

North West Hospital
and Health Service

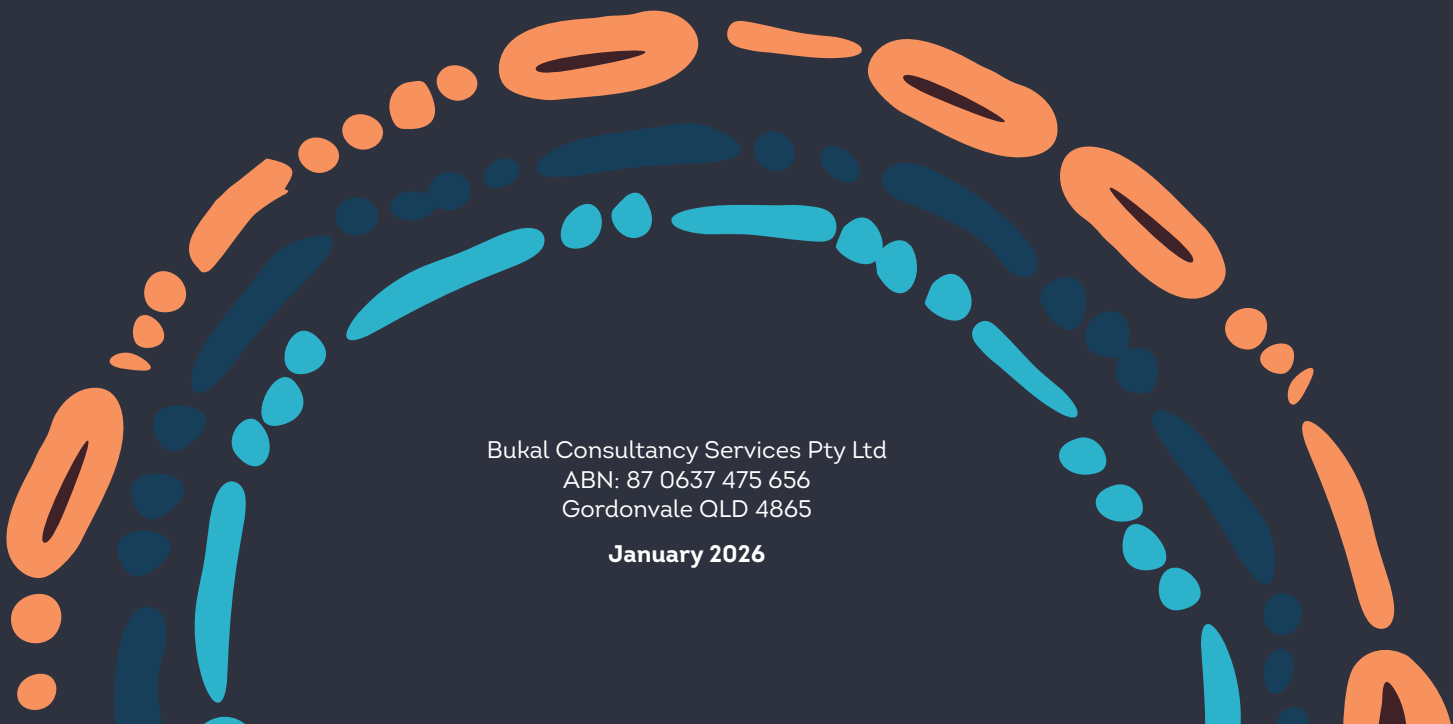
Institutional Racism Matrix Audit Report for 2024-2025

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Acknowledgement

The consultants acknowledge and pay our respects to the Traditional Owner groups of the North West Hospital and Health Service region and acknowledge their continuing connection to their land and sea country. We pay respect to them, their cultures, and their Elders past, present and future.

Language policy

In this report the First Peoples of the North West Queensland region are referred to as 'Aboriginal and Torres Strait Islander people', 'Aboriginal peoples and Torres Strait Islander peoples' or 'First Nations peoples' depending on the context.

The consultants would also like to thank Mel Riordan (Rural Health Consulting) and Erika Langham (Research Fellow, ARC Centre of Excellence for Indigenous Futures, University of Queensland) for their input and guidance in preparing this report.

Acronyms

ADCQ	Anti-Discrimination Commission Queensland – now the QHRC
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
CAC	Consumer Advisory Committee (NWHHS)
CAG	Consumer Advisory Group
DAMA	Discharge Against Medical Advice
DATSIP	Department of Aboriginal and Torres Strait Islander Partnerships (within Department of Women, Aboriginal and Torres Strait Islander Partnerships and Multiculturalism)
ED ATSIH / FNH	Executive Director Aboriginal and Torres Strait Islander Health / First Nations Health
ELT	HHS Executive Leadership Team
HEIP	Health Equity Implementation Plan 2022-2025
HER	Health Equity Report – refers to the March 2017 report Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland’s Public Hospital and Health Services (Marrie, 2017)
HHB Act	<i>Hospital and Health Boards Act 2011 (Qld)</i>
HHBA(HES)AR	<i>Hospital and Health Boards Act (Health Equity Strategies) Amendment Regulation 2021 (Qld)</i>
HSCE	Health Service Chief Executive
JRNA	Joint Regional Needs Assessment
KPA	Key Performance Area
KPI	Key Performance Indicator
KPM	Key Performance Measure
LANA	Local Area Needs Assessment
LBWB	Low Birthweight Babies
MoC	Model of Care
MOHRI	Minimum Obligatory Human Resource Information
MPHS	Multipurpose Health Service
NACTG2020	National Agreement on Closing the Gap 2020
NWHHB	North West Hospital and Health Board
NWHHS	North West Hospital and Health Service
NWHES	North West Health Equity Strategy 2022-2025
NWQ	North West Queensland
PS Act	<i>Public Sector Act 2022 (Qld)</i>
PTSS	Patient Travel Subsidy Scheme

QAIHC	Queensland Aboriginal and Islander Health Council
QAO	Queensland Audit Office
QAS	Queensland Ambulance Service
QH	Queensland Health
QHMT2018	Queensland Health Matrix Template 2018 (refers to the 2017 HER Matrix which was revised with stakeholder input in November 2018)
QH-NWHHSSA	Queensland Health – North West Hospital and Health Service: Service Agreement 2022/23 – 2024/25 [December 2024 Revision]
QHRC	Queensland Human Rights Commission
RFDS	Royal Flying Doctor Service
TCHHS	Torres and Cape Hospital and Health Service
WQPHN	Western Queensland Primary Health Network

Tables

Table 1	2017 and 2025 Matrix Audit Results based on overall scores for each of the 13 criteria
Table 2	Proposed Executive Leadership Team NACTG 2020 responsibilities

Executive Summary & Recommendations

Executive summary

In March 2017 the report *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services* (Marrie, 2017) – generally referred to as the “Health Equity Report” (HER) – was submitted to the Anti-Discrimination Commission Queensland (ADCQ) - now the Queensland Human Rights Commission. The report was funded by the Queensland Aboriginal and Islander Health Council (QAIHC). The report contained the results of an institutional racism matrix audit of Queensland Health's 16 Hospital and Health Services (HHS) using the *Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services* (Bukal Matrix) developed by Henrietta Marrie AM and Adrian Marrie in 2014, initially to address perceived institutional racism in the Cairns and Hinterland Hospital and Health Service (CHHHS).

NWHHS commissioned Bukal Consulting to undertake an audit against the Institutional Racism Matrix for the 2024-2025 period, to identify areas for continuous improvement, strengthen culturally safe practices, and ensure the delivery of high-quality health services for Aboriginal and Torres Strait Islander people across the North West region. However, the audit should be carried out using a revised version of the 2017 Matrix resulting from a stakeholder workshop convened by the ADCQ in November 2018 (the Queensland Health Matrix Template [QHMT 2018] - see Appendix 1). While still using the same basic structure based on the original five key indicators of institutional racism and their 13 criteria, some changes were made, principally by removing the criterion for legal visibility (with reference to the *Hospital and Health Boards Act 2011*) and replacing it with a criterion (and set of sub-criteria) for good governance (based on selected actions of Hospital and Health Boards). Some adjustments to the scoring of the criteria were made, but overall, the two versions are comparable.

The principal purpose of this document is to report on the results of the 2025 audit and the comparison between the institutional racism Matrix audit conducted in 2017 (see Appendix 2) and that carried out in 2025. While the Health Equity Report was presented to the ADCQ Commissioner in March 2017, the audit was based on the 2014-2015 reporting period enabling a 10-year comparison. In the 2017 Health Equity Report audit, NWHHS recorded 31 points out of a possible 140 placing it in the Very High level for institutional racism. In contrast to this, the 2025 audit NWHHS has received a score of 105.5 out of 140, a net improvement of 74.5 points and placing it within the Low level for institutional racism (see Table 1) – a remarkable improvement.

While good governance has replaced the criterion for legal visibility in the QHMT 2018, NWHHS could improve alignment with this criterion by increasing the level of publicly available information regarding outcomes and decisions in Board meeting summaries, specifically those related to issues and/or services impacting First Nations people. The improvements in the overall score are largely due to the development and publication of its statutory *North West Health Equity Strategy 2022-2025* (NWHES) and *Health Equity Implementation Plan 2022-2025* (HEIP). The NWHES and HEIP address many of the Matrix measurables with regard to the key indicators for policy implementation, service delivery and partnerships, and recruitment and employment. While the Implementation Plan addresses the key indicator for recruitment and employment in Key Priority Area 5: Delivering Sustainable, Culturally Safe and Responsive Health Services, the Matrix sub-criteria for the criterion: Aboriginal and Torres Strait Islander workforce development

were mostly fully achieved. NWHHS has an opportunity to further strengthen performance against the sub-criteria for Aboriginal and Torres Strait Islander participation in the health workforce, particularly by increasing First Nations employment within the Medical (+VMO) and Professional and Technical streams, where representation is currently limited. Consequently, the overall score for the recruitment and employment indicator is 22.5/30. The findings suggest that additional progress could be made in financial accountability and reporting for Closing the Gap funding, with the current score reflecting a 5-point improvement out of 20 compared with the 2017 audit report.

The Bukal Matrix is designed as a tool to measure and promote public accountability regarding federal and state policies designed to Close the Gap particularly with regard to health disparities between First Nations peoples and the Australian population more generally. However, the policy and legislative environment which gave rise to the 2017 and 2018 Bukal Matrices has been largely superseded by the *National Agreement on Closing the Gap* (2020) (NACTG 2020) and significant changes to the *Hospital and Health Boards Act 2011* in response to the 2017 Health Equity Report, particularly with the passage into law of the *Hospital and Health Boards Act (Health Equity Strategies) Amendment Regulation 2021* (Qld), which mandates the establishment by all HHSs of a First Nations Health Equity Strategy and Implementation Plan. However, the *Regulation* also addresses one of the major actions required by the NACTG 2020 with regard to Priority Reform Three – Transforming Government Organisations, namely, to identify and eliminate racism by identifying and calling out institutional racism, discrimination and unconscious bias in order to address these experiences (Clause 59.a). All HHS HESs must address this requirement.

At the state level, one of the most important policy drivers is the *Public Sector Act 2022* (Qld) in relation to reframing the State's relationship with Aboriginal peoples and Torres Strait Islander peoples. Queensland Health, at departmental level, has published its own *Reframing the Relationship Plan 2024-2025*. The Plan "provides a whole of health system response to meeting the mandated responsibilities in accordance with the *Public Sector Act 2022*" (p. 3). Under s.22(b) of the *Public Sector Act 2022*, Hospital and Health Services are prescribed entities, and, in accordance with s.23(1) "The chief executive of a prescribed entity must, as part of the entity's workforce planning, make a document (a **reframing the relationship plan**), informed by the matters mentioned in section 21, that identifies the measures for developing the cultural capability of the entity when – (a) providing advice to the State government; and (b) delivering services to the community. (2) The reframing the relationship plan must be published – (a) on the prescribed entity's website;".

In carrying out the research of the publicly available information used to conduct the 2025 QHMT Matrix audit, it came to our attention that systemic factors were also at play in limiting scores for certain criteria in the QHMT Matrix. For example, a deterioration in the quality of information provided in NWHHS and other HHS Annual Reports over the last nearly 10 years was noted, and this can only be traced back to changes in the Department of the Premier and Cabinet's *Annual report requirements for Queensland Government agencies* over the years.

It is also noted that the *National Agreement on Closing the Gap 2020* is now the primary Agreement to which all governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations have signed on to, and as the Productivity Commission has pointed out:

They committed to mobilizing all avenues available to them to achieve the objective of the Agreement – which is ‘to overcome the entrenched inequality faced by too many Aboriginal and Torres Strait Islander people so that their life outcomes are equal to those of all Australians’.¹

The Productivity Commission’s first review of the Agreement also shows that governments are not adequately delivering on this commitment.

We must also confront the appalling situation that the most recent publicly available estimates of life expectancy² for First Nations people in North West Queensland (NWQ) is some 11 years less than for the general population. Life expectancy for First Nations males in NWQ was baselined in the 2022-2025 NWHHS Health Equity Strategy as 68.2 years, and for non-indigenous males it was 80.2 years – a difference of 12 years. And for First Nations females, their life expectancy was baselined as 72.8 years, 10.6 years less than non-indigenous females (83.4 years).³ While there are different ways of reporting morbidity, mortality and life expectancy rates,⁴ basic information on life expectancy, for example, average age of death for First Nations people and non-indigenous people in NWQ goes un-reported in the NWHHS *Annual Reports*.⁵ The overarching priority of the NWHES and HEIP is “to Close the Gap and achieve life expectancy parity for Aboriginal peoples and Torres Strait Islander peoples by 2031”, yet there is an absence of publicly available and accessible data to demonstrate what progress is being made against health outcome indicators that contribute to differences in life expectancy but can be captured and reported more frequently than life expectancy. These would include figures such as infant mortality, preventable deaths, and average age at death. Reporting these figures on an annual basis could be considered an act of contemporary truth telling as required by s.21(2)(b) of the PS Act.

The most obvious way to do things differently, and as the Productivity Commission suggests, is to fully take on board and honour the terms of the NACTG 2020 at the HHS level. In conducting the 2025 NWHHS Matrix audit, the consultants have taken the view that the NACTG 2020 is one of the primary documents by which to evaluate many of the criteria contained in the 2018 Matrix. However, there are limitations in this approach, so the consultants have taken the liberty to propose actions that can be taken at government, departmental (system) and agency (service) levels in order to elevate the various obligations contained in the NACTG 2020, and to which the Queensland Government has committed, into their operations at the respective levels.

¹ Productivity Commission, 2024. *Review of the National Agreement on Closing the Gap: Study Report* (Volume 1). Australian Government, Canberra. P. 3.

² The 2022-2025 North West Hospital and Health Service Health Equity Strategy and the Draft 2025-2028 North West Hospital and Health Service Health Equity Strategy are the source of these figures. However, it is important to note that these are undated. Efforts to identify a more recent, and publicly available life expectancy for the region (Statistical Area level 3) that most closely aligns with the HHS boundaries) were unsuccessful. Figures for the state (Statistical Area level 4) were identified that indicate an increase in life expectancy.

³ Queensland Health and North West Hospital and Health Service *North West Health Equity Strategy 2022-2025*, p. 14.

⁴ See, for example, discussion in the NWHHS *North West Hospital and Health Service Local Area Needs Assessment* [2024 Update], pp. 25-27.

⁵ The TCHHS *Annual Reports* for 2022-23 (p. 11) and 2021-22 (p. 10) under the heading Our Challenges, provide the information that: “Our average age at death is 61 years, which is 19 years below the state average.” The statistic is not disaggregated for First Nations and non-indigenous people.

Recommendations

The rationale behind the recommendations is provided in a later section of this Report. The recommendations are as follows:

Recommendations to Queensland Government:

Recommendation 1: The *Hospital and Health Boards Act 2011* be amended to include a Closing the Gap committee as a statutory board committee

Recommendation 2: The Department of the Premier and Cabinet include in its *Annual Report Requirements for Queensland Government Agencies* reporting requirements on Closing the Gap

Recommendation 3: The Department of Women, Aboriginal and Torres Strait Islander Partnerships and Multiculturalism work with the Australian Institute of Company Directors to provide scholarships for board training for Aboriginal and Torres Strait Islander aspirants

Recommendations to Queensland Health:

Recommendation 4: Departmental reporting on the Our Performance website to include the health equity dashboard indicators by HHS, and to include outcome metrics with trend data for First Nations people not just activity counts [e.g. Proportion of healthy birth weights (outcome) as well as babies born (activity)]

Recommendations to NWHHS:

Recommendation 5: Closing the Gap responsibilities to be identified and shared by all members of the HHS executive management team

Recommendation 6: Elevate the profile of the NACTG 2020 in the operation of NWHHS by creating a Closing the Gap portal on the HHS website

Recommendation 7: Make summaries of outcomes and decisions from board meetings publicly available, including the details of the biannual reporting of Health Equity KPIs.

Recommendation 8: Annual reporting on Health Equity Strategy progress be included on the Health Equity webpage for ease of reference.

Recommendation 9: The Service Standards Performance data in the annual report be disaggregated.

Recommendation 10: Data snapshots in the Health Equity Strategy and other HHS documents include explanation and context, dates and sources of the data, and interpretation guidelines regarding the influences or limitations of the metric.

Recommendation 11: The NWHHS publish an annual Closing the Gap itemised summary of Commonwealth, State and HHS funds specifically allocated to First Nations health programs, projects and services in NWHHS annual reports as part of Aboriginal and Torres Strait Islander health / Closing the Gap reporting.

Recommendation 12: This audit report be made publicly available on the Health Equity webpage.

Introduction

*Institutional racism, for the purpose of the Regulation, 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 of people to limit their rights, causing and/or contributing to inherited disadvantage.*⁶

*Institutional racism is ‘structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator’ [Jones, 2000]. In the Australian health system, it ‘manifests in the exclusion of Aboriginal and Torres Strait Islander people from the governance, control and accountability of health care organisations’ [Bourke et al 2020].*⁷

In March 2017 the report *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland’s Public Hospital and Health Services* (Marrie, 2017) – generally referred to as the “Health Equity Report” (HER) – was submitted to Commissioner Kevin Cocks AM, Anti-Discrimination Commission Queensland (ADCQ - now the Queensland Human Rights Commission). The report was funded by the Queensland Aboriginal and Islander Health Council (QAIHC). The report contained the results of an institutional racism matrix audit of Queensland Health’s 16 Hospital and Health Services (HHS) using the *Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services* (Matrix) developed by Henrietta Marrie AM and Adrian Marrie in 2014. The NWHHS audit produced a score of 31/140, placing the HHS within the very high range of institutional racism.

While the HER became the catalyst for significant changes to Queensland’s health system, most notably, amendments to the *Hospital and Health Boards Act 2011* mandating that all Hospital and Health Service Boards must have First Peoples representation. A subsequent *Regulation* in 2021 required the development and implementation of HHS First Peoples Health Equity Strategies and Implementation Plans.

The original Matrix was developed without external input, and many stakeholders felt it could be improved for future audits. In November 2018, ADCQ convened a workshop with participants from QH, HHSs, QAIHC, ATSICCHOs and the Matrix authors. A revamped Matrix resulted, and while the original five key indicators were retained, some of the criteria were changed with the most significant difference being that the criterion regarding legal visibility (focusing on legislated

⁶ The *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021* (Qld) commenced on 30 April 2021. [Subordinate Legislation 2021 No. 34 made under the *Hospital and Health Boards Act 2011*].

The Regulation makes reference to “institutional racism” in Section 8 (a)(i), however does not define the term. “Institutional racism”, however, is defined as follows at p. 8 in the Explanatory notes for SL 2021 No. 34 made under the *Hospital and Health Boards Act 2011* (Qld). Accessed at: <https://www.legislation.qld.gov.au/view/pdf/published.exp/sl-2021-0034>

⁷ Australian Government, 2021. *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*, p. 51.

participation of Aboriginal and Torres Strait Islander people in the delivery of health services in the *Hospital and Health Boards Act 2011*) was replaced with a criterion (and some sub-criteria) for good governance. Other significant changes included the addition of more sub-criteria to provide more scope for measuring some of the criteria, particularly in regard to the criterion for an Aboriginal and Torres Strait Islander HHS Plan [Indicator 3], and for Aboriginal and Torres Strait Islander health workforce development [Indicator 4]. This Matrix is referred to in this report as the Queensland Health Matrix Template 2018 (QHMT 2018) [see Appendix 1] and provides the template for the current (2024-2025) institutional racism audit for NWHHS. The development of the QHMT 2018 reflects stakeholder input, so it should be used by other HHSs contemplating comparisons between the 2017 HER audits and an up-dated audit. However, the difficulties of making such comparisons are acknowledged, and it is hoped that the working through these difficulties in the current NWHHS audit may provide some guidance.

The comparison between the 2017 and 2025 audits shows that NWHHS, in scoring 105.5/140, has improved its score by 74.5 points (see Table 1), and now rates within the Low range of institutional racism. The main factor in this improvement is NWHHS's *North West Health Equity Strategy 2022-2025* (NWHES) and *Health Equity Implementation Plan 2022-2025* (HEIP).

In carrying out the audit, the consultants recognize that there has been a considerable shift in health policies since 2016 (when the bulk of the work was undertaken in preparing the Health Equity Report, itself based on the 2014-2015 reporting year), including in response to that 2017 report, particularly with the passage into law of the *Hospital and Health Boards Act (Health Equity Strategies) Amendment Regulation 2021*. With a life expectancy for First Nations people in North West Queensland of 68.2 years for males, and 72.8 years for females, more than 11 years less than for Queenslanders generally, this has become the realisation and motivation that things have to be done differently if the NWHHS is to have any hope of reaching the *National Agreement's* primary target of Closing the Gap in life expectancy within a generation, by 2031.

The *National Agreement on Closing the Gap* (2020) provides us with a roadmap detailing a number of ways in which we can go about achieving the Closing the Gap targets. Commonwealth and state reports to date reveal little in the way of progress towards achieving those targets, and the Productivity Commission has been roundly condemnatory of governments' actions to date. It's first review of the Agreement shows that governments are not adequately delivering on their commitments:

Despite some pockets of good practice, progress in implementing the Agreement's Priority Reforms has, for the most part, been weak and reflects tweaks to, or actions overlayed onto, business-as-usual approaches. The disparate actions and ad hoc changes have not led to improvements that are noticeable and meaningful for Aboriginal and Torres Strait Islander people. This raises questions about whether governments have fully grasped the scale of change required to their systems, operations and ways of working to deliver the unprecedented shift they have committed to. The Commission's overarching finding is that there has been no systematic approach to determining what strategies need to be implemented to disrupt business-as-usual of governments. **What is needed is a paradigm shift.** Fundamental change is required, with actions based on a clear logic about how they will achieve that change. It is too easy to find examples of government decisions that contradict commitments in the Agreement, that do not reflect Aboriginal and Torres Strait Islander people's priorities and perspectives and that exacerbate, rather than remedy, disadvantage and discrimination. This is particularly obvious in youth justice systems. The Commission heard a clear message from Aboriginal and Torres Strait Islander people during the course of this review: persistent barriers to progressing the Agreement's Priority Reforms are the lack of power sharing needed for joint decision-making, and the failure of governments to acknowledge and act on the reality that Aboriginal and Torres Strait Islander

people know what is best for their communities. Unless governments address the power imbalance in their systems, policies and ways of working, the Agreement risks becoming another broken promise to Aboriginal and Torres Strait Islander people [emphasis added].⁸

In responding to this assessment, we formed the view that there needs to be a number of actions taken at government, department, and HHS levels to raise the primacy of the *National Agreement* in their day-to-day operations. Accordingly, we have produced a set of recommendations addressing each level of operation, and which are explored in more detail in the Findings and Recommendations at the end of this report.

⁸ Productivity Commission, 2024. *Review of the National Agreement on Closing the Gap: Study Report* (Volume 1). P. 3.

The Health Status of Aboriginal and Torres Strait Islander People Living in The NWHHS Region

Over 30% of the population (approximately 8,500 people) in the NWHHS region identify as First Nations people.⁹ This is the second highest percentage of any of Queensland's 16 HHSs after the TCHHS region with approximately 70% of the population (16,000 people) identifying as First Nations people.¹⁰

The most recent publicly available estimates of life expectancy for First Nations people in North West Queensland (NWQ) is some 11 years less than for the general population¹¹. Life expectancy for First Nations males in NWQ was baselined in the 2022-2025 NWHHS Health Equity Strategy as 68.2 years, and for non-indigenous males it was 80.2 years – a difference of 12 years. And for First Nations females, their life expectancy was 72.8 years, 10.6 years less than non-indigenous females (83.4 years).¹² If NWQ were a country then its First Nations population would be placed with countries ranked some 130 places below Australia in terms of global life expectancy at birth.¹³ It is therefore something of a shock to the Queensland Health vision espoused in 2016 that: “By 2026 Queenslanders will be among the healthiest people in the world”.¹⁴

Base line data regarding the health status of the First Nations population of the NWHHS region¹⁵ that needs to be addressed indicated:

- 17.5% of First Nations babies are born with a low birth weight compared to 7.5% of low birth weight babies (LBWB) for all of Queensland
- 14.3% of First Nations people live in overcrowded households or are homeless compared to the state average of 2.1% for non-indigenous households
- There is a very high prevalence of ear conditions in children, with prevalence rates some of the highest of all Deadly Ears Program locations¹⁶
- Acute Rheumatic Fever (ARF)/Rheumatic Heart Disease (RHD) is significantly higher among First Nations people, compared to non-First Nations people. The prevalence rate is significantly higher

⁹ NWHHS, 2025. *Annual Report 2024-2025*, p. 12 and Queensland Health and North West Hospital and Health Service *North West Health Equity Strategy 2022-2025*, pp. 14-17.

¹⁰ TCHHS, 2023. *Annual Report 2022-2023*, pp. 8 and 13.

¹¹ The 2022-2025 North West Hospital and Health Service Health Equity Strategy and the Draft 2025-2028 North West Hospital and Health Service Health Equity Strategy are the source of these figures. However, it is important to note that these are undated. Efforts to identify a more recent, and publicly available life expectancy for the region (Statistical Area level 3) that most closely aligns with the HHS boundaries) were unsuccessful. Figures for the state (Statistical Area level 4) were identified that indicate an increase in life expectancy.

¹² Queensland Health and North West Hospital and Health Service *North West Health Equity Strategy 2022-2025*, p. 14.

¹³ According to rankings by Worldometer, *Life expectancy by Country and in the World (2025)*, Australia ranks 6th in the world with a life expectancy of 84.21 years (both sexes) and 85.97 (females) and 82.43 (males). Based on the figures given for First Nations male and female life expectancy of an overall life expectancy of around 70 years in NWQ, it would place NWQ among such countries as Nepal (140th), Solomon Islands (141st), Guyana (142nd), Turkmenistan (143rd) and the Philippines (145th). Source: <https://www.worldometers.info/demographics/life-expectancy/> accessed 14/11/2025.

¹⁴ Queensland Health, 2016. *My health, Queensland's future: Advancing health 2026*. p. 11.

¹⁵ Unless otherwise stated, this data is sourced from the Queensland Health and North West Hospital and Health Service *North West Health Equity Strategy 2022-2025*, pp. 14-17.

¹⁶ Deadly Ears clinics in Queensland are located at: Bamaga, Cherbourg, Doomadgee, Injinoo, Mornington Island, Mount Isa, Normanton, Palm Island, Thursday Island and Woorabinda. Four of these (Doomadgee, Mornington Island, Mount Isa and Normanton) are in the NWHHS region. See: https://www.childrens.health.qld.gov.au/_data/assets/pdf_file/0011/172010/deadly-ears-referral.pdf

in First Nations patients at 10.4 per 100 compared to the rate of 0.35 per 100 in non-First Nations patients. The highest contributor to premature death is circulatory system diseases and rheumatic heart disease is significantly prevalent across communities in the HHS.^{17 18}

- Higher proportion of developmentally vulnerable children compared with the rest of Queensland.¹⁹ In the Lower Gulf Region 80.3% of children were developmentally vulnerable on more than one domain of the Australian Early Development Census (AEDC)
- Diabetes is the largest contributor to chronic disease-related potentially preventable hospitalisations among First Nations people with a very high mortality rate of 47.4%. Parts of the NWQ region have a premature mortality rate from diabetes 5.5 times higher than the Queensland rate.
- The rates of suicide among First Nations people in the North West Region are almost double the non-indigenous rate. Between 2014-2018, the highest rate of suicide was experienced by First Nations peoples ages between 25 to 34, they were 2.4 times higher than other Queenslanders of the same age at 44.4 per 100,000
- Less antenatal visits - 48.2% of First Nations mothers have 8 or more antenatal visits compared to 83.9% of non-First Nations mothers.
- 2020-21 First Nations People Hospital Admissions Overall, 47% of NWHHS admitted patients (excluding renal dialysis) identified as First Nations people; 95% of renal dialysis patients identified as First Nations people.²⁰
- The extent of the burden of disease in the First Nations' population indicates significant inequity of access and under-provision of clinical services, particularly in relation to screening, diagnostic services and early intervention. Of particular note, are the key indicators relating to ear and eye disease, premature deaths from cancer, mental health and suicide, and maternal and child health.²¹

This is an appalling situation and demands a proportionate and aggressive response if we are to achieve life expectancy parity for Aboriginal and Torres Strait Islander people by 2031 in NWQ, as well as meeting the other targets and priority reforms which Queensland has signed on to in the *National Agreement on Closing the Gap 2020* (NACTG 2020). This is not indulging in what some might refer to as the “deficit discourse that often pervades documents that focus on First Nations people’s health”²² – it is truth telling. It is the continuation of a situation identified in a QH report nearly 30 years ago.²³ It is evidence of institutional racism on a systemic scale.²⁴ This situation is

¹⁷ North West Hospital and Health Service, 2025. *North West Hospital and Health Service Local Area Needs Assessment – 2025 Update*. P. 36. See also Wilson, N. 2023. *Coroners Court of Queensland Findings of Inquest into the deaths of the RHD Doomadgee Cluster*. Northern Coroner, Queensland Courts.

¹⁸ See also Halter A. and Nixon M., 2025. Rheumatic heart disease cases drastically reduced in North West Queensland. *ABC North West Qld*.

¹⁹ With the proportion of children in their first year of school who were developmentally vulnerable in one or more of the five Australian Early Development Census (AEDC) domains was much higher in the North West compared with the rest of Queensland.

²⁰ North West Hospital and Health Service, 2022. *North West Hospital and Health Service Clinical Services Plan 2022 – 2037*, p. 16. Effectively, First Nations people are responsible for nearly half the hospital admissions while accounting for slightly less than a third of the NWQ population.

²¹ North West Hospital and Health Service, 2022. *North West Hospital and Health Service Clinical Services Plan 2022 – 2037*, p. 22.

²² TCHHS, *Local Area Needs Assessment: Summary Report (December 2022)*, pp. 8-9.

²³ Queensland Health, 1996. *Health of Queensland’s Aborigines and Torres Strait Islanders: Status Report*. Health Information Centre, Brisbane (Foreword by Dr RL Stable, Director General).

²⁴ Australian Government *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*. “Institutional racism is one of the main drivers of poorer health outcomes for Aboriginal and Torres Strait Islander people. However, it is less well known or understood when compared to interpersonal racism. This is because it goes beyond health staff attitudes or behaviours to include: * how organisations and systems are structured, including how they are governed, staffed, resourced, operated and held

not the fault of NWHHS alone. It is also the collective failure of Queensland Health²⁵, the A&TSICCHOs and other organisations that deliver healthcare in the region, the Department of Housing, Department of Education, DATSIP, and ultimately the Queensland and the Commonwealth governments. There is no shortage of Aboriginal and Torres Strait Islander health and health-related policies, plans, strategies, frameworks at federal, state and service level – but if these are not backed by adequate human, medical and financial resources, then they are doomed to under-deliver. But as is pointed out in the TCHHS *Clinical Services Plan 2019-2029* (p. 14), “that if we are to genuinely change the trajectory of health outcomes for our community, we need to think and act differently about how, where and what health services are delivered.” This comment is also particularly relevant to the task confronting the NWHHS and the A&TSICCHOs in NWQ.

The Indigenous Information Strategy Team of QH’s Health Statistic Centre was under no illusion when it outlined in 2012 the magnitude of the task confronting governments and the health system if we are to Close the Gap in Aboriginal and Torres Strait Islander life expectancy within a generation, by 2033²⁶:

Eliminating gaps in life expectancy between Indigenous and non-Indigenous Queenslanders will require one of the greatest decreases in mortality for any population in human history. When the leading countries of the world, including Australia, have achieved improvements of between two and three months per year for many decades, Closing the Gap will require life expectancy gains for Aboriginal and Torres Strait Islander Australians of around three times that to be sustained from now until 2033 (p. 2).²⁷

But, as the Queensland Audit Office *Performance Audit Report: Health Outcomes for First Nations People* [Report 14: 2022-23] indicates: “Queensland is not on track to close the gap in life expectancy.”²⁸ It requires the “paradigm shift” that the Productivity Commission is advocating.²⁹

The absence of publicly available, current and trend data at the HHS level for relevant health outcomes is inconsistent with the contemporary truth telling as required by s.21(2)(b) of the PS Act. There is a need for Queensland Health to include health equity KPIs on the “Our Performance” website for the transparency and accountability necessary to establish trust and consistency with the practices of contemporary good government.

accountable; * how Aboriginal and Torres Strait Islander people are excluded from, and impacted by, such processes” (p. 53).

²⁵ See Queensland Audit Office, 2023. *Performance Audit Report: Health Outcomes for First Nations People* [Report 14: 2022-23]. One of the findings is that: Queensland Health must improve how it delivers culturally appropriate care. With reference to the *Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033* the report points out: “While this 23-year strategy is intended to guide engagement with First Nations people, Queensland Health has not delivered important outputs required under the framework, like regular implementation plans and performance reporting. As a result, it cannot demonstrate how its framework has improved its culturally appropriate care over the last 13 years (p. 1)”.

²⁶ The *National Agreement on Closing the Gap 2020* specifies “Target 1: Close the Gap in life expectancy within a generation, by 2031” (p.17).

²⁷ Queensland Health, 2012. *Closing the Gap between Indigenous and non-Indigenous Life Expectancy: Experimental Life Tables by Remoteness, Queensland, 2002-04 and 2005-07*. Indigenous Information Strategy Team, Health Statistics Centre, Brisbane.

²⁸ Queensland Audit Office, 2023. *Performance Audit Report: Health Outcomes for First Nations People* [Report 14: 2022-23], p. 8.

²⁹ Productivity Commission, 2024. *Review of the National Agreement on Closing the Gap: Study Report* (Volume 1). P. 3.

The Matrix for Identifying Measuring and Monitoring Institutional Racism Within Public Hospitals and Health Services

The development of the Bukal Matrix for Identifying, Measuring and Monitoring Institutional Racism in Public Hospitals and Health Services is based on the following guiding principles:

- Basic premise: what can be measured can be managed
- Purposes:
 - To encourage transparency and accountability in the implementation of public health policies intended to close the gap in Indigenous health disparities
 - To create a framework for discussion about particular issues that a Matrix audit may raise
- Methodology:
 - It is based on a simple measuring system – each of the criteria is allocated a number of points against which a score is given
 - The criteria selected for measurement are drawn from public federal and state closing the gap health policies, legislation and related documents
 - Only publicly available information (including that available online) is used in the measuring process (eg, HHS annual reports, health service agreements, board meeting summaries, strategic plans, RAPs, government reports, Closing the Gap reports, etc.)
 - d) It is a desk-top exercise – no interviews are conducted with people associated with the organisation subject of an institutional racism Matrix audit
 - Audits can be conducted periodically (the monitoring function of the Matrix) so that comparisons can be made over time towards the elimination of institutional racism
 - Application: as a measuring tool it can be used both externally and internally
 - It does not measure:
 - The incidence of interpersonal racist behaviour, casual racism, etc. However, it is argued that in organisations that exhibit high levels of institutional racism, a workplace culture can exist whereby interpersonal racist behaviours can flourish and go unaddressed.³⁰
 - Clinical performance
 - It is adaptable: it can be used in other domains where institutional racism is experienced by the Indigenous community (e.g. criminal justice system, child welfare, education, public housing, etc).

³⁰ Australian Government, *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*. “Interpersonal racism refers to the ‘interactions between people that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups’ [Paradies, et al 2008]”(p. 51).

Legislative And Policy Context

NATIONAL

- *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*.³¹
- National Agreement on Closing the Gap (2020)
- Productivity Commission Review of the National Agreement³²
- Australian Human Rights Commission *National Anti-Racism Framework*³³

QUEENSLAND

- *Hospital and Health Boards Act 2011* (Qld)
- *Hospital and Health Boards Act (Health Equity Strategies) Amendment Regulation 2021* (Qld).
- *Public Sector Act 2022* (Qld) Part 3 Reframing of State's relationship with Aboriginal peoples and Torres Strait Islander peoples³⁴

QUEENSLAND HEALTH

- First Nations First Health Budget 2024-25³⁵
- *HEALTHQ32: First Nations First Strategy 2032*
- Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033
- Queensland Health – North West Hospital and Health Service, 2022. *Service Agreement 2022/23 – 2024/25* [December 2024 Revision]
- *Reframing the Relationship Plan 2024-2025*³⁶

³¹ Australian Government Department of Health, 2021. *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*.

³² Productivity Commission, 2024. *Review of the National Agreement on Closing the Gap: Study Report* (Volume 1). Australian Government, Canberra.

³³ Australian Human Rights Commission, 2024. *The National Anti-Racism Framework: A roadmap to eliminating racism in Australia*.

³⁴ *Public Sector Act* (Qld), Part 3 ss. 19 – 23.

³⁵ Queensland Health, 2024. *First Nations First Health Budget 2024-25*. Available at: https://www.health.qld.gov.au/_data/assets/pdf_file/0013/1340014/First-Nations-First-Health-Budget-2024-25.pdf

³⁶ Queensland Health, 2024. *Reframing the Relationship Plan 2024-2025*. The Plan “provides a whole of health system response to meeting the mandated responsibilities in accordance with the *Public Sector Act 2022*” (p. 3). Under s.22(b) of the *Public Sector Act 2022*, Hospital and Health Services are prescribed entities, and, in accordance with s.23(1) “The chief executive of a prescribed entity must, as part of the entity’s workforce planning, make a document (a **reframing the relationship plan**), informed by the matters mentioned in section 21, that identifies the measures for developing the cultural capability of the entity when – (a) providing advice to the State government; and (b) delivering services to the community. (2) The reframing the relationship plan must be published – (a) on the prescribed entity’s website;”.

NORTH WEST HOSPITAL AND HEALTH SERVICE

- *Aboriginal and Torres Strait Islander Workforce Strategy 2019-2026*³⁷
- *Consumer Engagement Strategy - 2021-2023*
- *Health Equity Implementation Plan 2022-2025*³⁸
- *North West Health Equity Communications + Community Engagement Plan 2022-2025*³⁹
- *North West Health Equity Strategy 2022-2025*⁴⁰
- *North West HHS Equity and Diversity Plan 2024-2027*
- *North West Hospital and Health Service Clinical Services Plan 2022 - 2037*
- *NWHHS Local Area Needs Assessment 2022*
- *NWHHS Strategic Plan 2024-2028*
- *NWHHS Consumer + Community Engagement Strategy*

³⁷ North West Hospital and Health Service, 2019. *Aboriginal and Torres Strait Islander Workforce Strategy 2019- 2026*.

³⁸ Gidgee Healing and North West Hospital and Health Service, 2022. *Health Equity Implementation Plan 2022-2025*.

³⁹ North West Hospital and Health Service, 2022. *North West Health Equity Communications + Community Engagement Plan 2022*.

⁴⁰ Queensland Health and North West Hospital and Health Service, 2022. *North West Health Equity Strategy 2022 – 2025*.

NWHHS Matrix Audit for the 2024-2025 Reporting Period

NWHHS Institutional Racism Matrix Audit for 2024-25⁴¹

Key Indicators and Criteria	Scoring	Score
1 Participation in HHS governance		
Good governance⁴²	Total out of 10	
- Board interaction with Aboriginal and Torres Strait Islander community (1)	3	0.5
- HHS Aboriginal and Torres Strait Islander health performance reviewed by Board at least 2 x per year (2)	4	1.5
- Direct input to board by HHS Aboriginal and Torres Strait Islander Community Consultative Committee (3)	3	1
Aboriginal and Torres Strait Islander representation at board level (North West Hospital and Health Board (NWHHB))	Total out of 10	
- Indigenous representation (4)	10	10
Inclusion in Executive Management Structure	Total out of 10	
- Aboriginal and Torres Strait Islander Health Division (5)	5	5
- Aboriginal/Torres Strait Islander Executive Director (6)	5	5
Total	30	23
2 Policy Implementation		
Improving Aboriginal and Torres Strait Islander Health Outcomes (7)	Total out of 10	
- Explicitly identified as a strategic priority in HHS Strategic Plan (8)	5	5
- Aboriginal and Torres Strait Islander health outcome KPIs explicitly referred to in HHS Strategic Plan (9)	5	5
Community Engagement	Total out of 10	
- Aboriginal and Torres Strait Islander community consultative body (10)	3	3
- Aboriginal and Torres Strait Islander community engagement strategy (11)	3	3
- HHS Aboriginal and Torres Strait Islander community newsletter/e-letter (12)	2	2
- At least one Aboriginal and Torres Strait Islander community forum/meeting per year convened by the HHS chief executive (13)	2	2
Public Reporting and Accountability (via annual report) (14)	Total out of 10	
- Traditional Owner acknowledgement (15)	1	1

⁴¹ Revised Queensland Health Matrix Template: Reworked version based on discussions at ADCQ Workshop, 12 November 2018.

⁴² This criterion essentially measures Board interactions with the North West First Nations community. While the 14 monthly Board meeting summaries for the period July 2024 to September 2025 were viewed (no summary for November 2024), for assessment purposes, only the Board meeting summaries for the 2024-2025 reporting year will be referred to.

- Improving Aboriginal and Torres Strait Islander health outcomes		
i. Separate section in report devoted to Aboriginal and Torres Strait Islander health (16)	1	0.5
ii. Reporting on KPIs contained in current health service agreement (17)	1	0
- Policy References		
i. Cultural Capability Framework (18)	1	0
ii. Making Tracks (19)	1	1
- Aboriginal and Torres Strait Islander health division / unit placement on HHS organisational structure / chart (20)	1	1
- Data on Aboriginal and Torres Strait Islander access to and delivery of services (21)	1	1
- Aboriginal and Torres Strait Islander Employment		
i. Data on Aboriginal and Torres Strait Islander employment (22)	1	1
ii. Reference to workforce planning, recruitment, etc. (23)	1	1
- Other recognition (e.g., awards, scholarships, etc (24)	1	0.5
Total	30	

3 Service delivery and Partnerships

• Aboriginal and Torres Strait Islander HHS Plan (25)	Total out of 10	
- Co-designed with ATSICCHO(s) in HHS region (26)	2	2
- Formal agreement with ATSICCHO(s) in HHS region (e.g., MoU) (27)	2	2
- Commitment to Continuous Quality Improvement (28)	2	2
- Mutually agreed KPIs (29)	2	2
- Clear statement of parties' responsibilities (e.g., sharing of patient health records) (30)	2	2
• Cultural safety	Total out of 10	
- Cultural safety policy/strategy (31)	4	4
- Capacity to deliver Cultural Safety Training (CST)(32)	3	3
- Proportion of staff trained (33)	3	3
• Selected Health Service Performance Indicators	Total out of 10	
- Estimated level of completion of Indigenous status – specifically the reporting of 'not stated' on admission (34)	2	0
- Discharges against medical advice (DAMA) (35)	2	2
- Potentially preventable hospitalisations (PPH) (36)	2	2
- Access to mental health services (37)	2	2
- Low birth-weight babies (38)	2	2
Total	30	28

4 Recruitment and employment

• Aboriginal and Torres Strait Islander health workforce development	Total out of 20	
- Aboriginal and Torres Strait Islander workforce development policy/strategy/framework (to also include identified positions according to their nature, role, consumer type and objectives of the service to be provided) (39)	4	3
- HHS KPI for Aboriginal and Torres Strait Islander employment (40)	4	2
- Number of Aboriginal and Torres Strait Islander health practitioners, health workers and liaison officers (41)	4	3
- Number of identified Aboriginal and Torres Strait Islander positions (42)	4	4
- Number of salary bands occupied by Aboriginal and Torres Strait Islander employees (43)	4	4
• Aboriginal and Torres Strait Islander participation in the health workforce ^{43 44 45}	Total out of 10	
- Managerial and clerical (44)	1.5	1.5
- Medical including Visiting Medical Officers (VMOs) (45)	2	2
- Nurses (46)	2	0
- Operational and Support Services (47)	1.5	1.5
- Trade and Artisans (48)	1.5	1.5
- Health Practitioners (Professional and Technical) (49)	1.5	0
Total	30	22.5

⁴³ Employees of NWHHS are employed across six streams:

- Managerial and Clerical
- Aboriginal and Torres Strait Islander Health Workforce
- Medical including Visiting Medical Officers (VMOs)
- Nursing and Midwifery
- Operational

Professional and Technical.

The six streams have been adjusted to reflect this.

Source: Queensland Health, 2025. *Equity and Diversity Report 2025: North West Hospital and Health Service*, p. 7.

⁴⁴ The original purpose of this criterion was to show how many First Nations staff were employed in each workforce stream.

⁴⁵ First Nations MOHRI Occupied FTE

Stream	First Nations MOHRI FTE
Medical incl VMOs	<5
Nursing / Midwifery	25.54
Health Practitioners /Dentists/Clinical Asst	<5
Clinical Stream – Total	25.54
Non Clinical Stream – Total	62.36
Managerial and Clerical	17.68
Operational	15.68
Trade and Artisans	0.00
Professional and Technical (Non Clinical)	<5
Aboriginal and Torres Strait Islander Health Workforce	29.00
All Streams	87.9

Source: Queensland Government, Trip Pack Report (HRBI)

5 Financial Accountability and Reporting: Closing the Gap Funding

• Commonwealth contribution to HHS	Total out of 10	
- Commonwealth contributions (50)	10	0
• Queensland contribution to Indigenous specific health services and programs	Total out of 10	
- Making Tracks funded services (as per HHS Service Agreement) (51)	5	3
- Indigenous-specific non-Making Tracks health services (as per HHS Service Agreement) (52)	5	2
Total	20	5
Score	140	105.5

Institutional Rating scored against criteria

Score:	>110	80-109	60-79	40-59	20-39	<20
Evidence of Inst. Racism:	Very Low	Low	Moderate	High	Very High	Extreme

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Notes:

(1) Monthly Board meeting summaries follow a standard format: date held and attendance; board committee updates; HSCE report on HHS operations and activity for previous month; and a list of other key agenda items discussed (including but not limited to). All this is usually reported on one page, although some include a couple of pages of photographs and short descriptions of meetings involving Board members that have taken place within the community. This contrasts with the minutes of the quarterly meetings of the Consumer Advisory Networks (CAN) and Consumer Advisory Groups (CAG) which are around 6 to 10 pages containing substantive information [see Note 3 below]. Only one Board meeting summary, for May 2025, contains a reference to a meeting in the First Nations community when the Board Chair, HSCE and ED First Nations Health travelled to Doomadgee and Mornington Island on 28 May with the Queensland Minister for Health and Ambulance Services and the Director-General Queensland Health for the official renaming of Doomadgee Hospital to Yellagundgimarra and the grand opening of the newly completed Ngarnal Community Health Building on Mornington Island. Given the Tripartite Agreement between the NWHHS, Gidgee Healing and the WQPHN as the lead primary health care organisations, representing the key peak public health institutions within North West Queensland, it might be expected that there would have been at least one meeting (perhaps a Board engagement luncheon) between NWHHS members and Gidgee Healing. Given that only the Board Chair, and not the whole Board, travelled to Doomadgee and Mornington Island for these auspicious occasions, and in the absence of any other reported meetings in the Board meeting summaries with First Nations community groups and partners, only half a point is being awarded. **Score = 0.5/3**

(2) According to the Board meeting summary for July 2024, the Rheumatic Heart Disease (RHD) Report was discussed as a key agenda item. In the December meeting, a key agenda item

discussed was an update of the Health Equity Strategy implementation plan. The Gidgee Healing and North West Hospital Health Service *Health Equity Implementation Plan 2022-2025*, regarding performance monitoring, states that: “Progress against actions and performance measures will be reported quarterly to the NWHHS Board ...” (p. 8). Quarterly reports are delivered in September, December, March and June. However, the Board meeting summaries for 2024-2025 only record one report/update being discussed. For the one update on the HES implementation plan and the discussion of the RHD Report 1.5 points are awarded. **Score = 1.5/4**

(3) Because of its vast geographic spread of communities and facilities, the NWHHS maintains six, effectively, regional Consumer Advisory Groups (CAG) and Consumer Advisory Networks (CAN), none of which specifically constitute an Aboriginal and Torres Strait Islander community consultative body/committee, although all have First Nations representation. The CANs and CAGs are: Mount Isa and Camooweal Consumer Advisory Network; Cloncurry Consumer Advisory Network; Normanton Consumer Advisory Group; Burketown Consumer Advisory Group; Karumba Consumer Advisory Group; and Julia Creek Consumer Advisory Network. There is also a Mental Health, Alcohol and Other Drugs (MHATODS) Consumer Advisory Group. The CANs and CAGs meet every three months to talk about health services in their communities (See: <https://www.northwest.health.qld.gov.au/about-us/consumer-advisory-groups> Accessed 8/01/2026). The NWHHS *Annual Report 2024-2025* also records that “health councils [are] active in Doomadgee and Mornington Island” (p. 34).

The *North West Health Equity Strategy 2022-2025* and the *Health Equity Implementation Plan 2022-2025* are overseen by a Health Equity Governance Collaborative (HEGC)⁴⁶, which is represented by a majority of First Nations peoples and community health organisations. The HEGC meets quarterly. However, in the Board meeting summaries for 2024-2025, no references are made to any meetings/inputs of the HEGC with the NWHHB. Similarly, in the Minutes for quarterly CAG and CAN meetings for Mount Isa, Julia Creek MPHS, Normanton Hospital & Community Health, Cloncurry MPHS and Burke Shire for the 2024-2025 reporting period, no reference is made to the HEGC. In the Minutes of the NWHHB Stakeholder Engagement Committee Meeting (14/10/2024), under Item 3.2 Consumer and Community Engagement Strategy Update, it is recorded that “Consumer engagement activities were held in Doomadgee, Camooweal and Normanton, ... [and that] Executive, Board and senior staff attended all consumer group meetings during this period [ie, the quarter from mid-July to mid-October].”

Score = 1/3

(4) The NWHHB currently consists of eleven members, three of whom identify as Indigenous people (NWHHS *Annual Report 2024-2025*, pp. 16-19). **Score = 10/10**

(5) The NWHHS has an executive team of nine personnel. The HHS has an executive division of First Nations Health [NWHHS *Annual Report 2024-2025*, see pp. 22-24. The North West Hospital and Health Service *Financial Statements – 30 June 2025* (p. 30) lists 10 positions – the Chief Information Officer, Rural and Remote being the additional position]. **Score = 5/5**

(6) The position of Executive Director First Nations Health is occupied by an Indigenous person (See: <https://www.northwest.health.qld.gov.au/about-us/executive-team/> Viewed 16/10/2025) **Score = 5/5**

(7) With the passage into law of the *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021* (Qld) and the establishment of mandatory health equity strategies (HES) and implementation plans by all HHSs, these have effectively become the principal

⁴⁶ The HEGC comprises representation from Gidgee Healing, WQPHN, Mornington Island Health Council, Yellagundgimarra Health Council, QAIHC, and a community representative (QH-NWHHS *North West Health Equity Strategy 2022-2025*, p. 61). The NWHHS *North West Health Equity Governance Collaborative: Terms of Reference*, in addition to those members, also lists the NWHHS and North West Remote Health (p. 7).

mechanisms driving the improvement in health outcomes for Aboriginal and Torres Strait Islander people in Queensland.

(8) The NWHHS *Strategic Plan 2024-2028* has five focus areas, one of which is First Nations. With regard to First Nations, the strategic objectives are: “Increase health equity and parity of life expectancy by 2031; Strengthen relationships with communities; and Support First Nations workforce.” One of the strategic opportunities identified is: “Action the Health Equity reform agenda specifically with First Nations peoples.” See: https://os-data-2.s3-ap-southeast-2.amazonaws.com/nwhhs/bundle3/nwhhs_strategic_plan_20242028_2025_review.pdf viewed 16/10/2025). However, the NWHHS *Strategic Plan 2024-2028* is a short, focused document and does not contain the space to detail KPIs. Therefore, from a strategic planning perspective, the primary documents for First Nations health are the QH-NWHHS *North West Health Equity Strategy 2022-2025* and the Gidgee Healing and North West Hospital Health Service *Health Equity Implementation Plan 2022-2025*. **Score = 5/5**

(9) The Gidgee Healing -NWHHS *Health Equity Implementation Plan 2022-2025* contains some 27 KPIs which are separately listed under the following Key Performance Areas (KPA):

KPA 1: Improving First Nations health and wellbeing outcomes – 13 KPIs (pp. 11-12)

KPA 2: Actively eliminating racism from health services in the North West – 4 KPIs (p. 15)

KPA 3: Increasing access to quality healthcare – 7 KPIs (p. 20)

KPA 4: Influencing the social, cultural and economic determinants of health – nil

KPA 5: Delivering sustainable, culturally safe and responsive health services – 3 KPIs (p. 26)

Some of these KPIs are new initiatives with baselines still to be established, however, this does not detract from the range of the KPIs. **Score = 5/5**

(10) In the context of the *North West Health Equity Strategy 2022-2025* and the *Health Equity Implementation Plan 2022-2025* the Health Equity Governance Collaborative (HEGC), which is represented by a majority of First Nations peoples, is taken to be the Aboriginal and Torres Strait Islander community consultative body. See also Note 3. **Score = 3/3**

(11) The Gidgee Healing - NWHHS *Health Equity Implementation Plan 2022-2025* in accordance with KPA 6: Working with First Nations peoples, communities and organisations to design, deliver, monitor and review health services, one of the activities regarding 6.1.1: North West Health Equity Governance Collaborative, will be to “Maintain and galvanise the role of the North West Health Equity Governance Collaborative throughout the implementation period, to provide oversight of the key action areas and to ensure First Nations’ leadership in decisions relating to health services reform across the North West region”. This will also include: “Implement[ing] the strategies contained within the North West Health Equity Communications and Community Engagement Plan to ensure widespread community participation in the design, planning, implementation and evaluation of health services, including Traditional Owners, Elders, locally elected leaders, community-based organisations and other interested individuals/groups” (p. 27). Further, under 6.2.2: Strengthen community and stakeholder engagement in the design delivery and review of all health services for First Nations people, the implementation activity involves: “Continu[ing] to implement the recommended actions contained within the North West Health Equity Communication and Community Engagement Strategy to optimise community and stakeholder participation and engagement in the design, planning, implementation and evaluation of the First Nations’ Health Equity reform process” (p.28). The NWHES (and its Implementation Plan), therefore, contains within its structure and operations mechanisms for effective Aboriginal and Torres Strait Islander community engagement. **Score = 3/3**

(12) No evidence was found of a NWHHS [e-]newsletter published specifically for the First Nations community; however, the HHS publishes an e-magazine *Balance* quarterly. This is quite a large magazine (50+ pages) and it does have a section in each edition dedicated to Aboriginal and Torres Strait Islander health. See for example *Balance* Vol.13 (Winter Edition June 2025) pp. 37-47. This edition covers such topics as: the NWHHS partnership with Orange Sky and the

Reconciliation award; Reconciliation Week; the restoration of the name Yellagundgimarra to the hospital at Doomadgee; a new chapter for health on Mornington Island; a new generation of Nursing care in Western Queensland; the Health Equity Implementation plan and 13YARN (see: https://issuu.com/nwhhs/docs/balance_e-magazine_volume_13_-_winter_edition accessed 25/10/2025). The NWHHS website also enables ready access to First Nations health news. For example, the “Latest News” portal provides an item about North West HHS announcing the New Assistant Director of Nursing – Kidney Services who is an Indigenous person (16 June 2025) (see <https://www.northwest.health.qld.gov.au/about-us/latest-news/north-west-hhs-announces-new-assistant-director-of-nursing-kidney-services/> accessed 25/10/2025). The NWHHS website also has a Community Services portal with a link to Aboriginal and Torres Strait Islander Health, where information about, for example, the Indigenous Primary Health Care Service and the First Nations Health Skin Program can be found (see: <https://www.northwest.health.qld.gov.au/community-services/aboriginal-and-torres-strait-islander-health/> accessed 25/10/2025). **Score = 2/2**

(13) This is a difficult requirement to meet for such a region as vast and diverse as North West Queensland. It is clear from the NWHHS news items and the *Balance* magazine (see Note 12) that many meetings involving a range of people, including the HSCE, are held at communities (Doomadgee, Mornington Island, Camooweal, etc) around the region throughout the year. Many meetings also take place virtually. Given the logistical challenges faced in organising meetings in the region (compared to say those of the metropolitan HHSs), a formal forum/meeting convened by the HSCE would be impractical and probably ineffective. However, it is clear that the HSCE does attend First Nations community events, particularly in Mt Isa. For example, the HSCE attended the community’s NAIDOC Week (7-14/7/2025) celebrations, and most importantly, the Statement of Commitment to Reconciliation (originally published in 2019) was reaffirmed and signed by the HSCE, NWHHS Board Chair and the Assistant Commissioner QAS Northern Region at an event hosted by the ED FNH and attended by NWHHS Board members, community Elders, and community members (NWHHS *Balance* Vol. 9, pp. 42-44. See: https://issuu.com/nwhhs/docs/balance_magazine_-_winter_edition_2024 viewed 26/10/2025). **Score = 2/2**

(14) Annual reports are an important way of communicating HHS performance and accountability to the community. According to the Department of the Premier and Cabinet’s *Annual report requirements for Queensland Government agencies (2024-2025 reporting period)*: “Annual reports are a key accountability document and the principal way agencies report on non-financial and financial performance. The Auditor-General notes that ‘annual reports support transparency and can drive continuous improvement in performance. Where annual reports incorporate relevant and reliable performance information, they increase trust and confidence in government services delivery’ (*Auditor-General’s Report to Parliament No. 4 for 2013-14* p. 12). “All agencies have a strategic plan, which provides the foundation for annual reports. Agencies are expected to present meaningful, complete, and accurate information with an emphasis on quality” (p. 7). There are many different users of annual reports including members of the community who have an interest in the performance and achievements of government in relation to services provided to the community. Among the characteristics of a quality annual report is that it “provides a historical account of performance including longer term trends and outcomes” (pp. 7-8). Their content and format are laid out in the *Annual report requirements for Queensland Government agencies (2024-2025 reporting period)*, for which there is also a compliance checklist template (pp. 53-54) (See https://www.qld.gov.au/_data/assets/pdf_file/0029/259148/annual-report-requirements.pdf Accessed 24/11/2025). However, the only reference to Aboriginal and Torres Strait Islander people in the *Annual report requirements for Queensland Government agencies (2024-2025 reporting period)* is in relation to section 15. Governance – human resources, whereby agencies are required to report on their workforce profile in terms of the representation of women, women

in leadership roles, Aboriginal Peoples and Torres Strait Islander Peoples, people with disability and people with culturally and linguistically diverse (CALD) backgrounds in employment (pp. 24-25). Statutory bodies “are encouraged to include ... in the annual report how employment of Aboriginal and Torres Strait Islander peoples has been supported, identifying major commitments and strategies, relevant targets, and progress towards meeting targets” (p. 26). Annual reports are available online at QH and HHS websites and can be downloaded as PDFs.

(15) The NWHHS acknowledges the TOs/Custodians in the 11 regions/centres served by the NWHHS (*NWHHS Annual Report 2024-2025*, pp. 3 and 12). **Score = 1/1**

(16) There are two sections in the *NWHHS Annual Report 2024-2025* specifically regarding First Nations health, although other references are made in the annual report (for example, under *Our priorities*, p. 10; *Strategic workforce planning and performance*: Diversity target group data in relation to Aboriginal peoples and Torres Strait Islander peoples p. 27; and several references under *Our performance: non-financial performance*, pp. 33, 34, 36 and 37). The first: *Aboriginal and Torres Strait Islander health* (pp. 10-11); and the second: *Improving First Nations health and wellbeing outcomes* (pp. 38-40) cover various matters related to Aboriginal and Torres Strait Islander health, including the development of the NWHHS and Implementation Plan. A score of 0.5 is awarded on the basis that while there are two sections and multiple references in the 2024-2025 annual report devoted to Aboriginal and Torres Strait Islander health (and health related matters), however, they tell us little in the way of real health outcomes measured, for example, against relevant Closing the Gap targets, for example Target 1: Close the Gap in life expectancy within a generation, by 2031; and Target 2: By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent. **Score = 0.5/1**

(17) In the *QH-NWHHS Service Agreement 2022/23 – 2024/25* [December 2024 Revision], Table 9 HHS Performance Measures – Key Performance Indicators (p. 33) contains four indicators specifically mentioning First Nations peoples: Potentially Preventable Hospitalisations – First Nations peoples; Diabetes complications; and Selected conditions; Potentially avoidable deaths – First Nations Peoples; Proportion of healthy birthweight babies (.....) – Aboriginal and Torres Strait Islander babies; and Suicide count and rate – First Nations Peoples. Table 11 HHS Performance Measures – Outcome Indicators contains two indicators: First Nations peoples’ representation in the workforce, and General oral health care for First Nations peoples (p. 35). However, none of these KPIs and Outcome Indicators include a target number or percentage, or, for example, a set of quarterly targets. While the *NWHHS Annual Report 2024-2025* (p. 27) provides basic data on Aboriginal and Torres Strait Islander employment (99 employees comprising 9.92%), it provides no other KPI data for either of these sets of indicators. **Score = 0/1**

(18) No references to the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033* were found in the *NWHHS Annual Report 2024-2025*. **Score = 0/1**

(19) The *NWHHS Annual Report 2024-2025*, on p. 40, makes reference to Making Tracks: “North West HHS is investing \$3.1 million annually in the Making Tracks programs to address the health needs of First Nations people in the region. This investment aims to enhance healthcare outcomes by aligning with the First Nations Aboriginal and Torres Strait Islander Health Equity Framework.”. **Score = 1/1**

(20) The NWHHS organisational structure shows the Executive Director First Nations Health on the organisational chart (*NWHHS Annual Report 2024-2025*, p. 25). **Score = 1/1**

(21) The *NWHHS Annual Report 2024-2025*, in the section *Improving First Nations health and wellbeing outcomes* (pp. 38-40), provides a number of examples of improved access to healthcare services, including the Maternal and Child Health initiative (with funding of \$1.7 million aimed at First Nations mothers, infants and children; expanding renal dialysis services (currently available in Cloncurry, Doomadgee and Mornington Island); the patient transport service for individuals in Mt Isa which has doubled from 6,143 in 2021-2022 to 12,211 in 2024-

2025; and the investment in the Making Tracks programs which include chronic disease management, targeting renal health, cardiac and Rheumatic Heart Disease, and diabetes care.

Score = 1/1

(22) According to the NWHHS *Annual Report 2024-2025* (p. 28): “As at June 2025, 10 per cent of the North West HHS workforce identifies as Aboriginal and/or Torres Strait Islander.” [Aboriginal peoples and Torres Strait Islander peoples – Headcount = 99; Percentage = 9.92% (p. 27)]. **Score = 1/1**

(23) The NWHHS *Annual Report 2024-2025* (p. 28) makes mention of the *North West Aboriginal and Torres Strait Islander Workforce Strategy 2019-2026*. Key performance measure 5: Delivering sustainable, culturally safe and responsive health services of the *North West Health Equity Strategy 2022 - 2025* (pp. 55-60) is primarily concerned with First Nations workforce development. In relation to the heading Delivering sustainable, culturally safe and responsive health services, the annual report also references the North West HHS First Nations Leadership Program, Deadly Start and the Aboriginal and Torres Strait Islander Cadetship Program 2025 (p. 39), programs which recruit and train First Nations people for various possible roles within the NWHHS workforce. **Score = 1/1**

(24) While individual achievements of Aboriginal and Torres Strait Islander staff are often mentioned in news items on the NWHHS website, it is not a Queensland Government *Annual report requirements for Queensland Government agencies (2024-2025 reporting period)* requirement that HHSs maintain a section in their annual reports highlighting staff achievements. However, it is noted that: “On 2 June 2025, North West HHS alongside Orange Sky Australia were awarded Highly Commended in the Partnership category for the Queensland Reconciliation Awards for the collaborative work done contributing to the significant reduction in RHD rates in North West Queensland.” Orange Sky provided laundry services in Doomadgee and Mt Isa and commenced in Mornington Island in September 2024 [NWHHS *Annual Report 2024-2025* (p. 38)]. However, no mention is made in the annual report of awards, scholarships, recognition of special achievements, etc., for staff – Indigenous and non-Indigenous. Rather, *Balance*, the NWHHS quarterly e-magazine, is the principal publication for celebrating staff (Indigenous and non-indigenous) awards and achievements. **Score = 0.5/1**

(25) The NWHHS *Health Equity Strategy 2022-2025* and its *Implementation Plan 2022-2025* together effectively constitute the NWHHS’s Aboriginal and Torres Strait Islander health plan. The QH-NWHHS *Service Agreement 2022/23-2024/25* [December 2024 Revision] requires that: “1.3 ... The parties recognise the importance of the HHS’ Health Equity Strategy (as defined in the Act) and the parties commitment to improving health and wellbeing outcomes and achieving health equity for Aboriginal and Torres Strait Islander peoples” (p. 6). Furthermore: “3.1 In delivering services, the HHS is required to meet: (a) the applicable conditions of all national agreements and national partnership agreements between the Queensland Government and the Commonwealth and commitments under any related implementation plans “(p. 6). With regard to Commonwealth-state agreements, the Service Agreement states: “9.2 The Health Equity Strategy will act as the principal accountability mechanism between community and the HHS in achieving health equity for First Nations Queenslanders and forms a key part of the Queensland Government’s commitment to the *National Agreement on Closing the Gap* (2020)” (p. 10).

(26) With regard to the development of an Aboriginal and Torres Strait Islander HHS plan, the *North West Health Equity Strategy 2022-2025* is that plan. The NWHHS has had a Tripartite Agreement with Gidgee Healing and the Western Queensland Primary Health Network (WQPHN) since 2019. “As part of the Health Equity reform process, this formal partnership was expanded to establish the North West Health Equity Governance Collaborative (NWHEGC) with the membership of this group also comprising Yellagundgimarra Health Council (Doomadgee) [and] Mornington Island Health Council...” (p. 11). While NWHHS, Gidgee Healing and WQPHN remain the principal partners of the Tripartite Agreement (p. 19-20), the other stakeholders under

the leadership of the NWHEGC were responsible for leading the co-design process for the NWHES. **Score = 2/2**

(27) As stated above, the NWHHS has had a Tripartite Agreement with Gidgee Healing and WQPHN since 2019. The three partners are lead primary health care organisations. Combined, they represent the key peak public health institutions within NWQ. The basic terms of that Agreement are described in the *North West Health Equity Strategy 2022-2025* (pp. 19-20). The NWHHS, from time to time, also enters into formal agreements with the ATSICCHOs in its region, for example, the 2023-24 agreement with the Mornington Island Aboriginal Corporation for Health [under the Connected Community Pathways – First Nations Skin Health Initiative project]. See also *NWHHS Annual Report 2024-2025*, p. 33. **Score = 2/2**

(28) The Gidgee Healing & North West Hospital and Health Service *Health Equity Implementation Plan 2022-2025* demonstrates a clear commitment to continuous quality improvement. In terms of monitoring the performance regarding the implementation of the NWHES:

“Progress against actions and performance measures will be reported quarterly to the NWHHS Board, Executive Leadership Team, Health Equity Governance Collaborative and staff. A performance measures scorecard will be published annually and shared with stakeholders and the First Nations Health Officer, Queensland Health. The Implementation Plan will be reviewed and updated annually, responding to changes and priorities, emerging needs, data and performance measure analysis, ensuring continuous quality improvement” (p. 8). **Score = 2/2**

(29) Insofar as the NWHES and Implementation Plan are the product of a co-design process with the ATSICCHOs in the region [Gidgee Healing, Yellagundgimarra Health Council (Doomadgee), Mornington Island Health Council/Ngarnal Aboriginal Community Controlled Health Service] (see Note 26), then it is assumed that the KPIs are mutually agreed. **Score = 2/2**

(30) In response to the example provided re sharing of patient health records, the Gidgee Healing & North West Hospital and Health Service *Health Equity Implementation Plan 2022-2025* (p. 16) will, under KPA 3: Increasing access to quality healthcare, “3.1 Support an integrated, culturally safe Model of Care (MoC) aligned with Gidgee Healing, RFDS and general practice systems to ensure responsive and comprehensive care.” This will be done by, *inter alia*, “3.1.4: Ensuring the ethical and responsible exchange of patient information between providers to optimise continuity of care and promote multi-disciplinary team based care” for which there are four implementation activities described (p. 17). **Score = 2/2**

(31) The NWHHS does not have a stand-alone cultural safety policy/strategy as such. Instead, it is embedded within the NWHES 2022-2025 and Implementation Plan – see suite of actions to be taken under HES KPA2: Actively eliminating racism from health services in the North West (pp. 13-4). These are summarised in **Note 32** below. **Score = 4/4**

(32) The Gidgee Healing & North West Hospital and Health Service *Health Equity Implementation Plan 2022-2025* will, under KPA 2: Actively eliminat[e] racism from health services in the North West. To do this “2.1.1: NWHHS will monitor the effectiveness of cultural safety initiatives and report this to staff and community to ensure continuous and sustained improvement” and 2.2.1: “Ensure all staff have completed the mandatory Cultural Practice Program and continue to foster a continuous learning environment to optimise cultural safety of health services” (p. 13). Implementation activities for 2.2.1 involve: “* Ensuring cultural safety training, cultural mentoring and supervision frameworks are available and embedded in business operations; * Partner[ing] with Gidgee Healing to co-design and share cultural resources and best practice approaches to ensuring culturally-safe health services; and * Formalis[ing] local networks with cultural leaders and advisors e.g. Health Councils to assist implementation and co-design of locally developed and delivered cultural orientation programs” (p. 13). Collectively, these actions are designed to ensure capacity to deliver cultural safety training. **Score = 3/3**

(33) The NWHHS *Annual Report 2024-2025* (p. 31) states that: “Employees are required to undertake training regarding inappropriate workplace behaviours...., discrimination, ... ethics, fraud, and conflicts of interest.” Nothing about cultural safety training. The Gidgee Healing & North West Hospital and Health Service *Health Equity Implementation Plan 2022-2025* will, under KPA 2: Actively eliminat[e] racism from health services in the North West. To do this “2.1.1: NWHHS will monitor the effectiveness of cultural safety initiatives and report this to staff and community to ensure continuous and sustained improvement” and 2.2.1: “Ensure all staff have completed the mandatory Cultural Practice Program and continue to foster a continuous learning environment to optimise cultural safety of health services” (p. 13). The *Health Equity Implementation Plan* contains the following KPM for staff cultural capability training: 2.2: Increase proportion of NWHHS staff who have completed mandatory capability training from a baseline of 81.6% to a target of 90% (p. 15). **Score = 3/3**

(34) While a standard QH admission form question (see: https://www.health.qld.gov.au/data/assets/pdf_file/0029/159626/cct-aandtsi-identification-v1.pdf Accessed 7/01/2026), the QH-NWHHS *Service Agreement 2022/23-2024/25* [December 2024 Revision] does not list estimated level of completion of Indigenous status amongst its performance measures (see Tables 9, 11 and 12 pp. 33-6), and the NWHHS *Annual Report 2024-2025* does not contain any data on this indicator. There is also no reference to this indicator in the NWHHS and HEIP. **Score = 0/2**

(35) **DAMA** The QH-NWHHS *Service Agreement 2022/23-2024/25* [December 2024 Revision] in Tables 9 HHS Performance Measures – Key Performance Indicators; 11 HHS Performance Measures – Outcome Indicators; and 12 Statewide Health Equity Key Performance Measures does not list DAMA amongst its performance measures (pp. 33-35), and the NWHHS *Annual Report 2024-2025* does not contain any data on this indicator. The Queensland Audit Office *Health outcomes for First Nations people (Report 14:2022-23)*, however, reports that: “First Nations people leave hospital against medical advice at almost 3 times the rate of non-First Nations people.” For First Nations people living in rural and remote areas, 4% discharge against medical advice compared to 1% non-First Nations people (p. 20, Figure 4D). The Gidgee Healing & North West Hospital and Health Service *Health Equity Implementation Plan 2022-2025*, under Key Performance Measure (KPM) 3.1 includes as one of the measures: Reduced % of First Nations patients Discharging Against Medical Advice (DAMA), from a baseline of 7.4% by a targeted decrease to 5.0% within the life of the plan (by 30 June 2025) (p. 20). **Score = 2/2**

(36) **PPH** The QH-NWHHS *Service Agreement 2022/23 – 2024/25* [December 2024 Revision] in Table 9 HHS Performance Measures – Key Performance Indicators, contains an indicator for PPH specifically mentioning First Nations peoples: Potentially Preventable Hospitalisations – First Nations peoples: Diabetes complications; and Selected conditions (p. 33). However, the NWHHS *Annual Report 2024-2025* does not contain any data on this indicator. The Queensland Audit Office *Health outcomes for First Nations people (Report 14:2022-23)*, however, reports that potentially preventable hospitalisations occur at a rate 1.6 times greater in First Nations people in remote areas than for Queenslanders overall (p. 1 Figure A, also p. 8 Figure 3A). The Gidgee Healing & North West Hospital and Health Service *Health Equity Implementation Plan 2022-2025*, under Key Performance Measure (KPM) 1.2 includes as one of the measures: Decrease Potentially Preventable Hospitalisations (PPH) for First Nations people presenting at NWHHS Facilities, from a baseline of 17% to a targeted decrease of 15.5% within the life of the plan (by 30 June 2025) (p. 12. See also p. 20). **Score = 2/2**

(37) **Access to mental health services** The QH-NWHHS *Service Agreement 2022/23 – 2024/25* [December 2024 Revision] in Table 9 HHS Performance Measures – Key Performance Indicators, contains a KPI for: Suicide count and rate – First Nations Peoples (p. 33, and Table 12 p. 35). The Gidgee Healing & North West Hospital and Health Service *Health Equity Implementation Plan 2022-2025*, under Key Performance Measure (KPM) 1.3: Sustain a decreased rate and count of First Nations suicide deaths from a baseline of 56.1 (age standardised rate per 100,000

population) to 50 within the life of the plan (by 30 June 2025) (p. 12). This also addresses NACTG 2020 Target 14: Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero (p. 33). This is the key target within the context of Outcome 14: Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing (p. 33). The QH-NWHHS *Service Agreement 2022/23 – 2024/25* places First Nations suicide within the care domains of Mental health, alcohol and other drugs (p. 33, see also p. 35) and Prevention, early intervention, and primary health care (p. 34). For scoring purposes, addressing First Nations suicide is placed within the context of access to mental health services to produce a sustained reduction in the rate of First Nations suicide. **Score = 2/2**

(38) LBWB The QH-NWHHS *Service Agreement 2022/23 – 2024/25* [December 2024 Revision] in Table 9 HHS Performance Measures – Key Performance Indicators, contains an indicator addressing the “Proportion of healthy birthweight babies (2,500 grams to 4,499 grams at birth) – Aboriginal and Torres Strait Islander babies” (p. 33). However, the NWHHS *Annual Report 2024-2025* does not contain any data on this indicator. The Gidgee Healing & North West Hospital and Health Service *Health Equity Implementation Plan 2022-2025*, under Key Performance Measure (KPM) 1.1 includes as one of the measures: Increase the proportion of First Nations babies with healthy birthweights from a baseline of 86% (2022-23) to 90% within the life of the plan (by 30 June 2025) (p. 11). This would put the NWHHS on line to achieve NACTG 2020 Target 2: By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent. **Score = 2/2**

(39) The NWHHS has a comprehensive *Aboriginal and Torres Strait Islander Workforce Strategy 2019-2026* based on six interlinked focus areas: 1. Recruitment; 2. Retention; 3. Workforce Profile; 4. Leadership and Governance; 5. Inclusive Workplaces; and 6. Community Engagement (p. 8). However, the Strategy does not address identified positions as a key part of First Nations workforce development. **Score = 3/4**

(40) In the QH-NWHHS *Service Agreement 2022/23 – 2024/25* [December 2024 Revision] Tables 11 [HHS Performance Measures – Outcome Indicators] and 12 [Statewide Health Equity Key Performance Measures] contain an indicator for First Nations people’s representation in the workforce (p. 35). While the percentage of First Nations people in the NWHHS workforce is trending upward (see Note 23), there is no specific KPI by which to gauge performance in the Service Agreement. The NWHHS *Annual Report 2024-2025* provides no KPI data regarding First Nations employment. However, a 2% growth in the Aboriginal and Torres Strait Islander workforce per year will not be sufficient to achieve the equity workforce goal set in the *Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021* “**13A Prescribed requirements for health equity strategies** For section 40(3)(a) of the Act, a health equity strategy of a service must – (v) increase workforce representation of Aboriginal people and Torres Strait Islander people across all levels of health professions and employment streams at least commensurate with the health service area’s Aboriginal and Torres Strait Islander population[.]” This aligns approximately with Target 8 of the *National Agreement on Closing the Gap 2020* whereby: “By 2031, increase the proportion of Aboriginal and Torres Strait Islander people aged 25-64 who are employed to 62 per cent.” (p. 24). These targets were foreshadowed in the *Queensland Health Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026* whereby: “The Framework underpins the development of local action plans within the department and HHSs. The localised strategies will have Aboriginal and Torres Strait Islander workforce targets that are reflective of the populations in those communities” (p. 10). Nine years into the Strategy, Aboriginal and Torres Strait Islander workforce participation for the NWHHS sits at 9.92% - well under half the ultimate target participation rate of closer to 26% (or the National Agreement target of 62% by 2031). The Gidgee Healing and North West Hospital Health Service *Health Equity Implementation Plan 2022-2025* KPM 5.2: Increase in the proportion of workforce who identify as Aboriginal and/or Torres Strait Islander peoples from a baseline of 9.75% to a target of 26% (p.

26). The following table provides data on First Nations employment in the NWHHS workforce over the last 4 reporting periods.

Annual Report	Headcount	FN employees	% FN employees
2024-25 (pp. 26-7)	998	99	9.92
2023-24 (pp. 33-34)	964	97	10.06
2022-23 (p. 29 and 33)	900	84	9.33
2021-22 (p. 31)	846	68	8.86

While concerted efforts are being made through such programs as the NWHHS First Nations Leadership Program, the Deadly Start School-Based Traineeship Program, and the Aboriginal and Torres Strait Islander Cadetship Program 2025 (see NWHHS *Annual Report 2024-2025*, p. 39), there is still a way to go. **Score = 2/4**

(41) The Queensland Audit Office *Health Outcomes for First Nations people (Report 14:2022-23)* emphasises the importance of Indigenous Liaison Officers to the delivery of culturally appropriate care and recommends a target ratio for Indigenous Liaison Officers to First Nations patients in each HHS (pp. 24-25). Data provided in the North West Hospital and Health Service *North West Hospital and Health Service Clinical Services Plan 2022 – 2037* (p. 16) indicates that: “2020-21 First Nations People Hospital Admissions Overall, 47% of NWHHS admitted patients (excluding renal dialysis) identified as First Nations people; 95% of renal dialysis patients identified as First Nations people.” The Gidgee Healing & North West Hospital and Health Service *Health Equity Implementation Plan 2022-2025*, under KPA 5: Delivering sustainable, culturally safe and responsive health services, has as KPM 5.2 a target of a more than 20% increase in the number of qualified AHW/AHP working across the region from a baseline of 22 FTE. However, there is no specific mention regarding Indigenous Liaison Officers. **Score = 3/4**

(42) The NWHHS *Aboriginal and Torres Strait Islander Workforce Strategy 2019-2026* does not specifically include among its recruitment and retention actions (pp. 10 and 11) identifying positions for First Nations employees as a strategic option for increasing their participation in the NWHHS workforce. However, one of the retention actions to support and retain Aboriginal and Torres Strait Islander employees is: “Support staff who have been recruited into Identified roles to fill any skill gaps that might restrict their career progression/mobility in NWHHS” (p. 11). However, the Gidgee Healing & North West Hospital and Health Service *Health Equity Implementation Plan 2022-2025*, under KPA 5: Delivering sustainable, culturally safe and responsive health services, includes as one of the implementation activities to achieve this: “5.1 Enhance First Nations recruitment and retention outcomes by strengthening the cultural competence of NWHHS governance and organisational systems.” This will be done by: “5.1.1; Improv[ing] recruitment and attract[ing] more First Nations people to diverse roles within the NWHHS” with one of the implementation activities: “Review the current listing of Identified positions across the NWHHS workforce, ensure this aligns with targets, and actively recruit to all vacancies” (p. 24). It is clear that this is an ongoing process whereby numbers are irrelevant. **Score = 4/4**

(43) According to the *NWHHS Equity and Diversity Report 2025*, Aboriginal and /or Torres Strait Islander peoples were represented across all classification levels [AO2 Equivalent - SES Equivalent and above], including at Senior Officer and Senior Executive Service levels (p. 12). **Score = 4/4**

(44) Managerial and Clerical The NWHHS *Annual Report 2024-2025* (pp. 27 and 28) does not provide a breakdown of the number of staff employed in each of the six categories employed here. However, the First Nations MOHRI Occupied FTE for this stream is 17.68 **Score = 1.5/1.5**

(45) Aboriginal and Torres Strait Islander Health Workforce See Note 44. According to the NWHHS *Annual Report 2024-2025* (pp. 27 and 28) in 2024-2025 NWHHS employed 99 Aboriginal and Torres Strait Islander people [headcount] accounting for 9.92% of the total workforce [As at June 2025, 10 per cent of the North West HHS workforce identifies as Aboriginal and/or Torres

Strait Islander”, p. 28]. However, the annual report does not provide a breakdown of Aboriginal and Torres Strait Islander employment across the six occupational streams. Therefore, it is unclear, for example, whether this statistic includes both clinical and non-clinical First Nations staff, or clinical staff only. Or does it also include First Nations staff employed in non-clinical positions in the Managerial and Clerical, and Operational streams. However, according to the Queensland Government *Trip Pack Report (HRBI)* [see fn 45], the Aboriginal and Torres Strait Islander Health Workforce is categorised as a Non Clinical Stream. The First Nations MOHRI Occupied FTE for this stream is 29.00. **Score = 2/2**

(46) Medical including Visiting Medical Officers (VMOs) The First Nations MOHRI Occupied FTE for this stream is <5 **Score = 0/2**

(47) Nursing and Midwifery The First Nations MOHRI Occupied FTE for this stream is 25.54 **Score = 1.5/1.5**

(48) Operational The First Nations MOHRI Occupied FTE for this stream is 15.68 **Score = 1.5/1.5**

(49) Professional and Technical The First Nations MOHRI Occupied FTE for this stream is <5. **Score = 0/1.5**

(50) In the QH-NWHHS *Service Agreement 2022/23 – 2024/25* [December 2024 Revision] (p. 10), Section 9. Achieving health equity with First Nations Queenslanders, in clause 9.2, with reference to First Nations Health Equity Strategies: “The Health Equity Strategy will act as the principal accountability mechanism between the Aboriginal and Torres Strait Islander community and the HHS in achieving health equity with First Nations Queenslanders and forms a key part of the Queensland Government’s commitment to the *National Agreement on Closing the Gap* (2020).” Given the importance of the HESs to delivering on Closing the Gap outcomes and priority reforms, it is reasonable to expect the Commonwealth to make a financial contribution to the development and implementation of the HESs. The NWHHS *Annual Report 2024-2025* does not contain any information concerning the amount of Commonwealth funding allocated specifically to Aboriginal and Torres Strait Islander health and wellbeing programs in the NWHHS region. **Score = 0/10**

(51) The NWHHS *Annual Report 2024-2025* (Financial Statements p. 10) discloses that: “The HHS received funding from the First Nations Health Branch of the Department of Health in 2024-25 for the Making Tracks Investment Strategy of \$3.1 million. The First Nations Health Branch advised funding is reinvested recurrently to North West HHS under the Making Tracks Investment strategy from 2024-25.” However, how this \$3.1 million was allocated among specific Making Tracks programs, such as: chronic disease management, targeting renal health, cardiac and Rheumatic Heart Disease, diabetes care, and the Maternity Outreach service is not disclosed in the NWHHS *Annual Report 2024-2025* (p. 40). This kind of information should be disclosed in the annual reports. **Score = 3/5**

(52) The Queensland Health *First Nations First Health Budget 2024-25* over the next 4 years allocates an additional \$324.7 million dedicated to accelerating efforts to address health inequities among First Nations Queenslanders: “This significant investment in prioritising First Nations’ health and wellbeing demonstrates the government’s unwavering commitment to closing the gap by 2031. ... This investment is delivering on the MILES Government’s commitment to the National Agreement on Closing the Gap.” Annualised at around \$81.2 million /year for four years, the investment will deliver on Queensland’s *First Nations First Strategy 2032* across four priority areas: Eliminate racism; Reshape the system; Transform care; and Strengthen our workforce. While, for example, over four-year time frames, \$20 million will be invested to expand the Aboriginal and Torres Strait Islander Community Health Service in Logan into an integrated health and wellbeing precinct serving a local population of 4,000 First Nations people, and \$92.5 million will be invested into the Institute for Urban Indigenous Health, no specific amounts are allocated to the NWHHS region which serves an estimated First Nations population of around 8,500 people.. However, \$20 million has been allocated to transform care such that, “By 2032,

we will have a connected health system that First Nations people can access.” The NWHHS region will benefit from unspecified funding to transforming heart health in remote communities to support the prevention and early detection of acute rheumatic fever, and to extend the Health Housing Initiative program to Doomadgee and Mornington Island.

The Queensland Government’s *Regional Action Plan: Doing What Matters for Outback Queensland – Queensland Budget 2024-25* allocates \$607 million for health for the North West, Central West and South West Hospital and Health Services. Queensland Health is investing more than \$1 billion in the Building Rural and Remote Health Program which supports healthcare delivery in remote areas by enhancing or replacing infrastructure to ensure it meets the needs of the community. Doomadgee Hospital receives \$1 million in 2024-25 to address ageing infrastructure.

However, the NWHHS *Annual Report 2024-2025* does not contain any information concerning the above funding allocations and programs regarding Queensland Government funding [not from the Making Tracks budget] allocated specifically to Aboriginal and Torres Strait Islander health and wellbeing programs in the NWHHS region. **Score = 2/5**

Comparing the 2017 and 2025 NWHHS Matrix Audits

In comparing the 2017 and 2025 matrix audit results, it was decided to base the results on the overall scores for each of the criteria as these remained in common for both audits, whereas many of the sub-criteria were altered in the 2018 template, making comparisons problematic.

Table 1: 2017 and 2025 Matrix Audit Results based on overall scores for each of the 13 criteria

	Key indicators and criteria	2017	2025	Score
1	Participation in HHS governance			
	• Legal visibility/good governance	0.5	3	10
	• Representation on NWHHB	10	10	10
	• Executive management	0	10	10
	Total	10.5	23	30
2	Policy implementation			
	• Closing the Gap/Improving Aboriginal and Torres Strait Islander health outcomes	6	10	10
	• Community engagement	0	10	10
	• Public reporting and accountability (via annual report)	6	7	10
	Total	12	27	30
3	Service delivery/Service delivery and partnerships			
	• Aboriginal and Torres Strait Islander health/HHS plan	0	10	10
	• Cultural competence/safety	4	10	10
	• Selected Health Service Performance Indicators	0	8	10
	Total	4	28	30
4	Recruitment and employment			
	• Aboriginal and Torres Strait Islander health workforce development	4.5	16	20
	• Aboriginal and Torres Strait Islander participation in health workforce	0	6.5	10
	Total	4.5	22.5	30
5	Financial Accountability and Reporting: Closing the Gap funding			
	• Commonwealth contributions	0	0	10
	• Queensland contributions	0	5	10
	Total	0	5	20
	Overall totals	31	105.5	140

In the 2017 Health Equity Report, NWHHS recorded 31 points out of a possible 140 placing it in the Very High level for institutional racism. In the 2025 audit NWHHS has received a score of 105.5 out of 140, a net improvement of 74.5 points and placing it well within the Low level for institutional racism (see Table 1) – a remarkable improvement. While good governance has replaced the criterion for legal visibility in the QHMT 2018 (see Appendix 1), the findings suggest that NWHHS could improve alignment with this criterion by increasing the level of publicly available information regarding outcomes and decisions in Board meeting summaries, specifically those related to issues and/or services impacting First Nations people. The improvements in the overall score are largely due to the development and publication of its statutory *North West Health Equity Strategy 2022-2025* (NWHES) and *Health Equity Implementation Plan 2022-2025* (HEIP). The NWHES and HEIP address many of the Matrix measurables with regard to the key indicators for policy implementation, service delivery and partnerships, and recruitment and employment. While the HEIP addresses the key indicator for recruitment and employment in Key Priority Area 5: Delivering Sustainable, Culturally Safe and Responsive Health Services, the Matrix sub-criteria for the criterion: Aboriginal and Torres Strait Islander workforce development were mostly fully achieved. NWHHS has an opportunity to further strengthen performance against the sub-criteria for Aboriginal and Torres Strait Islander participation in the health workforce, particularly by increasing First Nations employment within the Medical (+VMO) and Professional and Technical streams, where representation is currently limited. Consequently, the overall score for the recruitment and employment indicator is 22.5/30. The findings suggest that additional progress could be made in financial accountability and reporting for Closing the Gap funding, with the current score reflecting a 5-point improvement out of 20 compared with the 2017 audit report.

The full NWHHS 2017 Health Equity Report Audit is included at Appendix 2 for ease of reference.

Good examples of financial accountability are provided by the TCHHS in their 2016-2017 and 2017-2018 annual reports in which each details Closing the Gap funding (included at Appendix 3). In 2016-2017 programs funded under the State Government's Making Tracks program and Commonwealth programs attracted \$9,092,382. Table 1: Making Tracks and Commonwealth-funded programs, identifies 20 programs and the amount allocated for each (p. 19). In 2017-2018, 17 closing the gap projects were allocated a total of \$21,909,270 under the State Government's Making Tracks program and by the HHS (see Table 1: Closing the gap programs, p. 22). Such information allows the First Nations community to give feedback (perhaps via their Community Advisory Groups / Community Advisory Networks) on these projects/programs particularly in relation to whether they are receiving value for money and whether the funding is in proportion to need.

Findings and Recommendations

THE NEED TO RAISE THE PROFILE OF THE NACTG 2020 IN HHS OPERATIONS

The *National Agreement on Closing the Gap 2020* is now the primary Agreement to which all governments (including local governments) and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations have signed on to, and as the Productivity Commission has pointed out:

They committed to mobilizing all avenues available to them to achieve the objective of the Agreement – which is ‘to overcome the entrenched inequality faced by too many Aboriginal and Torres Strait Islander people so that their life outcomes are equal to those of all Australians’.⁴⁷

The Productivity Commission’s first review of the Agreement also shows that governments are not adequately delivering on this commitment.

We must also confront the appalling situation that the most recent publicly available estimates of life expectancy⁴⁸ for First Nations people in North West Queensland (NWQ), is some 11 years less than for the general population. Life expectancy for First Nations males in NWQ was baselined in the 2022-2025 NWHHS Health Equity Strategy as 68.2 years, and for non-indigenous males it was 80.2 years – a difference of 12 years. And for First Nations females, their life expectancy was baselined as 72.8 years, 10.6 years less than non-indigenous females (83.4 years).⁴⁹ This is a situation that has largely remained unchanged for the last thirty years, and, as is pointed out in the TCHHS *Clinical Services Plan 2019-2029*, in an observation which is also relevant to the NWHHS, “that if we are to genuinely change the trajectory of health outcomes for our community, we need to think and act differently about how, where and what health services are delivered.”⁵⁰

The most obvious way to do things differently, and as the Productivity Commission suggests, is to fully take on board and honour the terms of the NACTG 2020 at the HHS level. In conducting the 2025 NWHHS Matrix audit, the consultants have taken the view that the NACTG 2020 is one of the primary documents by which to evaluate many of the criteria contained in the QHMT 2018. However, there are limitations in this approach, so the consultants have taken the liberty to propose actions that can be taken at government, departmental (system) and agency (service) levels in order to elevate the various obligations contained in the NACTG 2020, and to which the Queensland Government has committed, into their operations at the respective levels.

⁴⁷ Productivity Commission, 2024. *Review of the National Agreement on Closing the Gap: Study Report* (Volume 1). Australian Government, Canberra. P. 3.

⁴⁸ The 2022-2025 North West Hospital and Health Service Health Equity Strategy and the Draft 2025-2028 North West Hospital and Health Service Health Equity Strategy are the source of these figures. However, it is important to note that these are undated. Efforts to identify a more recent, and publicly available life expectancy for the region (Statistical Area level 3) that most closely aligns with the HHS boundaries) were futile. Figures for the state (Statistical Area level 4) were identified that indicate an increase in life expectancy.

⁴⁹ Queensland Health and North West Hospital and Health Service *North West Health Equity Strategy 2022-2025*, p. 14.

⁵⁰ Torres and Cape Hospital and Health Service, 2019. *Clinical Services Plan 2019-2029*. P. 14.

RECOMMENDATIONS TO QUEENSLAND GOVERNMENT

Closing the Gap committee as a statutory HHB committee

If the gap is to be closed on the health disparities experienced by First Nations peoples, then the obligations entailed in the *National Agreement on Closing the Gap* (2020) must be elevated so that they can be given due consideration by Hospital and Health Boards. One way of doing this is by the establishment of a Closing the Gap (or some such appropriately named) committee as a statutory committee functioning under the authority of a HHB under the *Hospital and Health Boards Act 2011* (Qld). The Act already mandates three committees: (i) the Executive and Performance Committee [s.32B(1) of the HHB Act and the *HHB Regulation 2012*]; the Safety and Quality Committee [which functions in accordance of Schedule 1, Section 8 of the HHB Act and performs the functions described under Part 7, s. 32 of the *HHB Regulation 2012*]; and (iii) the Audit, Risk and Finance Committee [which functions under the authority of the Board in accordance with Schedule 1, s. 8 of the HHB Act, Part 7 – ss.31 and 34 of the *HHB Regulation 2012*; and s.35 of the *Financial and Performance Standard 2019*].

Recommendation 1: The *Hospital and Health Boards Act 2011* be amended to include a Closing the Gap committee as a statutory board committee

Elevating the importance of the obligations entailed under the *National Agreement on Closing the Gap* (2020) in annual report requirements

According to the Department of the Premier and Cabinet's *Annual report requirements for Queensland Government agencies (2024-2025 reporting period)* p. 7: "Annual reports are a key accountability document and the principal way agencies report on non-financial and financial performance. The Auditor-General notes that 'annual reports support transparency and can drive continuous improvement in performance. Where annual reports incorporate relevant and reliable performance information, they increase trust and confidence in government services delivery' (*Auditor-General's Report to Parliament No. 4 for 2013-14* p. 12)." An agency's strategic plan provides the foundation for their annual reports. There are many different users of annual reports including "members of the community who have an interest in the performance and achievements of government in relation to services provided to the community." Among the characteristics of a quality annual report is that it "provides a historical account of performance including longer term trends and outcomes" (pp. 7- 8).

Again, in the view of the Productivity Commission:

...annual reports need to be documents that drive improved outcomes for Aboriginal and Torres Strait Islander people. To make them more useful, governments need to work more closely with Aboriginal and Torres Strait Islander partners. They need to agree on what actions are the most substantive and critical to achieving the objectives of the Agreement and how they will be implemented, and articulate these in their implementation plans and annual reports.⁵¹

The only reference to Aboriginal and Torres Strait Islander people in the Department of the Premier and Cabinet's *Annual Report requirements for Queensland Government agencies (2024-2025 reporting period)* is in relation to section 15. Governance – human resources, whereby agencies are required to report on their workforce profile in terms of the representation of women,

⁵¹ Productivity Commission, 2024. *Review of the National Agreement on Closing the Gap: Study Report* (Volume 1). P. 6.

women in leadership roles, Aboriginal Peoples and Torres Strait Islander Peoples, people with disability and people with culturally and linguistically diverse (CALD) backgrounds in employment (p. 24). Statutory bodies “are encouraged to include ... in the annual report how employment of Aboriginal and Torres Strait Islander peoples has been supported, identifying major commitments and strategies, relevant targets, and progress towards meeting targets” (pp. 25-26).

In reviewing the annual reports of the NWHHS and of some of the other HHSs of the last few years, a decline in the quality of information published has been discernible. For example, the Central Queensland HHS (CQHHS) *Annual Report 2018-2019* reports on its Closing the Gap performance with regard to 5 indicators, with comparisons made between non-Indigenous and Indigenous data (p. 20), and the NWHHS *Annual Report 2018-2019* provides information on 4 Closing the Gap indicators (p. 30). Likewise, the Central West HHS *Annual Report 2018-2019*, tabulates 6 performance indicators for both Indigenous and non-Indigenous people with changes since the previous year (p. 44), and on p.28 the number of Aboriginal and Torres Strait Islander employees in the Central West HHS (CWHHS) workforce is tabulated for 2014-2015 to 2018-2019. Similarly, such information is available in the South West HHS (SWHHS) *Annual Report 2018-2019* (p. 35 Table 2). Such detail in the presentation of information in current annual reports no longer exists.

As noted above, statutory bodies “are encouraged to include ... in the annual report how employment of Aboriginal and Torres Strait Islander peoples has been supported, identifying major commitments and strategies, relevant targets, and progress towards meeting targets”. None of this is currently occurring in the NWHHS and other HHS annual reports. Annual reporting becoming more and more a “tick-a-box” exercise.

It was noted in the Health Equity Report 2017, with regard to including a criterion for Matrix audits for HHS annual reporting that: “The purpose of this criterion is to provide evidence of inclusiveness of Aboriginal and Torres Strait Islander people within the HHS community, a sense that “this is our health service too” (p. 225-227). It was noted that, in terms of best practice, the NWHHS in its 2014-15 annual report provided the best example of inclusivity of Aboriginal and Torres Strait Islander people, and this was still evident in its 2018-2019 report.⁵²

It is noted that all HHSs in their recent annual reports contain a section on Aboriginal and Torres Strait Islander health yet references to the NACTG 2020 are virtually entirely absent. The TCHHS *Annual Report 2022-2023*, for example, in its 3-page section on Aboriginal and Torres Strait Islander Health (pp. 13-15), the NACTG 2020 is not mentioned, neither is it mentioned anywhere else in the report. Similarly, the section on Improving First Nations Health and Wellbeing outcomes in the NWHHS *Annual Report 2024-2025* (pp. 38-40), apart from mentioning National Close the Gap Day (20 March 2025) commemorations, does not provide any data on progress (or otherwise) towards achieving the various relevant targets of the National Agreement – not even on Target 1: Close the Gap in life expectancy within a generation, by 2031. The National Agreement is more than its 16 (17) targets, only three of which (Targets 1,2 and 14) are directly related to health and wellbeing. It also contains four priority reforms which are all relevant in their several ways to the operations of HHSs.

The Queensland Government is a signatory to the *National Agreement on Closing the Gap* (2020) and is binding on the government itself and all its agencies. The Queensland Government *Annual report requirements for Queensland Government agencies (2024-2025 reporting period)* does not

⁵² See also Health Equity Report 2017 (pp. 219-20) section 5.1.2.2

require government agencies, where relevant, to report on their performance towards Closing the Gap. The annual report requirements for Queensland government agencies must require that all agencies report on their Closing the Gap performance taking into account actions taken with regard to the four priority reforms and progress (or otherwise) towards achieving those targets which are relevant to their domains of responsibility.

Recommendation 2: The Department of the Premier and Cabinet include in its *Annual Report Requirements for Queensland Government Agencies* reporting requirements on Closing the Gap.

HHS training for Aboriginal and Torres Strait Islander board aspirants

While it is mandatory that all HHS Boards have Aboriginal and Torres Strait Islander representation, in the case of HHSs like TCHHS, NWHHS, Cairns & Hinterland HHS, CWHHS and SWHHS, these have Aboriginal and Torres Strait Islander populations significantly higher than the overall state average. It is therefore appropriate that there should be proportionate representation on their Boards. In order to support this to happen, it would be appropriate for the DWATSIPM to sponsor training programs for Aboriginal and Torres Strait Islander aspirants to enable them to compete on more equitable terms for Board positions when they become vacant.

Recommendation 3: The Department of Women, Aboriginal and Torres Strait Islander Partnerships and Multiculturalism work with the Australian Institute of Company Directors to provide scholarships for board training for Aboriginal and Torres Strait Islander aspirants

RECOMMENDATIONS TO QUEENSLAND HEALTH

Departmental reporting on the Our Performance website

The absence of publicly available, current and trend data at the HHS level for relevant First Nations health outcomes is inconsistent with the contemporary truth telling as required by s.21(2)(b) of the PS Act and inconsistent with good practice in public sector accountability and integrity⁵³. There is a need for Queensland Health to include health equity KPIs on the “Our Performance” website for the transparency and accountability necessary to establish trust and consistency with the practices of contemporary good government.

Recommendation 4: Departmental reporting on the Our Performance website to include the health equity dashboard indicators by HHS, and to include outcome metrics with trend data for First Nations people not just activity counts [eg., proportion of healthy birthweights (outcome) as well as babies born (activity)]

⁵³ Principles of good governance for public sector accountability and integrity as discussed in relation to Queensland in Coaldrake P. *Let the Sunshine In: Review of culture and accountability in the Queensland public sector*. Brisbane, 2022.

RECOMMENDATIONS TO NWHHS

Closing the Gap responsibilities shared among members of Executive Management Teams

The *National Agreement on Closing the Gap* (July 2020) between all Australian Governments and the Coalition of Peaks comprises four priority reforms and a set of 16 (now 19) socio-economic targets to be met by 2031.⁵⁴ Progress towards achieving these reforms and targets is uneven and in a state of flux.⁵⁵

The Productivity Commission, in its report of the *Review of the National Agreement on Closing the Gap*, proposes several ways of embedding responsibilities for driving action within the public sector. In its Review, the Productivity Commission made four recommendations. Under Recommendation Three: Mainstream systems and culture need to be fundamentally rethought, the Commission proposes five actions to drive deep and enduring change, one of which is:

Governments also need to embed responsibility for improving cultural capability and relationships with Aboriginal and Torres Strait Islander people into the employment requirements, performance agreements and KPIs of public sector CEOs, executives and employees (p. 9).

Elsewhere, in the view of the Productivity Commission:

It is not acceptable for government employees to treat adhering to the principles of the Agreement as optional – these principles reflect essential skills and behaviours without which governments cannot hope to deliver on their Closing the Gap commitments (p. 21).⁵⁶

Responsibility for achieving these reforms and targets should be placed within a chain of responsibility that extends from the Parties to the Agreement (ie, governments and the peaks) to the state/territory governments and local governments to their respective departments and agencies (system level responsibility) to, in the case of Queensland Health, the HHSs (service level responsibility). At the service level of responsibility, this level of responsibility should be placed with the individual members of the NWHHS Executive Leadership Team with oversight the responsibility of the NWHHS Board.

Within HHSs, members of the executive management team should take on NACTG 2020 responsibilities commensurate with their executive management portfolios (see Table 2). In terms of reporting, where there is an Executive Director in charge of an Aboriginal and Torres Strait Islander division/portfolio, the other EDs should report to that ED who in turn reports to the Closing the Gap committee of the HHB [refer Recommendation 1 above].

Closing the Gap responsibilities are focused on two areas: priority reforms and socio-economic targets. There are four priority reforms, and each has its own target distinct from the Agreement's socio-economic targets:

- **Priority Reform One - Formal partnerships and shared decision-making.** There are two forms of partnership: “policy partnerships” and “place-based partnerships”.

⁵⁴ The reforms are: Priority Reform One – Formal Partnerships and Shared Decision-Making; Priority Reform Two – Building the Community-Controlled Sector; Priority Reform Three – Transforming Government Organisations; and Priority Reform Four – Shared Access to Data and Information at a Regional Level (see pp. 5-15).

⁵⁵ Queensland Government, 2022. *Queensland Closing the Gap Snapshot Report 2022 Edition*. The Queensland Government's last Closing the Gap annual report was published in 2023 [available at <https://www.publications.qld.gov.au/dataset/closing-the-gap> with the webpage last up-dated 29 April 2025]

⁵⁶ This appears in the context of Recommendation 3 regarding essential actions and the need for change (Productivity Commission, 2024, pp. 17-21).

Target: There will be formal partnership arrangements to support Closing the Gap in place between Aboriginal and Torres Strait Islander people and governments in place in each state and territory enshrining agreed joint decision-making roles and responsibilities and where Aboriginal and Torres Strait Islander people have chosen their own representatives.

- **Priority Reform Two - Building the community-controlled sector.**

Target: Increase the amount of government funding for Aboriginal and Torres Strait Islander programs and services going through for Aboriginal and Torres Strait Islander community-controlled organisations

- **Priority Reform Three – Transforming government organisations.**

Target: Decrease in the proportion of Aboriginal and Torres Strait Islander people who have experiences of racism.

- **Priority Reform Four: Shared access to data and information at a regional level.**

Target: Increase the number of regional data projects to support Aboriginal and Torres Strait Islander communities to make decisions about Closing the Gap and their development.⁵⁷

The overarching priority of the Gidgee Healing-NWHHS *Health Equity Implementation Plan 2022-2025* (HEIP) is to “Close the Gap and achieve life expectancy parity with Aboriginal peoples and Torres Strait Islander peoples by 2031”.⁵⁸ The Plan lists 21 priorities to improve First Nations health and wellbeing outcomes, all of which will contribute to closing the gap in life expectancy for First Nations peoples within a generation, by 2031 – the first of the Plan’s priorities. Of these 21 priorities, some are explicitly linked to closing the gap targets of the NACTG 2020:

- Target 1: Close the Gap in life expectancy within a generation, by 2031.
- Target 2: By 2031, increase the proportion of Aboriginal and Torres Strait Islander babies with a healthy birthweight to 91 per cent.
- Target 14: Significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people towards zero.

Other priorities, such as “Increased representation of First Nations people across the NWHHS health workforce to 26%” are linked to several NACTG 2020 education and employment targets:

- Target 6: By 2031, increase the proportion of Aboriginal and Torres Strait Islander people aged 25-34 years who have completed a tertiary qualification (Certificate III and above) to 70 per cent.
- Target 7: By 2031, increase the proportion of Aboriginal and Torres Strait Islander youth (15-24 years) who are in employment, education or training to 67 per cent.
- Target 8: By 2031, increase the proportion of Aboriginal and Torres Strait Islander people aged 25-64 years who are employed to 62 per cent.

⁵⁷ NACTG 2020, Priority Reforms 1 – 4, pp. 5-15; Priority Reform Targets, p. 15.

⁵⁸ Gidgee Healing-NWHHS *Health Equity Implementation Plan 2022-2025*, p. 3.

Table 2: Proposed Executive Management Team NACTG 2020 responsibilities⁵⁹

Executive	NWHHS Portfolio Responsibilities	Suggested NACTG Responsibilities
HS Chief Executive	- Responsible and accountable for the day-to-day management of the HHS and for operationalizing the Board's strategic vision and direction. - Responsible for the overall management of North West HHS through functional areas to ensure the delivery of hospital and health service objectives.	Negotiate relevant Priority Reform actions and Targets into Service Level Agreements Oversight of PR #1: with regard to place-based partnerships with NWQ ACCHOs (Gidgee Healing, Yellagundgimarra Health Council (Doomadgee), Ngarnal Aboriginal Community Controlled Health Service (Mornington Island Health Council).
Chief Operating Officer	- Responsible for the overall management of the day-to-day administration and operational functions of NWHHS - Works collaboratively with HSCE and Executive Leadership Team to manage and coordinate all commissioning, planning and positioning of services to ensure optimal levels of health service delivery and patient safety are achieved. - Ensures effective, efficient and safe delivery of clinical services, non-clinical services and resources required for the NWHHS to achieve and sustain its responsibilities to its stakeholders. - Strategically leads the development of strategies to address key service gaps, high level risks and performance issues. - Provides advice to the HSCE and Board as required	Priority Reform 4: Data collection and presentation Within the partnership agreements established between the NWHHS and NWQ ACCHOs, compile and share disaggregated regional data and information on Closing the Gap performance Record such data in a dash-board format for publication in NWHHS annual reports, the quarterly magazine <i>Balance</i> and on the website. Target 14, data development * access/utilization of mental health (psychological and psychiatric) services, compared to need. * mental and behavioural mortality data including self-harm mortality data
ED – People, Culture and Planning	Responsible for all strategic, tactical, and operational strategy and service delivery, including Workforce and	Priority Reforms 1, 2 and 3

⁵⁹ The NWHHS portfolio responsibilities described in the following Table are taken from the NWHHS *Annual Report 2024-2025*, pp. 22-24 and the NWHHS Financial Statements – 30 June 2025, p.30.

Executive	NWHHS Portfolio Responsibilities	Suggested NACTG Responsibilities
	Organisational Planning, Recruitment, Talent Management, Organisational Development, Workforce Diversity, Employee Relations, Safety and Wellbeing and Human Resource operations and statutory compliance. • Provides strategic oversight and executive leadership of human resources, workplace health and safety and corporate and support services. • Provides oversight of key service planning activities. • Strategic leadership and oversight of corporate governance, strategy development and innovation. • Ensures compliance with all necessary legislation and statutory obligations through management systems, governance, policies and procedures. • Provides leadership of recruitment and retention to ensure NWHHS is an employer of choice.	Targets: 6,7 and 8 PR #3, Transformational Element b: embed and practice meaningful cultural safety within the NWHHS PR #3, Transformational Element a: Identify and eliminate racism, with one of the actions to include more Aboriginal and Torres Strait Islander people in the NWHHS through more identified positions, and in senior positions. Address Socio-Economic Targets 6,7 and 8.
ED – Medical Services	• Responsible for the overall management and coordination of clinical operational and medical services for the NWHHS. • Provides strategic oversight and executive leadership for medical and clinical workforce and clinical governance for the NWHHS • Provides clinical leadership in the education of the medical and clinical workforce. • Monitors and reports on compliance and performance functions of the NWHHS, including clinical benchmarks, clinical performance, risk and credentialing.	Targets 1 and 2 (4?) With regard to Target 1, oversee collection of regionalized data within the NWHHS regarding: • Hospitalization rates by leading cause • DAMA • Burden of disease from socio-economic factors

Executive	NWHHS Portfolio Responsibilities	Suggested NACTG Responsibilities
	Provides high-level expert advice and input relating to clinical governance, patient safety and medico-legal.	
ED – Nursing & Midwifery [and Clinical Governance]	- Responsible for the professional leadership of nursing services for the Mount Isa and remote Hospitals and clinical governance for the health service. - Provides strategic oversight and executive leadership for nursing and midwifery workforce for the NWHHS. - Works collaboratively with all members of the executive and clinical leadership team members across NWHHS, to fulfil the accountabilities in accordance with values, vision and strategic direction and engages with other internal and external partners to build relationships. - Provides leadership in nursing and midwifery education. - Monitors and reports on compliance and performance functions of the NWHHS, including clinical benchmarks, clinical performance, risk and credentialing. - Provides high-level expert advice and input relating to clinical governance and patient safety.	Target 2 Address drivers leading to low birthweight babies (LBWB) - Expectant mothers with pre-existing health conditions - Use of antenatal care Data development around: - Access to culturally appropriate care for First Nations women - Role of First Nations men in parenting
ED – First Nations Health	- Responsible for transforming the HHS services to improve the health outcomes of Aboriginal and Torres Strait Islander people through building strong partnerships. - Provides strategic oversight and executive leadership for Indigenous Hospital Liaison Office, First Nations Health workforce management, cultural practices, consumer engagement and consumer liaison.	Coordinate Executive Management Team Closing the Gap portfolio responsibilities and reporting Preparation of biannual Closing the Gap reports for the Board

Executive	NWHHS Portfolio Responsibilities	Suggested NACTG Responsibilities
	Executive Lead for the First Nations Health Equity reform agenda collaboratively with the health sector to ensure local needs are met with a more regionally coherent system of health care.	
ED – Remote Health Services	- Responsible for delivering effective and efficient services of all clinical and non-clinical services and resources within the portfolio. - Provides strategic oversight and executive leadership to remote health service facilities within NWHHS to ensure that teams deliver services and achieve high levels of service quality, safety, efficiency and effectiveness. - Strategically and collegiately work with the Executive Director First Nations Health, Community Elders and senior staff to achieve service improvements for First Nation people through a contemporary understanding of Aboriginal and Torres Strait Islander health, cultural issues and the social determinants of health. - Provides oversight of key service planning activities. - Provide strategic leadership and innovation in the management of all available resources within the portfolio with an emphasis on focused recruitment. - Deliver on agreed financial, activity and outcomes performance targets and reporting requirements.	Targets 4, 6, 7, 8, PR #2: PR #3: Transformation element c. Deliver services in partnership with Aboriginal and Torres Strait Islander organisations, communities and people PR#3: Transformation element f. Improve engagement with Aboriginal and Torres Strait Islander people Socio-economic Target 1. Develop data regarding access to services compared to need including availability and distance travelled, affordability, client preference and cultural safety. Target 9 re: appropriate housing Targets 6, 7 and 8
Chief Finance Officer	Responsible for the overall financial management of the NWHHS, including budgeting, activity-based funding measurement and	PR #3, Transformation element d: Increase accountability through transparent funding allocations PR 2: Clause 55. a and b (p. 10).

Executive	NWHHS Portfolio Responsibilities	Suggested NACTG Responsibilities
	departmental relationship management. Also responsible for the delivery of non-clinical support services, including building, engineering and maintenance services, capital infrastructure and contract management. • Provides strategic oversight and leadership of finance, accommodation, building, engineering and maintenance and ICT. • Provides oversight of the financial direction of the NWHHS budget across a diverse portfolio of clinical and corporate streams. • Provides expert and authoritative financial and commercial analysis and reporting. • Ensures fidelity and reliability of funding and costing information and modelling as a key part of service planning and performance governance. • Leads the annual financial audit process and audited financial accounts.	Socio-economic Target 8, in relation to raising First Nations employment through the procurement of Indigenous goods and services.
ED – Allied Health	• Responsible for clinical governance and professional leadership, direction and education of allied health services. • Provides strategic oversight and executive leadership of allied health and pharmacy. • Provides oversight of key service planning activities. • Strategic leadership and oversight of allied health and pharmacy credentialing, workforce planning, education, and research. • Ensures compliance with all necessary legislation and statutory obligations through management systems,	Target 1, rates of access/utilization of allied health services (audiology, optometry, physiotherapy, ATODs, etc.).

Executive	NWHHS Portfolio Responsibilities	Suggested NACTG Responsibilities
	governance, policies and procedures. • Provides high-level expert advice and input in relation to clinical governance and patient safety. • Deliver on the agreed financial, activity and outcomes performance targets and reporting requirements.	

Recommendation 5: Closing the Gap responsibilities to be identified and shared by all members of the HHS executive management team

Making Closing the Gap information readily available on the NWHHS website

The NWHHS website has no dedicated portal or link to Closing the Gap. The website maintains a newsletter (available at: <https://www.northwest.health.qld.gov.au/about-us/latest-news/balance-e-newsletters/>), and lists social media platforms: Facebook, LinkedIn, YouTube and Instagram.

In Queensland Health's document *My health, Queensland's future: Advancing health 2026*, concerning Focus area 2.1 **Consumer voice**, "Evidence shows that when information and performance data are presented in a user-friendly format, this increases consumer literacy and empowers people to make more informed care choices. ... This is formally recognised in Standard 2 of the *National Safety and Quality Health Service Standards*, which involves consumers in the organisational and strategic processes that guide the planning, design and evaluation of health services" (p. 17). In the context of fostering a continuous improvement culture and clinical practice, elsewhere it is stated that: "Part of continuous improvement is communicating system performance to the public. Evidence shows the publication of comparative reporting of clinical performance data at hospital and service level influences clinical practice and improves overall performance of the health system" (p. 18).

HHSs should maintain a Closing the Gap portal on their websites for the purpose of reporting in real time their actions and achievements in Closing the Gap.⁶⁰ This is also a relevant action for

⁶⁰ Explanatory Notes for SL 2021 No. 34 [HHB Act (HES) Amendment Regulation 2021 (Qld)]. Section 13A(1)(a)(v) states that the Health Equity Strategy must outline agreed key performance measures to ensure that the Hospital and Health Service works with Aboriginal peoples and Torres Strait Islander peoples and Aboriginal and Torres Strait Islander communities and organisations to design, deliver, monitor and review health services. This section seeks to improve the level of engagement by the Hospital and Health Service with Aboriginal peoples, Torres Strait Islander peoples, Aboriginal and Torres Strait Islander communities and organisations to allow greater collaboration in the design, delivery, monitoring and review of health services. The intended outcomes being to: • improve the effectiveness and outcomes of co-designed programs, as we know that when Aboriginal peoples and Torres Strait Islander peoples have a genuine say in the design and delivery of services that affect them, better life outcomes are achieved; • allow feedback and input from Aboriginal peoples and Torres Strait Islander peoples in the monitoring and review of healthcare services to determine their suitability and any potential improvements to improve access to those services in the future; and • increase the number of services that are provided

implementing PRIORITY REFORM FOUR – SHARED ACCESS TO DATA AND INFORMATION AT A REGIONAL LEVEL of the NACTG 2020 (see pp. 13 – 15).

The website portal should include information and data concerning, for example:

- NACTG 2020 outcomes (relevant Priority Reform actions and Targets)⁶¹
- Closing the Gap KPIs contained in current health service agreement
- HEIP key performance measures⁶²
- Closing the Gap Partnership Alliance reports⁶³
- Aboriginal and Torres Strait Islander Community Advisory Committee (CAC) meeting outcomes⁶⁴
- Aboriginal and Torres Strait Islander specific National Safety and Quality Health Service Standard Assessment outcomes⁶⁵
- Data on delivery of health services to, and their access by Aboriginal and Torres Strait Islander people⁶⁶

collaboratively with the Aboriginal and Torres Strait Islander community-controlled health sector, who provide healthcare services throughout the State. Key performance measures for this section may include targets about the number of partnership agreements entered into by the Hospital and Health Service, levels of participation of Aboriginal peoples and Torres Strait Islander peoples in decision-making and throughout the life-cycle of the initiative, level and extent of advice from the prescribed Aboriginal and Torres Strait Islander stakeholders adopted by the service, or targets relating to the amount of contracting out or procuring of services from Aboriginal and Torres Strait Islander community-controlled health organisations.”(p. 11).

⁶¹ Including for cultural safety and anti-racism training completion rates in accordance with Priority Reform Three (see Clause 59.a, p. 11).

⁶² QH-NWHHS *Service Agreement 2022-23 – 2024/25* [December 2024 Revision] in clause **9. Achieving health equity with First Nations Queenslanders** paragraph 9.5 states that: “The HHS will report publicly on progress against the Health Equity Strategy” (p. 11). In clause 1 of **Schedule 4 Performance Measures**, paragraph 1.4 states that: “HHSs are also required to report against the agreed Statewide Health Equity Key Performance Measures (Table 12)” (p. 33). Table 12 Statewide Health Equity Key Performance Measures lists 12 KPMs (pp. 35-6).

⁶³ NWHHS maintains a tripartite agreement with Gidgee Healing and the WQPHN. See also QH-NWHHSSA [December 2024 Revision] regarding other partnerships, p. 14.

⁶⁴ In 2024-2025 the CACs and CANs met quarterly. NWHHS *Annual Report 2024-2025*, p. 34.

⁶⁵ Australian Commission on Safety and Quality in Health Care *National Safety and Quality Health Service Standards: User Guide for Aboriginal and Torres Strait Islander Health*. The National Safety and Quality Health Service (NSQHS) Standards contain six actions that focus specifically on meeting the needs of Aboriginal and Torres Strait Islander people. These are: 1) Partnering with Consumers Standard: Action 2.13 The health service organisation works in *partnership with Aboriginal and Torres Strait Islander communities* to meet their needs; 2) Clinical Governance Standard: Action 1.2 The governing body ensures that the organisation’s *safety and quality priorities* address the specific health needs of Aboriginal and Torres Strait Islander people; 3) Action 1.4 The health service organisation *implements and monitors strategies* to meet the organisation’s safety and quality priorities for Aboriginal and Torres Strait Islander people; 4) Action 1.21 The health service organisation has strategies to improve the *cultural awareness and cultural competency* of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients; 5) Action 1.33 The health service organisation demonstrates a *welcoming environment* that recognises the importance of cultural beliefs and practices of Aboriginal and Torres Strait Islander people; and 6) Comprehensive Care Standard: Action 5.8 The health service organisation has processes to routinely ask patients if they *identify as being of Aboriginal and/or Torres Strait Islander origin*, and to record this information in administrative and clinical information systems (p. 3).

⁶⁶ In Queensland Health’s vision that by 2026 Queenslanders will be among the healthiest people in the world, one of the headline measures of success is that: “By 2026 we will: Ensure Queenslanders receive

- Comprehensive Aboriginal and Torres Strait Islander training, recruitment and employment report⁶⁷
- Aboriginal and Torres Strait Islander medical and health research⁶⁸
- Aboriginal and Torres Strait Islander chronic disease management and planning⁶⁹

Recommendation 6: Elevate the profile of the NACTG 2020 in the operation of NWHHS by creating a Closing the Gap portal on the HHS website

Making summaries of NWHHB meetings publicly available

The NWHHB meets monthly for eleven months of the year. Its board meeting summaries are published on the NWHHS website. However, the board summaries are very brief – averaging 1 to 2 pages with additional pages of photographs, effectively simply recording that the board met, attendance and apologies noted, the standing agenda items requiring board committee chair reports and up-dates, and the agenda items discussed. There is no detail and no reporting of decisions or outcomes, or the matters discussed as per each agenda item. The summaries are in stark contrast to those of the generally quarterly meetings of the Community Advisory Groups/Networks (Mt Isa, Normanton Hospital & Community Health, Julia Creek MPHS, Burke Shire, Partnering with Consumers, Cloncurry MPHS) which are usually 6 or 7 pages, and which contain useful quality information. More fulsome reporting of board meetings is required to enable the NWHHS public to have clear insights into the running of their Health Service.

Recommendation 7: Make summaries of outcomes and decisions from board meetings publicly available, including the details of the biannual reporting of Health Equity KPIs

clinical care within an appropriate time regardless of location”. Queensland Health, 2016. *My health, Queensland's future: Advancing health 2026*, p. 11.

⁶⁷ The portal should contain a breakdown of Indigenous training recruitment and employment according to sub-criteria in Indicator 4 of the NWHHS 2024-2025 Matrix Audit, and the on-line report to contain information on Aboriginal and Torres Strait Islander employment in each of the Executive Management divisions (roles and levels; casual, contract, permanent; employment streams; scholarships, trainee positions, etc); formal partnerships with VET and university providers; AO & OO Employee Training & Development Education Incentive Fund; etc. See also the NWHHS *Aboriginal and Torres Strait Islander Workforce Strategy 2019-2026*. QH-NWHHS *Service Agreement 2022/23-2024/25* [December 2024 Revision], with regard to Schedule 2, Part 3. Teaching, training and research, clause 3.1 Clinical education and training, in paragraph 3.1(a) “The HHS will provide education and training placements for the following professional groups consistent with and proportionate to the capacity of the HHS: (xi) Aboriginal and Torres Strait Islander Health Workers and Aboriginal and Torres Strait Islander Health Practitioners.” (pp. 18-19).

⁶⁸ QH-NWHHS *Service Agreement 2022/23-2024/25* [December 2024 Revision], with regard to Schedule 2, clause 3.3 Health and medical research: “The HHS will: (a) develop and implement a strategy to drive increased research activity and its translation into clinical practice; (b) support increased and equitable access to clinical trials for patients; (c) support clinicians to undertake research linked to their practice; and (d) ensure high quality and timely research governance approval processes” (p. 19).

⁶⁹ Refer Gidgee Healing and NWHHS *Health Equity Implementation Plan 2022-2025*, KPA 1 Improving First Nations Health and Wellbeing Outcomes: 1.2 Improving proactive management and prevention of chronic conditions (p. 9).

Annual reporting of Health Equity Strategy progress on Health Equity webpage

Publicly available, accessible, timely, and detailed reporting on progress of the NWHES is consistent with contemporary truth telling as required by s.21(2)(b) of the PS Act, good practice in public sector accountability and integrity⁷⁰, *My health, Queensland's future: Advancing health 2026*, which identifies that "Part of continuous improvement is communicating system performance to the public." (p18) and is consistent with Priority Reform 4 of the NACTG. This reporting compliments more narrative based, good news communications used in newsletters, annual reports, and social media to create transparency and accountability.

Recommendation 8: Annual reporting on Health Equity Strategy progress be included on the Health Equity webpage for ease of reference.

Service Standards performance data in the NWHHS annual reports be disaggregated

The NWHHS *Annual Report 2024-2025* (pp. 40-41) tabulates service standards performance including for:

- Percentage of emergency department patients seen within recommended timeframes (5 categories)
- Percentage of emergency department attendances who depart within 4 hours of their arrival in the department
- Percentage of elective surgery patients treated within clinically recommended times (3 categories)
- Rate of healthcare associated Staphylococcus (including MRSA) bloodstream (SAB) infections/10,000acute public hospital patient days
- Percentage of specialist outpatients waiting within clinically recommended times (3 categories)
- Percentage of specialist outpatients seen within clinically recommended times (3 categories)
- Median wait times for treatment in emergency departments (minutes)
- Median wait times for elective surgery treatment (days)
- Number of elective surgery patients treated within clinically recommended times (3 categories)
- Number of Telehealth outpatient service events
- Ambulatory mental health service contact duration (hours).

Patients are admitted to QH facilities according to the Queensland Hospital Admission Guidelines.⁷¹ Health Service staff are responsible for admitting patients and recording their

⁷⁰ Principles of good governance for public sector accountability and integrity as discussed in relation to Queensland in Coaldrake P. Review of culture and accountability in the Queensland public sector. Brisbane, 2022.

⁷¹ Queensland Health, 2025. Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual 2025-2026 Version 1.1 Available at: https://www.health.qld.gov.au/_data/assets/pdf_file/0027/1468242/2526-qhapdc-manual-v1.1.pdf

details, including whether or not they identify as a First Nations person. QH has this data and the capacity to disaggregate it across a range of patient characteristics, including age, gender and cultural identity. Disaggregated data would reveal much about, for example, First Nation patient access to services compared with patients who do not identify as First Nations, creating greater transparency and accountability.

Recommendation 9: The Service Standards performance data in the annual report be disaggregated

Data snapshots in the Health Equity Strategy and other HHS documents to include information such as dates and sources of data, and limitations on its interpretation

Statistical snapshots used to convey gaps in health outcomes experienced by First Nations people and communities can be problematic for a variety of reasons⁷². These include a lack of information about how the metric was generated (source and limitations of numerator and denominator⁷³), currency of the metric, limitations of the metric, restrictions of reporting for privacy (small cell suppression and aggregation) and guidelines for interpretation. Two of the three key NACTG targets for health services are impacted by these limitations: Life expectancy data at the Statistical Level 3 and disaggregated by Indigenous Identification is outdated⁷⁴ and data on deaths by suicide are impacted by privacy restrictions (small cell suppression)⁷⁵.

Poorly conveyed statistical snapshots can spark misinformation and misinterpretation⁷⁶ that will undermine public confidence and create unnecessary work to correct public perceptions of progress. Public facing documents should not utilise statistical snapshots without accompanying narrative to allow members of the public to critically engage with the metric, including trend reporting⁷⁷.

⁷² There is a large body of work by scholars such as Distinguished Professor Maggie Walter and the Maianayri Wingara collective members that outlines the history, issues and impact of Indigenous data use and reporting. See <https://www.maiamnayriwingara.org/> or <https://discover.utas.edu.au/Maggie.Walter/publications>.

⁷³ For example, the influence of the younger population structure (denominator).

⁷⁴ The Life Expectancy figures in the 2022-25 and 2025-2028 Draft NWHESs show no change. Efforts to find a publicly available and more recent figure was unsuccessful for SA3 level aligning to NWHHS boundaries, however at SA4 (state) there was improvement. The inclusion of the same life expectancy without any date or explanation of limitations of this metric promotes the idea that there has been no improvement and could be (deliberately) misinterpreted to suggest progress is not being made. There are people in the health sector who do not understand that progress in life expectancy will not be linear across time due to problems with measurement/calculation and lag effects of health gains. Reporting on key indicators that drive life expectancy (such as progress on infant mortality and preventable mortality) can provide a better indication of progress.

⁷⁵ Noting that reporting on suicide should be done in trauma informed and culturally appropriate ways also. Again, reporting on indicators relevant to addressing this issue is more meaningful but may require support to ensure accurate interpretation. For example: an increase in presentations for distress or suicidal ideation can be an indicator of progress if people are now seeking help and receiving support.

⁷⁶ Including wilful or deliberate misinterpretation.

⁷⁷ Proportion of healthy birthweight babies 2022-25 and 2025-2028 Draft NWHESs shows improvement and now meets the NACTG target. However, the reporting of the new baseline metric in the 2028 Draft NWHES (p15) does not tell that story.

The forthcoming NWHES, strategic documents and annual reports should contextualise and support meaningful interpretation of health outcome and service delivery metrics.

Recommendation 10: Data snapshots in the Health Equity Strategy and other HHS documents include explanation and context, dates and sources of the data, and interpretation guidelines regarding the influences or limitations of the metric.

Publication of annual Closing the Gap financial statement in NWHHS annual reports

The Bukal Matrix indicator regarding financial accountability and reporting on Closing the Gap funding is either ignored or poorly reported by HHSs. HHS First Nations communities have a right to accessibly presented information on how Commonwealth, State (QH) and HHS funds are allocated to various First Nations health programs and projects under Closing the Gap and Making Tracks funding arrangements. This will enable recipient groups to evaluate and feedback on whether the funding is appropriately apportioned and distributed, and whether the recipients are getting value for the services being funded. Examples of how such information can be presented occur in the TCHHS annual reports for 2026-2017 (p. 19) and 2017-2018 (p. 22) – see Appendix 3.

Recommendation 11: The NWHHS publish an annual Closing the Gap itemised summary of Commonwealth, State and HHS funds specifically allocated to First Nations health programs, projects and services in NWHHS annual reports as part of Aboriginal and Torres Strait Islander health / Closing the Gap reporting.

The report of this Institutional Racism Matrix Audit be made publicly available

Making this report publicly available via the NWHHS website is consistent with contemporary truth telling as required by s.21(2)(b) of the PS Act, good practice in public sector accountability and integrity⁷⁸, *My health, Queensland's future: Advancing health 2026*, which identifies that “Part of continuous improvement is communicating system performance to the public.” (p18) and is consistent with Priority Reform 3 of the NACTG 2020.

Recommendation 12: This audit be made publicly available on the Health Equity webpage.

⁷⁸ Principles of good governance for public sector accountability and integrity as discussed in relation to Queensland in Coaldrake P. Review of culture and accountability in the Queensland public sector. Brisbane, 2022.

References

- Australian Commission on Safety and Quality in Health Care, 2017. *National Safety and Quality Health Service Standards: User Guide for Aboriginal and Torres Strait Islander Health*.
- Australian Government Department of Health, 2021. *National Aboriginal and Torres Strait Islander Health Plan 2021-2031*. Available at: https://www.health.gov.au/sites/default/files/2025-01/national-aboriginal-and-torres-strait-islander-health-plan-2021-2031_0.pdf
- Australian Government Department of Health, 2021. *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031*.
- Australian Government Department of Health and Western Queensland Primary Health Network, 2024. *Joint Regional Health Needs Assessment November 2024*
- Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee, 2016. *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health: A National Approach to building a culturally respectful health system*.
- Australian Human Rights Commission, 2024. *The National Anti-Racism Framework: A roadmap to eliminating racism in Australia*. Available at: https://humanrights.gov.au/sites/default/files/2024-11/NARF_Full_Report_FINAL_DIGITAL_ACCESSIBLE.pdf
- Bourke, C., M. Truong, Y Jones, J Hunyor and P Lawton, 2020. 'Addressing racism to improve healthcare outcomes for Aboriginal and Torres Strait Islander people: a case study in kidney care', *Deeble Institute Perspectives Brief*, No. 9. Available at: https://www.researchgate.net/publication/345378062_Addressing_racism_to_improve_healthcare_outcomes_for_Aboriginal_and_Torres_Strait_Islander_people_a_case_study_in_kidney_care/link/5fa522ef299bf10f7328b484/download?_tp=eyJjb250ZXh0Ijp7ImZpcnN0UGFnZSI6InB1YmxpY2F0aW9uliwicGFnZSI6InB1YmxpY2F0aW9uIn19
- Coaldrake P, 2022. *Let the Sunshine In: Review of culture and accountability in the Queensland public sector*. Brisbane. Available at: <https://www.coaldrakereview.qld.gov.au/assets/custom/docs/coaldrake-review-final-report-28-june-2022.pdf>
- Department of Premier and Cabinet, 2025. *Annual report requirements for Queensland Government agencies (2024-2025 reporting period)*. Available at: https://www.qld.gov.au/_data/assets/pdf_file/0029/259148/annual-report-requirements.pdf
- Gidgee Healing and North West Hospital and Health Service, 2022. *Health Equity Implementation Plan 2022-2025*. Available at: https://os-data-2.s3-ap-southeast-2.amazonaws.com/nwhhs/bundle3/nwhhs_implementation_plan_2023.pdf
- Halter A. and Nixon M., 2025. Rheumatic heart disease cases drastically reduced in North West Queensland. *ABC North West Qld*. Available at: <https://www.abc.net.au/news/2025-12-05/rheumatic-heart-disease-cases-reduced-in-north-west-queensland/106099658>
- Health+Wellbeing Queensland, 2023. *Gather+Grow: Queensland Remote Food Security Strategy 2023-2032 (Consultation Draft – February 2023)*.
- Hospital and Health Boards Act 2011* (Qld).
- Hospital and Health Boards Act (Health Equity Strategies) Amendment Regulation 2021* (Qld) [Subordinate Legislation 2021 No. 34]. Available at: <https://www.legislation.qld.gov.au/view/pdf/asmade/sl-2021-0034>
- Hospital and Health Boards (Health Equity Strategies) Amendment Regulation 2021* (Qld) Explanatory Notes for SL 2021 No. 34 [HHB Act (HES) Amendment Regulation 2021 (Qld)].

Available at: <https://www.legislation.qld.gov.au/view/pdf/published.exp/sl-2021-0034>

Human Rights Act 2019 (Qld). Act No.5 of 2019.

Jones C.P. 2000. 'Levels of racism: a theoretic framework and a gardener's tale', *American Journal of Public Health*, 90(8):1212-5. Available at:

<https://pmc.ncbi.nlm.nih.gov/articles/PMC1446334/pdf/10936998.pdf>

Marrie A. 2017. *Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services*. ADCQ and QAIHC, Brisbane. Available at:

<https://www.qhrc.qld.gov.au/resources/reports/health-equity>

National Agreement on Closing the Gap July 2020. Closing the Gap in Partnership. Available at:

<https://static1.squarespace.com/static/62ebb08a9ffa427423c18724/t/64467ee62c9e8f38067d2352/1682341610670/National-Agreement-on-Closing-the-Gap-July-2020.pdf>

North West Hospital and Health Service, 2025. *Annual Report 2024-2025*.

North West Hospital and Health Service, 2025. *Minutes: Mount Isa Consumer Advisory Group (CAG) [Wednesday, 2 July]*.

North West Hospital and Health Service, 2025. *Minutes: Partnering with Consumers [10 June 2025]*.

North West Hospital and Health Service, 2025. *Minutes: Partnering with Consumers [14 May 2025]*.

North West Hospital and Health Service, 2025. *Minutes: Partnering with Consumers [13 May 2025]*.

North West Hospital and Health Service, 2024. *Minutes: Partnering with Consumers [10 September 2024]*.

North West Hospital and Health Service, 2025. *Minutes: Mount Isa Consumer Advisory Group [Wednesday, 19 March 2025]*.

North West Hospital and Health Service, 2024. *Minutes of Meeting: Cloncurry MPHS CAN Meeting [28.11.2024]*.

North West Hospital and Health Service, 2024. *Minutes of Meeting: Cloncurry MPHS CAN Meeting [22.05.2024]*.

North West Hospital and Health Service, 2024. *Minutes: Mount Isa Consumer Advisory Group (CAG) [Wednesday, 6 August 2024]*.

North West Hospital and Health Service, 2024. *Minutes: NWHHB Stakeholder Engagement Committee Meeting [14/10/2024]*

North West Hospital and Health Service, 2024. *Minutes: Burke Shire CAG [16 January 2024]*.

North West Hospital and Health Service, 2024. *Minutes: Julia Creek MPHS Consumer Advisory Network [28th November 2024]*.

North West Hospital and Health Service, 2024. *Minutes: Julia Creek MPHS Consumer Advisory Network [13th June 2024]*.

North West Hospital and Health Service, 2024. *Minutes: Julia Creek MPHS Consumer Advisory Network [14th March 2024]*.

North West Hospital and Health Service, 2024. *Minutes 19.03.2024: Normanton Hospital & Community Health - Consumer Advisory Group*.

North West Hospital and Health Service, 2024. *Minutes 11.06.2024: Normanton Hospital & Community Health - Consumer Advisory Group*.

North West Hospital and Health Service, 2024. *Minutes: Consumer Advisory Group - Normanton Hospital & Community Health [Tuesday 19th November 2024]*.

North West Hospital and Health Service, 2025. *North West HHS Stakeholder Engagement Committee Meeting - July 2025*.

North West Hospital and Health Service, 2025. *North West HHS Stakeholder Engagement Committee Meeting - April 2025*.

North West Hospital and Health Service, nd. *North West Health Equity Governance Collaborative: Terms of Reference*.

North West Hospital and Health Service, 2025. *North West Hospital and Health Service Local Area Needs Assessment – 2025 Update*. Available at: https://www.northwest.health.qld.gov.au/_data/assets/pdf_file/0026/443825/nwhhs-local-area-needs-assessment-2025.pdf

North West Hospital and Health Service, 2024. *North West Hospital and Health Service Local Area Needs Assessment – 2024 Update*. Available at: https://os-data-2.s3-ap-southeast-2.amazonaws.com/nwhhs/bundle17/local_area_need_assessment_-_2024.pdf

North West Hospital and Health Service, 2024. *North West HHS Equity and Diversity Plan 2024-2027*. Available at: https://os-data-2.s3-ap-southeast-2.amazonaws.com/nwhhs/bundle3/nwhhs_diversity_and_equity_plan_2024_2027.pdf

North West Hospital and Health Service, 2022. *North West Health Equity Communications + Community Engagement Plan 2022*. Available at: <https://www.northwest.health.qld.gov.au/search/?q=ty+North+West+Health+Equity+Communications+%2B+Community+Engagement+Plan+2022>

North West Hospital and Health Service, 2019. *Aboriginal and Torres Strait Islander Workforce Strategy 2019- 2026*. Available at: https://os-data-2.s3-ap-southeast-2.amazonaws.com/nwhhs/bundle3/nwhhs_aboriginal_and_torres_strait_islander_workforce_strategy_2019-2026.pdf

North West Hospital and Health Service, 2023. *Consumer Engagement Strategy - 2021-2023: Engaging our consumers to partner with us in every aspect of our health services*. [Document Number NW0928-V1-07/23]

North West Hospital and Health Service, 2024. *Consumer + Community Engagement Strategy* Available at: <https://os-data-2.s3-ap-southeast-2.amazonaws.com/nwhhs/bundle4/nw0928-nwhhs-consumer-engagement-strategy-2024.pdf>

North West Hospital and Health Service, 2022. *North West Hospital and Health Service Clinical Services Plan 2022 - 2037* Available at: https://os-data-2.s3-ap-southeast-2.amazonaws.com/nwhhs/bundle3/clinical_services_plan_2022-2037.pdf

Paradies Y, Harris R and Anderson I, 2008. *The Impact of Racism on Indigenous Health in Australia and Aotearoa: Towards a Research Agenda*, Discussion Paper No. 4. Cooperative Research Centre for Aboriginal Health, Darwin.

Productivity Commission, 2024. *Review of the National Agreement on Closing the Gap: Study Report* (Volume 1). Available at: <https://assets.pc.gov.au/inquiries/completed/closing-the-gap-review/report/closing-the-gap-review-report.pdf>

Queensland Audit Office, 2023. *Health Outcomes for First Nations people - Report 14: 2022-23*. Performance Audit Report 7 June 2023. Available at: <https://www.parliament.qld.gov.au/Work-of-the-Assembly/Tabled-Papers/docs/5723t737/5723t737-cbc9.pdf>

Queensland Government, 2022. *Local Thriving Communities Action Plan 2022-24: Building capacity through existing service delivery mechanisms*.

Queensland Government, 2022. *Queensland Closing the Gap: Annual Report 2022*.

Queensland Government, 2022. *Queensland Closing the Gap: Snapshot Report 2022 Edition*.

Queensland Government, 2021. *Queensland's 2021 Closing the Gap Implementation Plan*.

Queensland Government, 2019. *Aboriginal and Torres Strait Islander Housing Action Plan 2019-2023*.

Queensland Health, 2025. *Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual 2025-2026 Version 1.1* Available at: https://www.health.qld.gov.au/_data/assets/pdf_file/0027/1468242/2526-qhapdc-manual-v1.1.pdf

Queensland Health, 2024. *First Nations First Health Budget 2024-25*. Available at: https://www.health.qld.gov.au/_data/assets/pdf_file/0013/1340014/First-Nations-First-Health-Budget-2024-25.pdf

Queensland Health, 2025. *Equity and Diversity Report 2025: North West Hospital and Health Service*.

Queensland Health, 2024. *HealthQ32: First Nations First Strategy 2032 – Placing First Nations peoples at the centre of healthcare design and delivery*. Available at: https://www.health.qld.gov.au/_data/assets/pdf_file/0021/1307055/healthq32-first-nations-first-strategy-2032.pdf

Queensland Health, 2024. *Reframing the Relationship*. Available at: <https://www.health.qld.gov.au/public-health/groups/atsihealth/reframing-the-relationship>

Queensland Health, 2023. *LANA Review 2023: North West Hospital and Health Service*. Available at: https://os-data-2.s3-ap-southeast-2.amazonaws.com/nwhhs/bundle17/local_area_needs_assessment_2023.pdf

Queensland Health and North West Hospital and Health Service, 2022. *North West Health Equity Strategy 2022 – 2025*. Available at: https://os-data-2.s3-ap-southeast-2.amazonaws.com/nwhhs/bundle3/nwhhs_health_equity_strategy_final.pdf

Queensland Health, 2020. *Unleashing the potential: an open and equitable health system -Healthcare for Queenslanders in a pandemic ready world*. Reform Planning Group Final Report.

Queensland Health, 2019. *Aboriginal and Torres Strait Islander Environmental Health Plan 2019-2022*.

Queensland Health, 2018 *The health of Queenslanders 2018 – Report of the Chief Health Officer Queensland: Hospital and Health Service Profiles*.

Queensland Health, 2016. *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026* Available at: https://www.health.qld.gov.au/_data/assets/pdf_file/0023/628340/aboriginal-torres-strait-islander-workforce-framework.pdf

Queensland Health, 2016. *My health, Queensland's future: Advancing health 2026*.

Queensland Health, 1996. *Health of Queensland's Aborigines and Torres Strait Islanders: Status Report*. Health Information Centre, Brisbane (Foreword by Dr RL Stable, Director General).

Queensland Health and Queensland Aboriginal and Islander Health Council, 2021. *Making Tracks towards health equity with Aboriginal and Torres Strait Islander peoples – working together to achieve life expectancy parity by 2031. Discussion paper: a shared conversation*. Available at: https://www.qaihc.com.au/media/37942/0224-health-equity-discussion-paper_lr.pdf

Queensland Health – North West Hospital and Health Service, 2025. *Service Agreement 2025/26 – 2027/28 North West Hospital and Health Service December 2025*. Available at: <https://www.publications.qld.gov.au/dataset/north-west-hhs-service-agreements/resource/651d0650-e0e3-48f1-ab50-f6e176a0cca9>

Queensland Health – North West Hospital and Health Service, 2022. *Service Agreement 2022/23 – 2024/25 [December 2024 Revision]*. Available at: https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/21669457-a90b-42b9-ad4d-901943d8df63/ntw_aw2_2024-25_deed_signed.pdf?ETag=4bf7b46a105d3175b44b6946ec350b6f

Queensland Treasury, 2025. *Doing What Matters For Outback Queensland Regional Action Plan Queensland Budget 2024–25* Available at: https://www.treasury.qld.gov.au/files/RAP_2024-25_OutbackQueensland.pdf

Torres and Cape Hospital and Health Service, 2022. *Local Area Needs Assessment: Summary Report (December 2022)*. Available at: https://www.torres-cape.health.qld.gov.au/_media/about-us/report-2303.pdf

Torres and Cape Hospital and Health Service, 2019. *Clinical Services Plan 2019-2029*. Available at: <https://www.torres-cape.health.qld.gov.au/about-us/corporate-publications-and-reporting/clinical-services-plan>

Torres and Cape Hospital and Health Service, 2017. *Torres and Cape Hospital and Health Service Annual Report 2016-2017*.

Torres and Cape Hospital and Health Service, 2018. *Torres and Cape Hospital and Health Service Annual Report 2017-2018*.

Wilson, N. 2023. *Coroners Court of Queensland Findings of Inquest into the deaths of the RHD Doomadgee Cluster*. Northern Coroner, Queensland Courts. Available at: https://www.courts.qld.gov.au/_data/assets/pdf_file/0006/770109/cif-booth-sandy-george-20230630.pdf

Appendix 1: The 2018 Queensland Health Matrix Template (QHMT 2018)

Revised Queensland Health Matrix Template: Reworked version based on discussions at ADCQ Workshop, 12 November 2018

This version/template resulted from an HHS stakeholder workshop held in Brisbane to amend the Matrix that was used to conduct the institutional racism audit of Qld's 16 HHSs in 2016-17 to make it more reflective of HHS needs. It was intended, back then in 2018, that this Matrix Template would be used for future audits. The big difference with the 2016-17 version is that the criteria (and sub-criteria) examining the issue of legal visibility for Aboriginal and Torres Strait Islander people in the Hospital Health Boards Act were replaced with criteria (and sub-criteria) reflective of what constituted good HHS board governance. Attendees felt that the legal visibility criteria regarding the HHB Act were unfair and pointless because all HHSs were equally penalized for something they had no power over yet were subject to. In terms of scoring, the number of points allocated to legal visibility in the 2016-17 matrix were reduced from 20 to 10 in the 2018 version to measure the criterion for good governance. These points were re-allocated to the criterion for Aboriginal and Torres Strait Islander workforce development under the indicator for recruitment and employment. The original QH Matrix Template used by Adrian Marrie for the 2016-17 audit for the Anti-Discrimination Commission Queensland is on pp. 50-2 of the Health Equity Report available at: <https://www.qhrc.qld.gov.au/resources/reports/health-equity>

Key Indicators and Criteria

1 Participation in HHS governance

• Good governance	Total out of 10
- Board interaction with Aboriginal and Torres Strait Islander community	3
- HHS Aboriginal and Torres Strait Islander health performance reviewed by Board at least 2 x per year	4
- Direct input to board by HHS Aboriginal and Torres Strait Islander Community Consultative Committee	3
• Aboriginal and Torres Strait Islander representation at board level	Total out of 10
• Inclusion in Executive Management Structure	Total out of 10
- Aboriginal and Torres Strait Islander Health Division	5
- Aboriginal/Torres Strait Islander Executive Director	5
Total	30

2 Policy Implementation

• Improving Aboriginal and Torres Strait Islander Health Outcomes	Total out of 10
- Explicitly identified as a strategic priority in HHS Strategic Plan	5
- Aboriginal and Torres Strait Islander health outcome KPIs explicitly referred to in HHS Strategic Plan	5
• Community Engagement	Total out of 10
- Aboriginal and Torres Strait Islander community consultative body	3
- Aboriginal and Torres Strait Islander community engagement strategy	3
- HHS Aboriginal and Torres Strait Islander community newsletter/e-letter	2
- At least one Aboriginal and Torres Strait Islander community forum/meeting per year convened by the HHS chief executive	2

• Public Reporting and Accountability (via annual report)	Total out of 10
- Traditional Owner acknowledgement	1
- Improving Aboriginal and Torres Strait Islander health outcomes	
i. Separate section in report devoted to Aboriginal and Torres Strait Islander health	1
ii. Reporting on KPIs contained in current health service agreement	1
- Policy References	
i. Cultural Capability Framework	1
ii. Making Tracks	1
- Aboriginal and Torres Strait Islander health division / unit placement on HHS organisational structure / chart	1
- Data on Aboriginal and Torres Strait Islander access to and delivery of services	1
- Aboriginal and Torres Strait Islander Employment	
i. Data on Aboriginal and Torres Strait Islander employment	1
ii. Reference to workforce planning, recruitment, etc.	1
- Other recognition (e.g., awards, scholarships, etc)	1
Total	30

3 Service delivery and Partnerships

• Aboriginal and Torres Strait Islander HHS Plan	Total out of 10
- Co-designed with ATSICCHO(s) in HHS region	2
- Formal agreement with ATSICCHO(s) in HHS region (e.g., MoU)	2
- Commitment to Continuous Quality Improvement	2
- Mutually agreed KPIs	2
- Clear statement of parties' responsibilities (eg, sharing of patient health records)	2
• Cultural safety	Total out of 10
- Cultural safety policy/strategy	4
- Capacity to deliver Cultural Safety Training (CST)	3
- Proportion of staff trained	3
• Selected Health Service Performance Indicators	Total out of 10
- Estimated level of completion of Indigenous status – specifically the reporting of 'not stated' on admission	2
- Discharges against medical advice (DAMA)	2
- Potentially preventable hospitalisations (PPH)	2
- Access to mental health services	2
- Low birth-weight babies	2
Total	30

4 Recruitment and employment

• Aboriginal and Torres Strait Islander health workforce development	Total out of 20
- Aboriginal and Torres Strait Islander workforce development policy/strategy/framework (to also include identified positions according to their nature, role, consumer type and objectives of the service to be provided)	4
- HHS KPI for Aboriginal and Torres Strait Islander employment	4
- Number of Aboriginal and Torres Strait Islander health practitioners, workers and liaison officers	4
- Number of identified Aboriginal and Torres Strait Islander positions	4
- Number of salary bands occupied by Aboriginal and Torres Strait Islander employees	4
• Aboriginal and Torres Strait Islander participation in the health workforce	Total out of 10
- Managerial and clerical	1.5
- Medical including Visiting Medical Officers (VMOs)	2
- Nurses	2
- Operational and Support Services	1.5
- Trade and Artisans	1.5
- Health Practitioners (Professional and Technical)	1.5
Total	30

5 Financial Accountability and Reporting: Closing the Gap Funding

• Commonwealth contribution to HHS	Total out of 10
• Queensland contribution to Indigenous specific health services and programs	Total out of 10
- Making Tracks funded services (as per HHS Service Agreement)	5
- Indigenous-specific non-Making Tracks health services (as per HHS Service Agreement)	5
Total	20

Score	140
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Institutional Rating scored against criteria

Score:	>110	80-109	60-79	40-59	20-39	<20
Evidence of InstRacism:	Very Low	Low	Moderate	High	Very High	Extreme

Appendix 2: The NWHHS 2017 Health Equity Report Audit

The NWHHS 2017 Health Equity Report Audit (2014-2015 Reporting Period) (1)

This assessment is to be read in conjunction with the original Queensland Health Matrix Template (QHMT) – not the later 2018 version (QHMT 2018).

Key Indicators and Criteria	Scoring	Score
1 Participation in governance		
• Legal Visibility: the Hospital and Health Boards Act 2011 (Qld) and Hospital and Health Boards Regulation 2012 (Qld) (2)	20	0.5
• North West Hospital and Health Board (NWHHB) (3)		
- Indigenous representation	10	10
• Executive Management Structure (4)		
- Aboriginal and Torres Strait Islander Health Division	5	0
- Aboriginal/Torres Strait Islander Executive Director	5	0
Total	40	10.5
2 Policy Implementation		
• Closing the Gap in Aboriginal and Torres Strait Islander health outcomes		
- Explicitly identified as a strategic priority in Strategic Plan (5)	5	4
- Closing the Gap KPIs explicitly referred to in Health Services Agreement (6)	5	2
• Community Engagement		
- Aboriginal and Torres Strait Islander consultative body (7)	5	0
- Reconciliation Action Plan (8)	3	0
- Aboriginal and Torres Strait Islander Health Division / Unit community newsletter (9)	2	0
• Public Reporting and Accountability (via annual report) (10)		
- Traditional Owner acknowledgement (11)	1	1
- Closing the Gap		
i. Separate section in report devoted to Closing the Gap (12)	1	0
ii. Reporting on KPIs contained in 2013/14-2015/16 service agreement (13)	1	0
- Policy References (14)		
i. Cultural Capability Framework (15)	1.5	1.5
ii. Making Tracks (16)	1.5	1.5
- Organisation structure (Aboriginal and Torres Strait Islander unit placement within) (17)	1	1

-	Aboriginal and Torres Strait Islander Employment		
	i. Data on Aboriginal and Torres Strait Islander employment (18)	1	0
	ii. Reference to workforce planning, recruitment, etc. (19)	1	0
-	Other recognition (e.g., awards, scholarships, etc (20)	1	1
	Total	30	12

3 Service delivery and Partnerships

•	Aboriginal and Torres Strait Islander HHS Plan (21)	10	0
•	Cultural competence (22)		
-	Cultural competency policy/strategy (23)	3	1
-	Capacity to deliver Cultural Competency Training (CCT) (24)	3	3
-	Proportion of non-Indigenous staff trained (25)	4	0
•	Selected Health Service Performance Indicators		
-	Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission (26)	2	0
-	Discharges against medical advice (DAMA) (27)	2	0
-	Potentially preventable hospitalisations (PPH) (28)	2	0
-	Access to mental health services (29)	2	0
-	Access to drug and alcohol services (20)	2	0
	Total	30	4

4 Recruitment and employment

•	Aboriginal and Torres Strait Islander health workforce development		
-	Aboriginal and Torres Strait Islander workforce policy / strategy (31)	3	1.5
-	Aboriginal and Torres Strait Islander employment implementation body (32)	3	3
-	Employment equity (33)	4	0
•	Aboriginal and Torres Strait Islander participation in the health workforce (34)		
-	Managerial and clerical	1	0
-	Medical including Visiting Medical Officers (VMOs)	2	0
-	Nurses	2	0
-	Indigenous Health Practitioners / Health Workers / and Liaison Officers	2	0
-	Operational and Support Services	1	0
-	Trade and Artisans	1	0
-	Health Practitioners (Professional and Technical)	1	0
	Total	20	4.5

5 Financial Accountability and Reporting: Closing the Gap Funding (35)

• Commonwealth contributions (36)	10	0
• Queensland Contribution (37)	10	0
Total	20	0

Score	140	31
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Institutional Rating scored against criteria

Score:	>110	80-109	60-79	40-59	20-39	<20
Evidence of Inst. Racism:	Very Low	Low	Moderate	High	Very High	Extreme

Notes:

1. **North West Hospital and Health Service** The North West Hospital and Health Service (NWHHS) has responsibility for providing public hospital and other health services to the communities of North West Queensland. It serves a population of around 33,000 people distributed across a geographical area covering 300,000 square kilometres, providing services across one regional hospital (Mt Isa), two MPHSSs, three rural/remote hospitals, four primary health clinics and five community health centres. Around 7,000 people identify as Indigenous, comprising 23.1 percent of the people living in the North West compared to 3.6 percent within all of Queensland. The Indigenous population is concentrated in the two Local Government Areas of Doomadgee (1,185) and Mornington Island (1,005), and Mt Isa (3,206), Cloncurry (702) and Carpentaria (757). Three Local Government Areas have populations in which more than 85 percent of the population are in the most disadvantaged quintile according to the Index of Relative Socio-Economic Disadvantage: Mornington Island (100%), Doomadgee (97.8%) and Carpentaria (87.4%) (NWHHS *Annual Report 2014 – 2015*, pp. ii and 13 – 14. Based on 2011 Census). The NWHHS provides a comprehensive range of community and primary health services, including aged care assessment; Aboriginal and Torres Strait Islander health programs; child and maternal health services; alcohol, tobacco and other drugs services; home care services; community health nursing, sexual health service, allied health, oral health and health promotion programs.⁷⁹ The median age of death for Aboriginal and Torres Strait Islander people living in the NWHHS region is 53 years compared to the non-Indigenous rate of 73 years.⁸⁰ There are two ATSI CCHSs operating in the NWHHS area: the Mt Isa Aboriginal Community Controlled Health Service (trading as Gidgee Healing) which also operates a Mobile Health Clinic in Normanton⁸¹, and the Injilinj Aboriginal and Torres Strait Islander Corporation for Children and Youth Services (Mt Isa). There is also the Ngukuthati Children and Family Centre (Mt Isa) where the NWHHS provides a number of services (antenatal classes, immunisation clinics, etc) (NWHHS *Annual Report 2014-2015*, pp. 52-3).

2. **Legal visibility** See QHMT Note 4. The single reference in s.4(c)(vi) of the HHB Act earns 0.5 point out of 20 for all Queensland Health's 16 HHSs.

⁷⁹ Queensland Government (2014, p. 155).

⁸⁰ Queensland Health, 2014. *The health of Queenslanders 2014 - Fifth report of the Chief Health Officer Queensland: North West HHS*. p. 5.

⁸¹ Gidgee Healing website: <http://www.gidgeehealing.com/> Accessed 5/12/2016.

3. **NWHHB** The NWHHB comprises 8 members, one of whom is Aboriginal, and who also serves as a director of Gidgee Healing (NWHHS *Annual Report 2014 – 2015*, p. 40). **Score = 10/10.**

4. **Executive Management Structure** The Executive Management Group (EMG) comprises 6 members: Health Service Chief Executive; Executive Director Nursing and Midwifery; Executive Director Medical Services; Chief Operating Officer; Chief Finance Officer; and Executive Director People and Performance (NWHHS *Annual Report 2014 – 2015*, p. 43-44 and p. 38). There is no executive division for Aboriginal and Torres Strait Islander health and, according to their profiles, none of the EMG members identifies as an Aboriginal or Torres Strait Islander person. However, the Executive Director People and Performance “has experience in statewide Indigenous health roles” (p. 44). **Score = 0/10.**

5. **Closing the Gap health outcomes and the NWHHS Strategic Plan** According to the section “Our strategic direction” contained in the NWHHS *Annual Report 2014-2015* (p. 31), the strategy is underpinned by a number of national and state agreements, strategies and plans which include:

- *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*
- *National Indigenous Reform Agreement*
- *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033: policy and accountability frameworks*
- *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 - 2033*

In the NWHHS *Strategic plan 2012 – 2016* (reviewed June 2015), the Closing the Gap policy is not explicitly mentioned, however, reference is made to some of its elements (p. 2). On this basis, four points out of five are awarded. **Score = 4/5.**

6. **Closing the Gap KPIs included in the Health Service Agreement** Of the five Closing the Gap KPIs selected for inclusion in the Matrix (see QHMT, Note 23), only 2 (DAMA and PPH) are included in the NWHHS *Health Service Agreement 2013/14 – 2015/16* (p. 38). However, a third KPI: Aboriginal and Torres Strait Islander low birthweight babies, and which is not among the five selected in the QHMT for the audit, has been included in the service agreement (p. 38). **Score = 2/5.**

7. **Aboriginal and Torres Strait Islander consultative body** Engagement with communities in the NWHHS area is primarily through a Consumer Advisor who sits on high level planning groups, and regional advisory panels that a number of North West communities (such as Julia Creek, Cloncurry, Normanton and Karumba) have chosen to establish to formally engage with local health providers, including the NWHHS (NWHHS *Annual Report 2014 – 2015*, p. 15). Whether such regional advisory panels have been established in communities like Doomadgee and Mornington Island is not stated. The NWHHB established an Engagement Committee, as a board committee, in 2013 (NWHHS *Annual Report 2014 – 2015*, pp. 41-2). The Indigenous member of the NWHHB is currently a member of that committee (NWHHB, *Engagement Committee: a North West Hospital and Health Board Committee - Terms of Reference (Charter)*, p. 6). The NWHHS does not appear to have a dedicated Aboriginal and Torres Strait Islander community consultative/advisory body as such. **Score = 0/5.**

8. **RAP** The Queensland Government released its Reconciliation Action Plan in 2009 committing all government agencies to developing their own RAPs. With regard to COAG’s National Aboriginal and Torres Strait Islander reforms with regard to, *inter alia*, early childhood and health, all agencies were supposed to have strategies in place by December 2009 to put Queensland on

track to meet the COAG targets.⁸² Queensland Health co-signed with Reconciliation Australia⁸³ a *Statement of Intent for Reconciliation*, on 2nd June 2000, and an *Affirmation of Commitment to Reconciliation* on 13th January 2005. No references are made in the published information available from Reconciliation Australia or the NWHHS concerning the existence of a RAP. **Score = 0/3.**

9. **Aboriginal and Torres Strait Islander Health Division/Unit community newsletter.** A search of the NWHHS website has failed to reveal the existence of a Aboriginal and Torres strait Islander community newsletter.⁸⁴ **Score = 0/2**

10. **Annual report** The NWHHS *Annual Report 2014 – 2015*. The annual report is noteworthy for its inclusiveness of the Aboriginal and Torres Strait Islander people of the service area. For example, the report contains detailed descriptions of the breakdown of the numbers and percentages of Aboriginal and Torres Strait Islander people in the region's 10 main population centres (p.12), and the particular Traditional Owner groups associated with those centres (pp. 18-29). Also well documented are NAIDOC celebrations and awards (pp. i and 8), Board visits to communities with high Aboriginal and Torres Strait Islander populations, such as Mornington Island and Burketown (pp. 8 and 11), and clinical outreach and health promotion services to Doomadgee and Mornington Island and community controlled health centres (p. 53).

11. **Traditional Owner acknowledgement** The NWHHS *Annual Report 2014 – 2015* (p. i) contains the following acknowledgement of Traditional Owners:

The North West Hospital and Health Service respectfully acknowledges the traditional owners and custodians both past and present of the land, sea and waterways which we service and declare the North West Hospital and Health Service's commitment to reducing inequalities between Indigenous and non-Indigenous health outcomes in line with the National Indigenous Reform Agreement (Closing the Gap). **Score = 1/1**

12. **Closing the Gap section** The NWHHS *Annual Report 2014 – 2015* does not contain a separate section devoted to Closing the Gap. **Score = 0/1.**

13. **Reporting on KPIs** Unlike the NWHHS *2012-2013 Annual Report* (p. 36) which reported on the following Closing the Gap KPIs:

- Estimated level of completion of Indigenous status – specifically the reporting of 'not stated' on admission
- The proportion of Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice (quarterly data provided)
- Percentage of Aboriginal and Torres Strait Islander Cultural Practice Program participants,

the NWHHS *Annual Report 2014-2015* contains no such information in its performance statement (see p.36). **Score = 0/1.**

14. **Policy references** For the NWHHS, the primary Closing the Gap policy documents are the Australian Health Ministers' Advisory Council (2011) *Aboriginal and Torres Strait Islander Health Performance Framework*, Queensland Health (2010) *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Policy and Accountability Framework* and the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033*. *Making Tracks* articulates the Queensland Government's long-term strategy to close the health gap by 2033 and achieve sustainable gains for Aboriginal and Torres Strait Islander people in Queensland.

⁸² Queensland Government (nd, p. 19).

⁸³ Then, the Council for Aboriginal Reconciliation, with local Cairns Aboriginal Elder, Dr Evelyn Scott as the Chairperson and co-signatory.

⁸⁴ Website: <https://www.health.qld.gov.au/services/northwest/> Last update: 12 September 2014. Accessed 5/12/2016.

15. **Cultural capability framework** Reference is made to the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033* (NWHHS Annual Report 2014 – 2015, p. 31) in the context of the NWHHS's strategic direction. **Score = 1.5/1.5.**

16. **Making Tracks Reference** is made to both the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* and the *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033: policy and accountability framework* (NWHHS Annual Report 2014 – 2015, p. 31). It is also noted that the NWHHS 2012-2013 Annual Report (pp. 46-47) reported on initiatives taken for the implementation of two priority strategies in *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders*: (i) Improve access to culturally appropriate services for the Aboriginal and Torres Strait Islander population; and (ii) Engage Aboriginal and Torres Strait Islander health service providers and communities in the development and delivery of all health services. **Score = 1.5/1.5.**

17. **Organisational structure** The NWHHS Annual Report 2014 – 2015, p. 38). While there is no Indigenous Health Unit as such located on the organisation chart, there is a number of references to medical and nursing services provided at Doomadgee and Mornington Island, and Indigenous child health services provided as part of Community services, and to the position of NWHHS Cultural Advisor (see also p. 57 re: Cultural Advisor's role). **Score = 1/1.**

18. **Employment** No data on Indigenous employment provided in the NWHHS Annual Report 2014 – 2015 (see pp. 49-50). As at 30 June 2015, 664 full time equivalent staff were employed by the NWHHS (p 50). **Score = 0/1.**

19. **Workforce planning** With reference to the NWHHS's strategic direction, under Strategic Priority 2: Implement priority strategies to recruit and retain staff, no specific mention is made of recruiting and training Aboriginal and Torres Strait Islander people for the workforce (NWHHS Annual Report 2014 – 2015, p. 33). **Score = 0/1.**

20. **Awards, recognition, etc.** See NWHHS Annual Report 2014 – 2015 (pp. 1 and 54). 10 Indigenous staff were recognised for their achievements during the NWHHS NAIDOC day celebrations held on 8 July 2014, and the awarding of two Puggy Hunter Memorial Scholarships to NWHHS Indigenous staff. **Score = 1/1.**

21. **Aboriginal and Torres Strait Islander Health Plan** Commencing in July 2015, a new Cultural Advisor role has been established to guide current and future strategic and operational directions of the NWHHS with regard to the health needs and directions of the Aboriginal and Torres Strait Islander community. During 2015-2016, the Cultural Advisor will have a key role in developing and Aboriginal and Torres Strait Islander strategic health plan (NWHHS Annual Report 2014 – 2015, p. 57 – see also NWHHS Strategic plan 2012-2016 (reviewed June 2015), Strategic Priority 4, p.2). As this plan is not in place for the 2014-15 audit period, a penalty score of 0 results, but it does augur well with regard to a future audit. **Score = 0/10.**

22. **Cultural competence** In the document *Health System Priorities for Queensland 2013-14* it is pointed out that:

To reduce cultural barriers to accessing mainstream health services there is a need to ensure services are culturally capable of communicating with, diagnosing and treating Aboriginal and Torres Strait Islander Queenslanders. Specifically, there is a need to improve the cultural competence of health professionals and to increase the number of Aboriginal and Torres Strait Islander people in health professions.⁸⁵

Cultural competency training (CCT): the relevant policy document here is Queensland Health's *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033*. A revised and expanded Aboriginal and Torres Strait Islander Cultural Capability Learning Program was planned for development to assist in the development of cultural capability. The intended program was structured for:

⁸⁵ Queensland Health (2013b, p. 12).

- All employees (mandatory)
- Employees working in clinical and other consumer service areas
- Employees (and contractors) working directly with Aboriginal and Torres Strait Islander communities
- Aboriginal and Torres Strait Islander employees
- Non-clinical employees involved in education and training, safety and quality, policy, improvement, planning, funding, and infrastructure that has the potential to impact on Aboriginal and Torres Strait Islander peoples and their health outcomes
- All line managers
- Senior and executive managers.⁸⁶

23. Cultural competency policy/strategy. The NWHHS is funded in its 2013/14 – 2015/16 health service agreement to provide Indigenous cultural capability services (see Note 37). In terms of Strategic Priority 4: Implementation of state and national health priorities to enhance and produce better health for the individual, family and community, with the objective of providing culturally appropriate and equitable health care, one of the strategies is to engage Aboriginal and Torres Strait Islander health service providers and communities in the delivery of all health services. This strategy will be enhanced through the engagement and leadership of a Cultural Advisor (NWHHS *Annual Report 2014-2015*, p. 34; NWHHS *Strategic plan 2012-2016* (reviewed June 2015) (p. 2). However, nothing is stated about a cultural competency policy in terms of training the non-Indigenous staff as per the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033*. **Score = 1/3.**

24. Capacity to deliver CCT As in Note 21, the position of Cultural Advisor has been created. Presumably the Cultural Advisor will, *inter alia*, and with the assistance of local Elders from the many Traditional Owner groups located within the NWHHS service area, oversee the delivery of CCT to the non-Indigenous staff. The magnitude of this task of delivering CCT to the nearly 700 NWHHS staff can be compared with that of delivering CCT to the non-Indigenous staff of the major metropolitan HHSs with in excess of 10,000 employees (eg, MNHHS = 13,500; MSHHS = 14,000). On this basis, the NWHHS has the capacity to deliver regular face-to-face CCT to its staff. **Score = 3/3.**

25. Proportion of non-Indigenous staff to receive CCT In the NWHHS *Annual Report 2012-2013* (p. 36) it was stated that the NWHHS is still developing its capacity to deliver CCT and noted the staff percentage of those who had received CCT was 9% as at June 2013. The NWHHS *Annual Report 2014-2015* provides no data on the number of non-Indigenous staff who have completed CCT. **Score = 0/4.**

26. Indigenous status Although included in the NWHHS *Annual Report 2012 – 2013* (p. 36), Indigenous status – specifically the reporting of ‘not stated’ on admission, was not reported in the NWHHS *Annual Report 2014 – 2015*. **Score = 0/2.**

27. DAMA Queensland Health’s Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) provides the following data for 2013-2014 for the NWHHS:

DAMA by quarterly rates:

Sep-13 Target	Dec-13 Target	Mar-14 Target	Jun-14 Target
4.53%	5.20%	4.40%	4.40%
4.15%	3.50%	3.99%	2.70%

The NWHHS has bettered and equalled the targets for two of the quarters. Despite being included in the NWHHS *Service Agreement 2013/14-2015/16* (p. 38), data on DAMA rates were not published for the current assessment period (2014-15) in either the NWHHS *Annual Report 2014 – 2015* (see Performance Statement, p. 36) or the Queensland Health’s

⁸⁶ Queensland Health (2010c, p. 16).

Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*.
Score = 0/2.

28. **PPH** Queensland Health's Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2014* (p. 29) which provides the following data for 2013-2014 for the NWHHS:

PPH by quarterly rates:

Sep-13 Target	Dec-13 Target	Mar-14 Target	Jun-14 Target
20.10%	17.70%	17.90%	17.70%
20.30%	17.70%	19.60%	17.70%

While by no means the worst performer among the HHSs, NWHHS persistently failed to reach the target, however, a "marked improvement" in Aboriginal and Torres Strait Islander PPHs was noted for 2014-15 (NWHHS *Annual Report 2014 – 2015*, p. 15). Despite being included in the NWHHS *Service Agreement 2013/14-2015/16* (p. 38), data on PPH rates were not published for the current assessment period (2014-15) in either the NWHHS *Annual Report 2014 – 2015* (see Performance Statement, p. 36) or the Queensland Health's Aboriginal and Torres Strait Islander Health Unit *Closing the Gap performance report 2015*. **Score = 0/2.**

29. **Access to mental health services** Access to mental health services measured in terms of the percentage of in scope separations of Aboriginal and Torres Strait Islander consumers from the HHS' acute mental health inpatient unit(s) for which a community ambulatory service contact, in which the consumer participated (in person or via videoconference) was recorded in one to seven days immediately following that separation. The NWHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 25) to provide Indigenous Mental Health Services. This Closing the Gap KPI is not reported in the NWHHS *Annual Report 2014-2015*. **Score = 0/2.**

30. **Access to drug and alcohol services** The NWHHS was funded under its *Service Agreement 2013/14 – 2015/16* (p. 25) to provide both Indigenous Outreach Services and Indigenous Youth (12-17 years) Treatment Programs under the Alcohol and Other Drug Services program. Not reported in the NWHHS *Annual Report 2014 – 2015*. **Score = 0/2.**

31. **Aboriginal and Torres Strait Islander workforce development policy/strategy** In 2012-13 the NWHHS established an Aboriginal and Torres Strait Islander Workforce Development Unit (NWHHS *Annual Report 2012-2013*, p.25). While no information is presented in the NWHHS *Annual Report 2014- 2015*, the fact that the Unit was established, suggests a strategy for the unit to carry out its mandate, however, such a strategy has not been formally sighted. **Score = 1.5/3.**

32. **ATSI employment implementation body.** The Aboriginal and Torres Strait Islander Workforce Development Unit assists:

- with the realignment of Aboriginal Health Workers to clinical areas in order to meet the needs of clients, families and the community as a whole; and
- AHWs to progress through their formal qualifications, gain exposure to a variety of clinical specialty areas, and allow staff to gain competency in necessary clinical skills (NWHHS *Annual Report 2012-2013*, p.25).

It is assumed that the Aboriginal and Torres Strait Islander Workforce Development Unit is still operating.⁸⁷ **Score = 3/3.**

33. **Employment equity.** The Aboriginal and Torres Strait Islander population in the region served by the NWHHS is 23.1% of the total, they should therefore constitute 23.1% of the NWHHS workforce. Based on current NWHHS employment figures of 664 FTE staff (NWHHS *Annual Report 2014-2015*, p. 50), there should be about 140 Aboriginal and Torres Strait Islander employees in the NWHHS. In order to achieve parity with regard to closing the employment gap by 2033, this would mean adding some 8 Aboriginal and Torres Strait Islander staff per year for

⁸⁷ See also NWHHS website: <https://www.health.qld.gov.au/services/northwest/> Last update: 12 September 2014. Accessed 5/12/2016.

approximately the next 16 years. The NWHHS *Annual Report 2014-2015* provides no data on Aboriginal and Torres Strait Islander participation in its workforce. **Score = 0/4.**

34. **Workforce participation** No data has been provided in the NWHHS *Annual Report 2014-2015* (see Our staff, p. 50) regarding Aboriginal and Torres Strait Islander participation in the health workforce by employment category. However, according to NWHHS *Annual Report 2014-2015*, the Mornington Island Hospital and Primary Health Clinic includes Aboriginal and Torres Strait Islander health workers and nurses (p. 20), while the Doomadgee Hospital employs Aboriginal health workers (p. 21), and there is a trainee Aboriginal health worker at the Dajarra Primary Health Clinic (p. 25). The NWHHS, *Annual Report 2012-2013* profiled a doctor with local Kalkadoon, Waanyi and Gunggalida ancestry (p. 30). In addition to QH's six employment streams, an additional stream for Aboriginal and Torres Strait Islander Health Practitioners/Health Workers and Liaison Officers has been included as a category in its own right instead of IHWs and ILOs being included in the Managerial and clerical stream for future reporting purposes. This would be particularly relevant for the NWHHS given the role of the Aboriginal and Torres Strait Islander Workforce Development Unit in the development of, *inter alia*, the clinical skills of ATSI Health Workers (see Note 32). Unfortunately, in the absence of official employment stream data, no score can be given. **Score = 0/10.**

35. **Financial Accountability and Reporting:** Closing the Gap funding All HHSs provide a range of health services to Aboriginal and Torres Strait Islander people and their communities in Queensland as specified in their 2013/14-2015/16 health service agreements. Some of these services (such as the provision of Indigenous hospital liaison services and Indigenous cultural capability services) are funded in health service agreements under the Closing the Gap in Health Outcomes for Aboriginal and Torres Strait Islander People program; other services are funded under other HHS programs in their service agreements. For example, Aboriginal and Torres Strait Islander Health is located within the Primary Health, Community Services and Public Health program area and is among the range of services provided by HSSs together with Aged Care, Child Health, Health Promotion and Palliative Care, etc. Indigenous Mental Health Services are provided within the Mental Health and Alcohol and Other Drug Facilities and Services program area together with a range of other Community Ambulatory Mental Health Services, while Indigenous Outreach Services are among the Alcohol and Other Drug Services also offered by a majority of the HHSs (for a summary of these services see Tables 14 and 15). Most of these services are funded under a variety of different Commonwealth and Queensland programs. The purpose of this indicator is to identify the sources of these funds and their acquittal for disclosure in HHS annual reports as part of their annual Closing the Gap statement.

36. **Commonwealth contribution** Neither the financial statements contained in the NWHHS *Annual Report 2014 – 2015* nor the NWHHS *Health Service Agreement 2013/14 – 2015/16* disclose the Commonwealth contributions to the NWHHS's Closing the Gap programs or their acquittal. **Score = 0/10.**

37. **Queensland contribution** According to the Queensland Government's service delivery statements for Queensland Health, the NWHHS has an operating budget of \$140.5 million for 2014-15.⁸⁸ To support the delivery of the Making Tracks priorities and in accordance with NWHHS *Service Agreement 2013/14-2015/16* (p. 26), the NWHHS has been funded in schedule 2 to provide the following services focused on the needs of Aboriginal and Torres Strait Islander people:

- child and maternal health services
- chronic disease management services
- sexual and reproductive health services

⁸⁸ Queensland Government (2014, p. 155).

- smoking and alcohol prevention activities
- Indigenous cultural capability services

More details of the NWHHS Closing the Gap specific funding and reporting requirements are available in the memo entitled 'Closing the Gap funding allocations to North West Hospital and Health Service for 2013/2014', file reference PP003447 (10 May 2013) (NWHHS *Service Agreement 2013/14-2015/16*, p. 26), however, attempts to access this document have been unsuccessful.

Queensland Closing the Gap funding allocations should be disclosed within NWHHS annual reports in the interests of public accountability and transparency. The NWHHS Financial Statements, as disclosed in its *Annual Report 2014-2015* for the year ended 30 June 2015, contain no reference to Queensland Closing the Gap funding allocations and how they were spent. The report contains no information as to how much money was allocated by the NWHHS to each of the above services and what were their outcomes (e.g., number of people employed to deliver each service, and how many times each service was delivered, participation rates, etc.). **Score = 0/10.**

NWHHS documents consulted

- NWHHS *Annual Report 2012-2013*,
- NWHHS *Annual Report 2014-2015*,
- NWHHS *Strategic Plan 2014-2018* (revised 2015)
- NWHHS *Consumer and Community Engagement Strategy 2014 – 2018*
- NWHHB *Engagement Committee - a North West Health Board Committee: Terms of Reference (Charter)*. Endorsed 18/12/2014.
- NWHHS *Service Agreement 2013/14 – 2015/16*.
- NWHHB Board meeting summaries for:
 - (1) 2014: 29 January; and 28 February.
 - (2) 2015: 6 February; 20 March (however, the board summaries for February and March are identical); 16 April; 20 May; 30 June; 22-23 July; 21 August; no meetings in September and October; 5-6 November; and 4 December.

NWHHS documents not found

- Memo 'Closing the Gap funding allocations to North West Hospital and Health Service for 2013/2014', file reference PP003447 (10 May 2013)
- Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) (reference: NWHHS *Service Agreement 2013/14-2015/16*, p. 38).
- NWHHB Board meeting summaries for 2014: March - December; and January 2015.

Appendix 3: Annual Closing the Gap financial statement examples

Closing the Gap

Programs funded under the State Government's Making Tracks program and Commonwealth programs for 2016-2017 attracted \$9,092,382 and are listed in the table below.

Table 1: Making Tracks and Commonwealth-funded programs

Project name	Funding 2016-2017
Torres Strait Hostel – Meriba Mudh	\$226,375
Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033—Torres Strait	\$110,000
Northern Peninsula Area Maternal and Infant Service	\$207,754
Queensland Health Aboriginal and Torres Strait Sexual Health Men's Program	\$112,851
Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033—Cape York	\$110,000
Improving Sexual Health - Supporting Syphilis Outbreaks in Remote Indigenous Communities	\$864,685
Queensland Health Aboriginal and Torres Strait Islander Outreach Maternal Health Service	\$429,922
Queensland Health Aboriginal and Torres Strait Islander Women's Health Program	\$85,874
Project Support for regional oversight of the implementation of the North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016-2021	\$87,670
Enhanced Sexual Health Services in Torres Strait and Northern Peninsula Area	\$425,916
Child and Youth Mental Health Service Aurukun	\$524,142
HIV/AIDS Outreach Program	\$569,089
Population/Child Protection	\$559,238
Making Tracks Multidisciplinary Team	\$3,574,780
Women's Cancer Program	\$34,452
Commonwealth Home Support Program	\$734,989
Queensland Community Care Program	\$204,269
District Palliative Care (Southern)	\$45,542
Healthy Aging Loans Equipment	\$35,453
Indigenous Health Services	\$149,381
Total	\$9,092,382

Closing the Gap

Torres and Cape HHS has a number of programs targetted towards closing the gap for Aboriginal and Torres Strait Islander residents. These are funded under the State Government's Making Tracks program and by the HHS and are listed in the table below.

Table 1: Closing the gap programs

Project name	Funding (\$)
	2017-18
Social & Emotional Wellbeing	169,007
Indigenous Australians' Health Programme	3,737,659
Rheumatic Heart Disease	183,654
Making Tracks Investment Strategy 2015-2018	2,472,399
Suicide Prevention	55,088
Ear Health Program	116,975
End Of Life	78,702
Healthier Drinks	85,743
Breast Screening	154,244
Dental Innovation Program	582,009
Aboriginal and Torres Strait Islander Sexually Transmissible Infections program	1,450,845
Blood Borne Viruses Program	1,179,242
Indigenous Health Services Cape York Region	1,432,106
Making Tracks Investment Strategy 2033	4,703,967
Indigenous Health Services Torres and NPA Region	2,436,233
Renal And Oncology	1,920,410
TB Control Unit	1,150,987
Total	21,909,270

TCHHS Annual Report 2017-2018, p. 22.

Disclaimer:

Best endeavours have been made by the authors of this report to ensure the accuracy of the information used and referred to in conducting the Institutional Racism Matrix audit for the NWHHS. The responsibility for the interpretation and application of government policies both in the development of the Matrix and the conduct of the audit is the authors' alone. The concept of the Matrix as applied for the identification, measurement and monitoring of institutional racism within public hospitals and health services is and remains the intellectual property of the authors. The authors take no responsibility for the unauthorised use of the Matrix.

The interpretation of evidence and the views expressed in this report are the authors' alone and do not necessarily reflect the views of the North West Hospital and Health Service and/or Queensland Health. All responsibility for this report is borne by its authors.

The authors acknowledge that they are not qualified health professionals and that they do not work in the health sector either in a private or public capacity, and therefore any advice relating to specific health matters should be sought from an appropriately qualified health professional. The report has been produced in a private capacity concerning a matter of public interest. While the authors accept responsibility for the content of this report, they will not accept any liability, including for any loss or damage, resulting from the reliance by others on the content, or arising from its unauthorised use.

About the authors:

Henrietta Marrie AM (Masters in Environmental and Local Government Law; Dip. T; Grad. Dip. of Arts [Indigenous Studies]) is an Elder of the Gimuy Walubara clan of the Yidinji people and Traditional Owner of the land on which the City of Cairns and southern suburbs are now located. Henrietta was born in Yarrabah on her mother's Gunggandji country and spent her early years growing up there until her family moved to Palm Island in the mid-1960s.

Henrietta has wide experience in Indigenous cultural and natural resource management and impact assessment, intellectual and cultural property law, heritage legislation and philanthropy. As an academic she has had published over 80 papers in books and journals. She served for 6 years with the UN Secretariat of the Convention on Biological Diversity in Montreal, Canada before becoming the Program Officer/Manager for North Australia with The Christensen Fund, a California-based private philanthropic fund. She was also a Visiting Fellow with the United Nations University – Institute for the Advanced Study of Sustainability (based in Tokyo, and which serves as a research institution and “think tank” for various UN agencies) working on the Institute's Traditional Knowledge Initiative. Henrietta is Professor and part-time expert advisor with University of Queensland, QAAFI – Agricultural Research Centre and training. She is a Co-Patron of the Cairns Indigenous Art Fair, a position she shares with the Governor of Queensland.

Henrietta is listed among the Westpac and Australian Financial Review 100 Women of Influence for 2014 for her work in public policy. On January 26th 2018 Henrietta was made a Member of the Order of Australia in the General Division, and on June 8th she was recognised as a Queensland Great. In October 2023 she was made a recipient of a University of South Australia Alumni Award.

Until recently she served as a member of the Council of the Australian Institute of Aboriginal and Torres Strait Islander Studies, she is a member of the Queensland Human Rights Commission's Aboriginal and Torres Strait Islander Advisory Group, the Queensland Museum Aboriginal and Torres Strait Islander Consultative Committee (QMATSICC), and serves on the board of the Queensland Indigenous Family Violence Legal Service (QIFVLS).

At the invitation of the CEO, Henrietta carried out an extensive investigation into racially discriminatory behaviours against Aboriginal and Torres Strait Islander staff at the Cairns Hospital and Hinterland Health Service in 2013. As an outcome, Henrietta jointly with her husband Adrian Marrie designed a Matrix to identify, measure and monitor institutional racism within the public health sector and continued to carry out further studies using the “Marrie Matrix” as the auditing tool. The use of the Matrix as a tool to address institutional racism has led to significant changes in Queensland's public health system to eliminate institutional racism, including amendments to the Hospital and Health Boards Act 2011 (Qld) and a Regulation in 2021 mandating the establishment of HHS Health Equity Strategies. Henrietta was also the Chief Investigator for the National Environmental Science Program funded Great Barrier Reef Indigenous Tourism Project. The report Great Barrier Reef Indigenous Tourism: Translating Policy into Practice (Galloway McLean K., Marrie A. and Marrie H 2020) was published in March 2020. Henrietta is currently Honarary Professor at the University of Queensland. In August 2025, Adrian and his wife, Henrietta were recognised by the Queensland Human Rights Commission as Human Rights Heroes. Henrietta is also a recipient of a Queensland Museum Medal for 2025.

Adrian Marrie holds a BA with 1st Class Honours from the Elder Conservatorium, Adelaide University, a BA with 1st Class Honours from Flinders University (and a Flinders University Medal), and a Grad. Dip. of Arts from the University of South Australia. He is a director of Bukal Consultancy Services P/L, a company he founded with his wife, Henrietta in 1994, and also serves as company secretary. He has worked privately as a consultant with organisations such as the Foundation for Aboriginal and Islander Research Action (FAIRA) in Brisbane, Bama Wabu Rainforest Aboriginal Corporation in Cairns, and the Yarrabah Aboriginal Community Council, essentially advising on cultural heritage policy and issues, community development plans and the development of reference manuals and guides. As a director of Bukal Consultancy Services, he has been involved in a number of consultancy projects which include cultural impact assessments regarding major local and regional development projects, Indigenous tourism development, repatriation of cultural property and ancestral remains, and researching the Indigenous charities and non-profit sector, advocating for changes to Australian charity law. Consultancies have also included working with the Great Barrier Reef Marine Park Authority, CSIRO, the Reef and Rainforest Research Centre (Cairns), and the Health Performance Council SA. From 2017 to 2021 he was an Adjunct Associate Professor, School of Human Health and Social Sciences, Central Queensland University. Currently he is an Associate Professor and Chief Investigator with the Systematically Together Overcoming Racism Model (STORM) Project Team, Department of Linguistics, Macquarie University. In August 2025, Adrian and his wife, Henrietta were recognised by the Queensland Human Rights Commission as Human Rights Heroes.