Queensland Nurses & Midwives' Union

Submission to

Productivity Commission

Review of the National Agreement on Closing the Gap

Review Paper 2

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submission

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Productivity Commission for the opportunity to comment on the Review Paper 2: Proposed approach and invitation to engage with the review, from the Review of the National Agreement on Closing the Gap.

Nursing and midwifery is the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all classifications of workers that make up the nursing and midwifery workforce including registered nurses (RN), midwives, nurse practitioners (NP) enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 67,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from students and early career clinicians to senior management. The vast majority of nurses and midwives in Queensland are members of the QNMU.

Through our submissions and other initiatives, the QNMU expresses our commitment to working in partnership with Aboriginal and Torres Strait Islander peoples to achieve health equity and ensure the voices of Aboriginal and Torres Strait Islander nurses and midwives are heard. The QNMU supports the Uluru Statement from the Heart and the call for a First Nations Voice enshrined in our Constitution. The QNMU acknowledges the lands on which we work and meet always was, and always will be, Aboriginal and Torres Strait Islander land.

The QNMU regretfully acknowledges that for some Australians, the health services available to them are insufficient. This is evident for First Nations people where there has been limited progress against the life expectancy target reported within the Closing the Gap Report 2020 (Australian Government, 2020). Delivering culturally sensitive health care must be appropriate to the unique culture, language and circumstances of First Nations people.

General concluding comment

The QNMU strongly supports the objectives of the Closing the Gap strategy (2020) and supports the 4 overarching Priority Reform areas as fundamental to achieving the change that could be seen in areas such as the identified socioeconomic outcomes. It also strongly supports the value of having a formal and ongoing evaluation process embedded in the implementation process.

As requested, this submission provides comment on the strategy which the Productivity Commission is adopting for ongoing evaluation of the 2020 Plan – largely through a process and impact evaluation approach based around the very detailed program logic model. In summary, key comments on the approach include:

- While the overarching outcomes in the plan are supported, there is concern at the links between some actions and the high-level outcomes it is suggested that they will address.

- The four Priority Reforms define critical interrelated areas of change underpinning the achievement of the identified socioeconomic outcomes.
- Given the constraints on the achievement in the four PR areas, the QNMU feels that a greater inclusion of community level involvement across the implementation and evaluation processes is needed to better understand and respond to community needs and position communities in achieving community outcomes.

Background

In 2020, all Australian Governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations (Coalition of Peaks) signed the National Agreement on Closing the Gap (Commonwealth Government, 2020), with this plan based on a strengths-based approach (Fogarty et al., 2018). This agreement is underpinned by a program logic framework, based around four Priority Reforms (PR) and 17 identified socioeconomic outcomes (SEO) to be accelerated, with the assumption that where these strategies and actions are addressed the overall objective of "to overcome the entrenched inequality faced by too many Aboriginal and Torres Strait Islander people so that their life outcomes are equal to all Australians" will be met.

The QNMU recognises the importance of Closing the Gap in Aboriginal and Torres Strait Islander disadvantage. Examples from the Queensland Implementation Plan (Queensland Government, 2021a) have been used to drill down further to a more operational area to understanding how the plan will evaluate the achievement of the projected outcomes.

This submission is structured around six areas - the overall approach to its proposed evaluation approach, each of the four PR areas and finally the 17 SEO. It provides a response on each with an additional focus on aspects considered of importance but not specifically raised in the Document. Examples of experiences from our members are incorporated into the QNMU's submission for illustration.

1 The evaluation approach

The QNMU stresses the importance of recognition that each Aboriginal and Torres Strait Islander community is diverse, and a one-size-fits-all approach is likely to place constraints on its success. Any approach needs to ensure that every community can self-determine its needs and approaches, thus ongoing input and involvement at the community level will contribute to the achievement of real outcomes for the Closing the Gap targets.

In the QNMU submission on the Productivity Commission's Indigenous Evaluation Strategy (QNMU, 2020) issues were raised with limitations in an available evidence-base to support evaluations. Concern also was raised regarding the need for leadership development and capacity building to support constructive engagement. These issues are of continued concern.

One concern with the proposed approach, broadly articulated in the program logic model, is in the overall dimension of the model, based around an extensive set of measurable/achievable actions. This appears to adopt an evaluation approach firstly targeting the process – linked to the achievement of the actions defined in the model - but then also by implication an outcomes approach, through the assumptions of the model. Where there are, as suggested above, weaker links between the actions and the achievement of outcomes it will be very important to have a strong feedback link to agencies targeting such outcomes to reassess appropriate steps.

For example, one existing action item, PR3.01, in the Queensland Government Implementation Plan (Queensland Government, 2021a), calls on all government departments to implement and update their Cultural Capability Plans, a highly achievable action. While this action is designed to impact on the incidence of racism within agencies, achieving this underlying outcome will require significant change at all levels across all agencies as well as mechanisms for measuring the effectiveness of these changes.

The measurability of strategies, for evaluation and accountability purposes, is valuable. However, a successful process evaluation result could just reflect the successful achievement of key actions. This links to the concept of a "measurement trap" in the evaluation process (e.g., Bleuel, 2005), highlighting the difference between process and outcome change. The links between the included strategies and actions and the ultimate outcomes needs greater transparency and detail.

A further issue is the leadership of and responsibility for change, given the range of current Closing the Gap Implementation Plans. Interestingly, many of those recorded actions already exist – for example of the 51 actions reported under the four Priority Areas for Queensland (Queensland Government, 2021a), only seven are associated with new funding. This raises the question of whether these actions will deliver the change envisaged under the PR areas. Further, while actions, such as the development of plans and strategic documents, are likely to largely be achievable in the timeframes, their direct impact on change is less reliable. This leads to the final question of where the ultimate responsibility for any lack of outcomes from this process rests.

The QNMU strongly supports the use of Case Studies in the overall evaluation approach. This will strengthen the focus on community level needs and considerations and contextualise the issues. However, it is suggested a greater focus on these could add a more holistic consideration of health, and the associated achievement of change in the SEO and provide valuable information for the feedback loop across the implementation process. The QNMU would be happy to discuss further with the Productivity Commission the provision of more detailed information for the development of further or more in-depth Case Studies if requested.

2 PR1: Formal partnerships and shared decision making

As stated in the Review Paper 2 "When Aboriginal and Torres Strait Islander People have a genuine say in the design and delivery of services that affect them, better life outcomes are achieved". While such partnerships and shared decision-making are critical, partnerships are not defined in the Agreement and the Productivity Commission has requested input on the understanding of partnerships.

In addition to understanding what is/should be meant by partnerships it also is important to question with whom partnerships are envisaged. Are they meant to be high-level arrangements? Arrangements between communities and health providers? Associated with this is the question raised by the Productivity Commission regarding the level to which government agencies are sharing decision-making with Aboriginal and Torres Strait Islander people.

In defining partnerships, some basic aspects are important. Given the plan is about how Governments can work with the Aboriginal and Torres Strait Islander communities to achieve the change envisaged in the Plan's objective, these operating rules are critical. Thus, for effective partnerships to operate all parties need to be well informed (including having good access to the data on which decisions are made), have an agreed and achievable role in the decision-making process and be able to act as representatives of their identified group. Effective robust consultation mechanisms would be required to establish such partnerships.

The Productivity Commission also raised the issue of adequate funding of, and governance arrangements for partnerships. A key aspect of this PR is likely to be capacity. If there are formal partnerships in equitable decision-making, all parties must have the capacity to fully participate. And that capacity is not just the provision of documentation but an adequate capacity for all parties to effectively use the information provided – for example, a full understanding of the data, its background, and the analytical capacity to manage and interpret it.

Recognising the interrelatedness between the four PR areas it is noted that an overarching shift comes from PR3, which has a focus on transforming government. PR4 then focuses on the shared access to data and information.

The QNMU would see key elements of effective partnerships to include:

- A clear definition of the partnership, those involved, the role of the partnerships and the operation processes (governance);
- Adequate funding for the effective engagement of all parties in discussions and decision-making; and
- Clear definitions of the decision-making processes and capacity of the partnership.

Comments/examples

One example of a developing partnership in Queensland is that between Queensland Aboriginal and Islander Health Council (QAIHC), Hospital and Health Services (HHS) and the Queensland Government. While this partnership is in its initial stage there are common interests and objectives. Agreements have been signed on issues with legislation now passed to move forward the Aboriginal & Torres Strait Islander Making Tracks to Health Equity Strategy (Queensland Health, 2021b). There is a 3-year timeframe to fully implement this strategy.

An area where a strong partnership would be valuable is between local HHS, Primary Health Networks (PHNs), Aboriginal Community Controlled Health Organisations (ACCHO) and

primary, secondary and tertiary hospital levels. A new design of these relationships would facilitate the capacity to establish and operate specialist clinics within ACCHO's to better assist the community. Identified constraints to this approach include the need for additional funding to support the initiative and given the different levels of bureaucracy involved, some barriers to overcome through the process. Thus, new strategies are required to allow for co-design across the community – identifying strategies to make it easier to set up specialised clinics, including funding aspects.

Finally, given the ongoing concerns regarding workforce capacity, now and into the future, there is a need to work with training providers to identify transition pathways into the health workforce. This may require the development of stronger partnerships between HHS's and training providers, such as TAFE and Universities. An important element of such partnerships in developing viable solutions would be around recognition of skills bought into the training whether formal or experience, the broad recognition of financial support whether for the time of training or for living costs – recognising the housing shortage in many communities.

3 PR2: Building the community-controlled sector

The National Aboriginal Community Controlled Health Organisation (NACCHO) provides leadership on Aboriginal and Torres Strait Islander health in Australia. It represents 144 ACCHOs (nacho.org.au) and delivers holistic health care to communities.

Before looking specifically at the Community Controlled Health Sector, and in particularly responding to questions regarding the effectiveness and efficiency of operation of the sector, it is important to contextualise this discussion through a consideration of issues such as:

1. The burden of disease for the Aboriginal and Torres Strait Islander people (Australian Institute of Health and Welfare, 2018), also recognising that the incidence of mental health associated disorders is very high;
2. Funding to address Aboriginal and Torres Strait Islander health issues; and
3. The capacity of the system, including staffing, to deliver on the identified needs.

With regard to the first 2 aspects, a report commissioned by NACCHO estimated the gap in health funding between Indigenous and non-indigenous Australians (Equity Economics, 2022). From that report, based on the assumption of a 2.3 times greater burden of disease level compared to non-indigenous Australians, an annual funding gap of $4.4 billion was identified. This translated into an at individual level annual gap of $5,042 per indigenous person.

A further issued raised through consultation within the QNMU is that of workforce – with workforce constraints severely limiting the capacity of health delivery by ACCHOs. This is an increasingly major issue across all health systems in Australia, but, given the often regional, rural and remote location of ACCHO service provision, and the need for culturally safe facilities for both staff and for the Aboriginal and Torres Strait Islander people using the facilities, this is a particularly important and acute issue to recognise.

As in other sectors, accessing skilled staff for rural/remote workforce is difficult, and for ACCHOs there is a need for much of this workforce to be Aboriginal or Torres Strait Islander staff. Thus, while the QNMU supports the approach provided through the Community Controlled Health sector, it also stresses the need for a strong focus to be placed on identifying incentives and novel processes to attract and retain appropriate staff including pathways through the TAFE system to encourage and develop the skills of future staff.

To address these concerns more targeted strategies and incentives are needed to encourage future workers to gain skills for entry to the health sector and a range of strategies to encourage the development of a broader workforce. This would also include the best use of skills available. For example, the QNMU recognises the opportunities of fully utilising the skills of Nurse Practitioners (NP) in such situations, for example located in communities to provide links to specialist care and provide a representation of their communities in across community health assessments.

Incentives for such staff need to recognise the cost of attraction and also longer-term retention. Thus, access to safe and cost-effective housing is, for health practitioner staff working in communities, essential. There are many factors in this, including broader aspects of infrastructure planning, which includes the consideration of associated developments that occur. This is particularly important in isolated Indigenous communities where there is very limited housing infrastructure available and new developments can place additional pressure on an already stressed system. The complexities of fringe benefits tax (FBT) requirements and the Remote Area Nurse Incentive Package (RANIP) must also be considered here as a disincentive.

The system also needs to include consideration of the maintenance of professional development skills – an essential part of this workforce. It is understood that Queensland Health is developing an updated Workforce Plan associated with the Closing the Gap approach, and the QNMU looks forward to involvement in this process.

Comments/ suggestions

- More needs to be spent on training and utilising traditional healing methods.
- The value of paid cultural/ceremonial leave for staff to attend events like NAIDOC week - this assisting with Spiritual & Mental wellbeing.
- Partnering with Universities to develop rural/remote models of delivery, so that students can stay on country while they complete certain modules of their training.
- While Nurse Practitioners (NP) are a valuable resource, particularly in communities, the design of their positions could better use their skills, for example representing community needs.
- Flexibility in appointment of staff – given both cultural alignment with individual communities and also access to viable housing.

With regard to the identification of ACCHO Case Studies, the QNMU has members working in a number of ACCHOs in Queensland and would be happy to further discuss opportunities for

consultation on specific details. It is felt that rather than identifying one case study situation from each state to inform the evaluation, situation specific case studies could provide details on strategies and implementation that are location and situation specific. The following case study gives an example how specific involvement of QNMU First Nations members initiated and provided an important community level solution to a major issue during COVID.

One example that demonstrates the effective role that First Nations health practitioners have played in more effective management is in the First Nations led vaccination program. In October 2021 the QNMU First Nations Branch wrote to the Premier expressing concern at the likely impact of the proposed COVID roadmap on Aboriginal and Torres Strait Islander peoples. In this communication, following detailed concerns regarding the implications of the Rollout, they identified a suite of integrated solutions that could be implemented to address the concerns, including communications to Aboriginal and Torres Strait Islander communities regarding Aboriginal and Torres Strait Islander community vaccination rates, consultation processes with Aboriginal and Torres Strait Islander Nurses and midwives regarding vaccination rollouts in their communities and also the development of COVID-safe plans for vulnerable health practitioners.

This led to a far more effective rollout process and increase in vaccination rates in Aboriginal and Torres Strait Islander communities than would have otherwise been the case. It also demonstrates the importance and value in working at the community level to identify and deliver community level health solutions.

4 PR3: Transforming government organisations

This Priority Reform commits governments to a major transformation in their operation. The Review Paper 2 suggests the Plan will provide a significant focus to:

- Address racism, including institutional racism, and promote cultural safety;
- Integrate current government service provision with ACCHOs and people;
- Improve engagement with Aboriginal and Torres Strait Islander people; and
- Embed an understanding of Aboriginal and Torres Strait Islander culture in organisations.

Identifying examples of racist behaviour is always difficult, as there are implications in making such comments. A valuable insight into the work environment in the health sector is provided in the results in a survey by the Indigenous Doctors Association (Australian Indigenous Doctors Association, 2017) on bullying, racism and lateral violence in the workplace. The survey highlighted the broad incidence of such behaviours, with specific summary points such as:

> More than 48% of Aboriginal and Torres Strait Islander respondents had experienced either a few incidents per month, or daily incidents of bullying, racism and lateral violence in their workplaces. Only 43% of those who experienced these incidents reported them. A further 14% of respondents preferred not to say.

Clearly indicating the lack of cultural safe workplaces that these comments reflect.

5 PR4: Shared access to data and information at a regional level

Quality data is integral to rigorous decision-making. However, data can be very extensive and challenging in its use and interpretation with extensive consideration needed both in the data collection design and in the analysis and reporting of such data.

If for example Aboriginal and Torres Strait Islander communities are going to share in decision-making, in partnership with other agencies, they not only need wide access to data (both final reports and the data leading to such syntheses), but also the capacity to effectively interpret and use that data for decision making purposes. One example, from the Queensland Government Implementation plan (Queensland Government, 2021a), is useful to unpack this concept.

Action PR4.03, a current strategy, operating within existing resources, commits to the provision of "targeted statistical reports covering education, health, community and child safety, and justice outcomes to remote and discrete Aboriginal and Torres Strait Islander communities to facilitate engagement in local decision-making". However, this does raise issues in what the shared decision-making process might look like.

This action foreshadows providing information 'to' communities about community level performance. Many of these data reports, issues such as poor educational or health outcomes, then become the communities' responsibility and has the perception of shifting performance and outcomes risks to the very groups often least able to manage this. It may be that more effective outcomes could be found through true engagement and partnerships between government agencies working 'with' communities, exploring such data to better understanding the precursors behind the data and the longer-term strategies through which improved outcomes might be achieved into the future. Another area likely to need very detailed data is that associated with decision-making around health provision, thus for example access to epidemiological reports essential to understand disease incidence and progression.

In both cases detailed data would need to be available under shared decision-making partnerships, but also considerations of the capacity of all partners to effectively interrogate such data addressed.

Examples/comments

One suggested overall strategy is for organisations to support First Nations people into research project roles. This would have multiple benefits. Firstly, this will assist the research teams in understanding the broader meanings of the data and also in provide support in translating the data and language to the community. This strategy would also be one step in capacity building.

Interactions between the 4 Priority Reforms

While the 4 PR areas all offer very important and specific foci, they all also have a level of interdependence. One perception of the interrelationship is suggested below.

PR3 has an across sector focus – at broad policies on operation and engagement – starting with strategies to address Racism. Thus, if this reform area is not successful the other three will be constrained in their effectiveness. PR1 then takes a more operational direction to develop partnerships and develop approaches for shared decision-making. This clearly links to access to and use of the information that underpins that decision-making – thus PR4. However, success on PR3 is essential to for these reforms to be effective. Finally, PR2, focussing on building the Community Controlled Sector, requires true partnerships and high-quality health and community information, in a transformed environment, to support its effective public health provision role.

One element raised by the QNMU is the need, under PR3, for the formal recognition that to address racism the incidence of institutional racism must be acknowledged and formally addressed. The difficulty of achieving major cultural change is well recognised. But without achieving full buy-in at the organisational level for such shifts, the wide gap between process and impact level outcomes will remain.

The QNMU suggests, a first step on this could be a move to education on culturally safe and respectful practice beginning in the first semester of every health practitioner degree and flow through every core subject over the course of the degree and also be assessed at practical placements. It's a significant part of the code of conduct for nurses and midwives and clearly aligns with all health practice and thus would align with their professional preparation through the University and TAFE system.

6 The 17 socioeconomic outcomes (SEO)

While 17 SEO to be accelerated have been identified, it is suggested that, in this early stage of the process, a focus on a subset of these measures is suggested. These provide a focus across multiple areas, reflecting the holistic nature of health and well-being, and thus the integrated picture that is needed to understand change.

In considering a possible subset of SEO to progress, the balance between assessment and its place in a profile of change needs to be considered. It is suggested that rather than reducing the number of SEO monitored, a more efficient and effective approach may be to refine the monitoring process of all strategies to more strongly focus where effort will achieve change.

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