Submission to the 2026 Closing the Gap Productivity Commission Review

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This submission addresses the following questions in the Questions to guide submissions;

1. How are parties building the community-controlled sector (Priority Reform 2)?
2. How are government organisations transforming to meet the needs of Aboriginal and Torres Strait Islander people (Priority Reform 3)?
3. How are government organisations enhancing shared access to data and information (Priority Reform 4)?
4. How have actions supported progress towards Agreement objectives?
5. How have actions facilitated progress towards SEOs?

Authors backgrounds

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This submission draws from the article 'Indigenous health data and international recommendations for national planning and data governance' by Ring Griffiths et al, which considers some of the implications from the World Health Assembly Resolution 76.16 on the health of Indigenous people, previous reviews by the Productivity Commission (PC) and relevant aspects of the Health Performance Framework. The advice and assistance of Chris Holland is also acknowledged. *Except where specifically stated, the content of this submission represents the views of the authors and not necessarily the views of the sources or organisations with which the sources are associated.* The core conclusion of the submission is that after almost 20 years of the Closing the Gap program there is now clear evidence that for many key aspects of the program, **there is little or no chance of many of the national targets being achieved with current policy processes and service settings**, for some within the specified time frames, and for others, ever. However, adjustments to the program with a much greater emphasis on services, program logic, and reform of government processes, particularly with enhanced planning processes and clearer accountability, could transform the program and achieve significantly improved outcomes in relatively short time frames.

Context

The context for this submission is best expressed in an extract written by A/Prof Kalinda Griffiths from a recent article[1]

"Indigenous communities around the globe know intimately the realities that face them in exercising their right to the highest attainable standard of health, particularly regarding navigating health systems and access to quality, culturally safe and comprehensive care. Importantly, communities also possess the knowledge and collective authority to define solutions grounded in culture and self-determination. Yet, despite decades of declarations, resolutions, and national policy commitments, Indigenous Peoples continue to experience significant health and social inequities that are not acceptable. At the heart of these gaps is a fundamental and ongoing tension between Indigenous communities' knowledge of their priorities and needs, and health systems that have and continue to operate without recognising Indigenous peoples' rights to participate in, lead, and influence those decisions that affect their health and the health of their communities. Too often, health services are framed through biomedical and technocratic lenses that are disconnected from the lived realities of Indigenous Peoples and divorced from broader human rights obligations. This is despite these systems sitting within and being funded through entities and governments with fundamental obligations to respect, protect, and fulfil the right to health. Framing health services within a human rights paradigm demands not only the right to health, but also the inherent rights of Indigenous Peoples to determine their own pathways to health and wellbeing.

Indigenous Peoples continue to face significant barriers. These includes structural racism embedded within policy and health systems, discrimination in access to services, resource allocation that fails to reach communities that need it the most, and chronic underfunding of the community-controlled health sector. These issues affect the ability for substantive and transformative changes to be made. Governments, as duty bearers under international law

hold clear responsibilities to ensure equitable systems and services that support the health of the people they serve. This responsibility extends beyond rhetoric or aspirational commitments, it requires vision, concrete action, adequate resourcing, and accountability. A key enabler of such action is the ethical and effective use of data.

Accurate, relevant, and timely data, governed in ways that uphold Indigenous rights, is essential for transforming health systems, informing policy, guiding resources, and evaluating progress. Yet Indigenous health measurement remains fraught with challenges. Data are frequently incomplete, poorly integrated across systems, disconnected from Indigenous priorities, or presented as static snapshots rather than dynamic tools for planning, monitoring, and accountability. Moreover, many data systems remain deficit-focused, measuring disparities without offering pathways to solutions or recognising Indigenous strengths and capabilities. For Indigenous communities, these issues result in systems and services that do not reflect lived realities, as well as policies and practices that fail to respond to needs.

There is, therefore, both a political and ethical imperative for Member States to translate international commitments, most notably those embedded in the World Health Assembly Resolution 76.16 on the Health of Indigenous Peoples, into practical, systemic reforms. Such reforms must centre Indigenous leadership, embed ethical and Indigenous-governed data practices, and establish robust planning cycles where data are actively used, not just collected, to inform decisions, allocate resources, and ultimately, improve outcomes.

This paper emerges from the recognition that the gap between global commitments and local realities remains unacceptably wide. It explores challenges and opportunities for reimagining Indigenous health measurement, planning, and governance through the lens of WHA Resolution 76.16 [Appendix A]. It examines the responsibilities of governments, statistical agencies, and relevant institutions and organisations to ensure that data serve Indigenous communities as tools of empowerment. This work is driven by the fundamental question: How do we ensure that Indigenous Peoples not only have their health measured, but that such measurement leads to meaningful, rights-based action, services that reflect Indigenous priorities, and systems that uphold Indigenous rights?"[1]

Summary

Our central recommendation is that each service-planning partnership has funded Aboriginal and Torres Strait Islander governance and data capability. This capability must support community authority over the definition of need, the interpretation of evidence and decisions about service design and resourcing. Priority Reforms should operate together throughout the planning cycle.

The need and opportunity for significantly enhanced progress in achieving the Closing the Gap (CtG) targets is evident. Only one target has been achieved, three targets are on track (two of which are land and sea), five are improving but not on track, with the Australian Institute of Health and Welfare (AIHW) projecting three may be achieved in the 2040s and one in the 2070s. Six appear to have no prospect of being achieved with current processes,

including the important birthweight, early development, suicide and justice targets. While the overarching life expectancy measure has improved since the 2005–07 baseline, there has been little progress in the past decade.

A significant part of the underlying issues around the relative lack of progress have to do with implementation issues, highlighted by the Productivity Commissions in its reviews and in both the World Health Assembly Resolution 76.16 (Appendix A) which recommends effective planning systems and a **focus on services**, and in the Ring, Griffiths article[1]. The abstract of that article captures the key points "Greater progress in Indigenous health is long overdue. World Health Assembly (WHA) Resolution 76.16 is a potentially groundbreaking tool for improving Indigenous health and wellbeing. It is, however, fundamentally reliant on the collection and use of data and information within national health planning systems - particularly '**ethical data collections to measure needs, coverage, gaps and barriers to access to services'** and covering social determinants. This paper proposes a practical approach to operationalizing WHA 76.16 that builds on processes already used, so that WHA commitments can be embedded into routine statistical production, evaluation, and decision-making. We argue that the central implementation gap is partially **lack of key data systems, and crucially, the absence of formal mechanisms that translate data into action**. The data requirements are neither novel nor complex, they are standard, feasible, and decades overdue. Their implementation should now be treated as an urgent priority by policy makers, statistical agencies, administrators, service providers and communities. **Indigenous participation in decision-making** is a core requirement in the World Health Organization's Global Plan of Action for the Health of Indigenous Peoples and in the United Nations Declaration on the Rights of Indigenous Peoples, and foundational to effective implementation of the WHA 76.16."

The five questions we address in this submission are all interrelated and centre around the need to transform government processes, both for governments themselves, and organisations they fund. In particular, we highlight the following:

- In a complex federal system with a multiplicity of providers, there is a need to assign **governance and accountability** on key topics (see examples outlined below) **to partnerships** between relevant government agencies and First Nations peoples
- Targets cannot be achieved without **program logic** which analyses the policies, services and resources required to achieve the targets
- A focus on information about outcomes, without information on the inputs and **levers of change** (services, resources, workforce, funding) required to achieve the targets, perpetuates rather than remediates lack of progress
- A constructive planning process requires **regular structured, formal performance reviews** at all levels – national, jurisdictional and service so that management actions can be taken as needed to improve performance
- Regular structured, formal performance reviews can only be effective if they include **information on services and resourcing** as well as outcomes. Information on both is generally inadequate and often not available and is an essential ingredient for achieving the targets.

- Annual and quarterly reviews need to not just note progress or lack thereof but analyse the reasons for any lack of progress and take **appropriate management ac**tions to improve performance. This is a continuous rather than an episodic process.
- Mainstream services must be accountable for equitable access, culturally safe care and the elimination of racism. **First Nations Community Controlled services** should be seen**, as preferred wherever practicable** and consistent with community priorities and the commitment to strengthen the community-controlled sector.
- For key topics, **capacity building plans c**entred around the identification and filling of service gaps, preferably with First Nations Community Controlled providers, will be required and this is an important inadequacy of many areas of current Closing the gap policy
- As the key areas of Closing the gap are interrelated, an **integrated rather than siloed** approach, as seen in Australia and internationally, is preferred.

Plans exist but they lack some of the key ingredients to turn them into effective instruments. Many, if not most of these issues require strengthening of current planning processes.

It is the conclusion of this submission that substantial progress requires system reform, including stronger service delivery, shared-decision making, adequate resourcing and mechanisms for accountability.

- **Strengthening long-term service planning. Make planning continuous and action-oriented.** Closing the Gap challenges are complex, interconnected and longstanding. Annual adjustments may help, but sustained action is required across every area. Productivity Commission reviews have questioned whether current responses match the scale of change needed to achieve the Priority Reforms and targets. Replace annual plans with formal planning cycles of up to ten years that specify the services and resources needed to meet targets, the capacity-building required to close service gaps, clear milestones and accountability for ACCO sectors (PR 2) and government service transformation (PR 3), including the necessary workforce training pipelines.
- **Identifying, integrating and filling system and service-capability gaps.** Address the gaps that impede target achievement and integrate capabilities to maximise benefits across multiple socioeconomic outcome (SEO) areas. Aboriginal Community Controlled Organisations (ACCOs) should be the preferred providers.
- **Schedule, data-based reviews at national, jurisdictional, regional and service-delivery levels**. Scheduled, data-based reviews should combine evidence and judgement with **timely management decisions** on policy, resourcing and service delivery at national, jurisdictional, regional and service-delivery levels. Planning must

look beyond outcomes to the **levers of change**, particularly the services and resources needed to meet objectives. Continuous review should identify what works and prompt timely adjustments to policy, funding, resourcing and delivery. Decision-makers at each level need reliable data on services, resources and other key inputs.

Data and resourcing requirements

Continuous planning requires input-focused data on service availability, appropriateness and access, funding, workforce and other resources at national, jurisdictional, regional and service-delivery levels. Planning should begin with a current, coherent picture of service need, access and funding across ACCO, government and private providers, updated regularly. Without data on these levers of change, effective planning and achievement of the Priority Reforms and SEOs are difficult—and, at times, impossible—as the past two decades demonstrate. Providing this information would create a significant opportunity to accelerate progress.

- **Base plans and budgets on the funding and resources required to achieve the targets.** Two decades of experience show that setting targets and allocating resources without systematically assessing what is required is ineffective. Service planning should identify necessary capital works, workforce, administration, information systems and investment across budget cycles. Replace short-term, incremental allocations with longer-term funding that closes service-coverage gaps over successive budgets. Budgets should recognise the costs and benefits of reinvestment, including a shift towards service-focused prevention, and provide equitable, needs-based shares of new and continuing national and other initiatives.

Priorities for closing system and service-capability gaps

- **Map service-coverage gaps and establish long-term plans to close them.** Wherever practicable, ACCOs should deliver the required services. Where mainstream programs remain necessary, planning should determine the needs-based share of provision required and include a corresponding ACCO capacity-building plan, drawing on existing CtG Sector Strengthening Plan processes. A funded, overarching workforce capability plan would support economies of scale. Meeting the CtG targets requires universal access to coordinated and integrated core service capabilities that improve outcomes across all SEOs.
- **Prioritise ACCO delivery and a First Nations workforce, consistent with PR 2.** Services should not be 'cherry-picked' because they are *intrinsically interconnected*. Core capabilities should operate as a coordinated system rather than as parallel programs, with community-controlled coordination enabling clients to move seamlessly between services as their needs change. This model reflects CtG's holistic intent and broadly aligns with the comprehensive PHC approach used by larger ACCHOs and described in

the 2021 *NACCHO Core Services and Outcomes Framework*. See *Integrating Service Capabilities* below for existing examples.

- **Access benchmarks:** provide access to core service capabilities against universal, agreed or region-specific standards.
- **Create a dedicated planning stream for remote Australia.** The scale of service gaps and the distinct challenges facing remote areas require long-term regional planning cycles built on CtG place-based partnerships. A primary objective should be to improve access to regional and remote data. Each regional plan should address the following priorities:
- **Essential services:** revitalise SEO 9(b) to secure essential services for discrete communities and town camps.
- **Regional economies:** use investment in regional services—including SEO 16(b) and housing (SEO 9)—to create local employment, strengthen community economies and advance SEOs 7 and 8.

Roles and responsibilities

In a federal system characterised by multiple service providers, **accountability for each of the service capabilities must be clearly delineated**. For each capability, whether responsibility resides with the Commonwealth, the states and territories, or jointly, should be determined, and the allocation of specific responsibilities occur on that basis. The analysis that follows proceeds on the basis that the clear, capability-by-capability allocation of Commonwealth and jurisdictional responsibility constitutes a precondition for the effective closure of the service capabilities gaps. Allocation of government responsibility should be accompanied by Aboriginal and Torres Strait Islander decision-making authority.

Key Systems and Services (illustrative - for discussion)

This submission conceptualises the Closing the Gap program as consisting of broad systems each of which contains a number of services centred around the Priority Reforms, and broad groupings of the Socio-Economic Objectives but these topics are illustrative only for the purpose of this submission

1. Shared decision-making – national, jurisdictional, regional, service levels
2. Strengthening the community-controlled sector – health, education, housing, family support, language, culture, community and other sectors as determined by local communities. – see How are parties building the community-controlled sector (Priority Reform 2)?
3. Transforming government organisations – genuine partnerships, planning, administration, resourcing, other. – see How are government organisations transforming to meet the needs of Aboriginal and Torres Strait Islander people (Priority Reform 3)?
4. Improving access to data and information – information on **services** (inventories, gap analysis, effectiveness and appropriateness), **resources** (funding – capital and operating

and including needs-based requirements, workforce), **regional/community data -** How are government organisations enhancing shared access to data and information (Priority Reform 4)?

5. Primary health Care – mothers and babies,– How have actions facilitated progress towards SEOs and how have actions supported progress towards Agreement objectives?
6. Education and learning support - first year of school phonics and numeracy screening and assessment, learning support services, other – see How have actions facilitated progress towards SEOs and how have actions supported progress towards Agreement objectives?

We recommend parallel approaches to those illustrated be used for other priority areas including housing, justice and the other topics included in the Agreement. The rationale for the above recommendations is illustrated below in response to the questions raised for the 2026 PC CtG review.

1. How are parties building the community-controlled sector (Priority Reform 2)?

The specified objective is "Outcome: Building the community-controlled sector: There is a strong and sustainable Aboriginal and Torres Strait Islander community-controlled sector delivering high quality services to meet the needs of Aboriginal and Torres Strait Islander people across the country". Note 'meet the needs of Aboriginal and Torres Strait Islander people across the country". However, the target is: "Increase the amount of government funding for Aboriginal and Torres Strait Islander programs and services going through Aboriginal and Torres Strait Islander community-controlled organisations". The operative word in this target is 'increase' which lacks specificity so that any increase, no matter of what kind or how large or small would satisfy the target. The relevant document (https://www.closingthegap.gov.au/national-agreement/priority-reforms) goes on to say:

"**Strong community-controlled sector elements**

- Sustained capacity building and investment.
- Dedicated and identified Aboriginal and Torres Strait Islander workforce.
- Community-controlled organisations are supported by a Peak Body, which has strong governance and policy development and influencing capacity.
- Community-controlled organisations have a dedicated, reliable and consistent funding model designed to suit the types of services required by communities.

Governments will:

- Commit to building strong Aboriginal and Torres Strait Islander community-controlled sectors and organisations in line with the strong sector elements.
- Include in annual reports information on action taken to strengthen the community-controlled sector.

- Implement measures to increase the proportion of services delivered by Aboriginal and Torres Strait Islander organisations.

The partnership will:

- Recognise that building strong community-controlled sectors to deliver Closing the Gap services and programs requires national effort and joined up delivery against all sector elements in agreed priority areas.
- Identify sectors for joint national strengthening effort every three years through Sector Strengthening Plans. The initial Sector Strengthening Plans will focus on:
    - Early childhood care and development
    - Housing
    - Health
    - Disability.
- Develop Sector Strengthening Plans in line with the strong community-controlled sector elements and have the following four streams:
    - Workforce
    - Capital infrastructure
    - Service provision
    - Governance."

However, the Sector Strengthening Plan: Health (https://www.closingthegap.gov.au/sites/default/files/2021-12/sector-strengthening-plan-health_2.pdf) which has worthwhile commitments for capital works, staff accommodation and other initatives is "not designed to commit any specific party to resources or actions not already announced" says "it will take a long time to transition all government-run clinics to community control" and **makes no systematic attempt to identify and fill the crucial PHC service gaps** which are underpinning the relative lack of progress with the life expectancy gap, and as noted later, there has been no significant net increase in the number of Indigenous specific health organisations in the last 16 years.

Targets are not achieved with 'Frameworks', Roadmaps and Plans that lack funding, accountability and defined actions and in particular, concrete capacity building plans to identify and fill service gaps. It is that **lack of specificity, accountability, and most importantly, a lack of any formal assessment of services and resources required to achieve targets, coupled with no assessment of current services or service gaps, and no capacity building plans to fill service gaps, which has underpinned the relative lack of progress in the SEO targets – and which will continue to do so without transformation of current processes.**

2. How have actions facilitated progress towards SEOs and how have actions supported progress towards Agreement objectives?

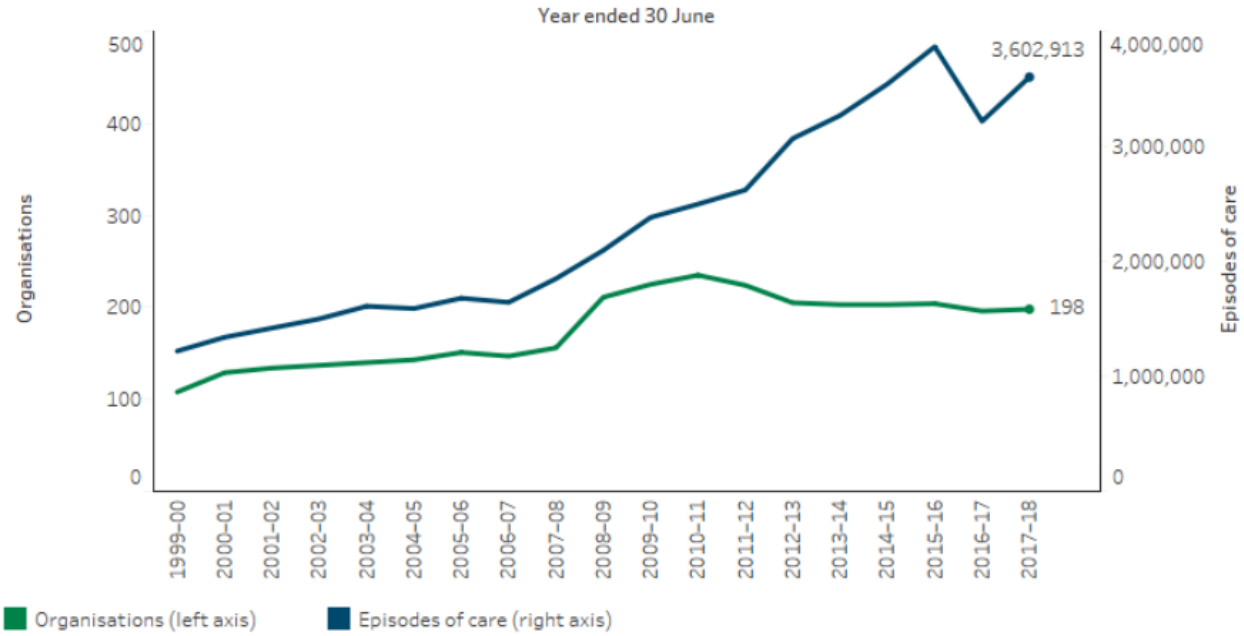
A. Primary Health Care

Primary Health Care (PHC) is the main health service vehicle for the achievement of the life expectancy and healthy birthweight targets. Social, economic, environmental, and political conditions also shape these outcomes. The evidence presented below supports systematic assessment of unmet need and investment in community-controlled services. Organisation counts alone cannot establish whether service capability has kept pace with need. Claims about the contribution of the service gaps to national outcome trends require evidence that accounts for other determinants and measurement changes.

There has been an overall increase in the number of Commonwealth-funded Indigenous primary health care organisations, from 108 in 1999–2000 to 198 in 2017–18. However, over the decade 2008–09 to 2017–18, the number of organisations decreased from 211 to 198. While there has been a slight overall increase in the number of Commonwealth-funded First Nations primary care health care organisations, from 210 in 2018-2019 to 2015 in 2024-2025, there has been **little or no change in the number of Indigenous primary health care services in the last 16 years.** These figures count organisations rather than service sites or clinical capacity. This has been associated with **little or no progress with key related health indices** – life expectancy, avoidable deaths, birthweight and perinatal mortality, despite convincing **evidence of the potential effectiveness of ACCHO services in lowering mortality and improving birthweight.** Interpretation requires consistent reporting coverage and information on sites, staffing, operating hours, service scope and the population served along with other key indicators.

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Figure 3.14.6: Number of organisations and episodes of care in Indigenous primary health care services, 1999–2000 to 2017–18



Source: Table D3.14.47. AIHW analysis of Service Activity Reporting and AIHW Online Services Report data collections.

Evidence of need to identify and fill PHC service gaps

Burden of disease and preventable mortality. In 2018, First Nations people experienced 2.3 times the burden of disease of non-Indigenous Australians. Closing the life expectancy gap depends on reducing the chronic disease gap. **Potentially preventable deaths** are deaths that could be avoided through health-service interventions supporting behaviour change, early detection, treatment or management (HPF 1.24) and ~60% of preventable deaths are from chronic diseases. **From 2021 to 2023, First Nations people died from preventable causes at 3.3 times the rate of non-Indigenous Australians.** From 2019 to 2023, **preventable causes accounted for 59% of deaths among First Nations people aged under 75** (HPF 1.24). **Between 2016 and 2021, the age-standardised rate of potentially avoidable deaths did not change significantly for First Nations people, increasing by 3%, while for non-Indigenous people the rate decreased significantly by 11%** and over this same period, the relative difference in rates between First Nations people and non-Indigenous Australians (rate ratio) increased. Smoking alone contributed to about half of deaths among First Nations adults aged over 45 - more than 10,000 deaths over the past decade.

Service reach and coverage. In 2024–25, 215 organisations delivered First Nations-specific PHC. Of these, 71% (152) were ACCHOs and 47% (102) operated in remote or very remote areas. Together, they served approximately 434,000 First Nations Australians. In 2017-18, the most commonly reported **service gaps were MHSEWB (68%), youth services (54%), and alcohol, tobacco and other drug services (45%)** (HPF 3.14).

Unmet need. Potentially preventable hospitalisation (PPH) rates provide a key indicator of unmet PHC need. In 2019-21, **First Nations Australians were hospitalised for preventable causes at about three times the rate of non-Indigenous Australians** (53 per 1,000), rising to 97 per 1,000 in remote areas. COPD (11.2%) and diabetes (9.6%) were leading causes, and **the PPH gap is widening** (HPF 3.07).

Expenditure relative to need. In 2022-23, **per-person MBS expenditure for First Nations people was 0.9 times that for non-Indigenous Australians**. In the same year, PHC expenditure was $4,176 per First Nations person, compared with $3,080 per non-Indigenous person - a ratio of 1.4 (HPF 3.21). **First Nations use of the MBS and PBS remains well below needs-based requirements.** Given the 2.3 times greater burden of disease, these findings demonstrate the scale of the PHC service gap and the need to expand ACCHO capacity as the principal means of closing it.

Evidence of potential effectiveness of PHC in achieving CTG Targets

Role of PHC. Primary Health Care (PHC) is the most effective and efficient way to prevent deaths from chronic disease and can deliver cost-effective results within short timeframes. It spans healthy lifestyle promotion and primary prevention (Tier 2 HPF measures, HPF 3.03); early detection and prevention of disease progression (secondary prevention) (HPF 3.04); and

ongoing management, including after acute episodes, to reduce mortality (HPF 3.05, 3.06, 3.18).

Evidence of impact. **A systematic kidney disease mortality program in Tiwi Islands communities reduced chronic disease deaths by approximately 50% within three years** (HPF 1.10). Recent gains in First Nations life expectancy in the Northern Territory and Queensland are also associated with improved access to health services and chronic disease management (HPF 1.19). PHC also plays a critical role in tobacco cessation programs, complementing broader public health measures.

Effectiveness of community-controlled care. **ACCHOs outperform mainstream services on chronic disease outcomes.** The CtG Agreement recognises that ACCOs achieve better results, employ more First Nations people and are often communities' preferred providers. HPF measures 1.09, 3.04, 3.05 and 3.18 provide examples of ACCHOs improving outcomes through MBS health checks, GP Management Plans, Team Care Arrangements and telehealth platforms in remote areas, contributing to lower chronic disease hospitalisation and mortality.

Closing the Gap PHC programs and Gaps

Current investments. The 2026 Commonwealth CtG Implementation Plan, which supports the CtG Health Sector Strengthening Plan, funds 86 First Nations health infrastructure and major capital works projects ($300 million), establishes eight Medicare Urgent Care Clinics in remote and very remote areas of the NT and WA, and expands the Nutrition Workforce from 21 to 106 positions over two years.

Capacity-building model. Co-designed with the ACCHO sector, the *Aboriginal and Torres Strait Islander Cancer Plan* provides a model for strengthening ACCHO and workforce capacity to address chronic disease and major causes of preventable death.
Remaining gap. Although valuable, these initiatives **do not constitute a comprehensive capacity-building plan to identify and close PHC service gaps through ACCHOs.**

What needs to be done

Map need and existing capacity. Identify service and workforce gaps by mapping areas with relatively high rates of preventable deaths and PPH against the locations of existing ACCHOs.

Consolidate the evidence. Assess needs first at regional and jurisdictional levels, then combine the findings nationally.

Develop a long-term response. Use this evidence to inform a five-to-ten-year **national capacity-building plan to identify and close PHC service gaps through ACCHOs.**

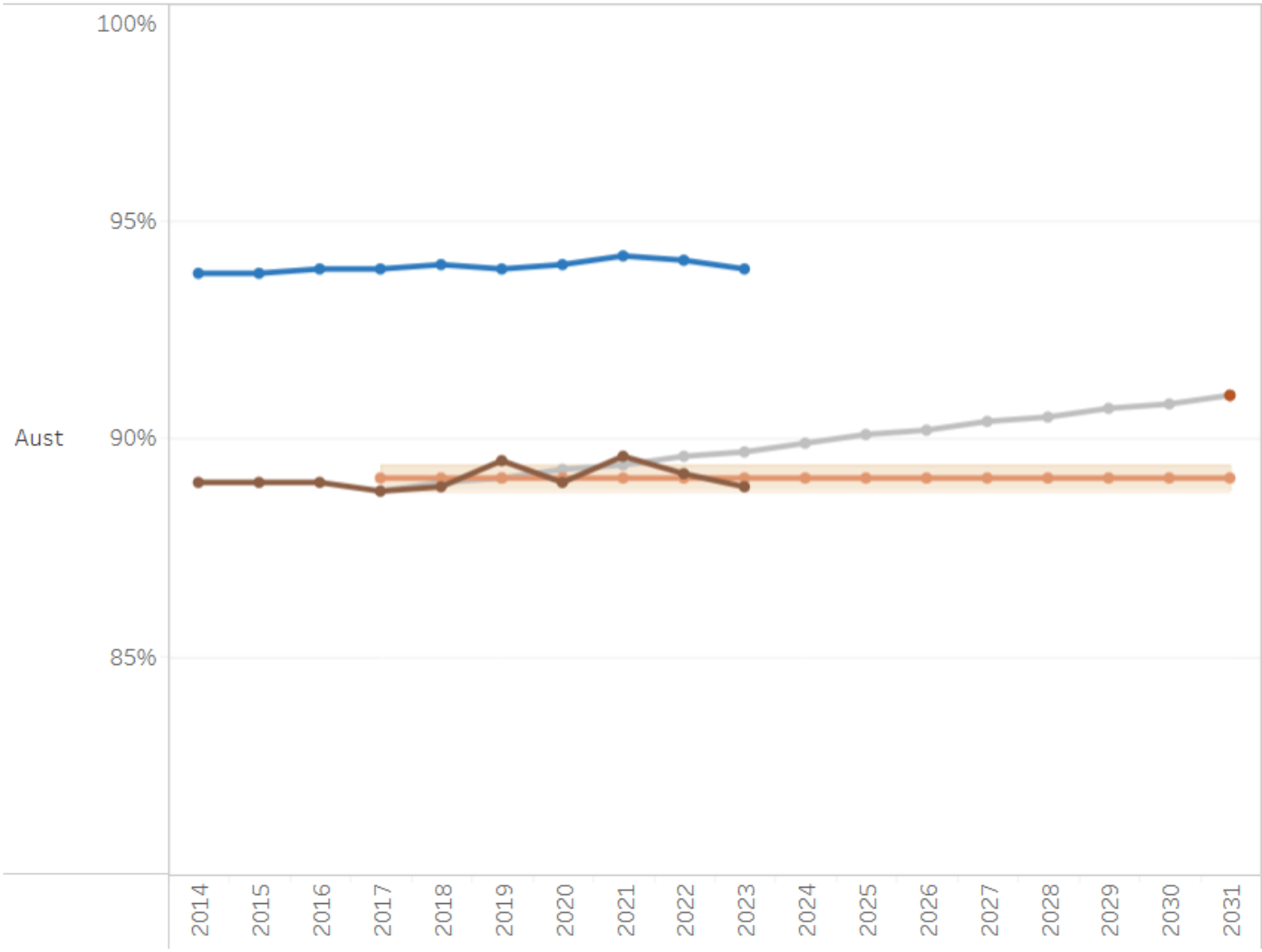
Accountability and Funding

- Identification and filling of PHC service gaps with ACCHS - Commonwealth
- Transfer of jurisdictional PHC services to ACCHO - jurisdictions

B. Mothers and Babies

A healthy start to life is essential, with effects not only on infant and childhood mortality, but also for chronic conditions in later life. While **there is clear evidence of the effectiveness of well run ACCHS services for mothers and babies** in improving the birthweight distribution and lowering perinatal mortality, there has been **little improvement on birthweight and the associated mortalities in early life**. There is also clear evidence of lack of access to ACCHS services for mothers and babies but there is **no formal program to identify and fill gaps in the provision of ACCHS services for mothers and babies** which should be seen as a core service requirement. The healthy birthweight target is unlikely to be achieved until there is such a program.

Figure CtG2.1 Live-born singleton babies of healthy birthweight (2,500-4,499g) (a)



Source: Productivity Commission, Closing the Gap dashboard, table CtG2A.1

(a) Targets and trajectories are only available nationally.

- Aboriginal and Torres Strait Islander babies, Actual
- Aboriginal and Torres Strait Islander babies, Linear regression estimates
- Aboriginal and Torres Strait Islander babies, Target
- Aboriginal and Torres Strait Islander babies, Trajectory
- Non-Indigenous babies, Actual

Progress against the target

Target and current position. SEO 2 aims for 91% of First Nations babies to have a healthy birthweight by 2031. In 2023, the rate was 89%—about five percentage points below the non-Indigenous rate - with **little evident progress since the 2017 baseline**. *At the current rate of progress, the gap will not close.*

Context and wider impacts

Early-life mortality. Most childhood deaths occur very early in life (HPF 1.20, 1.21). Healthy birthweight is a major determinant of perinatal and infant mortality and therefore contributes directly to life expectancy (SEO 1).

Development and later health. Poor maternal health is associated with developmental difficulties (SEO 4), which can affect outcomes across SEOs 5–8. Low birthweight also increases the risk of chronic disease later in life (HPF 1.01), creating a further link to SEO 1.

Broader effects of maternal AOD use. Maternal AOD use during pregnancy contributes to low birthweight and is associated with Fetal Alcohol Spectrum Disorders (FASD) and approximately seven times the likelihood of OOHC placement (SEO 12).

Evidence of gaps in mothers and babies services

Smoking-related risk. In 2020, First Nations mothers smoked at 3.8 times the rate of non-Indigenous mothers (HPF 2.21), making maternal smoking the largest single risk factor. Babies whose mothers smoked both before and after 20 weeks of pregnancy had the lowest healthy birthweight rate of any cohort, at 82.5%—the same rate recorded in very remote areas. By contrast, the rate among babies whose mothers did not smoke during pregnancy was 92.3%, already above the target.

Antenatal-care access. Unmet need is also reflected in the lack of improvement in attendance at five or more antenatal visits among First Nations females. According to the PC, **progress has been flat**: attendance fluctuated between 87.5% and 89% from 2017 to 2023, while the seven-to-eight-percentage-point gap with non-Indigenous females did not narrow.

Evidence that mothers and babies services can advance CtG targets

Role of antenatal care. *Antenatal care is the most effective and efficient way to improve maternal health and support full-term, healthy-birthweight births.* It can address maternal smoking, nutrition, underlying health conditions and MHSEWB.

Evidence of impact. In 2020, the low birthweight rate among First Nations mothers who attended five or more antenatal visits was 7.5%, compared with approximately 17% among those attending two to four visits and 16% among those attending one visit (HPF 1.01).

Demonstrated outcomes. ACCHOs are preferred providers of antenatal care and deliver measurable improvements in maternal and birth outcomes. An evaluation of the **Mums and Babies Program - an ACCHO-based antenatal care model operating in Townsville since**

1999 - found that improved access and early reductions in preterm births led over time to higher birthweights and a statistically significant reduction in perinatal deaths (HPF 1.01).

Supporting evidence. A 2014 AIHW report (Australian Institute of Health and Welfare 2014. Timing impact assessment of COAG Closing the Gap targets: Child mortality. Cat. no. IHW 124. Canberra: AIHW) provided further evidence and examples of successful mothers and babies services.

Conditions for success. Reviews consistently identify the features that make ACCO First Nations maternal health programs effective and encourage attendance: genuinely safe and welcoming environments where women are respected; trusted relationships, particularly given histories of institutional harm; transport, outreach and home visiting; flexible service delivery; and an appropriately trained workforce that includes First Nations and female staff (HPF 3.01).

Closing the Gap programs and remaining gaps

Current commitments. The 2026 Closing the Gap Implementation Plan allocates $44.4 million to the Birthing on Country Program for 2026–28 , extends professional indemnity insurance coverage to ACCHOs employing midwives to support culturally safe maternity care outside hospitals , and transfers 15 Australian Family Partnership Program sites to ACCO control.

Remaining gap. Although these investments expand service capacity, there is still **no formal national program to identify and close gaps in ACCHS Mums and Bubs services**.

Required action

Objective. Establish a systematic process to **identify gaps in antenatal services** and support it with a **five-to-ten-year national capacity-building program** to close them.
Evidence base. Map areas without antenatal services to identify service and workforce gaps and guide the long-term plan.

Supporting data. This work could draw on a revitalised PC Indigenous Expenditure Report and/or an adapted PC Report on Government Services, complemented by OSR IAHP PHC organisation service-gap reporting.

Accountability and Funding

- Identification and filling of PHC service gaps with ACCHS – Commonwealth

Interpretative Comment

In both the Primary Health Care and Mothers and Babies examples above, the related targets are not on track, notwithstanding clear evidence of the effectiveness of studies demonstrating dramatic reductions in chronic disease and perinatal mortality from appropriate service models, twenty years ago. For healthy birthweight and lowered perinatal mortality, an **AIHW report in 2014 described a number of examples of services achieving beneficial results**. There has been **no policy response to ensure services based on these models are provided nationally**. There has been no attempt to identify and fill service gaps, **information on services and resourcing for these topics is generally lacking** and there has been no constructive management and administrative review process to identify the reasons for the lack of progress with consequent action to remediate the situation. Formal processes to comprehensively fill the service gaps on a national basis with Community Controlled services have not been undertaken. In summary, the approach since its inception almost 20 years ago has **not exhibited program logic with an analysis of what is needed to achieve the targets, including the type of services shown to be effective, with consequent service inventory, service gap analysis, capacity building plans to fill the gaps with ACCHS services, effective monitoring and review processes with management decisions and actions to ensure policies and services achieve the desired outcomes**. Continuation of current processes will lead to further lack of progress, and we submit that adoption of the processes outlined in this submission would lead to **significant improvements in relatively short time periods.**

C. Learning Support

Progress towards the target

Target indicator. SEO 5 measures the proportion of students achieving at or above National Assessment Program - Literacy and Numeracy (NAPLAN) minimum standards in reading, writing and numeracy in Years 3, 5, 7 and 9.

Scale of learning need. **The developmental gap between First Nations and non-Indigenous children evident at SEO 4 contributes to a learning-needs gap across every NAPLAN data point** from Year 3 onwards. In the first year of school, teachers identified 33.2% of First Nations students as requiring further assessment to determine whether a developmental difficulty affected their capacity to learn (CtG Dashboard, SEO 4). In 2025, **one in three First Nations students in Years 3, 5, 7 and 9 required additional literacy and numeracy support**, compared with about one in ten non-Indigenous students (CtG Dashboard, SEO 5).

Trend and priorities. NAPLAN data indicate that the proportion of First Nations students

requiring support increases gradually after Year 3. Remote areas and the NT are priority locations.

Context

Why learning support matters. Reading proficiency is fundamental to schooling and predicts later education, health and employment outcomes. Supporting First Nations students with learning needs—including, but not limited to, developmental difficulties—is therefore critical to closing gaps across multiple SEOs, particularly 5–8.

Critical intervention window. **Research indicates that Year 3 marks the end of a key learning-opportunity window: fewer than one in five students who are behind at that point catch up and remain caught up.**

Long-term potential. Conversely, when First Nations and non-Indigenous students achieve comparable academic results by age 15, research shows no significant difference in Year 12 completion or participation in university or vocational education (HPF 2.04).

Evidence of the need to identify and close service gaps

Review finding. The *Review of the National School Agreement* concluded that jurisdictions must do substantially more to help the unacceptably high number of students who fall behind in the early years of school to catch up. It recommended **addressing gaps in preschool provision, teacher retraining and teaching resources**.

Closing the Gap programs

Growth in First Nations-specific services. The PC reports that the number of First Nations-specific early-years services reached 166 in 2024, with two-thirds operated by ACCOs (CtG Dashboard, SEO 3).

Service models. Examples include Aboriginal and Torres Strait Islander Child and Family Centres, Multifunctional Aboriginal Children's Services and other long day care centres.

Government commitments. Through the CtG Early Childhood Care and Development Sector Strengthening Plan, the Australian Government has committed to expanding ACCO-delivered services by transitioning 15 Australian Family Partnership Program sites through the Community Child Care Fund Restricted Expansion Program and investing through the $1 billion Building Early Education Fund.

Investment opportunity. Together, these initiatives provide mechanisms for more equitable investment.

Required action

Learning-support service model. Learning-support services and programs should continue until at least Year 3. Delivery should combine one-to-one mentoring and school-based programs with proven models such as the ACCO-delivered Connected Beginnings program and the NT Families as First Teachers program. Connected Beginnings supports children from birth to school age across 50 sites, reaching approximately 25,000 First Nations children.

Screening and support pathway. Following the universal developmental screening outlined above, **universal screening of learning needs should occur at preschool or school entry**, and thereafter as required, with **learning support continuing until at least Year 3**. Several jurisdictions already conduct universal phonics and numeracy screening in the first year of school , but **national coverage remains incomplete**.

Implementation mechanisms. The *Better and Fairer Schools Agreement 2025–2034* provides potential mechanisms: universal first-year and as-required phonics and numeracy screening and assessment to identify needs early; designation of First Nations students as a priority cohort; explicit alignment with the CtG Priority Reforms; and funding for intensive support. Through the Agreement's First Nations partnership-planning processes, implementation could include training First Nations teachers and tutors and supporting ACCOs. This would build on universal first-year preschool or school screening already operating in several jurisdictions.

Language and culture. HPF 2.04 identifies that incorporating First Nations languages into school curricula improves attendance, engagement, learning outcomes and self-esteem among young First Nations students.

Immediate priority. Achieve **national coverage of universal first-year phonics and numeracy screening and assessment**. Support implementation with a five-to-ten-year sector plan, informed by needs analysis, to systematically **identify and close gaps in learning-support service coverage**.

Accountability and Funding

Jurisdictional

3. How are government organisations enhancing shared access to data and information (Priority Reform 4)?

- The current situation is described in Ring, Griffiths et al[1] "The National Aboriginal Community Controlled Health Organisation (NACCHO), jointly funded with government, has developed a Core Services and Outcomes Framework. This framework provides an important articulation of service expectations and outcomes and is frequently used to support advocacy for appropriate funding. However, it is explicitly an aspirational framework and does not specify data requirements, measurement standards, or formal mechanisms for data use in planning and accountability. More operational data are collected through the Online Services Report (OSR) administered by the Australian Government Department of Health and Aged Care. The OSR annually collects aggregated, organization-level data from services funded under the Indigenous Australians' Health Programme (IAHP) funded medical services. Reporting includes information on staffing, service types, client volume, contacts by provider type, episodes of care as well as organisational governance, accreditation and information systems. In principle, these data may be used to monitor service activity; identify areas of need, inform policy development and program delivery, support continuous quality improvement, contribute to Closing the Gap targets, inform funding allocations; and brief ministers. In practice though, it is not clear how these uses are realised, or whether or not there is a systematic formal process to do so. Moreover, there are no comparable national data for the large proportion of Aboriginal and Torres Strait Islander peoples who receive care from mainstream providers. This further results in a fragmented and incomplete picture of service use and need.
- Broader national reporting mechanisms prioritise outcomes over services. The Overcoming Indigenous Disadvantage (OID) report, last produced in 2020, measures the wellbeing of Aboriginal and Torres Strait Islander people but has limited information on the services, investments, and system inputs required to achieve such outcomes. Likewise, the Report on Government Services presents selected indicators including vaccine coverage, cancer screening rates, waiting times, hospital admissions, and potentially preventable hospitalisations. However, notwithstanding the title, the report focusses on activities rather than services.
- The 2017 Indigenous Expenditure Report provides estimates of Australian, state and territory government expenditure on services relating to Aboriginal and Torres Strait Islander people in Australia. Data are currently only available for 2015–16 and there have been no subsequent reports. Further, the data only covers government expenditure and not private expenditure. This makes comparisons over time and with health expenditure for non-Indigenous peoples, difficult, if not impossible.
- The Aboriginal and Torres Strait Islander Health Performance Framework (HPF)[2] represents the most comprehensive up-to-date national synthesis of Aboriginal and Torres Strait Islander health outcomes, health system performance, and the broader determinants of health. It contains information on service-related domains such as antenatal care, immunisation, chronic disease management; access to hospital procedures, potentially

preventable admissions, cultural competency, mental health services, alcohol and drug service, workforce, governance access to prescription medicines, after-hours care, access to services, and expenditure relative to need. It also includes information on social determinants including housing, education, income, employment, justice system contact, community safety, and access to traditional lands. However, the HPF lacks formalised processes for the use of this valuable information or for linking it to national health planning, funding allocation, or service redesign".

In addition,

- The Closing the Gap Information Repository comes from the National Agreement on Closing the Gap (the Agreement) and is produced by the Productivity Commission. The information repository includes a dashboard and Annual Data Compilation Report: The purpose of the information repository is to inform reporting on progress in Closing the Gap. The dashboard provides the most up-to-date information available on the targets and indicators in the Agreement. The Annual Data Compilation Report provides a point-in-time snapshot of the dashboard material. The Agreement specified 23 targets and 164 supporting indicators across the Priority Reforms and socio-economic outcome areas. It has not been possible to report data against all targets/indicators from the commencement of the Agreement. The Productivity Commission is working with the Parties to the Agreement to develop the Information Repository. Reporting against targets, supporting indicators and further supporting material will be added over time.
- The AIHW Regional Insights for Indigenous Communities (RIFIC) website brings together a range of **regional statistics** about the health and wellbeing of Aboriginal and Torres Strait Islander people and their communities. The aim of the website is to provide access to data at a local level, to help communities set their priorities and participate in joint planning with government and service providers. The *Indigenous communities* and *Other locations* referenced, are derived from the Australian Government Indigenous Programs & Policy Locations and Australian Bureau of Statistics' State Suburbs data sets. This work should be seen as a high priority and extended where possible to local communities

Summary

The central issue here is whether government organisations are enhancing shared access to the data and information that is key to actually Closing the Gap. In some ways, despite, as the PC reports, a plethora of indices, key information on expenditure and services is lacking and for some of these key measures the data is out of date, decreased or simply no longer provided. A major initiative to provide the necessary information on services and expenditure is essential if Gaps are to Close with key decision makers having to fly blind in the absence of data on the levers of change.

Integrating Service Capabilities

Rationale for integration. Achieving the CtG targets requires universal access to integrated core service capabilities. Because the drivers of inequality interact and reinforce one another, the capabilities will be most effective when delivered as a coordinated system. This holistic approach reflects both CtG's intent and the broader First Nations concept of MHSEWB, which recognises that the determinants of health and wellbeing are inseparable.

Planning for integrated delivery. Integration should begin at the planning stage. An overarching planning cycle should systematically identify and close coverage gaps across the ten service capabilities, supported by a complementary workforce capability plan.

Examples in practice. The Australian and New Zealand examples below demonstrate how First Nations community-controlled organisations already integrate some or all of these capabilities.

Victorian ACCO structural framework. Developed by the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), this holistic, strengths-based and trauma-informed model integrates culturally safe primary health care with wraparound social services. VACCHO identifies reduced government expenditure on hospital and tertiary care, acute mental health, AOD, justice, crisis accommodation, family violence, child protection and homelessness as direct downstream benefits. The framework provides one Australian model for the integrated capability system supported by this review and directed towards the CtG targets. Communities could add capabilities to reflect local needs. The VACCHO model is illustrated on the opposite page.

Another model is provided by the **Kalwun Development Corporation,** an ACCO serving South-East Queensland, which demonstrates multi-service integration under a single governance structure. Its services include PHC—general practice, health assessments, immunisation and population health—alongside allied health and dental care, aged care and disability programs, housing support, child and family protection, education initiatives and emergency relief.



New Zealand examples. In Aotearoa New Zealand, **Māori-controlled integrated service organisations** demonstrate how capabilities can be combined across different settings and scales. Canterbury-based Purapura Whetū integrates Māori mental health, MHSEWB, AOD co-existing-problems, and child and youth services for people aged 5-24. Its services include counselling, smokefree and gambling-harm support, school-engagement programs and transition-to-adulthood assistance. Maranga Fanau brings together social housing, school mentoring, employment guidance, support for older people, holiday programs and child-protection advocacy under community governance. Te Puke Karanga Hauora provides a comparable model of multi-capability integration in rural and remote settings.

Proposed integrated model. Drawing on these examples, this submission proposes ACCO-operated, integrated capabilities that provide seamless multidisciplinary care across the life course.

Governance and coordination. Where several organisations deliver services, their governing bodies could form a council to coordinate activities and resources.

Remote delivery. In remote areas, a single provider could deliver all capabilities, including through co-location in one facility.

4. How are government organisations transforming to meet the needs of Aboriginal and Torres Strait Islander people (Priority Reform 3)?

Governments have committed to the following (https://www.closingthegap.gov.au/sites/default/files/2025-09/priority-reform-3.pdf);

1. Identify and eliminate racism
2. Embed and practice meaningful cultural safety
3. Deliver services in partnership with Aboriginal and Torres Strait Islander organisations, communities and people
4. Increase accountability through transparent funding allocations
5. Support Aboriginal and Torres Strait Islander cultures
6. Improve engagement with Aboriginal and Torres Strait Islander people.

Comments by the Productivity Commission argue that governments have not appreciated the "nature and scale of change required to meet the obligations they signed up to". In its first review the PC noted "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'[3]

The common themes in the above examples support those comments as there has been:

1. Inadequate progress towards targets
2. No clear assignment of governance **and accountability** with partnerships on the key topics between First Nations peoples and relevant agencies
3. **Lack of underpinning analysis for program logic** which analyses the policies, services and resources required to achieve the targets
4. A focus on outcomes without information on the inputs and **levers of change** (services, resources, workforce, funding) required to achieve the targets, perpetuates rather than remediates lack of progress
5. A constructive planning process requires **regular structured, formal performance reviews** at all levels - national, jurisdictional and service so that management actions can be taken as needed to improve performance
6. **Lack of information on services and resourcing** as well as outcomes.
7. Lack of annual and quarterly reviews needed to not just note progress or lack thereof but analyse the reasons for any lack of progress and take **appropriate management ac**tions to improve performance.
8. Lack of **capacity building plans c**entred around the identification and filling of service gaps, preferably with First Nations Community Controlled providers,

Strengthening current planning processes

Many, if not most of these issues require **strengthening of current planning processes**

To support systematic, consistent and data-driven long term planning cycles with the goal of achieving universal service coverage across the evidence supported service capabilities, an example planning process is outlined below based on WHO health service planning cycles (see Figure 1)

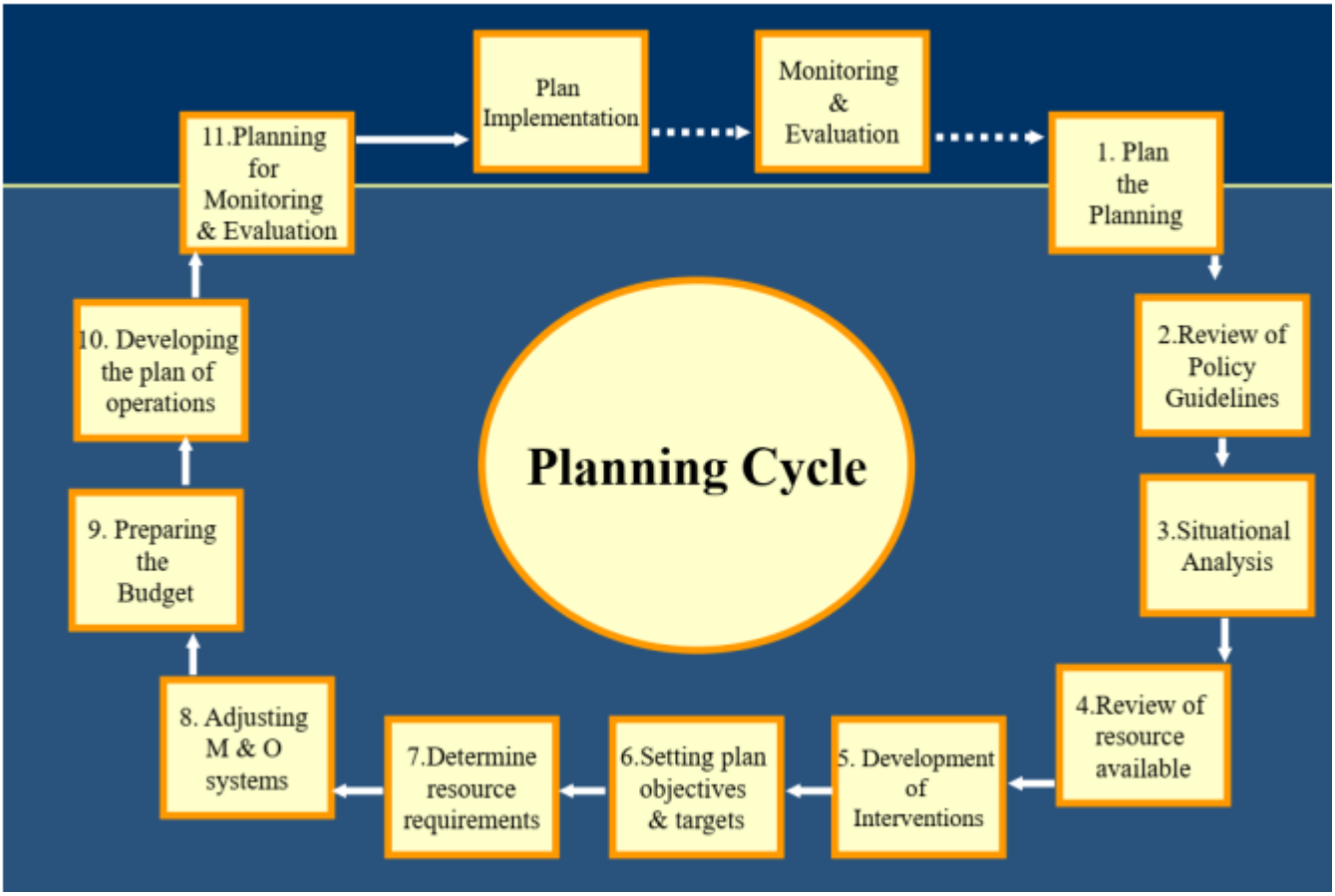


Figure 1. Core elements of the world health organization health planning cycle illustrating the iterative relationship between needs
assessment, planning, monitoring, and evaluation | SOURCE world health organization. National health planning tools [Internet].
Geneva: WHO; 2025

***System design*.** Monitoring and evaluation of service capabilities should be designed from the outset as a continuous, cyclical and action-oriented process - not as retrospective reporting. Intended users and accountability roles should be defined at the design stage.

Potential system and service topics for rolling reports (for discussion) – Dashboard references in brackets

- Partnerships/culture (PR1)
- Building the Community Controlled sector (PR2)
- Transforming government organisations (PR3)
- Shared access to data, regional data (PR4)
- Primary health Care (1)
- MHSEWB, AoD (14)
- Mothers and Babies (2)
- Family support (13)
- Justice (10,11, 12)
- Preschool/child development (4)
- Learning support (5)
- Education/Employment (5,6,7,8)
- Housing (9)
- Other?

Reporting framework. Frameworks should distinguish clearly between structures, processes and outcomes. They should capture both what occurs and the factors that produce results, including service inputs, resources, responsibilities, workforce, governance and social determinants.

Measurement and presentation. Measures should cover service availability, accessibility, acceptability and quality, and assess whether resourcing is adequate. Needs-based funding should be recognised as a core principle of equitable public policy. Reports should be concise, accessible and supported by clear visuals where useful.
First Nations governance. Consistent with PR 4, First Nations governance must be embedded throughout the data lifecycle.

Establish governance and planning capability

- **Assign oversight.** Place overall oversight with the Joint Council on Closing the Gap and the Partnership Working Group.
- **Use policy partnerships as planning forums.** Planning could occur through Sector Strengthening Plan development or be led by a First Nations–government partnership under Priority Reform 1, with all relevant data shared under Priority Reform 4.

- **Build specialist planning capability.** Recognise health-service planning as a specialised function by training the planning team and providing access to expert advisers.
- **Ensure long-term governance continuity.** Establish governance arrangements capable of overseeing up to ten years of implementation and successive long-term planning cycles, including succession plans for key personnel.

Identify and quantify service gaps

- **Quantify population need.** Assess First Nations service needs at national, jurisdictional, regional and community levels, in full partnership with First Nations peoples at every level.
- **Map existing provision.** Compile a comprehensive inventory of current services.
- **Identify service gaps.** Compare assessed need with current provision to determine where services are insufficient or absent.
- **Plan capacity building.** Develop a five-to-ten-year plan specifying the capital and operating funding and workforce required to close identified gaps.
- **Use the existing evidence base.** Draw on the AIHW report *Closing the Gap targets: key findings and implications*.

Define program logic and service models

- **Build on proven approaches.** Adapt effective existing programs where appropriate.
- **Define the program logic.** Link service models, workforce and resources to activities, outputs and outcomes through an explicit theory of change.
- **Engage relevant expertise.** Consult appropriate expert bodies during program design.
- **Agree on the service model.** Select a model that delivers the program logic and places workforce requirements at the centre of implementation.
- **Evaluate existing responses.** Assess current service models and programs where further evidence is needed.
- **Apply the health-sector framework.** For health services, use the NACCHO Core Services and Outcomes Framework to guide decision-making partnerships.

Audit services, workforces and capability gaps

- **Conduct a national audit.** Assess services, workforce and capabilities at national, jurisdictional, regional and community levels to support systematic planning to close health gaps.
- Use existing AIHW access **tools.** The Aboriginal and Torres Strait Islander people and primary health care: patterns of service use, preferences, and access to services webpage includes an interactive map of drive times from First Nations population centres to the nearest health service. Complementary resources include the Access Relative to Need

(ARN) index, Access to primary health care relative to need for Indigenous Australians and, for remote areas, Regional Insights for Remote Communities (RIFIC).

- **Compare provision with agreed models.** Map existing services against the agreed service models.
- Identify **and benchmark** gaps**.** Document insufficient or absent services using the service-gap analysis, and apply equity benchmarks based on non-Indigenous or non-remote cohorts.

Identify service and workforce data gaps

- **Map service-data gaps.** Identify gaps at national, jurisdictional, regional and community levels. The CtG Agreement already anticipates a broader measure of access relative to need under SEO 1, covering availability, distance, affordability, client preferences and cultural safety.
- **Include governance capability in workforce planning.** Treat ACCHO governance and management—including potential training for community members—as workforce requirements.

Plan the progressive closure of service and workforce gaps

- **Define responsibilities and dependencies.** Identify the organisations, decision-makers and actions required at national, jurisdictional, regional and community levels. Build workforce training and other dependencies into a staged rollout.
- **Prioritise community-controlled delivery.** Prefer ACCO/ACCHO delivery in line with Priority Reform 3. Where Commonwealth-funded First Nations-specific primary health care is not community controlled, earmark it for transition to community control in consultation with local First Nations communities.
- **Set measurable milestones.** Define goals, targets and time-bound measures for closing service gaps.

Fund and implement the plan

- **Cost the full rollout.** Estimate capital works and workforce recruitment and training costs.
- **Estimate recurrent costs.** Quantify ongoing operating expenditure.
- **Set equity-based funding benchmarks.** Draw on finance expertise where required and specify the funding quantum, sources and allocations across budget cycles. Plans without adequate funding are unlikely to succeed.
- **Recognise remote-service costs.** Apply a remote-service funding premium and draw on agencies experienced in remote-area costing, particularly the Department of Finance.

- **Align budgets with delivery milestones.** Develop a realistic budget with spending targets linked to goals and milestones, and plan funding across multiple budget cycles.
- **Secure needs-based funding.** Draw from equitable *needs-based* allocations in mainstream health funding under Priority Reform 2, First Nations funding streams, and state and territory governments. See AIHW HPF 3.21.

Report, evaluate, ensure accountability and adapt

This is a continuous rather than an episodic process as illustrated in Figure 2

- **Define the information needed for action.** Existing CtG indicators focus mainly on service use, access and barriers. Priority Reform 4 also envisages a First Nations-determined reporting framework measuring access to, ability to use, and custodianship of data supporting local service planning and delivery. Identify the systems-level and service data needed at national, jurisdictional, regional and community levels to show what is and is not working.
- **Report progress against equity benchmarks.** The currently unreported Priority Reform 2 indicator—the number of ACCOs contracted by governments across SEO areas—supports this approach. Reporting could include annual funding growth against benchmarks reflecting the additional investment required to close health and related gaps.
- **Specify reporting arrangements.** Define what will be reported, to whom, how often and in what format. Align reporting with service-level continuous quality improvement, CtG National Agreement requirements and Priority Reform 4.
- **Set a tiered review cycle.** Review programs and services annually at national and jurisdictional levels, at say, every six months at regional levels, and quarterly at service-delivery levels. Define implementation accountability and escalation pathways where gaps are not closing.
- **Trigger corrective action.** Specify escalation triggers, corrective actions, responsible entities and escalation pathways.

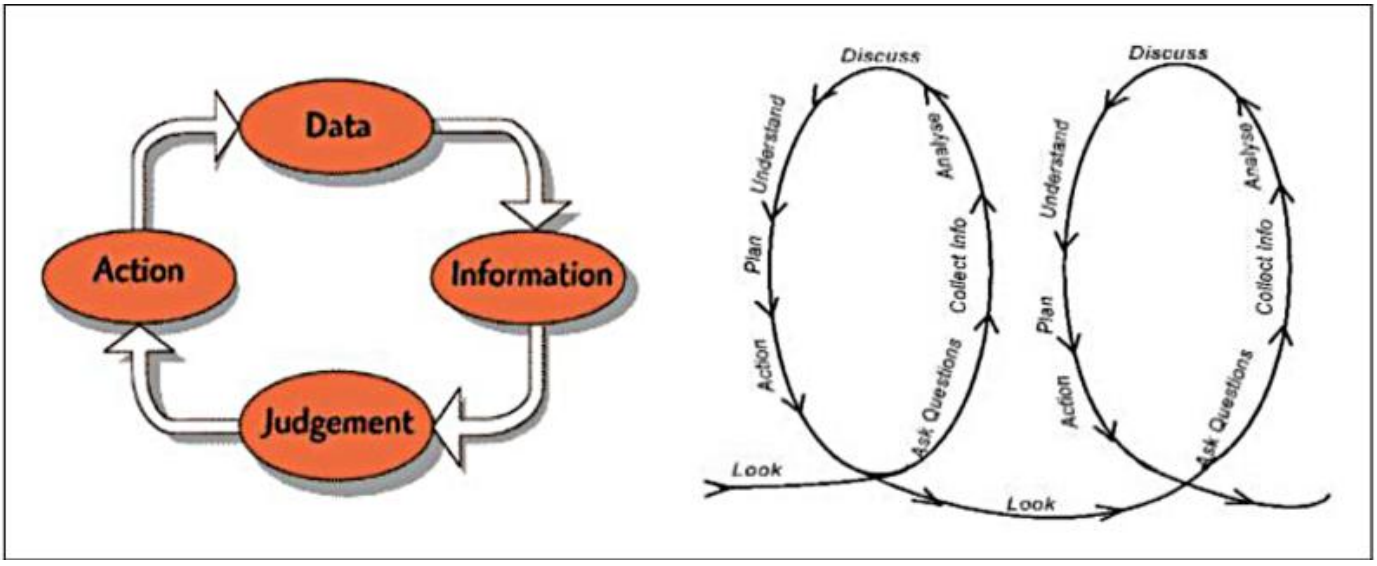


Figure 2. Ali M. Health planning cycle [Internet]. Geneva: WHO; 2012

- **Suggested report format:** The Productivity Commission Dashboard contains outcome data but not information on the levers of change. The HPF contains detailed information on 68 measures across the three tiers (Health status and outcomes, determinants of health and health system performance). We suggest these two valuable sources be combined and the HPF produce a **rolling cycle of reports on the key Systems and Services** (See **Potential system and service topics for rolling reports above -** topics amended as need be by decision makers) where each report integrates information from the three tiers under the following broad headings – i) Progress towards Target; ii) Context; iii) Evidence of need to identify and fill service gaps; iv) Evidence of potential effectiveness of relevant services in achieving CTG Targets; V) Closing the Gap PHC programs and Gaps; vi) Opportunities for improved progress; vii) Accountability and funding

Conclusions

- After almost 20 years it is evident that while one target has been achieved and three are on track (two of which are land and sea), **many of the Closing the Gap targets will not be achieved in the specified time frames and others have no prospect of ever being achieved**. This is often in the face of evidence that **much greater progress is possible**.
- Much greater progress is possible through the **adoption of standard processes used widely throughout governments and industry and recommended by national and international agencies**

Recommendations

- Fundamental to this submission is the need for **enhanced joint planning processes between government agencies and First Nations peoples** and along the lines described by WHO and other bodies in the Appendix to the HPF review with the following features:
- Introduction of **program logic** and formal analysis **to match service and resource requirements (workforce, funding etc) with targets and objectives** under the auspices of the Joint Council and the PWG
- An explicit **focus on services**: Service inventory, gap analysis and 5-10 year ACCS capability building plans to fill service gaps in health, education, housing, justice, data sciences and analysis, and other areas as required
- **Training** of all agencies involved, government and nongovernment, in planning and implementation processes
- Formation of **joint support units** to optimise service delivery on key systems and services

- **Needs based funding** to be institutionalised as a standard practice
- **New or revised data sets** to focus not just on outcomes but on the **levers of change** and particularly on services and expenditure required to achieve objectives and in particular, i) renew the indigenous Expenditure report to include non-government expenditure and an assessment of needs-based funding levels; ii) expand the ROGS to include government funded services as well as government provided services and assessment of service gaps.
- Definition of **accountability** for individual key systems and services
- Institutionalising formal processes of **regular management review** at all levels from policy to service delivery, whereby progress towards targets is assessed, together with analysis to identify reasons for lack of progress and opportunities to enhance progress towards objectives and decisions taken as required to achieve greater progress and supported by a rolling program of structured HPF reports on key systems and services to accompany the PC Dashboard and provide information on the levers of change
- A specific community led process for **remote areas** with consideration of suggestions in this report
- **Language, culture and child development** to be considered as foundational

Author contributions

- The general thrust of the paper represents the views of both authors. The sections on primary health care, mothers and babies, learning, and planning represent a synthesis of articles, lectures and other activities by Dr Ring, in a variety of settings over a number of years. Apart from numerous contributions on policy matters throughout the submission, A/Prof Griffiths wrote the context section, which was included as an extract from the JIAOS article[1] .

References

1. Ring 1, Connolly M, Waldon J, Tractenberg R, Griffiths K. Indigenous health data and international recommendations for national planning and data governance, DOI: 10.1177/1874765526143089 Statistical Journal of the IAOS 1–22
2. https://www.indigenoushpf.gov.au/
3. (https://assets.pc.gov.au/inquiries/completed/closing-the-gap-review/report/closing-the-gap-review-report.pdfgl=1*13e19rp*_gcl_au*MjQzMDcyOTMzLjE3ODUyMDU2MTU.*_ga*NTMwMzM4NzAzLjE2OTU0MzI0ODQ.*_ga_XNW84J8HF8*czE3OTE5NTIyOTckbzc0JGcxJHQxNzkxOTUzMjQ5JGo2MCRsMCRoMA..)

Appendix A

World Health Organization

SEVENTY-SIXTH WORLD HEALTH ASSEMBLY **WHA76.16**
Agenda item 16.3 **30 May 2023**

The health of Indigenous Peoples

The Seventy-sixth World Health Assembly,

Recalling that Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health, as declared by the United Nations Declaration on the Rights of Indigenous Peoples adopted by the United Nations General Assembly through resolution 61/295;

Recalling the commitments of the World Conference on Indigenous Peoples in 2014 to intensifying efforts to reduce rates of HIV and AIDS, malaria, tuberculosis and noncommunicable diseases and to ensure their access to sexual and reproductive health, as reflected in resolution 69/2;

Recalling further the United Nations resolutions on Indigenous Peoples and the Outcome document of the high-level plenary meeting of the General Assembly known as the World Conference on Indigenous Peoples, adopted by the United Nations General Assembly on 22 September 2014;

Recalling the Constitution of the World Health Organization, which recognizes that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity;

Recalling the Expert Mechanism on the Rights of Indigenous Peoples, including its study on Right to Health and Indigenous Peoples with a focus on children and youth (A/HRC/33/57), as well as taking note of the work of the United Nations Permanent Forum on Indigenous Issues and the United Nations Special Rapporteur on the Rights of Indigenous Peoples, recognizing the contribution that Indigenous Peoples make to these discussions;

Recalling also resolutions WHA62.14 (2009) on reducing health inequities through action on the social determinants of health, WHA65.8 (2012) that endorsed the Rio Political Declaration on Social Determinants of Health and WHA74.16 (2021) on the Social Determinants of Health;

Recognizing regional WHO activities on the health of Indigenous Peoples;

Recalling the United Nations General Assembly resolutions 75/168 (2020), 76/148 (2021) and 77/203 (2022) on the rights of Indigenous Peoples, the latter of which reaffirms that Indigenous Peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, and also reaffirms that Indigenous individuals have the right to access, without any discrimination, to all social and health services;

Also recalling United Nations General Assembly resolution 74/2 (2019), entitled "Political declaration of the high-level meeting on universal health coverage", which recognizes the need to tackle health inequities and inequalities within and among countries through political commitment, policies and international cooperation, including those that address social, economic and environmental and other determinants of health;

Recognizing the importance of holding consultations and cooperating in good faith with the Indigenous Peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them as outlined in the United Nations Declaration on the Rights of Indigenous Peoples;

Recognizing that the health needs and vulnerabilities of Indigenous Peoples vary as they are heterogenous groups of peoples and live in different environmental and social contexts;

Recalling that the United Nations Declaration on the Rights of Indigenous Peoples expressed concern that Indigenous Peoples have suffered from historic injustices as a result of, inter alia, their colonization and dispossession of their lands, territories and resources, thus preventing them from exercising, in particular, their right to development in accordance with their own needs and interests;

Noting reports of the United Nations Department of Economic and Social Affairs, according to which life expectancy can be considerably lower for Indigenous Peoples, lack of access to medical services is higher among Indigenous Peoples, and, as to social, economic and environmental determinants of health, Indigenous Peoples are disproportionally subject to poverty, poor housing, cultural barriers, violence, including gender-based violence, racism, experiencing disability, pollution and lack of access to education, economic opportunities, social protection, water and sanitation, as well as appropriate resilience planning for climate change and natural and other emergencies;

Also noting with concern that Indigenous women often experience disproportionally poorer maternal health outcomes and face considerable barriers to accessing primary health care and other essential health care services, with particular risks to young mothers;

Recognizing the particular vulnerability of Indigenous youth, caused by the changing living environments, including social, cultural, economic and environmental determinants;

Recognizing further that the political, social and economic empowerment, inclusion and non-discrimination of all Indigenous Peoples can support and promote the building of sustainable and resilient communities and facilitate addressing social determinants of health and challenges during public health emergencies;

Recognizing also the need to mainstream a gender perspective and support the full, equal and meaningful participation and leadership at all levels of Indigenous women and girls, and protect their human rights;

Recognizing that Indigenous Peoples are likely to disproportionately experience disability as compared with the general population,[1]

1. URGES Member States, taking into account their national contexts and priorities, and the limitations set out in the United Nations Declaration on the Rights of Indigenous Peoples Article 46.2, and in consultation with Indigenous Peoples, with their free, prior and informed consent:

(1) to develop knowledge about the health situation for Indigenous Peoples through ethical data collection about the health situation for Indigenous Peoples in national contexts with the

[1] Indigenous Peoples are often likely to experience disability disproportionately as compared with the general population with some research indicating rates as high as 20–33% (IASG Thematic Paper – Rights of Indigenous Peoples/Persons with Disabilities, 2014).

(10) to promote basic, accessible and intercultural information and support health promotion and disease prevention in Indigenous communities that are not in voluntary isolation;

2. CALLS ON relevant actors in consultation with Indigenous Peoples, with their free, prior and informed consent:

(1) to engage and support full, effective and equal participation of Indigenous Peoples, through their own representative institutions, in the development, as well as monitoring and evaluation of the implementation, of the relevant health plans, strategies or other measures for Indigenous Peoples, including those related to public health emergencies;

(2) to foster the appropriate funding of research and development related to the health of Indigenous Peoples including through the relevant resources and collaboration, while ensuring that rights related to Indigenous Peoples' cultural heritage, traditional knowledge and cultural expressions, and the valuing of Indigenous knowledge systems are respected;

(3) to follow the highest ethical principles when carrying out research and development related to the health of Indigenous Peoples using appropriate culturally diverse consensual approaches and observing the rights of Indigenous Peoples over their traditional lands, territories and resources, cultural heritage, traditional knowledge and traditional cultural expressions, as set out in the United Nations Declaration on the Rights of Indigenous Peoples;

(4) to engage in dialogue and cooperate with relevant sectors with the aim of ensuring that equity guides all policies that address the social and cultural determinants of health which have an adverse impact on Indigenous Peoples, including through ensuring the highest quality, availability and affordability of goods and services essential to their health and well-being, including during public health emergencies, as set out in the United Nations Declaration on the Rights of Indigenous Peoples;

3. REQUESTS the Director-General:

(1) to develop, for the consideration of the Seventy-ninth World Health Assembly through the 158th session of the Executive Board, a Global Plan of Action for the Health of Indigenous Peoples, in consultation with Member States, Indigenous Peoples, relevant United Nations and multilateral system agencies, as well as civil society, academia and other stakeholders, in line with WHO's Framework of Engagement with Non-State Actors, taking a life course approach, with a particular emphasis on the reproductive, maternal and adolescent health, and with a specific focus on those in vulnerable situations, and bearing in mind local context;

(2) to provide technical support, upon request of the Member States, for the development of national plans for the promotion, protection and enhancement of the physical and mental health of Indigenous Peoples, including in the context of public health emergencies;

(3) to propose, in consultation with Member States, strategic lines of action for the improvement of the health of Indigenous Peoples in the development of the fourteenth WHO General Programme of Work.

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purpose to identify specific needs and gaps in access to and coverage by current physical and mental health services and obstacles in their use, identification of reasons for these gaps and recommendations on how to address them;[1]

(2) to develop, fund and implement national health plans, strategies or other measures for Indigenous Peoples, as applicable, to reduce gender inequality as well as social, cultural and geographic barriers to their equitable access to quality health services, provided in Indigenous languages, including during public health emergencies, and taking a life course approach with a particular emphasis on the reproductive, maternal and adolescent health, while recognizing the Indigenous health practices, as appropriate;

(3) to pay particular attention to ensuring universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes;

(4) to incorporate an intercultural and intersectoral approach in the development of public policies on the health of Indigenous Peoples that also accounts for equitable opportunities for partaking in participatory platforms, overcoming gender inequality as well as barriers related to geographical remoteness, disability, age, language, information availability and accessibility, digital connectivity and other factors;

(5) to explore ways to integrate, as appropriate, safe and evidence-based traditional and complementary medicine services, within national and/or subnational health systems, particularly at the level of primary health care, and mental health and wellness services;

(6) to adopt an inclusive and participatory approach in the development and implementation of research and development to promote Indigenous health, taking into account their traditional knowledge and practices;

(7) to encourage the attraction, training, recruitment and retention of Indigenous Peoples as health workers, as well as training and capacity-building of human resources to care for Indigenous Peoples with an intercultural approach, including in the context of public health emergencies;

(8) to contribute to capacity-building for Indigenous Peoples so that they may conduct health and environmental monitoring and surveillance in Indigenous territories, with appropriate consideration to the specific conditions of vulnerability, marginalization and discrimination experienced by Indigenous Peoples, and recalling their right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including, inter alia, human and genetic resources, seeds, medicines and knowledge of the properties of fauna and flora;

(9) to address the health needs of Indigenous Peoples, strengthening access to mental health services and care and adequate nutrition, with full consideration to their social, cultural and geographic realities, providing access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services and strengthening access to immunization in Indigenous territories and for Indigenous Peoples irrespective of where they live;

[1] See for example, https://datascience.codata.org/articles/10.5334/dsj-2020-043/.