Submission to the Productivity Commission

Indigenous Evaluation Strategy

Close the Gap Campaign Steering Committee

23 August 2019

Background

The Close the Gap Campaign Steering Committee (the Campaign)[1] welcomes the opportunity to provide a submission to the Productivity Commission's Issues Paper - Indigenous Evaluation Strategy (IES) and is encouraged by the appointment of Commissioner Mokak. Our Campaign is led by our Aboriginal and Torres Strait Islander leadership including the National Health Leadership Forum (NHLF) and the Campaign also supports the NHLF submission to the Productivity Commission.

As the Productivity Commission's Issues Paper (June 2019) highlights, The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) [1] is the most comprehensive tool we have to advance and protect the rights of Aboriginal and Torres Strait Islander peoples. It is a comprehensive statement of principles that guide the work of the Aboriginal and Torres Strait Islander Social Justice Commissioner.

The Declaration is based on the fundamental rights of self-determination, participation in decision-making, respect for and protection of culture, and equality and non-discrimination.

These four principles guide Aboriginal and Torres Strait Islander communities, government, civil society and the private sector as they work to realise the human rights of Aboriginal and Torres Strait Islander people. Any IES should align with the principles above and involve Aboriginal and Torres Strait Islander people as equal partners in every stage of the design and development of such as strategy.

Close the Gap: Aboriginal and Torres Strait Islander Health Campaign

Almost 50 of Australia's peak Aboriginal and Torres Strait Islander and non-Indigenous health bodies, NGOs and human rights organisations are working together to achieve equality in health and life expectancy for Aboriginal and Torres Strait Islander peoples.

The Close the Gap Campaign aims to close the health and life expectancy gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians within a generation. The Campaign is built on evidence that shows significant improvements in the health status of Aboriginal and Torres Strait Islander peoples can be achieved by 2030.

In February 2018, we released the Close the Gap: 10 Year Review. The review examined why Australian governments have not succeeded in closing the health gap, and why they will not succeed by 2030 if the current course continues.

[1] Appendix 1 list current members of the Close the Gap Campaign Steering Committee as of August 2019

Our objectives

The Close the Gap Statement of Intent is the touchstone of the Close the Gap Campaign. When the Australian Government signed the Statement of Intent it committed to a sound, evidence-based path to achieving health equality, a path supported by the entire Aboriginal and Torres Strait Islander health sector.

The Close the Gap Statement of Intent includes a commitment to:

- Develop a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequalities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2030.
- Ensure the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.

Reports on Aboriginal and Torres Strait Islander expenditure and programs

Professor Tom Calma AO, Aboriginal and Torres Strait Islander Social Justice Commissioner (2004-2010) and signatory on the Close the Gap Statement of Intent stated in February 2010;

"The Government should be commended for taking significant steps forward and for honouring its commitment to report annually, but there are gaps in its approach, and the lack of a comprehensive, long-term plan of action is one of these. Without an evidence-based and targeted plan, efforts to Close the Gap will simply fail." [2]

In the nine years since, many young lives have been lost and much preventable illness and suffering has been endured. In an environment where Aboriginal and Torres Strait Islander stakeholders are finally becoming equal partners in decision making on their own lives the current Aboriginal and Torres Strait Islander Social Justice Commissioner June Oscar AO and co-chair of the Campaign strongly echoes and affirms Professor Calma's sentiments of 2010.

The *Mapping the Indigenous program and funding maze* research report by the Centre for Independent Studies (2016) chronicles the failures to measure outcomes and gain a satisfactory return on investment in Aboriginal and Torres Strait Islander affairs. [3]

The Close the Gap Campaign's Position on Evaluation

Clearly it is time to operate differently in order to close the gap with evaluation systematically informed by performance. It is time to genuinely take a human rights approach to healthcare and be informed by the social and cultural determinants of health. The Campaign welcomed the announcement in December 2018 that Australian governments, through COAG, will work in genuine partnership with Aboriginal and Torres Strait Islander peoples, and their appropriate organisations and representatives through the *Partnership Agreement on Closing the Gap 2019–2029*. This is a critical time for government to work side-by-side with Aboriginal and Torres Strait Islander people on solutions, and this includes co-designing evaluation frameworks for both Aboriginal and Torres Strait Islander and mainstream organisations who work in Aboriginal and Torres Strait Islander health.

A principle-based approach to evaluation is recommended allowing for adaptability and ethical partnerships with Aboriginal and Torres Strait Islander peoples and consideration given to existing frameworks developed for Aboriginal and Torres Strait Islander peoples such as the Lowitja Institute Evaluation Framework for Aboriginal and Torres Strait Islander Health and others.

The current approach to evaluation of Aboriginal and Torres Strait Islander health funding is ineffective. At present, evaluation is patchy and simplistic and **does not drive service improvement** - which it should. The Close the Gap Campaign Steering Committee (CTGCSC) supports the development of an evaluation framework for Aboriginal and Torres Strait Islander policy and programs which also includes evaluation of mainstream organisations in receipt of funding for Aboriginal and Torres Strait Islander service provision.

Key points

The lack of a systematic evaluation framework and the lack of co-design and shared responsibility between governments and Aboriginal and Torres Strait Islander stakeholders to date are critical elements in the failure to drive down preventable admissions, deaths and close the mortality gaps. An evaluation framework is best conceptualised as part of a real planning process in which not only the aims are specified, but the means by which they are to be achieved. Evaluation planning needs to be embedded from the very beginning of service provision planning processes.

In this respect, the National Aboriginal and Torres Strait Islander Health Implementation Plan (NATSIHIP) lacks clear funding commitments and actual implementation and thereby has limited usefulness to date. Nonetheless an evaluation framework should start with a review of the elements in the NATSIHIP itself to see which of the items have actually been implemented and which have not – and more importantly, what activities would need to be done, by whom, when, and how they would be funded, if the goals and targets were to be achieved. An evaluation review of funded programs on Aboriginal and Torres Strait Islander

health is required beyond the NATSIHIP, to all existing funding arrangements that claim to offer services to Aboriginal and Torres Strait Islander peoples.

A Review of existing policies and programs

1. A key point is to understand the relationship between inputs and outputs. The evaluation framework needs to identify what services and funding are needed to achieve a given result, what services are currently available, and where are the service gaps. If services are available and the results still don't measure up, evaluation needs to identify the reasons for lack of progress.
2. In relation to service provision by mainstream services the evaluation framework should answer the following questions;
   (i) Are the models of care suitable?
   (ii) Are the services accessible for Aboriginal and Torres Strait Islander peoples?
   (iii) What is the nature of the all-important relationship between providers and those for whom the service is being provided?
   (iv) Is the funding adequate and the training of staff sufficient?
3. As indicated above, a major focus of the Evaluation Framework should initially be on the NATSIHIP itself, focusing particularly on aspects relevant to the COAG Closing the Gap Strategy goals of **child mortality and life expectancy. A review needs to include the associated mental health and suicide prevention efforts**. In addition, there needs to be evaluation of progress with:

   - Strategy 1A (identification of **service capacity & need, workforce requirements, CQI framework, funding methodologies**)
   - 1B (**racism, elimination of differential access, cultural issues**)
   - 1C (**NSFCC, mental health, suicide prevention, MBS**)
   - 1D (**regional planning, data development plan, CQI, research partnerships**.)

   NATSIHP Strategies 2 and 3 relate directly to child mortality issues and Strategies 4-6 (and to a lesser extent 1 and 2) relate to the life expectancy goal.

4. Critically, policies that have resulted in funding cuts to services for Aboriginal and Torres Strait Islander peoples need immediate review and evaluation if efforts to close the gap are genuine.

Cultural safety, responsiveness and evaluation expertise

5. Aboriginal and Torres Strait Islander peoples have a right to own data collected during research or evaluation practices that have been undertaken with Aboriginal and Torres Strait Islander peoples. Data sovereignty and data governance are areas to be considered fully by any IES.
6. Those involved at all levels, clinicians, administrators and public servants often have limited training in evaluation. This a yet another reason why a **National Training Plan** is crucial. All stakeholders need to understand that evaluation is not to be undertaken haphazardly and opportunistically to see whether some program should be continued or not, but rather, it is a core part of ongoing service delivery and program funding.
7. There should be a national evaluation centre to provide training in evaluation and service enhancement, and to systematically disseminate knowledge about evaluation. It should also provide evaluation expertise for mainstream providers.
8. All stakeholders involved in policy and evaluation development and program delivery should be engaged in activities that allow for the measurement of institutional racism within their institutions. In addition, cultural safety and responsiveness training must be completed by evaluators, policy developers and those involved in program delivery.

Genuine co-design and equal accountability

9. It needs to be determined what evaluation and effectiveness means for Aboriginal and Torres Strait Islander community members and whether the voices of Aboriginal and Torres Strait Islander community members are genuinely included in designing and determining evaluation frameworks.
10. There are three interlocking sets of interests in evaluation – i) **communities, ii) funders and iii) service providers**. Ultimately, all three have the same fundamental interest – to continually improve program delivery (including appropriateness, access, effectiveness and efficiency and ultimately, outcomes for Aboriginal and Torres Strait Island peoples. The fundamental basis for successful evaluation is therefore a **full partnership between all three groups**. This means the establishment of **management and evaluation committees at both service levels and at government levels, composed of all three groups** and all focused on the same question – **how can this service be continuously improved?**
11. Co-design, co-development and implementation of evaluation activities with Aboriginal and Torres Strait Islander stakeholders such as the Coalition of Peaks is critical. Through mechanisms such as the partnership with the Coalition of Peaks an initial evaluation of why 80% of funds for Aboriginal and Torres Strait Islander service provision is provided by mainstream organisations should be undertaken and every effort made to provide increased funding to Aboriginal community controlled health organisations (ACCHOs) that deliver better results.

12. When government is evaluating Aboriginal and Torres Strait Islander policies, consideration is required to redirect funding from non-Indigenous organisations towards Aboriginal and Torres Strait Islander organisations that achieve better health outcomes for their consumers. ACCHOs should be treated as **preferred providers** because of their advantage in terms of better access, service model and outcomes, and should receive a greater share of health funding for Aboriginal and Torres Strait Islander service provision.
13. **Evaluation activities need to be appropriately and separately funded** and the personnel/resources required to evaluate must be adequately funded. Training must be funded and provided to policy developers and service providers to ensure appropriate skills are available. An integrated approach and flexibility are important and the Campaign agrees with the point made in the Issues Paper (p4) on the importance of *"planning for, administering and responding to evaluations at different points in the policy design and implementation cycle."*.

Are we measuring what is on-track, targets, trends or trajectories?

14. All organisations (mainstream and Aboriginal and Torres Strait Islander) receiving funding for Aboriginal and Torres Strait Islander affairs need to evaluate their service provision including reporting on what percentage of their consumers identify as Aboriginal and Torres Strait Islander. Senior executives should be held accountable contractually for the services they are responsible for.
15. **Evaluation needs to be an integral (not optional) component of service delivery**. Far too many programs and services currently lack in-built evaluation.
16. **Much more attention needs to be given to timing and trajectories.** The interval between an announcement of a new program (and funding) and results, in terms of process and health outcomes needs to be understood. The publication, *Timing impact assessment for COAG Closing the Gap targets: child mortality* by the Australian Institute of Health and Welfare (2014) covers these time lags. [4] For example if $100m is allocated to smoking reduction, it takes a year or two to get the money out to providers, then staff have to be employed, those staff have to develop programs and services and those services, in turn, take years to have effect. There is then a further lag before a smoking survey can be undertaken and the results reported. Smoking changes then have to be reflected in disease outcomes. For example outcomes can be seen around three years for cardio-vascular disease and more than 20 years for smoking related cancers. These disease outcomes then have to be measured and reported (with further lags) in vital statistics and hospital admissions. **The important point is, for any program, to know which of these measures to expect at any given point in time, and then there can be a much more meaningful understanding of whether a program is 'on track' or** not.

17. Evaluation needs to **focus on both process and outcomes** and for each, trajectories established to set out exactly what results are expected in different time frames for example six-monthly (mid-year review), annual review, three-yearly, five-yearly etc.
18. There needs to be a recognition that investments need to be long-term, and **arbitrary short-term withdrawal of funding is absolutely counterproductive**. This means an **end to blind contract management** in which the ultimate result is either discontinuation of funding or renewal of funding, without necessarily asking the question of how the service could best be improved. It does not serve the interests of funders, communities or service providers if a long-standing underfunded service with well-established links suddenly has its funding withdrawn after an arbitrary external evaluation. From the funder's perspective, this seriously diminishes the return on previous investment, from the communities' point of view it destroys trust and leads to service denial and withdrawal, and for service providers, loss of skill, established relationships and employment.
19. Evaluation is critically dependent on **adequate information systems** which need to be byproducts of service delivery and not provide excessive time burdens on service providers.

Continuous Quality Improvement (CQI)

20. The key point is to find out not just whether a program or service is working or not, but more importantly, why, and what can and should be done to make the service more effective and efficient. Currently, far too much focus is on simplistic notions like whether or not a program is 'on track". If it is, then the assumption is that nothing more needs to be done (for example, if the annual child mortality rate falls inside the confidence band or predictable range, some assume that there is no need for further action. If next year's estimate happens to fall outside the confidence band, then everyone throws their hands up in despair and says it's all hopeless (and we need 'refreshed' targets because the existing ones are too ambitious/ unrealistic etc). Of course, neither response is appropriate.
21. No **management processes** are linked to evaluation, so people sit around more or less hoping next year's numbers will be better without understanding the factors behind the results and most importantly, what needs to be done to improve them – see 23/24 below.
22. Evaluation is not an external process to be handed to some costly accountancy firms but something that **needs to be done by the service providers themselves and linked to internal management processe**s e.g. monthly, half yearly, annual etc formal reviews by clinicians, administrators, public servants and governments.
23. Evaluation must be an integral part of continuous quality improvement. Much health improvement is possible but only from high quality services, delivered in the right way to the right people. Is the service as effective and efficient as possible and how can it be improved? Those questions need to be continuous, not episodic.

24. The whole point of collecting data is to take action so as to continuously improve service quality and outcomes. This means that **there must be formal management processes to consider the evaluation information**.
25. These **management processes must be structured,** e.g. weekly/monthly team meetings of service providers to consider largely process, information. There should be more formal evaluation meetings of service providers to consider summary results quarterly and six-monthly meetings of service providers and communities to take management decisions on local service provision, and annual meetings of funders, communities and service providers to consider summary results and make appropriate management and policy decisions.
26. Unsatisfactory results in this proposed partnership arrangement should be seen as much the responsibility of funders as it is of the other two groups.
27. **A standard set of questions** needs to be asked in the annual, three and five-yearly meetings for example;

    (i) Is the policy appropriate?
    (ii) Is funding adequate?
    (iii) Are staff properly trained?
    (iv) What are the views of the community on service delivery and how it could be improved?
    (v) How could effectiveness and efficiency be further improved?

    Evaluation is not to be retrofitted or an additional, external imposed feature but an integral part of service delivery and approached as a means of CQI. This means that **all service provision must be adequately funded** for evaluation as a core component of service provision not some optional add on or expensively contracted out at the expense of service provision.

Conclusion

There are a number of overarching themes for consideration;

1. Evaluation framework development emphasises Aboriginal and Torres Strait Islander values and requires **genuine partnership**. This includes Aboriginal and Torres Strait Islander stakeholders being equal partners with equal accountability and power to make decisions and are not simply 'invited guests' for consultations.

2. An IES should relentlessly **underpin continuing improvements in service delivery** and outcomes.

3. An IES should encompass an **integrated approach involving and consumers, service delivery organisations, regional bodies, State & Commonwealth governments & ultimately COAG.**

4. An IES should **engage clinicians, administrators, public servants and communities**.

In conclusion we commend the Commission for embarking on this critical work and would appreciate the opportunity to further engage in the development of this strategy as it is firmly aligned with our continuing efforts to close the gap.

References

[1] Australia, Reconciliation. "The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)." (2017).

[2] Oxfam Australia. PM's report welcome but Government yet to develop plan to Close the Gap: Media Release (2010) Accessed 23 Aug 2019 [https://media.oxfam.org.au/2010/02/pms-report-welcome-but-government-yet-to-develop-plan-to-close-the-gap-new-report/]

[3] Hudson S. Mapping the Indigenous program and funding maze. Sydney: Centre for Independent Studies (2016).

[4] Australian Institute of Health and Welfare. Timing impact assessment for COAG Closing the Gap targets: child mortality. Canberra: AIHW; 2014.

Appendix 1 – Close the Gap Campaign Steering Committee Members

1. Aboriginal Health and Medical Research Council of New South Wales
2. Australian Healthcare and Hospitals Association
3. Aboriginal Health Council of South Australia
4. Australians for Native Title and Reconciliation
5. Australian College of Midwives
6. Australian College of Nursing
7. Australian College of Rural and Remote Medicine
8. Australian Human Rights Commission
9. Australian Indigenous Doctors' Association
10. Australian Indigenous Psychologists' Association
11. Australian Medical Association
12. Australian Physiotherapy Association
13. Australian Student and Novice Nurse Association
14. beyondblue
15. Community Mental Health Australia
16. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
17. CRANAplus
18. Expert Adviser – Alcohol and Other Drugs, Professor Pat Dudgeon
19. Expert Adviser – Epidemiology and Public Health, Professor Ian Ring
20. First Peoples Disability Network
21. Heart Foundation Australia
22. Indigenous Allied Health Australia
23. Indigenous Dentists' Association of Australia
24. Indigenous Eye Health Unit, University of Melbourne
25. Kidney Health Australia
26. Menzies School of Health Research
27. National Aboriginal and Torres Strait Islander Health Workers' Association
28. National Aboriginal Community Controlled Health Organisation
29. National Association of Aboriginal and Torres Strait Islander Physiotherapists

30. National Congress of Australia's First Peoples
31. National Coordinator: Tackling Indigenous Smoking - Dr Tom Calma AO, Campaign founder and former Aboriginal and Torres Strait Islander Social Justice Commissioner
32. National Rural Health Alliance
33. NSW Aboriginal Land Council
34. Oxfam Australia
35. Palliative Care Australia
36. PHILE Network
37. Public Health Association of Australia
38. Reconciliation Australia
39. Royal Australasian College of Physicians
40. Royal Australian College of General Practitioners
41. SBS, the home of National Indigenous Television (NITV)
42. The Fred Hollows Foundation
43. The Healing Foundation
44. The Lowitja Institute
45. The Pharmacy Guild of Australia
46. Torres Strait Regional Authority
47. Victorian Aboriginal Community Controlled Health Organisation
48. Winnunga Nimmityjah Aboriginal Health Service
49. National Aboriginal and Torres Strait Islander Family Violence Legal Service