

*Making Tracks Together: Queensland's Aboriginal and
Torres Strait Islander Health Equity Framework*

System Level Implementation Evaluation
Summary of Findings



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Acknowledgements

The Australian Research Council Centre of Excellence for Indigenous Futures acknowledges and honours the Traditional Custodians of the lands on which our Centre and team operate. We acknowledge Elders past, present, and emerging and recognise this was always a place of learning, teaching, and research, and that Sovereignty was never ceded.

The evaluation team respectfully acknowledges the enduring leadership, advocacy and cultural authority of First Nations people, communities and organisations who have long driven health system reform and demanded accountability across Queensland.

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We particularly acknowledge Cleveland Fagan*, whose visionary leadership and unwavering commitment to health equity played a foundational role in shaping this reform.

**Name used with family's permission.*

Terminology

Within this report, the terms “First Nations people” and “Aboriginal and Torres Strait Islander people” are used interchangeably rather than “Indigenous”. The evaluation team acknowledges First Nations people’s right to self-determination and their choices to describe their own cultural identities using these or other terminology.

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Document Purpose

This document is a summary of the findings from the system level implementation evaluation of *Making Tracks Together*: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework.

For information on the full evaluation report or supplementary materials, please contact the First Nations Health Office.

Key Health Equity Strategy Documents

There are a number of documents relevant to the health equity reform agenda. A list of documents that have guided and informed health equity reform are listed below.

Document	Purpose
Hospital and Health Boards (Health Equity Strategies) Amendment Regulation (2021)	The regulation provides the legal requirements associated with the Hospital and Health Boards in relation to Health Equity Strategies. This includes the prescribed requirements to fulfil the obligations of the Act.
Health Service Directive: First Nations health equity strategies (QH-HSD-053:2021)	The directive provides the requirements for the process to develop Health Equity Strategies in relation to consultation and shared decision making.
Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework	The framework provides the background, basis and objectives for health equity reform. It provides guidance and information to support the development and ongoing implementation of Health Equity Strategies.
Health Equity Strategy Template	The template provides a structure for Health Equity Strategies that meets the regulatory requirements and to support consistency in their publication.
Health Equity Strategy Toolkit	The toolkit provides practical tools to support the development of Health Equity Strategies.
Health Equity Strategies Monitoring and Evaluation Framework	The M&E Framework provides guidance for the three system level assessments of the effectiveness and impact of the Health Equity Strategies.

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List of Acronyms

ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
FNHO	First Nations Health Office
HHS(s)	Hospital and Health Services
KEQ(s)	Key Evaluation Questions
KPI	Key Performance Indicators
QAIHC	Queensland Aboriginal and Islander Health Council

Health Equity for First Nations people in Queensland: what changed and why it matters

There is a long history of advocacy and partnership to improve public health services for First Nations people in Queensland. A major turning point came in 2017 with the release of the report *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services*. The report showed that progress depended on goodwill rather than accountability and the health public health system itself created barriers to fair and equal care.

Early actions, but not enough

In 2018 Queensland Health responded through the release of a Statement of Action that set out a plan to make the health system more culturally safe and responsive by:

- Increasing First Nations representation in leadership, decision making, and the workforce
- Strengthening partnerships with First Nations communities and organisations
- Improving transparency and accountability for health outcomes

Hospital and health services were asked to develop Closing the Gap plans to improve health equity and grow the First Nations workforce. However, progress was inconsistent and depended on goodwill rather than accountability.

Pushing for change

In response, the Queensland Aboriginal and Islander Health Council (QAIHC), called for change. QAIHC argued that Queensland's commitments to Closing the Gap needed to be written into law so they would be consistent, sustained, and enforceable across the public health system.

Health Equity written into law

In 2020, the Queensland *Hospital and Health Boards Act 2011* was amended. For the first time, health equity for Aboriginal and Torres Strait Islander people was embedded in law.

The changes require every Hospital and Health Service (HHS) in Queensland to:

- Have at least one Aboriginal and/or Torres Strait Islander person on its Board
- Develop and publicly share a Health Equity Strategy that explains how it will improve health outcomes for First Nations people

Clear rules and guidance support these requirements, including practical tools co-designed by Queensland Health and QAIHC following extensive, statewide community consultation.

Queensland Health also created new leadership roles to support change, including the Chief First Nations Health Officer, the First Nations Health Office (FNHO), and a statewide clinical network.

Why this matters

Queensland is now recognised as a national leader in health equity reform. The 2024 Productivity Commission's Closing the Gap Review highlighted Queensland's approach as a strong example of how governments can change systems, not just programs.

Health Equity Strategy Requirements

The legislation establishes the requirement for:

- HHSs to develop and publish the strategy (Sect 40(1)(c))
- The prescribed persons who must be consulted with in developing that strategy (Sect 40(2)(c))
- That the strategy meets the requirements of the regulation (Sect 40(3)(a)) and is publicly available (Sect 40(3)(b))
- That the HHS give effect to the strategy (Sect 40(4)) and in consultation with the prescribed people (Sect 40(5))
- To review the strategy every 3 years (Sect 41(1)) in consultation with the prescribed people (41(2)) and subsequently re-published (Sect 41(3))

The regulation establishes the requirement for:

- The strategy to state the performance measures as agreed with the Chief First Nations Health Officer for addressing the five priority areas (Sect 13A(1)(a))
 1. Actively eliminate racial discrimination and institutional racism within the Service
 2. Increasing access to healthcare services
 3. Influencing the social, cultural and economic determinants of health
 4. Delivering sustainable, culturally safe and responsive healthcare services
 5. Working with Aboriginal and Torres Strait Islander people, Aboriginal and Torres Strait Islander communities and organisations to design, deliver, monitor and review health services
- The strategy to state the actions the HHS will take to (Sect 13A(1)(b)):
 - achieve those measures
 - work with implementation stakeholders
 - improve the integration of health service delivery
 - support First Nations people to give feedback
 - increase workforce representation of First Nations people to be commensurate with the population within the HHS footprint
- The strategy to state how it aligns with (Sect 13A(1)(c)):
 - HHS strategy and objectives
 - other applicable strategies, policies, guidelines and directives
 - Health Equity Strategies of other Services
 - Other applicable national, state, and local strategies, policies and standards
- The prescribed people for consultation
- Prescribed requirements for protocol with local primary healthcare organisations

The directive (HSD) establishes the requirement for:

- Consistent and transparent development process with the prescribed stakeholders including transparency of decision-making processes
- Comprehensive consultation practice standards including feedback
- Mediation processes

System Level Implementation Evaluation

All sixteen Queensland HHSs published their Health Equity Strategies between July 2022 and February 2023 and began putting them into action. Each service then released their Health Equity Implementation Plans detailing what they would do, when they would do it, and how progress would be tracked. These plans were published between March 2023 and March 2024. Under the legislation every HHS must review its Health Equity Strategy every three years and share the updated version publicly. This helps ensure the strategies remain relevant, transparent and accountable. In addition to the local HHS reviews, system level evaluations are also carried out. These evaluations look at how all the Health Equity Strategies are working together across the health system and whether the legislation is helping to drive real change. The evaluations support learning and improvement by identifying what is working well, what needs to change, and how the system can keep improving to achieve health equity. This first evaluation focuses on system level influences on how the strategies were developed and are being put into practice.

The overall goal of this evaluation is to learn from experience so future action can be stronger and more effective. What is learned will help improve health equity in Queensland and may also inform reform in other sectors and jurisdictions.

How the evaluation was done

The evaluation was guided by *Making Tracks Together: Monitoring and Evaluation Framework*. It was carried out by an independent research team from the ARC Centre of Excellence for Indigenous Futures at the University of Queensland. The work was led by an Aboriginal researcher and evaluator and used Indigenous research approaches. This ensured the evaluation was culturally grounded and informed by First Nations ways of knowing, being, and doing. The First Nations Health Office provided oversight of the evaluation, with input from key stakeholders as required.

What information was used

The Monitoring and Evaluation Framework was created to help bring together learning from the 16 Health Equity Strategy Reviews happening across the system. Because these reviews are still underway, this evaluation did not use their detailed findings or consult directly with service level stakeholders to reduce the demand on them. Information for the evaluation came from several sources including:

- Review of documents related to Health Equity Strategies, their implementation, and the wider health system and policy environment
- Yarns and interviews with people involved in the work

People who participated included:

- First Nations Health Leads, HHS Board members and senior leaders
- Queensland Health staff
- Representatives from QAIHC and the community controlled sector

Not all relevant documents were available to the evaluation team, and this was taken into account when interpreting the findings.

Key Evaluation Questions

Organisational context, understanding, and commitment

The Queensland public health system is decentralised, with 16 HHSs delivering care while the Queensland Health oversees the system. Each HHS works in different local conditions, from geography and population needs to workforce, budgets and service capacity. All parts of the health system, including HHSs, the department, community controlled health care, primary care, and other providers are under pressure from rising demand and limited resources. While COVID-19 created challenges, it also highlighted the strength and effectiveness of First Nations led responses, strong partnerships, and better system integration.

1. What contextual factors influenced the design of the health equity strategies and how will the activities under each priority area respond to them to achieve health equity in service delivery and health outcomes?

- The Health Equity Strategy requirements were designed so each HHS could tailor their strategy to their local needs by using flexible guidelines and tools, and working with local First Nations organisations and communities to co-design strategies that reflect their unique contexts and aspirations.
- Differences in funding, staffing, and local conditions meant some HHSs faced more challenges when consulting, co-designing, and developing their Health Equity Strategies. Extra resourcing was provided, but giving every HHS the same funding did not match their very different starting points, and some people felt this was not truly equitable.
- To help address these gaps, Queensland Health, QAIHC, and the network of First Nations Health Leads offered additional support such as knowledge sharing, providing expert advice, helping build relationships, and working together on solutions, reflecting a shift towards a more connected, networked way of working across the system.

2. How did institutional understanding and commitment to addressing health equity influence the design and implementation of health equity strategies?

- The requirement for HHSs to co-design and deliver Health Equity Strategies built on many years of First Nations advocacy and over a decade of policy shifts in Queensland and nationally that called for structural change to make the health system more culturally safe, accountable by moving towards partnership driven ways of improving health outcomes for First Nations people.
- Both the Queensland Health and QAIHC supported the rollout of Health Equity reform through broad consultation and communication, including discussion papers, statewide consultations, briefings, and regular updates across sector events and publications, all designed to provide guidance on how the requirements could work in different local contexts.
- All HHSs had access to plenty of information and support about Health Equity reform, but their understanding and commitment varied depending on how early and genuinely they chose to engage. Some focussed on improving their own systems, while others treated Health Equity as an external problem to manage. This difference reflects the broader shift called for in the Closing the Gap reforms: moving away from assimilation-based approaches and towards addressing the structural causes of inequity in public health systems.

- Differences in understanding and commitment to Health Equity reform show up in how organisations and individuals behave. First Nations staff and partners want to work with leaders who genuinely listen and act, and while many leadership teams have improved, resistance remains in some areas, highlighting the need for clear, active, and authentic leadership.

Was there a better way to address contextual differences?

The evaluation looked at whether a staggered roll out of Health Equity Strategies, based on HHS's self-assessed readiness would have worked better than the single deadline set by the government's election commitment. By looking at a similar system reform, Ryan's Rule, it showed that even when services face different challenges, a mandated requirement is still what drives action. Many stakeholders felt that a readiness based rollout of Health Equity would not have helped, as services tend to delay work when given more time and are always managing competing pressures. While earlier funding might have sped things up for some HHSs, the real drivers of progress were each services' capacity and commitment to prioritising Health Equity reform.

Process and fidelity with prescribed requirements

3. *How were the activities under each priority area identified and decided by the co-design group, and with what effect? To what extent were there opportunities for innovation or influence by stakeholders? What influence did existing programs, initiatives, or alliances to improve health outcomes for First Nations people have on the development of Health Equity Strategies?*
 - The Health Equity framework and toolkit gave HHSs clear guidance, examples, and tools, co-developed with First Nations partners to help them design their strategies, map existing work, and identify new ideas through genuine partnership.
 - Each Health Equity Strategy had to be approved by the Chief First Nations Health Officer, who could give feedback, but the other prescribed stakeholders (QAIHC and Health and Wellbeing Queensland) were only able to comment.
 - The first round of Health Equity Strategy document vary widely in detail and transparency, with many lacking clear information on who was consulted, how decisions were made, or how actions would be measured. There is a need for more transparency in the next cycle.
 - Many HHSs have learned a lot since developing their Health Equity Strategy, recognising that early plans were sometimes shaped by perceptions of performance. Through experience and reflection, many are shifting towards more realistic, community driven actions, adapting activities and focussing on long-term sustainable change. This growth was reflected in stories of deeper listening, honest conversations about what is and is not possible, and stronger advocacy based on respect and community priorities.
 - Many HHSs have grown in their understanding of Health Equity reform, shifting away from a culture focussed on comparison. This change supports broader reforms that promote local decision making. However, the system still needs clearer communication, more consistent

review processes, and cultural change to avoid competition or “league tables” that can push HHSs towards superficial actions instead of meaningful, sustainable improvements.

4. *How did the health equity strategies co-design processes uphold the legislative requirements, the principles of Making Tracks Together, and the commitment to reframing the relationship with First Nations peoples? What effect did this have on the decision making and implementation?*

- Health Equity reform is built on strong, respectful partnerships with First Nations peoples, backed by laws and policies that require genuine consultation, shared decision making and transparency. HHSs that had already started building these relationships and transforming their processes through earlier Closing the Gap plans were prepared to co-design and deliver their Health Equity Strategies.
- HHSs received practical support from the system such as guidance materials, briefings, drop in sessions, peer learning, and funding for staff and community consultations. This was especially valuable for services with fewer resources or less policy experience.
- A weakness was the lack of a strong system level oversight to ensure HHSs actually met the legislative requirements. With no formal compliance checks, some strategies lacked transparency about who was consulted, how decisions were made, or whether co-design principles were upheld.
- Experiences of co-design varied widely. While many positive partnerships were reported, some community members and organisations felt excluded or pressured, and some First Nations staff felt overlooked, despite being prescribed stakeholders.
- Responsibility for meeting the legislative requirements sits with each HHS Board, but the current mediation process offers limited protection against power imbalances because it relies on internal escalation rather than independent oversight.
- Stronger accountability is urgently needed to ensure HHSs genuinely meet the legislative requirements and uphold the principles of partnership and transparency, as current processes lack oversight and undermine trust. The existing mediation process should be redesigned to address power imbalances, and the Queensland Aboriginal and Torres Strait Islander Health Planning Partnership offers a pathway for co-designed, system level oversight.

5. *What governance, monitoring and accountability arrangements were adopted to oversee the implementation of the health equity strategies and what was the rationale for this?*

- Health Equity reform is built on strong policy foundations and genuine power-sharing with First Nations partners. Effective governance depends on centring First Nations knowledge, transparency, and real accountability, meaning organisations must clearly understand their responsibilities, openly report their performance, and take action when they fall short.
- HHSs are required to work transparently with prescribed stakeholders when developing their Health Equity Strategies, but system level oversight is limited. Beyond FNHO approving activities and measures, there is no strong mechanism to ensure HHSs actually meet their legislative requirements.
- FNHO and the system monitor progress through quarterly meetings and service performance reporting, but governance arrangements differ widely across HHSs. While local variation is

appropriate, public transparency is low, with minimal detail available in Board reports, annual reports or online for many HHSs.

- Despite commitments to transparency and accountability, very little information is publicly shared about Health Equity Strategies' governance and monitoring. This lack of visibility, combined with the loss of system level governance with the ATSICCHO sector, creates a "data rich, information poor" environment that limits genuine accountability.

Policy alignment

6. *How do the health equity strategies align with the Closing the Gap priority reforms?*

- Health Equity reform strongly aligns with the National Agreement on Closing the Gap and were included in Queensland's 2021 Closing the Gap Implementation Plan.
- A review of all 16 Health Equity Strategies identified ways that system level policy alignment has influenced local planning, with each Health Equity Strategy acknowledging Closing the Gap in some form. In addition to addressing health outcome targets, Health Equity reform is consistent with the Priority Reforms.
- **Priority Reform 1 Formal partnerships and shared decision-making:** The legislation requires HHSs to work in formal partnerships with ATSICCHOs and share decision making. Whilst the published Health Equity Strategies do not clearly show how those decisions were made, many include new models of care that are being delivered through these formal partnerships.
- **Priority Reform 2 Building the community controlled sector:** Although Health Equity Reform is built on partnership with the ATSICCHO sector, limited resourcing for their involvement in co-design and governance has created pressure and inconsistency with Closing the Gap priorities. However, where HHSs fund or commission ATSICCHOs for service delivery, strong partnership models and culturally responsive services are emerging, supported further by new system level investment in the community controlled sector.
- **Priority Reform 3 Transforming government organisations:** Health Equity reform requires HHSs to transform how they work by strengthening engagement, partnership, co-design, and shared governance with First Nations communities. These requirements, supported by tools and strong First Nations leadership are driving change, with staff describing meaningful shifts in everyday practices, greater respect for community expertise, and a growing focus on continuous improvement.
- **Priority Reform 4 Shared access to data and information at a regional level:** Although data sharing is not a formal requirement of Health Equity reform, many HHSs have included actions that will strengthen shared access to data over time. During the first cycle, some HHSs have put in place the necessary authorisations and safeguards to support data sharing with ATSICCHOs.
- Sustained commitment to Health Equity reform will maintain Queensland's policy leadership in implementing its responsibilities to the National Agreement on Closing the Gap and support achievement of health outcome targets.

7. *How do the health equity strategies support and align with the other state and national policy goals to improve the health and wellbeing of First Nations Peoples?*

- Health Equity reform is strongly aligned with other state and national policy goals because it embeds and reflects broader policy shifts driven by the National Agreement on Closing the Gap.
- Health Equity Strategies strongly support the National Aboriginal and Torres Strait Islander Health Plan 2021-2031 because the co-design requirements and five priority areas directly advance many of the Plan's priorities including the elimination of racism, improving access to care, addressing social determinants of health, strengthening cultural safety of services, partnering with communities, and increasing First Nations workforce representation.
- Health Equity reform also aligns with the National Aboriginal and Torres Strait Islander Workforce Strategic Framework and Implementation Plan, because of the strong focus at HHS and system level on building a skilled and supported First Nations workforce. System level initiatives such as new workforce pathways, training programs, and industrial relations changes, led by a dedicated First Nations workforce team in the department supports local initiatives and activities.
- The First Nations First Strategy strengthens overall policy cohesion by providing system level direction that was missing in the early stages of Health Equity reform. The system level strategy now creates clear alignment between local Health Equity Strategies, statewide enablers, and national frameworks to guide more consistent and coordinated reform.
- Maintaining embedded First Nations leadership and dedicated teams at the HHS and system level will ensure policy alignment is institutionalised and sustainable, which will support Queensland to meet its policy obligations.

Outcomes and influences

8. *In the Monitoring and Evaluation Framework, KEQ 8 is used in the second and third evaluations to assess progress and not included in the current implementation evaluation.*

- Progress towards Health Equity is happening, even when Key Performance Indicators (KPIs) cannot fully capture it. HHSs are beginning to shift how they work, build and repair relationships, and redesign services in ways that reflect First Nations ways of working, showing early signs of the deeper cultural and organisational transformation needed for long term change.

9. *What unanticipated positive and negative outcomes resulted from developing and implementing the health equity strategies for consumers, ATSI CCHOs, services, the system or other stakeholders?*

- The positive and negative outcomes of developing Health Equity Strategies were largely anticipated because of the extent of consultation and the collaboration between the department and ATSI CCHO sector in developing the requirements.
- Many HHSs found that truth telling and acknowledging past harm or failings was essential for rebuilding trust with communities, with some openly recognising the depth of hurt and mistrust caused by previous poor experiences with the public health system.

- Hearing and acknowledging the effects of past service and system failures has provided health service leaders an opportunity to learn, understand, and respond to their communities' needs, creating more responsive and effective health services.

10. What are the activities under each priority area's roles and intended effects, and how will they work together to create the desired impacts?

- The five priority areas were developed through an extensive co-design process with broad stakeholder input and statewide community consultation ensuring they reflected best practice, human rights principles, and what communities identified was needed.
- Whilst workforce was not listed as a standalone priority area, it remains a critical enabler across all priorities, and some HHSs have chosen to elevate it separately.
- The most challenging area for HHSs is influencing social determinants of health, but its inclusion requires services to better understand their communities beyond the Health Needs Assessment process and consider where they can contribute to change.
- The priority areas are interconnected rather than siloed, and although some Health Equity Strategies reflect this more clearly than others, HHSs are increasingly recognising the interplay between the priority areas to guide more integrated, locally responsive reform.
- The five priority areas provide sufficient flexibility to incorporate local priorities and aspirations.

11. How have the health equity strategies embedded issues of intersectionality to address the needs of people such as the LGBTIQISGBB+ community, people experiencing incarceration, people with disabilities, and young people in out of home care?

- First Nations people who also experience additional forms of discrimination and marginalisation, disability, incarceration, or out-of-home care face even greater health challenges, so health service need to understand their needs and ensure models of care are safe and responsive.
- The Health Equity reform agenda is helping to address this by embedding First Nations leadership and strengthening local partnerships which brings lived experience and cultural knowledge into decision making. This has enabled some HHSs to be more responsive to emerging issues without waiting for statewide directives.
- Intersectional needs are already being addressed in both direct and indirect ways through the first cycle of Health Equity Strategies and future cycles will strengthen this further as embedded First Nations representation, stronger partnerships, and clearer monitoring requirements continue to shape more inclusive and responsive service design.

12. What have been the key facilitators and inhibitors to developing and implementing health equity strategies at the service, system, or sector level?

- Legislation alone cannot drive Health Equity reform, progress is dependent on values driven leadership, embedded cultural governance, genuine collaboration, and treating Health Equity as core business rather than an add-on.

- HHSs that were strategically ready, because of principled and responsive leadership, moved faster by building relationships, recruiting key staff, and early adoption of cultural change.
- Strong existing relationships with First Nations communities and ATSI CCHOs made co-design easier, whilst HHSs with weak or fractured relationships had to rebuild trust first and this shaped pace and nature of the process.
- Genuine understanding of why reform is needed, grounded in community voices and lived experience rather than abstract metrics, was a major driver of commitment, helping leaders move beyond deficit based thinking and towards person-centred change. System level resources, such as the First Nations First Strategy and the Ryan's Rule training video, can help humanise the statistics and need for institutional change rather than blaming individuals or communities.
- For long term success, the system must balance data driven performance culture with opportunities for leaders and staff to develop a deeper understanding and shift their focus from problems of populations to the creating a more patient centred and response health service.
- The requirement for engagement with First Nations communities and stakeholders serves an important purpose in creating the structural and cultural change needed to transform the public health system. Meaningful engagement will improve understanding and commitment, accountability, and trust.
- At a system level, the introduction of more reflexive cultural capability, leadership and professional practices will support the organisational shift needed to create a more patient centred and effective public health system for the whole population.

Does legislation make a difference?

- Yes, legislation made a major difference because it has shifted First Nations health equity from something optional or “nice to do” to a mandatory requirement that every HHS must act on, regardless of competing pressures.
- Health services are always stretched, so regulatory requirements help ensure important reforms for marginalised or disempowered groups of people are actioned.
- Before the legislation, many HHSs saw First Nations health as the responsibility of a small unit rather than the whole organisation, but commitment and ownership is now increasing across the system.
- Legislation is essential because social attitudes and discrimination continue to create resistance to meaningful change. However, legislation must be backed by strong leadership, transparency, and accountability to ensure real improvements in First Nations health and wellbeing.

Sustainment and embedding transformation

13. What successes have already been realised, and how can they be leveraged to progress health equity reform?

The development and implementation of the Health Equity Strategies have delivered a range of notable successes, each producing tangible outcomes. Seven key successes, their related outcomes, and potential leverage points are listed below.

Key Success	Outcomes	Leverage Points
Catalytic system reform	Stronger trust and service accessibility	Embed monitoring and accountability for addressing structural racism
Embedding First Nations governance	Leadership stability and cultural safety	Require First Nations leadership roles
Authentic community led co-design	Legitimate strategies and community-led programs	Standardise genuine community led co-design
Data driven accountability	Improved service responsiveness and transparency	Embed KPIs and public Health Equity reporting
Innovation and cultural transformation	Organisational cultural shift and better clinical outcomes	Fund flexible local innovation hubs
Resilient leadership	Repaired relationships and increased workforce participation	Invest in leadership pipelines and staff wellbeing
Embedding equity into business as usual	Sustainable governance and system wide equity	Mandate equity in governance and funding
Regional collaborative models	Scalable reforms, collective accountability, and better data sharing	Support and scale regional collaborative models

14. How are the First Nations Leadership reforms at the service and system level contributing to the health equity reform agenda, and what can be done to amplify their impact?

- First Nations leadership at both the system and service levels has been fundamental to driving Health Equity Strategy reform, strengthening cultural authority, improving decision making, and ensuring reforms are grounded in community priorities.
- Where First Nations leaders have been elevated, supported, and embedded in governance and decision making groups, reform has moved beyond “ticking the box” to genuine organisational change. However, the impact of First Nations leaders depends heavily on the genuine commitment, respect, and inclusion of the broader leadership team.
- First Nations leaders and staff carry additional demands to other personnel due to representation requirements and cultural labour. First Nations leaders and staff can experience strong support from colleagues and peer networks, many still face resistance and racism, highlighting the need for ongoing cultural change, supportive leadership, and safe, accountable workplaces.

15. What approaches to institutionalising and sustaining change have been incorporated into the health equity strategies or implementation plans?

- Even though HHSs can make many of their own decisions, they still operate within statewide rules and policies and national standards.
- The First Nations First Strategy is intended to create an environment that supports and sustains Health Equity reform, but no visibility of its Action Plan makes it not possible to assess how well this is happening and is inconsistent with other policy goals of transparency and accountability.
- Knowledge sharing across the system relies heavily on informal relationships and individual efforts rather than structures and processes. Whilst FNHO, the First Nations Health Leads Forum, and the Aboriginal and Torres Strait Islander Clinical Network play important roles in supporting knowledge sharing, their influence is constrained by resourcing, remit, and institutional biases.
- First Nations teams are often most effective when they act as facilitators of change, providing support or advice to organisational units rather than carrying all the responsibility for change. This approach embeds change by increasing knowledge, capacity and ownership across the organisation.
- Health Equity Project Officers lack a system level community of practice to support implementation and knowledge sharing. A department facilitated network would strengthen collaboration, knowledge sharing, support for First Nations staff, and capacity building whilst potentially reducing inefficiencies.
- Many innovations developed through Health Equity Strategies are not considered for scaling beyond First Nations programs, even though they could potentially benefit all patients. Leaders who understand the broader drivers of inequity and patient centred care are better at recognising these opportunities.
- Successful examples like the Sistas Shawl project and Better Together Medication Access show how First Nations led innovations can improve care for everyone and improve service effectiveness. Leaders can unlock more of these benefits through scaling and translating Health Equity innovation by asking reflexive questions about their assumptions and practices in service delivery, potential beneficiaries of innovation, and organisational learning.

Cost Effectiveness

16. How well can the design and implementation costs of the health equity strategies be captured? What benefits to health outcomes, service improvements, and broader social outcomes will be created by health equity strategies, and how can these be effectively?

- The primary aim of Health Equity reform is to tackle institutional racism and improve health outcomes by transforming business as usual, the everyday assumptions, processes and systems that shape how care is delivered, **not** by creating short term programs or duplicate services.
- It was not possible to determine the costs from the implementation of Health Equity reform because there is no agreed approach to determining what should be attributed as a direct cost of the development and implementation of Health Equity Strategies or the benefits gained.
- Some costs are clear and easy to identify, such as the dedicated funding to the HHSs and consultation activities, however others would be harder to separate from business as usual or shared funding streams.
- Measuring benefits is even more complex because many health gains take years to be realised, some outcomes are difficult to attribute directly, and many initiatives do not have simple, measurable cost-benefit indicators.
- Because of these challenges there is an urgent need to develop consistent, transparent, co-designed approach to costing and valuing Health Equity reform, including agreed rules for identifying costs, benefits, timeframes, and reporting.
- These guidelines should be made publicly available, reduce reporting burden, and be grounded in Indigenous Data Sovereignty principles, with oversight from the Queensland Aboriginal and Torres Strait Islander Health Planning Partnership to ensure accountability and alignment with broader system reforms.

Overall findings

A strong policy foundation

Queensland's Health Equity reform is recognised nationally for turning the Closing the Gap Priority Reforms into real action. The legislation behind the reform created the authority needed to prioritise equity in a system that has historically contributed to health inequities. The reform has a clear and defensible policy basis because it was co-designed with First Nations partners and closely aligns with other state and national First Nations health policies. It centres First Nations voices and knowledge in decision making, although there is a need to strengthen system level governance and improve how knowledge is shared across the health system.

Strengths and gaps in implementation

Whilst the reform has strong foundations, implementation has been inconsistent. Some parts of the systems have embraced the opportunity with genuine commitment building on existing collaboration whilst others have needed to repair fractured relationships or develop capacity. At a system level, power sharing which was strong during the early co-design phase, has weakened

in some areas, highlighting the need for ongoing, principled partnership between the public health system and First Nations people and organisations.

Accountability mechanisms are improving but need to be stronger and more consistent. Health Equity must be embedded across the whole system, not just within the HHSs, so that governance, funding and reporting structures all support Health Equity outcomes. Without this alignment, progress will depend too heavily on individual champions.

Why progress looks different across the system

Every HHS started from a different place. Each had different organisational cultures, relationships with community, and levels of readiness. As a result, progress has varied, and this is expected. Many first cycle Health Equity Strategies were ambitious, and the public health system is large, complex, and resistant to change. The reform asks people and organisations to confront uncomfortable truths about racism and cultural safety which can create additional resistance.

Leadership as the key driver

Leadership is the most important factor in progress. First Nations leadership has driven the reform from the start, and the most progress has occurred where non-Indigenous leaders showed genuine commitment, humility and cultural accountability. Real change has happened when leaders looked inward, acknowledged institutional racism, built strong relationships with First Nations communities, and embraced cultural governance, not when they just followed compliance requirements.

A paradigm shift for the public health system

Despite the challenges, Health Equity Reform is driving the cultural and structural shift needed for the public health system to contribute meaningfully to Closing the Gap targets and achieve health equity for First Nations people in Queensland. The reform is not about short term programs or duplicate services. It requires organisations to rethink how they work, challenge long-held assumptions, and create culturally safe, patient centred care. This shift helps health services understand the real drivers of First Nations health outcomes, rather than reducing them to simplistic metrics.

There is clear evidence that HHSs are learning and beginning to apply Health Equity principles and lessons more broadly. This learning needs to be strengthened and shared more effectively across the system so that cultural safety and responsiveness become core expectations in all care and not limited to isolated projects or programs.

Benefits for all Queenslanders

Health Equity reform is already re-shaping how services think, plan, and deliver care. By focussing on cultural safety, person centred care, and structural change, the reform has the potential to improve health outcomes for all Queenslanders. Transformation is happening, unevenly but meaningfully, and the system is beginning to move towards the kind of healthcare that communities have long called for.

Recommendations

The following recommendations are provided to accelerate progress from Health Equity reform, ensure Queensland meets its responsibilities under the National Agreement on Closing the Gap, and improve First Nations health and wellbeing. Each recommendation is presented with a summary statement, list of sources, and recommended actions at the system level.

1. Maintain policy leadership and sustained commitment to Health Equity reform.

Transformation is happening and progress is being made across the public health system. Building blocks of organisational learning and repaired or strengthened relationships to create local partnerships are evident in all HHSs. The changes being realised are improving outcomes for First Nations people, and shaping a more responsive, patient centred, and effective health system. Sustained commitment to the reform is required to support progress, continue to build trust, and signal that the public health system is becoming a safe space for First Nations people as clients or staff.

It is recommended that Queensland Health sustain their commitment to Health Equity reform to support achievement of Queensland's Closing the Gap and other national policy commitments as well as position the system to meet anticipated requirements of the revised National Health Reform Agreement and National Safety and Quality Health Service Standards. Health Equity reform is demonstrating opportunities to drive cost effective whole of system improvements.

2. Improve transparency and accountability. The lack of transparency and accountability at both service and system level is inconsistent with the legislative requirements, the principles of open and transparent government, and best practice in public sector administration. Transparency is a prerequisite for accountability and a mechanism for building the trust and confidence necessary for effective partnerships.

Transparency and accountability need to be addressed in the current service reviews and development of the second cycle Health Equity Strategies. Recommended actions include:

- Ensuring compliance with all the prescribed Health Equity Strategy requirements for development, content, and reporting are assessed, monitored, and enforced by the department
- Establishing system level governance through the reconstituted Queensland Aboriginal and Torres Strait Islander Health Planning Partnership
- Co-developing a mediation process that embeds cultural safety and is responsive to power differentials
- Embedding individual accountability through performance management processes
- Make all departmental strategies, frameworks, implementation plans, and evaluations relevant to First Nations health and Health Equity reform publicly available
- Co-commission future evaluations of Health Equity reform with prescribed stakeholders
- The full system level evaluation report be made publicly available

3. Strengthen knowledge translation and scaling up of innovations across the system.

Clarify, communicate, and improve the current approaches to translation and institutionalising innovation from the Health Equity Strategies by leveraging off existing technologies and relational ways of working; resourcing and supporting the Queensland

Aboriginal and Torres Strait Islander Clinical Network; and integrating the Health Equity Strategy innovations into whole of system improvements. Improving the transfer and scaling of innovation will accelerate health gains for all Queenslanders and deliver system efficiencies.

Specific system level recommendations are limited by the lack of access to whole of system implementation plans and guidelines. However, recommended actions include:

- Establishing a Community of Practice for Health Equity project officers to facilitate information exchange, share resources, and support capacity building
- Resource the Queensland Aboriginal and Torres Strait Islander Clinical Network to leverage their unique position to support translation, scaling up, and system level reform
- Include requirements and pathways for service and system level identification and translation of innovations developed through Health Equity reform to improve the overall responsiveness and effectiveness of the public health system

- 4. Acknowledge and actively support First Nations staff for the critical role in reshaping the public health system and the unique load they carry in undertaking their duties.** First Nations workforce, embedded leadership, and representation underpin all state and national health policy. Meeting Queensland's responsibilities in relation to Closing the Gap and creating a culturally safe and responsive public health system is not possible without the First Nations workforce. Ensuring there are effective, self-determined, supports in place to respond to micro aggressions, resistance, and hostile work environments; ensure their input is being included in Health Equity Strategy development and implementation; and there are career pathways in place.

Noting that mandates are required to ensure reform is not vulnerable to individual choices, the recommended actions include:

- Mandating the requirement for First Nations Health Lead positions to be at the executive level and part of the executive leadership team
- Mandating the requirement for First Nations Health Leads to be provided the appropriate resourcing and support to execute their role, including staff, funding, data access, and support by shared services
- Increasing resourcing for the Queensland Aboriginal and Torres Strait Islander Clinical Network to reflect the additional load in comparison to other Clinical Networks due to the unique focus, support of the reform agenda at a system level, and cultural load
- Recognise the additional load First Nations staff carry in all positions in relation to committee memberships, selection panel membership, cultural advice and education, and cultural load in the development of position requirements, workload calculations, and organisational design

- 5. Institutionalise cultural responsiveness through reflexive practice and system accountability.** To sustainably embed cultural change, it is essential to institutionalise culturally responsive practices by aligning individual behaviour, organisational processes and system-level governance. Cultural accountability must be embedded as part of the public health system and extend beyond education through individual goal setting, recruitment criteria and reflexive practice.

Recommended actions include:

- System wide recruitment practices such as advertisement content and position descriptions to include an explicit expectation of staff's understanding and commitment to Health Equity reform.
- Selection criteria for roles to include demonstration of their understanding and commitment to Health Equity reform or equivalent cultural reform
- Individual goal setting and performance reviews to include individual learning and contribution to organisational structural reform.
- Mandate cultural capability training that shifts from just learning about First Nations culture, to reflecting on individual's values and drivers of behaviour and bias