eminent Panel August 2020*
- *Statement of Commitment to reframe the relationship between Aboriginal and Torres Strait Islander peoples and the Queensland Government* (2019)
- *Working Together, Changing the Story: Youth Justice Strategy 2019–2023*
- *Supporting Families, Changing Futures 2019–2023—The Queensland Government's plan for helping Queensland children, young people, parents and families experiencing vulnerability*
- *A Wellbeing Outcomes Framework for Aboriginal and Torres Strait Islander children and young people in Queensland* (2019)
- *A Better Housing Future: Aboriginal and Torres Strait Islander Housing Action Plan 2019–2023*
- *Shifting minds—Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023*
- *Every Aboriginal and Torres Strait Islander Student Succeeding* (2019)
- *Advancing Aboriginal and Torres Strait Islander education: An action plan for Queensland* (2019)
- *Thriving Communities Thriving Queensland Commitment Statement* (2018)
- *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families 2017–2037*
- *Queensland Indigenous (Aboriginal and Torres Strait Islander) Procurement Policy* (2017)
- *Moving Ahead—a strategic approach to improving the participation of Aboriginal and Torres Strait Islander people in Queensland's economy 2016–2022*

Appendix 2: List of acronyms

ATSICHS Brisbane	Aboriginal and Torres Strait Islander Community Health Service Brisbane
ATSICCHOs	Aboriginal and Torres Strait Islander Community Controlled Health Organisations
CCAR	Courageous Conversations About Race
CHHHS	Cairns and Hinterland Hospital and Health Service
COAG	Council of Australian Governments
CSCF	Clinical Services Capability Framework
GCHHS	Gold Coast Hospital and Health Service
KPI	Key Performance Indicator
HHS	Hospital and Health Service
IUIH	Institute for Urban Indigenous Health
LANA	Local Area Needs Assessment
LTC	Local Thriving Communities
nKPI	National Key Performance Indicators
QAIHC	Queensland Aboriginal and Islander Health Council
QAS	Queensland Ambulance Service
QGNI	Queensland Geographic Needs Index
TAIHS	Townsville Aboriginal and Torres Strait Islander Corporation for Health Services
SCHHS	Sunshine Coast Hospital and Health Service
VET	Vocational education and training
WHO	World Health Organization

Notes and references

[1] Article 1, *International Covenant on Civil and Political Rights (ICCPR)* and Article 1, *International Covenant on Economic, Social and Cultural Rights (ICESCR)*, The United Nations General Assembly, (adopted 1966).

[2] Article 23, *United Nations Declaration on the Rights of Indigenous Peoples*, 2007, The United Nations General Assembly (adopted 2007).

[3] Odette Mazel, *Self-Determination and the Right to Health: Australian Aboriginal Community Controlled Health Services*, Human Rights Law Review, Volume 16, Issue 2, June 2016, Pages 323–355.

[4] Behrendt L, Jorgenson M, Vivian A, *Self-Determination: Background Concepts*, 2005, accessed 26/12/20, https://www2.health.vic.gov.au/about/publications/ResearchAndReports/self-determination-background-concepts

[5] Queensland Aboriginal and Islander Health Council, Queensland Aboriginal and Torres Strait Islander Community Controlled Health Organisations' Model of Care, 2019, p4, https://www.qaihc.com.au/media/37570/modelofcare_19082019_hr.pdf (accessed 26/12/20).

[6] Ibid, p5.

[7] See Southphommasane, D.T, *The many faces of racism*, UNESCO Chair Annual Oration, Alfred Deakin Institute for Citizenship and Globalisation, Deakin University, www.humanrights.gov.au/about/news/speeches/many-faces-racism (accessed 5/01/21); Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2017*; Paradies.Y., Cunningham C., *The DRUID study: racism and self-assessed health status in an indigenous population*, BMC Public Health, 2012.

[8] See Gee G.,Dudgeon P.,Schultz C., Hart A., Kelly K., *Aboriginal and Torres Strait Islander social and emotional wellbeing*, 2014 (in Dudgeon P., Milory H., Walker R., *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing*).

[9] Behrendt L., Jorgenson M., Vivian A., *Self-Determination: Background Concepts*, 2005, (accessed 26/12/20) https://www2.health.vic.gov.au/about/publications/ResearchAndReports/self-determination-background-concepts

[10] O'Sullivan, D, (2012). *Justice, culture and the political determinants of Indigenous Australian health.* Ethnicities, 2011, https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=1070&context=aprci (accessed 26/12/20).

[11] National Aboriginal Community Controlled Health Organisation, https://www.naccho.org.au/about/aboriginal-health-history/definitions (accessed 26/12/20)

[12] Life expectancy at birth is a key metric for measuring population health. Gains in life expectancy at birth can be attributed to a number of factors including rising living standards, improved lifestyles and better education, as well as greater access to quality health services. Refer Organisation for Economic Cooperation and Development (OECD), https://data.oecd.org/health.htm#profile-Health%20status (accessed 26/12/20). Refer to Queensland Health, *Closing the Gap Performance Report 2018*, for the latest data about health status, https://www.health.qld.gov.au/__data/assets/pdf_file/0034/857662/CTG_report_2018v2.pdf (accessed 26/12/20).

[13] The first publication on health equity was released in 1966 but the first cited reference can be traced to the 1800s. See Qiang Yao, Xin Li, Ju Sun, *The historical roots and seminal research on health equity: a referenced publication year spectroscopy (RPYS) analysis*, International Journal for Equity in Health, 18, Article Number: 152 (2019), https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1058-3 (accessed 26/12/20).

[14] World Health Organization, *Closing the Gap in a generation: health equity through action on the social determinants of health*, 2008, www.WHO_IER_CSDH_08.1_eng.pdf (accessed 6/01/21).

[15] Marmot M, *Inclusion health: addressing the causes of the causes*, The Lancet, Volume 391, January 2018 (accessed 23/01/21); https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)32848-9/fulltext

[16] Australian Institute for Health and Wellbeing, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2020* (accessed 9/01/21), https://www.indigenoushpf.gov.au

[17] Marrie, A., *Addressing Institutional Barriers To Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services. Report to Commissioner Kevin Cocks AM, Anti-Discrimination Commission Queensland*, March 2017. https://www.adcq.qld.gov.au/resources/Aboriginal-and-Torres-Strait-Islander/health-equity

[18] Ibid, p13.

[19] Australian Government, *Australian Health Sector Emergency Response plan for novel coronavirus (COVID-19)*, March 2020, www.health.gov.au/resources/publications/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19-short-form (accessed 26/12/20). Emergency provisions in the *Biosecurity Act 2015 (Cth)* restricted access to designated Aboriginal and Torres Strait Islander rural and remote communities in Queensland from 26 March until 12 June 2020 (the end date varied across other states and territories). From 12 June 2020 until 10 July 2020, travel restrictions to designated Aboriginal and Torres Strait Islander rural and remote communities came under the legislative authority of the Queensland Chief Health Officer public health directions.

[20] Many Aboriginal and Torres Strait Islander-led initiatives were undertaken across the country in response to the pandemic. For example, at a national level NACCHO partnered with the Australian Department of Health to form a COVID-19 Aboriginal and Torres Strait Islander Advisory Group in early March 2020 and later released the Management Plan for *Aboriginal and Torres Strait Islander Populations* on 30 March 2020. For more information see: *Parliament of Australia, COVID-19 and Indigenous Australians: a chronology*, July 2020, accessed 26/12/20, https://parlinfo.aph.gov.au/parlInfo/download/library/prspub/7467598/upload_binary/7467598.pdf

[21] For an overview of the impact of colonisation on Aboriginal and Torres Strait Islander peoples see the Queensland Human Rights Commission, *Aboriginal People in Queensland: A brief human rights history*, 2017, https://www.qhrc.qld.gov.au/your-rights/for-aboriginal-and-torres-strait-islander-people/Aboriginal-people-in-Queensland (accessed 26/12/20); *Torres Strait Islander People in Queensland: A brief human rights history*, 2017, https://www.qhrc.qld.gov.au/your-rights/for-aboriginal-and-torres-strait-islander-people/torres-strait-islander-people-in-qld (accessed 26/12/20).

[22] *The Health Legislation Amendment Act 2020* received Royal Assent on 20 August 2020. Subject to Governor-in-Council approval, the amendments contained in the *Health Legislation Amendment Act 2020* to section 40 of the *Hospital and Health Service Board Act 2011* are proposed to commence in April 2021.

[23] McGowan J., Pradeep P., Tiernan A., *Advice on Queensland Health's Governance Framework*, June 2019, accessed 27/12/20, www.health.qld.gov.au/__data/assets/pdf_file/0039/929955/Final_Advice-on-Queensland-Healths-Governance-Framework.pdf

[24] As the Regulation has not yet been made, the Regulation will now be referred to as the Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021 instead of the Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2020.

[25] As the Health Legislation Amendment Bill 2019 was passed in 2020, any reference to the Health Legislation Amendment Bill 2019 or the *Health Legislation Amendment Act 2020* are referring to the same piece of legislation.

[26] Subsidiarity is the principle that authority to decide and act should rest at the closest level possible to the people or organisations the decision or action is designed to serve. A devolved system results in greater local input into decision-making. See the Council for the Australian Federation, https://www.caf.gov.au/subsidiarity.aspx (accessed 27/12/20) and McGowan J., Pradeep P., Tiernan A., *Advice on Queensland Health's Governance Framework*, June 2019, www.health.qld.gov.au/__data/assets/pdf_file/0039/929955/Final_Advice-on-Queensland-Healths-Governance-Framework.pdf (accessed 27/12/20).

[27] Indigenous data sovereignty is a global movement concerned with the right of Indigenous peoples to govern the creation, collection, ownership and application of their data. Aboriginal and Torres Strait Islander data sovereignty refers to First Nations peoples' right to govern and exercise ownership over their data, as expressed through the creation, collection, access, analysis, stewardship, interpretation, management, dissemination and (re)use of their data. Exercising Aboriginal and Torres Strait Islander data governance empowers First Nations peoples to make the best decisions to support their communities and peoples in ways that meet their place-based development needs and aspirations.

[28] A set of common KPIs will be developed for all HHS to report against to allow a statewide snapshot of progress, in addition to tailored KPIs unique for each HHS based on the health needs and priorities in each region.

[29] *Health and Disability System Review—Final Report—Purongo Whakamutunga*, 2020, www.systemreview.health.govt.nz/final-report (accessed 9/01/21)

[30] Unpublished data, Department of Health.

[31] For example, in the Torres and Cape HHS and North West HHS, 18.36% and 8.17% of their workforces respectively are Aboriginal peoples or Torres Strait Islander peoples.

[32] Since its commencement in 2015, the Northern Territory *Aboriginal Employment and Career Development Strategy 2015–20* has resulted in a 2 per cent increase in Aboriginal employment from 8.8 per cent in 2015 to 10.9 per cent in 2019–20. See: Office of Commissioner for Public Employment, *Annual Report 2019–20*.

[33] *Building a regional health ecosystem: a case study of the Institute for Urban Indigenous Health and its System of Care*, Australian Journal of Primary Health, 2019, 25, 424–429.

[34] NOUS, *History and performance: charting the way forward. Independent Review of the Institute for Urban Indigenous Health*, January 2019.

[35] Queensland Aboriginal and Islander Health Council, *A blueprint for Aboriginal and Torres Strait Islander health reform in Queensland*, 2011, https://www.qaihc.com.au/media/1092/qaihcs-blueprint-book-2011-launch.pdf (accessed 10/01/21)

[36] Waratah Partners Lawyers+ Consultants, *Cultural Capability—Indigenous Heath is Everyone's Business. A review of the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033*, 2017.

[37] Marrie, A., *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services*. Report to Commissioner Kevin Cocks AM, Anti-Discrimination Commission Queensland, March 2017. https://www.adcq.qld.gov.au/resources/Aboriginal-and-Torres-Strait-Islander/health-equity

[38] Ibid

[39] Refer Schedule C, *National Health Reform Agreement*, (accessed 6/01/21), www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf

[40] Marmot, M., *Social determinants and the health of Indigenous Australians*, The Medical Journal of Australia, 2011, 194 (10), https://www.mja.com.au/journal/2011/194/10/social-determinants-and-health-indigenous-australians (accessed 6/01/21).

[41] Codling, K., Allen J., *Health Equity in Greater Manchester: The Marmot Review* 2020, (accessed 6/01/21), http://www.instituteofhealthequity.org/resources-reports/greater-manchester-evaluation-2020/greater-manchester-evaluation-2020.pdf

[42] Department of Aboriginal and Torres Strait Islander Partnerships, *Queensland Indigenous (Aboriginal and Torres Strait Islander) Procurement Policy*, 2017.

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