

Making Tracks Together

Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

For Hospital and Health Services, Aboriginal and Torres Strait Islander Community Controlled Health Services and other healthcare providers

October 2021



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Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

Published by the State of Queensland (Queensland Health) and Queensland Aboriginal and Islander Health Council (QAIHC), October 2021



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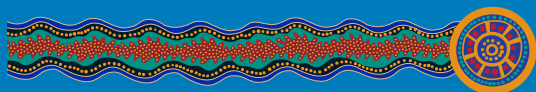
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An electronic version of this document is available at health.qld.gov.au and qaihc.com.au

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Making Tracks artwork produced by Gilimbaa for Queensland Health.



Sharing Knowledge artwork produced by Casey Coolwell for QAIHC.

Acknowledgement of Country

Queensland Health (QH) and the Queensland Aboriginal and Islander Health Council (QAIHC), the peak body representing Aboriginal and Torres Strait Islander Community Controlled Health Organisations 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.

We also acknowledge the more than 500 people who shared their ideas and hopes for a more equitable future for Aboriginal and Torres Strait Islander peoples.

Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework has been guided by the wisdom and expertise of Aboriginal and Torres Strait Islander peoples and partners across the health and wellbeing continuum.

Terminology

Throughout the Framework, the terms 'First Nations peoples' and 'Aboriginal and Torres Strait Islander peoples' are used interchangeably rather than 'Indigenous'. Acknowledging First Nations peoples' right to self-determination, QH and QAIHC respect the choice of Aboriginal and Torres Strait Islander peoples to describe their own cultural identities which may include these or other terms, including particular sovereign peoples (for example Yidinji or Turrbal) or traditional place names (for example, Meanjin Brisbane).

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Message from the Minister for Health and Ambulance Services

The Palaszczuk Government is committed to safeguarding the health of all Queenslanders—throughout the current pandemic and into the future. But this future needs to look very different for our First Nations peoples. The status quo—our current ‘normal’—isn’t the future that Aboriginal peoples or Torres Strait Islanders want. Aboriginal and Torres Strait Islander peoples want a better, just and equitable future where everyone has the potential to live long and healthy lives. And importantly, they want to lead the way towards this new future.



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

We received this message loud and clear from Aboriginal and Torres Strait Islander peoples across the State when we asked what was needed to eradicate institutional racism and drive health equity across the public health system.

Listen to us. Work with us. Journey with us.

Partner with us to create the future we want for our children.

Learn from the past.

Trust us to lead.

And we have done that. In a national and historic first, we have codified the voices of Aboriginal peoples and Torres Strait Islanders into the law that governs Queensland’s public health system. We have created the strongest public health system legislation ever enacted in Queensland by requiring Hospital and Health Services to partner with Aboriginal and Torres Strait Islander peoples and organisations in the design and delivery of local healthcare services.

Making Tracks Together: Queensland’s Aboriginal and Torres Strait Islander Health Equity Framework, co-designed in partnership with the Queensland Aboriginal and Islander Health Council, explains the new legislation governing the public health system. We legislated these new requirements because we want to create the strongest foundation we could to drive health equity, achieve life expectancy parity by 2031 and eliminate institutional racism through a combination of laws, policies and practices.

We still have a long way to go and further improvements are needed across the health system and society more broadly to right the wrongs of our colonial past and reframe our relationship with Aboriginal and Torres Strait Islander Queenslanders based on trust, respect and cultural humility.

The Palaszczuk Government is confident our new Health Equity Strategies—which places First Nations voices at the centre of care—will redesign and reshape our local health systems based on what Aboriginal and Torres Strait Islander peoples need and want to live long and healthy lives.

I look forward to walking beside our First Nations peoples as we create a better, just and equitable future together.

Message from Minister for Seniors and Disability Services and Minister for Aboriginal and Torres Strait Islander Partnerships

The release of Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework is a significant step towards providing Aboriginal and Torres Strait Islander Queenslanders a say and a choice in the health care they want and need.

The Framework will guide how we work in true partnership with First Nations Queenslanders to improve health and wellbeing outcomes going forward.

The co-design of the Framework in partnership with the Queensland Aboriginal and Islander Health Council recognises that a shift in how we develop and implement government policies and programs is required to significantly improve the lives of Aboriginal and Torres Strait Islander Queenslanders. It reflects our commitment under the National Agreement on Closing the Gap to work in genuine, formal partnership with Aboriginal and Torres Strait Islander peoples.

Through the Queensland Government's Path to Treaty work, we are also listening to the voices of people from all walks of life to create a more inclusive and just future for all Aboriginal and Torres Strait Islander Queenslanders and non-Indigenous Queenslanders.

This means facing the true history of our State, which dates back more than 60,000 years.

The Health Equity Framework strongly aligns with this vital work and with our Local Thriving Communities reform to build on local decision making and transform the way government connects with community.

I congratulate Queensland Health and the Queensland Aboriginal and Islander Health Council on the co-development of the framework.

This is an important landmark commitment that addresses health inequity between First Nation Queenslanders and non-Indigenous Queenslanders on our pathway to a new future.



The Honourable Craig Crawford MP
Minister for Seniors and Disability Services and Minister for Aboriginal and Torres Strait Islander Partnerships

Message from the Chair and Chief Executive Officer, QAIHC

Health Equity is bringing a vision from the 1980s held by our Aboriginal and Torres Strait Islander leaders, to life.

It is fulfilling the commitment that past health leaders made to their communities about having a voice to say what they need, to improve their health.

Health Equity is also about me being able to deliver on my promise to my mother, to my wife and daughters, to my grandchildren, to my grandparents, to my Uncles, to my Aunties, to my nieces, my families and my community.

With this commitment is the realisation that we can only achieve this by working together and by connecting health and social determinants.

While there are inequities when compared to non-Indigenous Queenslanders, there are also inequities amongst Aboriginal and Torres Strait Islander people that must be addressed. Everyone has the right to have access to health care that services their specific needs, when and where they need it; regardless of who they are, where they live or who they know.

Health system reform is essential to creating a system that meets the needs of the most disadvantaged parts of our communities. The reform must be co-designed, empowering the right of self-determination amongst Aboriginal and Torres Strait Islander people.

We want to see all parts of the health system working together.

If the reformed health system is able to improve the health of Aboriginal and Torres Strait Islander people, then it should be able to also meet the needs of all Queenslanders.

It will be hard and we won't always agree, but if there is a shared commitment to making a difference, then unachievable things can be achieved.



Matthew Cooke,
*Chairperson, Queensland
Aboriginal and Islander
Health Council*



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

Message from the Director-General and Chief Aboriginal and Torres Strait Islander Health Officer

The vision that guides us every day is creating a world class health system for all Queenslanders.

With over 5 million Queenslanders from different cultural, social, economic, demographic and geographical backgrounds, our challenge is delivering equitable, culturally safe and clinically effective care that genuinely responds to patient's needs. 'Patient centred care' is easy to write and say but not so easy to achieve in practice.

Our current health equity reform agenda is to ensure all Queenslanders have an opportunity to attain their full health potential and no-one is disadvantaged from achieving this potential. This means creating an agile and responsive health system that recognises that different people with different levels of advantage require different approaches and resources to achieve equitable health outcomes.

Importantly, for our First Nations peoples—the Aboriginal and Torres Strait Islander peoples and nations who have lived on these lands for millennia—we have additional responsibilities as a health system and a country. When we say 'First Nations first' it means we must reshape the health system and get it working for Aboriginal and Torres Strait Islander peoples. If we can do this, we will establish the right systems, processes and practices for all groups of people who currently experience health inequities. 'First Nations first' also acknowledges the unique rights and cultural authority of Aboriginal and Torres Strait Islander peoples as the Traditional and Cultural Custodians of our lands and seas, and the responsibility we all share to eliminate avoidable, unjust and remediable health differences.

Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework is the next stage of our journey to create an integrated health system in Queensland that **sees** more First Nations peoples employed across the system, **listens** to First Nations voices in the system, and **supports** a better integrated and coordinated system for First Nations peoples.



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



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*



Introduction and context

Introduction and context

Making Tracks Together

Queensland's Aboriginal and Torres Strait Islander Health Equity Framework

Making Tracks Together outlines the strategic framework to drive health equity, eliminate institutional racism across the public health system and achieve life expectancy parity for First Nations peoples by 2031.

It details the policy settings and strategic directions for Hospital and Health Services (HHSs) to develop and

implement new Health Equity Strategies as required by the recent amendments to the *Hospital and Health Boards Act 2011* and the *Hospital and Health Boards Regulation 2012*.

An accompanying First Nations Health Equity Toolkit has also been prepared to provide operational guidance for HHSs to develop and implement the Health Equity Strategies.

The aim of the First Nations health equity reform agenda is to galvanise a renewed and shared agenda to improve Aboriginal peoples' and Torres Strait Islander peoples' health outcomes, experiences, and access to care across the health system.

This agenda builds on the foundations of the past to reshape the health system by placing 'health equity' and Aboriginal and Torres Strait Islander voices at the centre.

The success of this new approach is dependent on representation, leadership and shared decision-making with Aboriginal peoples and Torres Strait Islander peoples.

It will only succeed by listening to and respecting the voices, lived experiences and cultural authority of Aboriginal and Torres Strait Islander peoples.

Our health, our way

Caring for self, kin, community and country is core to Aboriginal and Torres Strait Islander knowing, being and belonging. Good health and wellbeing are built upon deep and enduring social, emotional, and cultural connections between self and the whole community.

Having good health from before conception and throughout the life course is paramount to enable Aboriginal and Torres Strait Islander peoples to thrive and fulfil their role in caring for country and community.

We know that society as a whole—and not the health system alone—creates the foundations for good health.¹ Health inequities arise because of inequities in the conditions of daily life (such as housing, education and employment).

The health system plays a pivotal role in addressing health inequities, however, every segment of society underpins health through the economic and social conditions in which people grow, live, work, and age.



Image source: Health-Equity-Framework-launch-document_FINAL.pdf (ourhealthhb.nz)

1. Australian Institute for Health and Wellbeing, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2020* (accessed February 2021), <https://www.indigenoushpf.gov.au>

Our guiding principles

- ✓ Partnerships
- ✓ Cultural respect
- ✓ Aboriginal and Torres Strait Islander health is everyone's business
- ✓ Aboriginal and Torres Strait Islander community control of primary health care
- ✓ Evidence-based and accountable
- ✓ Community engagement and participation in decision-making.

Making Tracks towards achieving First Nations health equity—Interim Investment Strategy 2021–2022

Introduction and context

What does success look like?

Our overarching targets

- ✓ **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 affordable 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
- ✓ **People enjoy high levels of social and emotional wellbeing**
- ✓ People maintain distinctive relationships with their land and waters
- ✓ Cultures and languages are strong
- ✓ People have access to information and services to make informed decisions about their own lives

No individual socio-economic target exists in isolation when considering the Aboriginal and Torres Strait Islander holistic concept of health. However, three specific health targets have been included in the National Agreement on Closing the Gap (2020):

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

National Agreement on Closing the Gap (2020)

Where are we now?

The health status of Aboriginal and Torres Strait Islander Queenslanders—2021



In 2019, **4.6% of Queensland's population identified as Aboriginal and/or Torres Strait Islander**. By 2031, the **First Nations population is projected to grow to over 300,000 people** with the greatest growth in the Brisbane region.^{1,9}

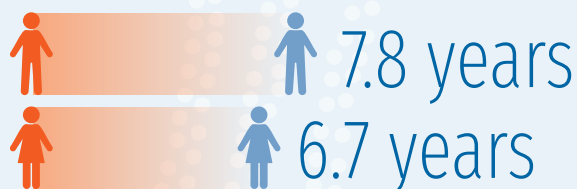


Aboriginal and Torres Strait Islander peoples could potentially **gain 5.6 years of healthy life** if cardiovascular burden (3.1 years) and diabetes burden (2.5 years) were experienced at the same rate as the total Queensland population.⁵

54% of Aboriginal and Torres Strait Islander Queenslanders were **under the age of 25** in 2019.¹

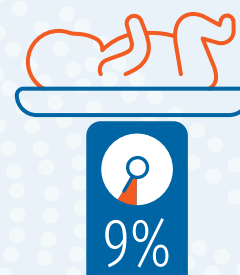


Health adjusted life expectancy (years)



Between 2015–2017, the **gap in life expectancy** was 7.8 years for males and 6.7 years for women.²

In 2019–20, **more than 9%** of Aboriginal and Torres Strait Islander **babies were born with a low birth weight**, placing them at greater risk of perinatal mortality, ill-health in childhood and chronic disease as adults.⁴



58% of Aboriginal and Torres Strait Islander peoples **lived in inner regional and major cities** in 2019.¹



Between 2014–2018, the highest rate of **suicide** was experienced by Aboriginal and Torres Strait Islander peoples **aged between 25 to 34 (44.4 per 100,000)**—**2.4 times** higher than other Queenslanders of the same age (18.0 per 100,000).³



¹ Source: ABS Catalogue No. 3235.0 - Regional Population by Age and Sex, Australia

² Source: ABS, Life Tables for Aboriginal and Torres Strait Islander Australians, 2015–2017, Cat. No. 3302.0.55.003

³ Source: ABS (unpublished) Causes of Death, Australia, Cat. No. 3303.0

⁴ Source: Perinatal Data Collection

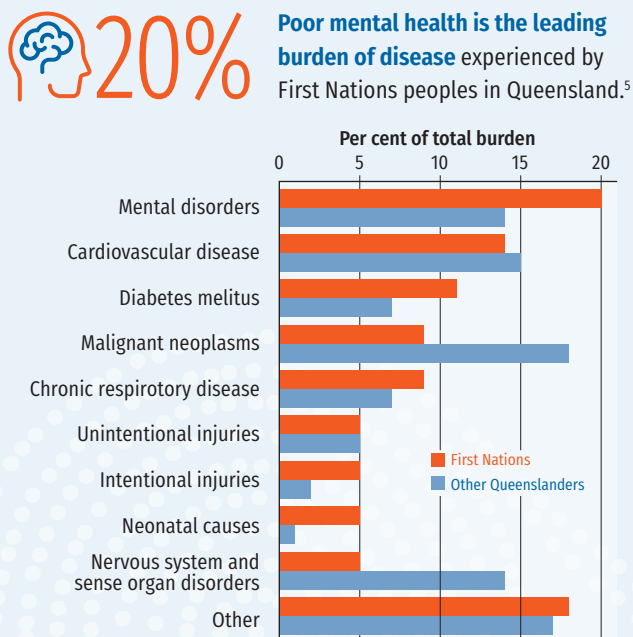
⁵ Source: The burden of disease and injury in Queensland's Aboriginal and Torres Strait Islander people 2017 (reference year 2011)

⁹ Source: ABS Census of Population and Housing, 2016

Introduction and context

Where are we now?

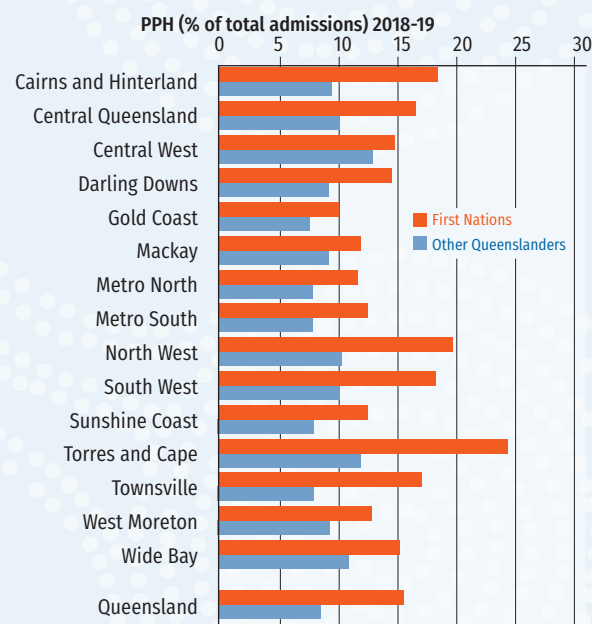
The health status of Aboriginal and Torres Strait Islander Queenslanders—2021



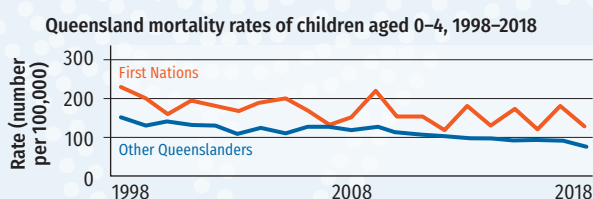
In 2019–20, Aboriginal and Torres Strait Islander peoples accounted for **6.1% of the total hospitalisations** (all Queensland hospitals). **More than a third (37.7%) of hospitalisations were for diseases and disorders of the kidney and urinary tract.**⁷



Aboriginal and Torres Strait Islander peoples experience **greater numbers of potentially preventable hospitalisations** when compared to other Queenslanders.⁸



Mortality rates of Aboriginal and Torres Strait Islander children has decreased from 228 to 128 per 100,000 but a gap still remains.¹⁰



As at June 2021, **2.15% of Queensland Health employees** (headcount) identified as **Aboriginal and/or Torres Strait Islander** people. 2021–2022 stretch target is 3.5%.⁶

There are **21 First Nations Board members** across the 16 Hospital and Health Services—this equates to **15.2%** of total membership. Torres and Cape Hospital and Health Service Board has the first (and only) First Nations chairperson.

⁶ Source: SPR HR dashboard, July 2021

⁷ Source: Queensland Hospitals Admitted Patient Data Collection (QHAPDC)

⁸ Source: The health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Brisbane 2020.

¹⁰ Source: Australian Institute of Health and Welfare 2020. Aboriginal and Torres Strait Islander Health Performance Framework 2020 key health indicators—Queensland. Cat. no. IHPF 6. Canberra: AIHW

Where are we going? Our Future

Building a world class, safe and equitable health system with Aboriginal and Torres Strait Islander Queenslanders

In 2021, Aboriginal and Torres Strait Islander peoples continue to experience disparities and inequities accessing health services, their experiences with health and wellbeing services, and their overall health outcomes.

This can and must change, and all partners in the health care system have an important role to play. The public health system is committed to ***Making Tracks Together***

and achieving health equity because health differences between groups of people are **avoidable, unfair, and remediable.**

The Aboriginal and Torres Strait Islander health equity reform agenda adopts a **social justice and human rights-based approach** to health and healthcare access by redesigning the health system to deliver care based on what First Nations peoples need to attain their full health potential.

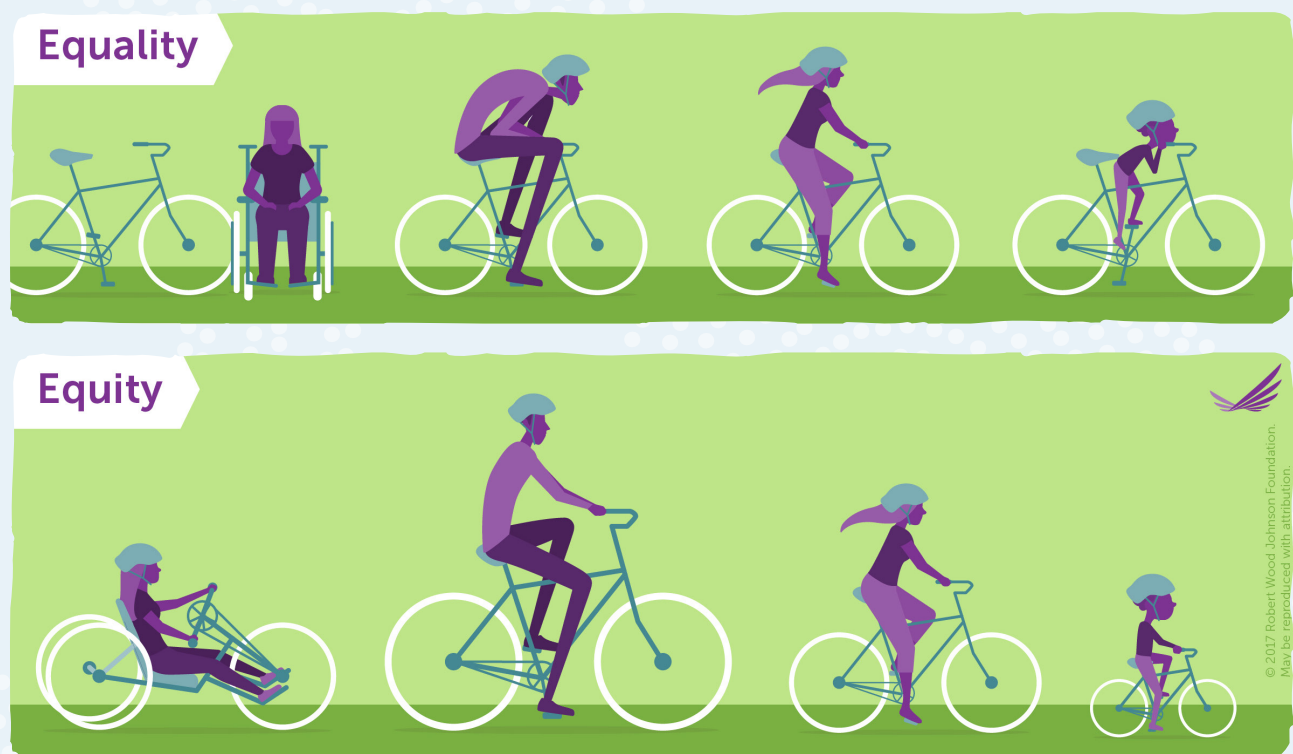


Image source: Robert John Wood Foundation

Introduction and context

Where have we come from? Our Past

Building on what works

Queensland's health system has a long history of supporting First Nations peoples achieve their health aspirations. Throughout this journey, there have been extensive learnings that have shaped the policies, programs and practices being implemented across our health system today.

We have journeyed through the design and implementation of the 1989 *National Aboriginal Health Strategy*, Queensland Health's *Aboriginal and Torres Strait Islander health policy* in 1994 and the 2010 *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033 Policy and Accountability Framework*. Our priorities have been:

- ✓ Providing culturally safe pregnancy, maternal and child health care during the first 2000 days
- ✓ Establishing foundations for good health in children and young people
- ✓ Supporting healthy homes and healthy environments
- ✓ Preventing illness and living a healthy active lifestyle by:
 - reducing rates of smoking
 - reducing obesity
 - increasing engagement in sport and exercise
 - supporting people to address alcohol and other drug use
- ✓ Coordinating care to address chronic disease including:
 - cancer
 - cardiovascular disease
 - respiratory disease
 - diabetes and kidney care
- ✓ Supporting good mental health and wellbeing, and reducing suicide.

During this time, Queensland has seen the emergence of a strong and well-connected Aboriginal and Torres Strait Islander community controlled health sector who have been at the forefront of responding to the essential health and wellbeing needs of our communities. 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 peoples, by our peoples.

Because Aboriginal and Torres Strait Islander cultural and community values dictate the delivery of care, healthcare services and practices are culturally safe 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.

Our public health system, alongside private healthcare providers, have also undertaken a journey over the last 30 years to better respond to the needs, interests and health aspirations of First Nations peoples. Since the release of the first Queensland Health policy in 1994, increased investment, effort and leadership has been directed towards embedding culturally safe practices across the health system, removing barriers to accessibility, growing the Aboriginal and Torres Strait Islander health workforce and listening to the voices of consumers and community members.

A framework for our new Health Equity Strategies



A framework for our new Health Equity Strategies

Leaning toward the future, what's next...

Structures, systems and strategies for long term success

We have learned that we must establish the structural enablers for long term success.

The Queensland Government has heard from Aboriginal and Torres Strait Islander peoples, communities and organisations about what is required to amplify efforts to achieve health equity and close the life expectancy gap by 2031.

Over the last 12 months, the Queensland Government has passed legislation that has substantively changed the legal framework guiding the public health system in Queensland. It prioritises First Nations health equity and mandates the participation of Aboriginal and Torres Strait Islander peoples in the design, delivery, monitoring and review of healthcare services.

Guiding principles in the *Hospital and Health Boards Act 2011* include a commitment to achieving health equity for Aboriginal peoples and Torres Strait Islander peoples, and a commitment to the delivery of responsive capable and culturally competent health care.

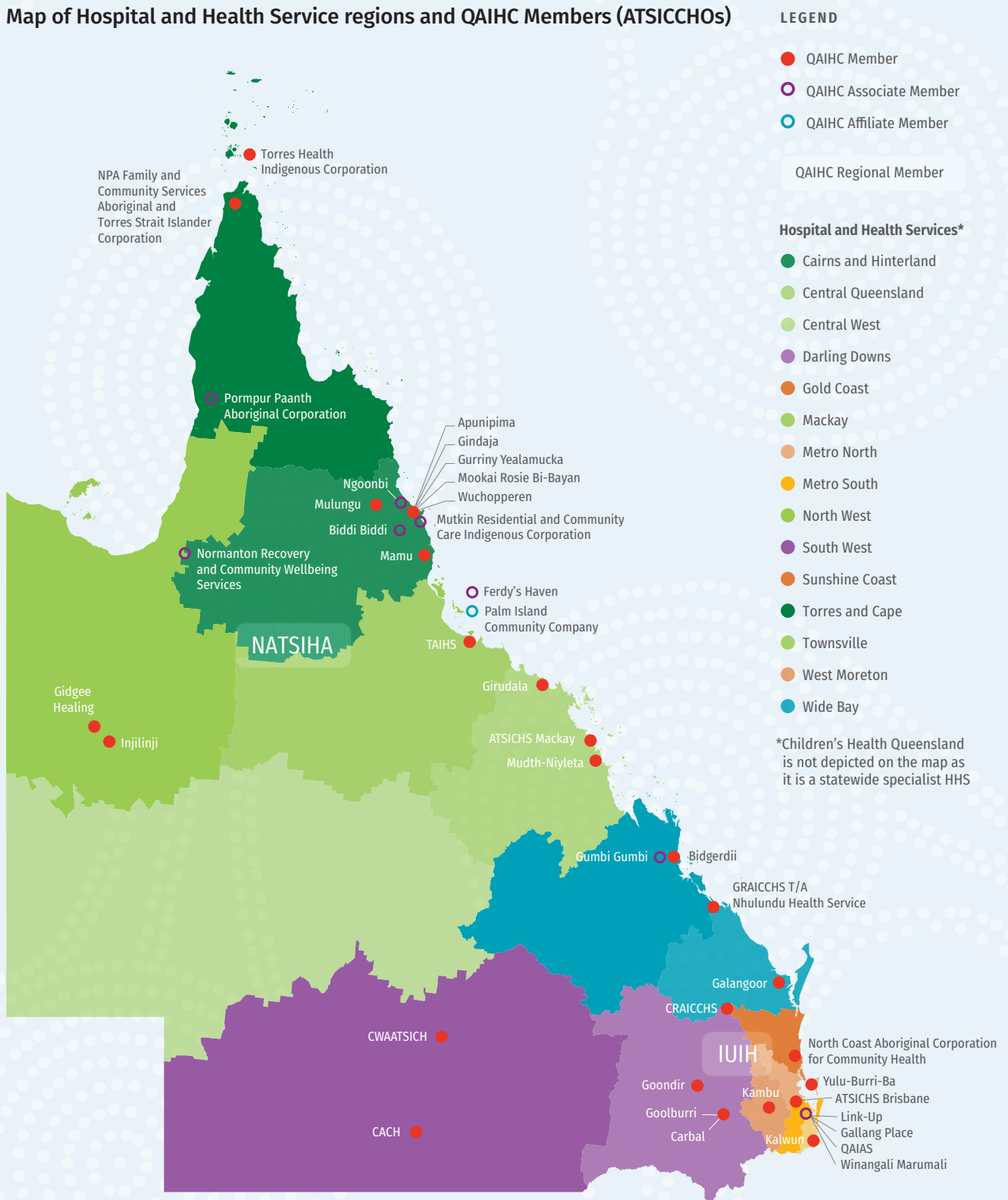
The *Hospital and Health Boards Act 2011* requires each HHS to:

- ✓ ensure Aboriginal and Torres Strait Islander peoples represent one or more of the members of a Hospital and Health Service Board
- ✓ develop and publish a strategy to achieve, and to specify the Service's activities to achieve, health equity for Aboriginal and Torres Strait Islander peoples in the provision of the health services by the Service.

On 30 April 2021, the *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021* changed the *Hospital and Health Boards Regulation 2012* to specify the minimum requirements each Hospital and Health Service must adhere to during the development and implementation of their Health Equity Strategy, including prescribed stakeholders, key priority areas and actions to achieve health equity.

The development of the *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021* was co-designed between Queensland Health and QAIHC. It was guided by the collective wisdom of a multi-sectoral leadership group who worked together to shape the legislative architecture to drive long-term reform.

Map of Hospital and Health Service regions and QAIHC Members (ATSICCHOs)



A framework for our new Health Equity Strategies

Key elements of our new Health Equity Strategies

From 2022, each of the 16 HHSs in Queensland will have a Health Equity Strategy.



They will enable communities to develop local solutions to local issues in the context of local service systems. Health Equity Strategies will focus on addressing the structural and systemic inequities, and enable provision of culturally safe and accessible health services.

Health Equity Strategies will be co-designed, co-owned and co-implemented between Aboriginal and Torres Strait Islander peoples, key organisations and HHSs.

They will set out the activities and key performance indicators to improve First Nations health and wellbeing outcomes by:

- ✓ actively eliminating racial discrimination and institutional racism within the Service
- ✓ increasing access to healthcare services
- ✓ influencing the social, cultural and economic determinants of health
- ✓ delivering sustainable, culturally safe and responsive healthcare services
- ✓ working with First Nations peoples, communities and organisations to design, deliver, monitor and review health services.

The voices, lived experiences and cultural authority of Aboriginal and Torres Strait Islander peoples are integral to the co-design, co-ownership and co-implementation of the Health Equity Strategies.

The Health Equity Strategies will support progress towards the broader Closing the Gap targets agreed in the *National Agreement on Closing the Gap (2020)*, which stretch across the social, cultural and economic determinants of health. Actions taken across these broader targets will also have a positive influence on health outcomes.

Health Equity Strategies must be delivered in accordance with the principles of the *Statement of Commitment to reframe the relationship between Aboriginal and Torres Strait Islander peoples and the Queensland Government (2019)*:

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



First Nations Health Equity Strategies—at a glance

DEVELOPMENT STAKEHOLDERS

First Nations *staff members*
 First Nations *health consumers*
 First Nations *community members*
 Traditional custodians/owners and native title holders in the service area

IMPLEMENTATION STAKEHOLDERS

Health and Wellbeing Queensland
 The Chief Aboriginal and Torres Strait Islander Health Officer (CATSIHO)
 Queensland Aboriginal and Islander Health Council (QAIHC)



SERVICE DELIVERY STAKEHOLDERS

Aboriginal and Torres Strait Islander community-controlled health organisations (ATSICCHOs) in the service area
 Local primary healthcare organisations (including Primary Health Networks – PHNs)

✓ State the KPIs agreed with the CATSIHO&DDG to improve First Nations health and wellbeing outcomes, including:

- actively eliminating racial discrimination and institutional racism within the Service
- increasing access to healthcare services
- influencing the social, cultural, and economic determinants of health
- delivering sustainable, culturally safe and responsive healthcare services
- working with Aboriginal and Torres Strait Islander peoples, communities and organisations to design, deliver, monitor, and review health services.

✓ Set out the actions the HHSs will take to:

- Achieve the KPIs, including through Partnership Arrangements with Service Delivery stakeholders
- Work with Implementation stakeholders for greater collaboration, shared ownership, and decision-making
- Improve integration of health service delivery with Service Delivery stakeholders
- Provide inclusive mechanisms for First Nations peoples of all needs and abilities to provide feedback to the Service
- Increase First Nations workforce representation to levels commensurate with local population across all levels and employment streams.

✓ State how the Strategy aligns with:

- strategic and operational objectives of the Service
- other policies, guidelines or directives made by or applying to the Service (e.g. Consumer and Community Engagement Strategy)
- Health Equity Strategies of other HHSs
- other national, state and local government policies, agreements and standards relevant to promoting shared decision-making, shared ownership and working in partnership with First Nations peoples.

A framework for our new Health Equity Strategies

What are the five Health Equity Strategy priority areas?

Actively eliminate racial discrimination and institutional racism within the Service

Racial discrimination and institutional racism are well-documented structural determinants of Aboriginal and Torres Strait Islander health inequity,² with a growing body of evidence showing strong associations between self-reported racism and poor health outcomes across minority groups worldwide.³ Racial discrimination and institutional racism result in poorer self-reported health status, disengagement in health care, a reduction in patient experience and outcomes, mistrust of providers; and individual, family and community wide avoidance of health care. Substantial under-reporting also exists because health consumers are concerned about the potential negative impacts it could have on the quality of care they receive.

There are four levels of racism: internalised racism (rests within individuals), interpersonal racism (occurs between individuals), institutional racism (occurs within institutions and systems of power), and structural racism (among institutions and across society).

In the health system, institutional racism is evident in the 'one size fits all' approach to service delivery that does not meet the requirements, requests or unique needs of Aboriginal and Torres Strait Islander patients and communities. It can also be reflected in funding decisions, governance structures, healthcare models and clinical practices that fail to acknowledge the cultural needs of Aboriginal and Torres Strait Islander peoples. Racial discrimination can contribute towards fatalities with some coronial inquiries about Aboriginal or Torres Strait Islander deaths in care reporting inadequate, biased or racist care.

“Institutional racism refers to the ways in which racist beliefs, attitudes or values have arisen within, or are built into the operations and/or policies of an institution in such a way that discriminates against, controls or oppresses, directly or indirectly, a certain group to limit their rights; causing and/or contributing to inherited disadvantage”.

Explanatory notes; Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021

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2. See, for example, Paradies, Y., Harris, R & Anderson, I. (2008). *The impact of racism on Indigenous health in Australia and Aotearoa: towards a research agenda.* (Discussion Paper No. 4) Darwin: Cooperative Research Centre for Aboriginal Health; Dixon, J. & Welch, N. (2000). Researching the rural-metropolitan health differential using the 'social determinants of health'. *Australian Journal of Rural Health*; 8(5):254-260.
 3. See, for example, Paradies, Y. Colonisation, racism and indigenous health. *J. Popul. Res.* 2016, 33, 83–96. Durey, A.; Thompson, S.C. Reducing the health disparities of Indigenous Australians: Time to change focus. *BMC Health Serv. Res.* 2012, 12, 151; Ford, C.L.; Airhihenbuwa, C.O. Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis. *Am. J. Public Health* 2010, 100, S30–S35; Awofeso, N. (2011). Racism: a major impediment to optimal Indigenous health and health care in Australia. *Australian Indigenous Health Bulletin*, vol. 11, no. 3; Paradies, Y., Harris, R & Anderson, I. (2008). *The impact of racism on Indigenous health in Australia and Aotearoa: towards a research agenda.* (Discussion Paper No. 4) Darwin: Cooperative Research Centre for Aboriginal Health.

Some examples of actions needed to eliminate racial discrimination and institutional racism within the health system are:

- ✓ Identify the needs and interests of Aboriginal and Torres Strait Islander peoples in health service assessment, system design and strategic planning, ensuring visibility in decision-making.
- ✓ Review existing policies, procedures and practices to identify and address racial discrimination or institutional racism.
- ✓ Adopt a zero-tolerance workplace culture to address racism.
- ✓ Develop resources for patients and health consumers to understand their rights if they experience racism and what they can do.
- ✓ Call out racist assumptions and profiling as and when it occurs across the health system.
- ✓ Improve strategies to recruit, retain, and provide career progression for Aboriginal and Torres Strait Islander staff at all workforce levels in HHSs.
- ✓ Increase the representation of Aboriginal and Torres Strait Islander peoples in leadership positions and across all clinical streams.
- ✓ Undertake surveys and use other mechanisms to listen to Aboriginal and Torres Strait Islander patients and workforces to identify and address instances of racial discrimination or institutional racism that may be occurring.
- ✓ Encourage patient feedback and increase access to culturally safe complaints mechanisms.
- ✓ Train, assess and mandate regular anti-racism, unconscious bias and equity training for all staff.
- ✓ Encourage 'courageous conversations' within HHSs about racism and cultural capability.
- ✓ Undertake regular organisational assessments (both self assessments and independent) against the Marrie Institutional Racism Matrix.
- ✓ Encourage truth-telling about the historical and contemporary injustices and inequities

experienced by Aboriginal and Torres Strait Islander peoples accessing care across the healthcare system.

- ✓ Employ cultural or community advocates to support Aboriginal and Torres Strait Islander consumers and patients who experience racism when accessing care, and Aboriginal and Torres Strait Islander workforces delivering care.

Obligations under the *Anti-Discrimination Act 1991* and the *Human Rights Act 2019*

As public entities, HHSs and their employees must act and make decisions in a way that is compatible with human rights and give proper consideration to human rights when making decisions. Relevant rights include rights to equality (including a person's race), privacy, cultural rights of Aboriginal and Torres Strait Islander peoples and access to health services.

The *Anti-Discrimination Act 1991* makes unfair discrimination, sexual harassment, vilification and victimisation unlawful in Queensland, including in work, administering state laws and programs, and in providing goods and services. Discrimination based on race can be direct or indirect. Direct discrimination means treating someone less favourably because of their race than someone else of a different race in similar circumstances. Indirect discrimination happens when there is an unreasonable requirement that people with a certain attribute (or characteristic) would have difficulty complying with, compared to others without the attribute. A person's race includes their colour, descent or ancestry, ethnicity or ethnic origin, and nationality or national origin.

More information about the obligations of HHSs is available from the Queensland Human Rights Commission.

A framework for our new Health Equity Strategies

Increasing access to healthcare services

Aboriginal and Torres Strait Islander peoples continue to be disproportionately represented in access to health services compared to other Australians. This may be for a range of reasons including: experiences of racism within healthcare settings (including beliefs or perceptions of implicit bias or unconscious bias from health practitioners), access barriers relating to cost for service provision, a lack of culturally respectful and culturally competent health services, difficulty in navigating systems, and lack of transport and distance to services.⁴

Some examples of actions needed to increase access to healthcare services include:

- ✓ Improve co-ordinated care and active efforts by HHSs and primary health care providers to ensure health consumers and patients remain engaged, including while waiting for specialist care or elective surgery.
- ✓ Create individual case management and integrated care plans (including care pathways) for all Aboriginal and Torres Strait Islander health consumers and patients.
- ✓ Establish culturally safe and welcoming places throughout HHSs and provide people with information about additional support services provided by the various multidisciplinary teams and other mechanisms including care coordination services delivered by local Aboriginal and Torres Strait Islander Community Controlled organisations.
- ✓ Undertake research and consultation to elicit views on local barriers to service access and engagement, where access is having a significant impact on health outcomes.
- ✓ Engage Aboriginal and Torres Strait Islander consumers and workforces on organisational quality improvement processes, including clinical and corporate governance.
- ✓ Increase the delivery of innovative models of care that provide care closer to home or in partnership with local Aboriginal and Torres Strait Islander health organisations, including brokerage models and increasing the use of telehealth and digital health.
- ✓ Improve communication with health consumers and patients by using language and terminology that community understand.
- ✓ Design cultural models to care to meet community needs across each stage of life by adopting a lifecourse approach including more in-reach and outreach services.
- ✓ Ensure Aboriginal and Torres Strait Islander people have choice in accessing healthcare services they need and want.
- ✓ Implement targeted strategies for hard-to-reach groups in the community.
- ✓ Ensure transport and accommodation assistance, and cultural support, is available and offered to all patients travelling off country for care.
- ✓ Improve quality data collection on patient engagement and follow-up services delivered by Aboriginal and Torres Strait Islander Health Practitioners, Health Workers and Hospital and Community Liaison Officers.
- ✓ Leverage digital technologies to enable new models of care closer to home and community, support information sharing across the healthcare ecosystem, and improve data collection.

4. See, for example: Australian Institute of Health and Welfare (2020). *Aboriginal and Torres Strait Islander Health Performance Framework – Summary report 2020*. Australian Government: National Indigenous Australians Agency, Canberra; State Coroner's Court of New South Wales, Inquest into the Death of Naomi Williams. State Coroner's Court of New South Wales, Lidcombe, NSW. Available online: <https://coroners.nsw.gov.au/documents/findings/2019/Naomi%20Williams%20findings.pdf> (accessed April 2021).

Influencing the social, cultural and economic determinants of health

The Australian Institute of Health and Welfare (AIHW) reports more than 53 per cent of the health gap is linked to the social determinants of health.⁵ We must consider the context of colonisation and former policies and practices that resulted in enduring intergenerational trauma. Aboriginal and Torres Strait Islander health equity is a matter of not just human rights but of social, distributive, and restorative justice.

In spite of this 'weight of history', what has and continues to serve Aboriginal peoples and Torres Strait Islander peoples as protective factors and significant sources of strength and support, are the cultural determinants of health. This includes connection to land, cultural expression, self-determination, spirituality, ancestry, family and community.⁶

Embedding the cultural determinants approach into public health policy will re-balance the structural inequities by empowering Aboriginal and Torres Strait Islander communities, organisations, and voices throughout the entire policy-making and implementation process by clearly mapping out the opportunities for First Nations: partnership (and partnering), collaboration, empowerment and self-determination.

As one of the largest employers in the Queensland Public Service and the state, there is a lot the public health system can do to address the economic determinants of health by increasing local First Nations employment and procurement of goods and services from Aboriginal and Torres Strait Islander owned businesses. Growing the size, capacity, and capability of the Aboriginal and Torres Strait Islander health workforce will improve cultural safety and address the social and economic determinants of health. Building on the current 3 per cent Queensland

Health Aboriginal and Torres Strait Islander workforce target set in 2016 (and the 3.5% stretch target for the 2021-22 financial year), the new provisions in the *Hospital and Health Boards Regulation 2012* require HHSs to increase Aboriginal and Torres Strait Islander workforce representation across all classifications and employment streams, at rates commensurate to the local Aboriginal and Torres Strait Islander population.

Some examples of actions needed to address the multiple determinants of health include:

-  Identify linkages and establish partnerships across the healthcare and broader social systems (which includes other health services and healthcare providers, government agencies, as well as non-government and corporate organisations) with a view to developing regional responses to addressing critical determinants of health such as education, housing and employment.
-  Prioritise the recruitment of local First Nations peoples, procurement of Aboriginal and Torres Strait Islander owned businesses, and (where unavailable) procurement of goods and services that provide quality employment opportunities for local First Nations peoples.
-  Invest in local 'grow your own' workforce development pipelines to increase First Nations workforces in both the health and social services sectors.
-  Increase the Aboriginal and Torres Strait Islander workforce across all classifications and clinical streams through localised health workforce plans.
-  Influence workforce investment across Queensland health sectors and strengthen workforce planning capability.

5. AIHW (2020) Social determinants and Indigenous health - Australian Institute of Health and Welfare (aihw.gov.au)

6. Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. (2009). Living on the edge: social and emotional wellbeing and risk and protective factors for serious psychological distress among Aboriginal and Torres Strait Islander People, Discussion Paper No. 10. Cooperative Research Centre for Aboriginal Health: Darwin.

A framework for our new Health Equity strategies

Delivering sustainable, culturally safe and responsive healthcare services

Delivering a First Nations health equity reform agenda requires a strong focus on the delivery of sustainable services where they are needed most.

Since commencement in 2010, approximately \$800 million has been invested toward targeted initiatives to improve health outcomes under *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033: Policy and Accountability Framework*.

Through a whole of system investment and collective effort to improve outcomes, Queensland Health has learnt from effective Aboriginal and Torres Strait Islander led models of care that have proven to be responsive to the unique issues and differential experiences faced by Aboriginal peoples or Torres Strait Islander peoples who are consumers of healthcare services. And in many cases, ATSI CCHOs or other healthcare providers may be better positioned to deliver services and programs in more accessible and culturally safe settings closer to where people live rather than HHSs.

“Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive healthcare...”

Australian Health Practitioners Regulation Agency

Some examples of actions needed to deliver sustainable, culturally safe, and responsive healthcare services:

- ✓ Prioritise First Nations health equity in HHS strategic and operational plans.
- ✓ Use accreditation standards to embed culturally safe care into business as usual and standardised practice.
- ✓ Increase the number of staff who have undertaken cultural capability training and anti-racism training, particularly frontline staff.
- ✓ Supplement existing registration and credentialing requirements with mandatory HHS cultural capability and anti-racism training (for example, as part of Continuing Professional Education).
- ✓ Adopt First Nations led validation tools to regularly assess workforce cultural capability as part of broader institutional racism assessments.
- ✓ Re-educate (non-Aboriginal and Torres Strait Islander) health staff—western models of care don't work for Aboriginal and Torres Strait Islander peoples.
- ✓ Develop innovative recruitment practices to attract more Aboriginal and Torres Strait Islander people to diverse roles within HHS, including but not limited to Aboriginal and Torres Strait Islander identified roles.
- ✓ Ensure Aboriginal and Torres Strait Islander health workers and practitioners work to their full scopes of practice and are integrated into multi-disciplinary service delivery teams.

- ✔ Improve attraction and recruitment processes to engage practitioners who can demonstrate working in a culturally safe way.
- ✔ Increase ease of access to feedback services and ensure responsiveness to consumer and staff complaints about the cultural safety of a service.
- ✔ Increase the amount and percentage of mainstream (or baseline) funding for Aboriginal and Torres Strait Islander health service staff, programs and budgets.
- ✔ Reduce duplication and improve efficiency by identifying healthcare services that could be transitioned to the Aboriginal and Torres Strait Islander community controlled health sector.
- ✔ Employ more Aboriginal and Torres Strait Islander health workforces across tertiary and chronic disease management.
- ✔ Strengthen partnerships between Aboriginal and Torres Strait Islander Community Controlled organisations and the public health system to support seamless access across the care continuum.
- ✔ Embed, evaluate and enhance Aboriginal and Torres Strait Islander led models of care in antenatal and early years care, mental health and chronic disease management.
- ✔ Deliver value-based care that personalises and engages Aboriginal and Torres Strait Islander health consumers and patients in decision-making about their care.
- ✔ Embed cultural governance within clinical services design.
- ✔ Establish or enhance existing data portals to share healthcare data between local healthcare providers for health system planning.
- ✔ Ensure mandatory discharge planning includes information relevant for First Nations patients including their preferred healthcare provider for ongoing care.
- ✔ Empower community to make informed decisions about their own health literacy.
- ✔ Provide opportunities for Aboriginal and Torres Strait leaders to have a role in mentoring the clinical and emerging leader workforce.

A framework for our new Health Equity strategies

Working with First Nations peoples, communities and organisations to design, deliver, monitor and review health services

Aboriginal and Torres Strait Islander peoples have led cultural systems of governance for more than 60,000 years. We know that voice and participation in the design, delivery and monitoring of health services is fundamental to success and reconciling the impact of former policies and practices that have created the inequities experienced today.

Some examples of actions needed to work with Aboriginal and Torres Strait Islander peoples, communities and organisations to design, deliver, monitor, and review health services include:

- ✓ Strengthen Aboriginal and Torres Strait Islander representation at the board and executive levels, and actively develop future leaders by providing training and mentoring opportunities.
- ✓ Establish cultural governance at the board and executive levels that includes diverse representation from within and external to the HHS.
- ✓ Create mentorship opportunities for community members to become future Hospital and Health Board members.
- ✓ Establish partnering arrangements with local Aboriginal and Torres Strait Islander community controlled organisations to collaborate and share best practice in supporting health professionals to provide culturally safe and responsive health services to communities.
- ✓ Co-design and co-deliver organisational performance reviews and evaluations with First Nations health consumers, workforces and academics to assess the cultural safety of health services.
- ✓ Implement research projects with a First Nations health focus that are led (or co-led) by First

Nations researchers, workforces or organisations (including Aboriginal and Torres Strait Islander community controlled organisations and other Aboriginal or Torres Strait Islander organisations).

- ✓ Work with specific Aboriginal and Torres Strait Islander communities to develop active partnerships with key government and non-government agencies and community health providers.
- ✓ Adopt a systems approach to health service planning by ensuring the active involvement of Aboriginal and Torres Strait Islander community controlled organisations in the planning and delivery of health services targeted for First Nations peoples.
- ✓ Ensure local health data is governed by Aboriginal and Torres Strait Islander people.
- ✓ Increase opportunities for Aboriginal and Torres Strait Islander representation and participation in consumer engagement, including Health Consumers Queensland.

“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”.

United Nations Declaration on the Rights of Indigenous Peoples, Article 23

Implementation and evaluation



Implementation and evaluation

Health Equity implementation milestones— *where we're heading*



Who will be involved?

We know the value of meaningful partnerships that engage Aboriginal and Torres Strait Islander voices in decision-making processes. Effective participation in policy and implementation ensures effective decision-making and improved service delivery that meets local needs. Co-design—which represents the strongest type of partnership arrangement because it involves sharing decision-making authority—will ensure the voices, lived experiences and cultural authority of Aboriginal and Torres Strait Islander peoples influence the design and delivery of care across the public health system.

The *Hospital and Health Boards Regulation 2012* stipulates the prescribed stakeholders HHS must work with to develop and implement their Health Equity Strategy. Prescribed stakeholders include:

- ✔ **Development stakeholders**—those that must be involved in the co-design and co-development of the Health Equity Strategies.
- ✔ **Implementation stakeholders**—those that must be involved and worked with as part of co-design, co-development and co-implementation.

- ✔ **Service delivery stakeholders**—those that must be partnered and worked with in co-design, co-development, co-implementation and service delivery.

The prescribed stakeholders list is not exhaustive and HHSs are encouraged to work with other relevant individuals and organisations not prescribed by the regulation. This may include the participation of government agencies at a state and national level, relevant statutory bodies, non-government organisations, universities and Australian Government service delivery partners.

Various equity groups within the Aboriginal and Torres Strait Islander community also need to be engaged during the development of the Health Equity Strategies. This includes but is not limited to young people, the LGBTIQ+ community, people in correctional settings, people with disabilities, people living in rural and remote areas, older people and young people in care or in the youth justice system.

The voices and rights of Aboriginal and Torres Strait Islander children and young people, and the unique challenges they face in accessing care, are critical for reducing health inequities and need careful consideration during the design of the Health Equity Strategies.

DEVELOPMENT STAKEHOLDERS

First Nations staff members
 First Nations health consumers
 First Nations community members
 Traditional custodians/owners and native title holders in the service area

IMPLEMENTATION STAKEHOLDERS

Health and Wellbeing Queensland
 The Chief Aboriginal and Torres Strait Islander Health Officer (CATSIHO)
 Queensland Aboriginal and Islander Health Council (QAIHC)



SERVICE DELIVERY STAKEHOLDERS

Aboriginal and Torres Strait Islander community-controlled health organisations (ATSICCHOs) in the service area
 Local primary healthcare organisations (including PHNs)

Implementaton and evaluation

What does co-design mean?

Co-design—or shared decision-making—begins as early as possible on the journey. Well established governance arrangements will ensure local priorities and key issues impacting Aboriginal and Torres Strait Islander peoples are addressed in the Health Equity Strategies. The new strategies must be developed in accordance with the principles of continuous quality improvement, shared decision-making, collaboration, and genuine partnership with each *development stakeholder*, in particular, the Aboriginal and Torres Strait Islander community controlled health sector.

Using the International Association of Public Participation (IAP2) spectrum about engagement processes (refer Diagram 1), ‘co-design’ is situated at the ‘collaborate’ and ‘empower’ levels of engagement. These two levels of engagement have the greatest impact on decision-making because they require either sharing decision-making with First Nations peoples (‘collaborate’) or devolving decision-making to Aboriginal and Torres Strait Islander peoples (‘empower’).

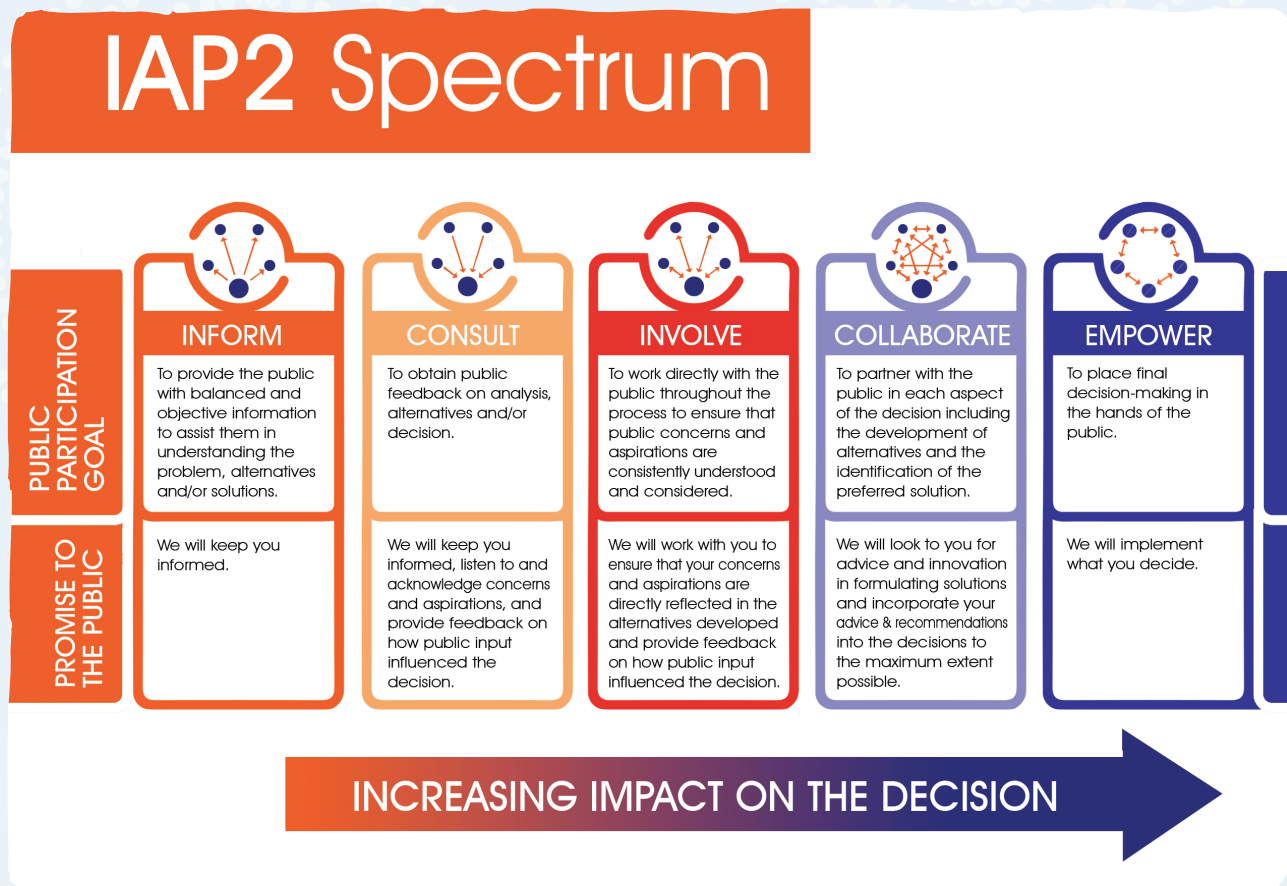


Diagram 1: Engagement process spectrum
 Image source: © International Association for Public Participation iap2.org

Consultation practice standards

The purpose of the consultation practice standards is to ensure a consistent and transparent decision-making process during the co-development of the Health Equity Strategies.

TERM	DESCRIPTION
Continuous Quality Improvement	A deliberate and defined quality management process that is responsive to community needs and concerned with improving population health via incremental improvements in the practices and processes of health care for measurable improvements in: outcomes, efficiency, effectiveness, performance, accountability, and/or other quality indicators.
Shared decision-making	To work with the prescribed Development stakeholders in each aspect of the decision including the development of alternatives and the identification of the preferred solution.
Collaboration	The act of working together with other people or organisations to create or achieve something.
Partnership	A formal arrangement and/or collaborative relationship between two or more parties that have agreed to work together, that is based on trust, equality, and mutual understanding, and focuses on the pursuit of common goals or interests.
Development stakeholder	Development stakeholders are prescribed in the <i>Hospital and Health Boards Regulation 2012</i> .
Prescribed stakeholders	Prescribed stakeholders are the persons prescribed by regulation in section 11D in the <i>Hospital and Health Boards Regulation 2012</i> .

Consultation practice timeframes

Mandatory timeframes have been set to establish consistent processes and standards across the public health system. During the development of Health Equity Strategies, HHSs are required to:

- ✓ Provide a draft First Nations Health Equity Strategy to each **development stakeholder** and allow at least 30 days for the stakeholder to provide feedback to the HHS.
- ✓ Consider the feedback received from the **development stakeholder** and provide a report back with respect to how their feedback has

been incorporated into the First Nations Health Equity Strategy. Any feedback must be provided to the **development stakeholder** in written form within 90 days from the date the feedback was received.

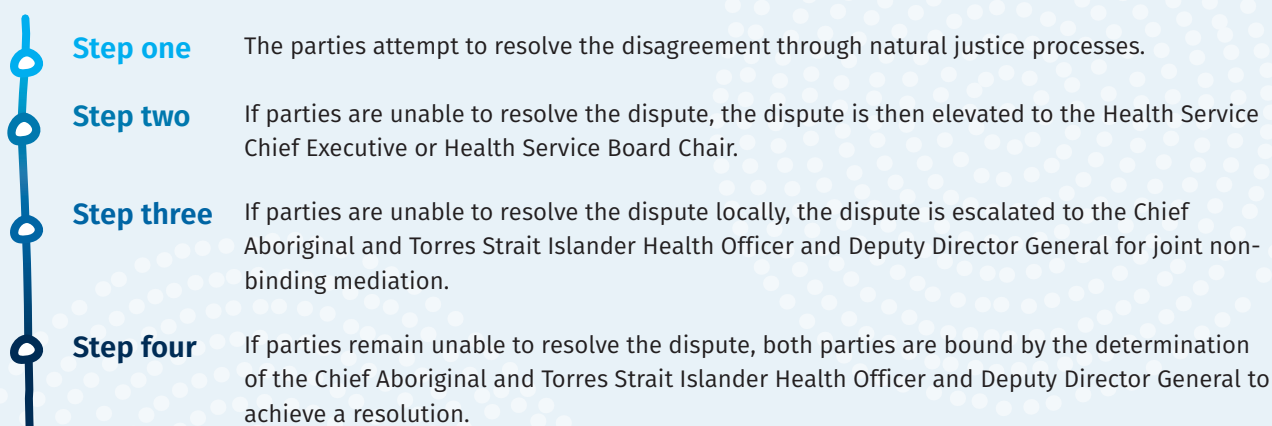
Local consultation and engagement mechanisms will be co-designed by each HHS in partnership with their local development stakeholders.

Implementation and evaluation

Mediation and conflict resolution processes

Good governance requires agreed mediation and conflict resolution processes if disagreements arise between partners during the development and implementation of the Health Equity Strategies.

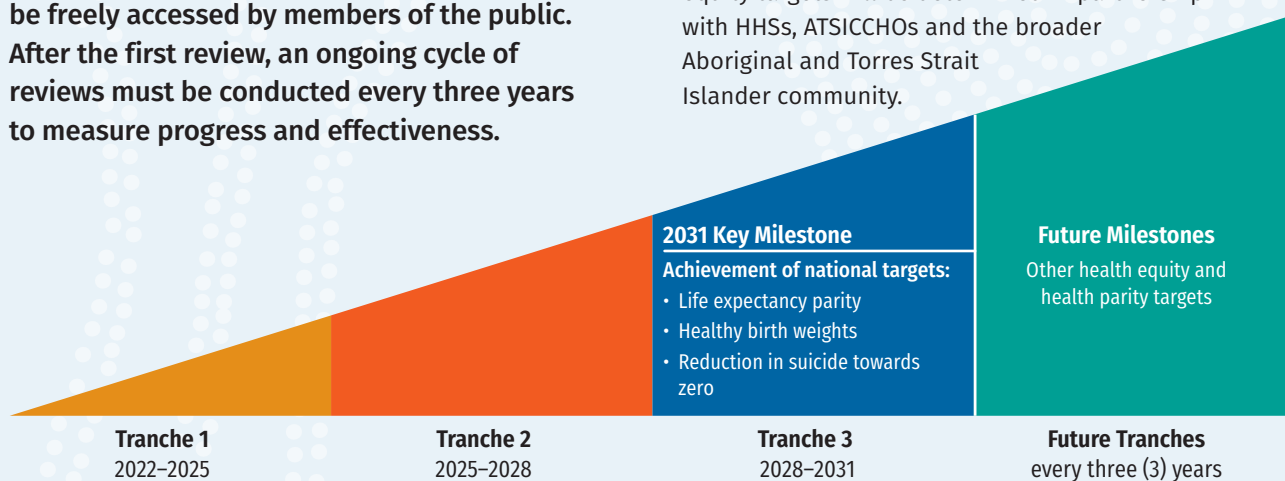
A four-step escalating mediation process has been developed with parties bound by the determination of the mediation process at each step. If the conflict cannot be resolved locally (via step one and two), the Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director General will provide either non-binding (step 3) or binding (step 4) mediation to resolve disputed issues between the HHS and prescribed stakeholders.



When will Health Equity Strategies be developed and reviewed?

HHSs will have until 30 April 2022 to co-develop and publish their first Health Equity Strategy. The strategy must be reviewed within three years of its release and the review findings published in a way that allows the strategy to be freely accessed by members of the public. After the first review, an ongoing cycle of reviews must be conducted every three years to measure progress and effectiveness.

Each Health Equity Strategy will have a three year timeframe and include actions to be delivered during that time period to achieve the national Closing the Gap targets, including the life expectancy parity target by 2031. From 2031 other identified First Nations health equity targets will be determined in partnership with HHSs, ATSI CCHOs and the broader Aboriginal and Torres Strait Islander community.



How will Health Equity Strategies be developed?

Health Equity Strategies will be developed, implemented and reviewed over a phased approach.

1. **Co-own:** Exploration and evidence gathering—

includes determining First Nations health equity priority issues (either health specific issues, health systems issues, or priority determinants of health). Priorities need to take into account what the health data is telling us about the causes and impacts of health inequities, and what is important to local Aboriginal and Torres Strait Islander peoples.

2. **Co-design:** Planning and design—

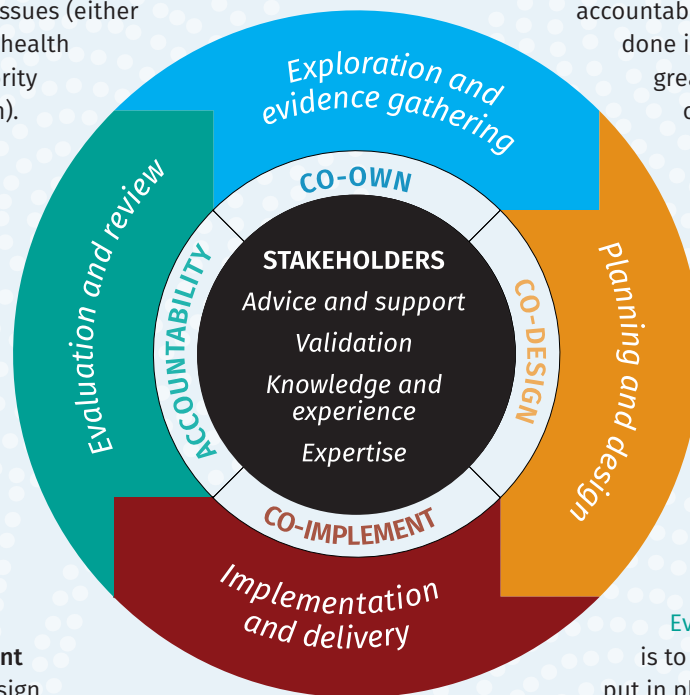
this involves working with prescribed **Development Stakeholders** to co-design solutions that will be effective in each local context. Incorporating lessons from existing best-practice and evidence-base of ‘what works’, whilst ensuring prescribed stakeholders are engaged and decide on local solutions that will work for them.

3. **Co-implement:** Implementation and delivery—

putting solutions in place requires clear accountability for delivery and done in a way that ensures greater collaboration, shared ownership and shared decision-making to implement the Health Equity Strategies. Collaborating with **Implementation Stakeholders** will ensure activities being undertaken are aligned with other initiatives across the broader health system.

4. **Accountability:**

Evaluation and review—this is to ensure that the solutions put in place are effective and can undergo continuous quality improvement, with a principal focus on outcomes. Involving prescribed stakeholders and First Nations peoples, communities and organisations, their experiences and voices (patient reported measures) alongside health outcomes data, is important when defining what success looks like.



The Local Area Needs Assessments (LANA) will be a critical source of local health system data to inform the development of the new Health Equity Strategies.

The assessments are being undertaken in partnership with ATSICCHOs, PHNs and other healthcare providers to better understand local health needs and service gaps. The LANA results will be used to inform local health system planning, new model of care development and future health service commissioning.

Implementation and evaluation

Regional collaboration

Health consumers do not recognise service boundaries between healthcare providers within or across geographic regions. In order to better support the patient journey and strengthen the continuity of care, HHSs, ATSI CCHOs and other healthcare providers need to integrate care across traditional organisational and service boundaries.

This may result in one overarching regional Health Equity Strategy being created for a number of HHSs or specific First Nations care pathways created between HHSs and included in their respective Health Equity Strategy. Whether an overarching Health Equity Strategy is created for multiple regions or individual strategies are developed, each HHS is responsible for working in partnership with prescribed stakeholders in their region and remain individually accountable.

Integrating existing regional plans and strategies

HHSs have a number of plans and strategies aimed at improving Aboriginal and Torres Strait Islander health outcomes. This includes (but are not limited to): Closing the Gap Health Plans, Aboriginal and Torres Strait Islander health workforce action plans, Aboriginal and Torres Strait Islander Cultural Capability Action Plans and Reconciliation Action Plans.

Wherever practicable, the aim is to bring together and integrate all existing Aboriginal and Torres Strait Islander health plans under the new Health Equity Strategies to reduce duplication, streamline reporting, and refocus efforts on the key priorities and specified actions outlined in the regulation.

How will the Health Equity Strategies support broader social and economic improvements (social determinants of health)?

The *National Agreement on Closing the Gap (2020)* outlines the agreed national approach to improve socio-economic outcomes with First Nations peoples, including three specific health targets. Because many of the causal factors of health and ill-health sit outside the health system, an interdependency exists between improving First Nations health outcomes and improving broader economic and social outcomes—they go hand-in-hand. The health system still needs to make substantial improvements to improve the accessibility, experience and cultural safety of Aboriginal and Torres Strait Islander peoples when they receive care, however, a whole of society response is required to improve health outcomes and achieve life expectancy parity by 2031. The health system can't do it alone.

At local and regional levels, the Health Equity Strategies will be the primary mechanisms for QH to implement its commitments to the *National Agreement on Closing the Gap (2020)* and partner with other stakeholders across and outside the health system to improve the social and economic conditions in which First Nations peoples live their lives.

At a state level, QH and QAIHC will partner and support the Department of Seniors, Disability Service and Aboriginal and Torres Strait Islander Partnerships and other departments to drive the implementation of the *National Agreement on Closing the Gap (2020)* through various state-wide governance and implementation arrangements.

How will we measure impact?

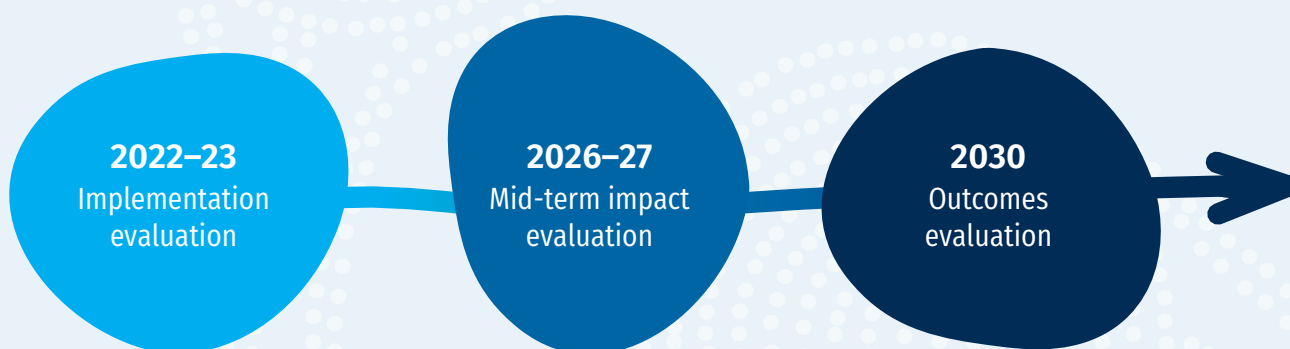
Monitoring and evaluation

The effectiveness of the Health Equity Strategies in embedding equity across the health system, eliminating institutional racism and improving health and wellbeing outcomes, will be measured throughout each strategy's three year life cycle and at regular points leading up to 2031 timeframe to achieve life expectancy parity.

A statewide First Nations Health Equity monitoring and evaluation framework will be developed and a suite of key performance indicators (KPIs) will monitor the progress of the Health Equity Strategies.

The monitoring and evaluation framework will be co-designed in partnership with the Aboriginal and Torres Strait Islander community controlled sector and First Nations health leaders across the public health system. This will ensure the monitoring and evaluation framework is culturally appropriate, without methodological (non-Aboriginal and Torres Strait Islander) bias and adheres to the principle of Aboriginal and Torres Strait Islander data sovereignty by ensuring the narrative reflects the voices and experiences of Aboriginal peoples and Torres Strait Islander peoples.

An evaluation plan will include the following evaluation cycle to assess effectiveness and include independent external evaluations:



Appendices

Glossary of Terms

Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSI CCHOs)

In accordance with the *Hospital and Health Boards Regulation* (2012), an ATSI CCHO means a body corporate that has a governing body whose members are Aboriginal people or Torres Strait Islander people elected by a local Aboriginal or Torres Strait Islander community; has rules preventing the distribution of the association's property to its members; and delivers health services to the local Aboriginal or Torres Strait Islander community.

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 ATSI CCHOs, which are formalised through agreements.

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".⁷ 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".⁸

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.⁹

ATSI CCHOs 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.¹⁰

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 ATSI CCHOs, 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,¹¹ 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.¹² 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.¹³

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.¹⁴

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.¹⁵ The resulting grief and trauma have been culturally devastating and is inextricable from the identity of present-day Aboriginal and Torres Strait Islander peoples.

Appendices

Acronyms

AIHW	Australian Institute of Health and Welfare
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
CATSIHO	Chief Aboriginal and Torres Strait Islander Health Officer
DDG	Deputy Director-General
HHS	Hospital and Health Service
IAP2	International Association for Public Participation
KPIs	Key Performance Indicators
LANA	Local Area Needs Assessments
QAIHC	Queensland Aboriginal and Islander Health Council
QH	Queensland Health
PHN	Primary Health Network

Notes and references

¹ Australian Institute for Health and Wellbeing, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2020* (accessed February 2021), <https://www.indigenoushpf.gov.au>

² See, for example, Paradies, Y., Harris, R & Anderson, I. (2008). *The impact of racism on Indigenous health in Australia and Aotearoa: towards a research agenda*. (Discussion Paper No. 4) Darwin: Cooperative Research Centre for Aboriginal Health; Dixon, J. & Welch, N. (2000). Researching the rural-metropolitan health differential using the 'social determinants of health'. *Australian Journal of Rural Health*; 8(5):254-260.

³ See, for example, Paradies, Y. *Colonisation, racism and indigenous health*. J. Popul. Res. 2016, 33, 83–96. Durey, A.; Thompson, S.C. *Reducing the health disparities of Indigenous Australians: Time to change focus*. BMC Health Serv. Res. 2012, 12, 151; Ford, C.L.; Airhihenbuwa, C.O. *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis*. Am. J. Public Health 2010, 100, S30–S35; Awofeso, N. (2011). Racism: a major impediment to optimal Indigenous health and health care in Australia. *Australian Indigenous Health Bulletin*, vol. 11, no. 3; Paradies, Y., Harris, R & Anderson, I. (2008). *The impact of racism on Indigenous health in Australia and Aotearoa: towards a research agenda*. (Discussion Paper No. 4) Darwin: Cooperative Research Centre for Aboriginal Health.

⁴ See, for example: Australian Institute of Health and Welfare (2020). *Aboriginal and Torres Strait Islander Health Performance Framework – Summary report 2020*. Australian Government: National Indigenous Australians Agency, Canberra; State Coroner's Court of New South Wales, Inquest into the Death of Naomi Williams. State Coroner's Court of New South Wales, Lidcombe, NSW. Available online: <https://coroners.nsw.gov.au/documents/findings/2019/Naomi%20Williams%20findings.pdf> (accessed April 2021).

⁵ AIHW (2020) Social determinants and Indigenous health - Australian Institute of Health and Welfare (aihw.gov.au)

⁶ Kelly, K., Dudgeon, P., Gee, G. & Glaskin, B. (2009). *Living on the edge: social and emotional wellbeing and risk and protective factors for serious psychological distress among Aboriginal and Torres Strait Islander People*, Discussion Paper No. 10. Cooperative Research Centre for Aboriginal Health: Darwin.

⁷ 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).

⁸ Article 23, *United Nations Declaration on the Rights of Indigenous Peoples*, 2007, The United Nations General Assembly (adopted 2007).

⁹ 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.

¹⁰ 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>

¹¹ 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).

¹² 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.

¹³ See Gee G., Dudgeon P., Schultz C., Hart A., Kelly K., *Aboriginal and Torres Strait Islander social and emotional wellbeing*, 2014 (in Dudgeon P., Milroy H., Walker R., *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing*).

¹⁴ 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>

¹⁵ 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).

