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Australian Government, Productivity Commission: Submission regarding the Indigenous Evaluation Strategy, 23rd August 2019, from Associate Professor Sophia Couzos.

Background:

Dr Sophia Couzos is a public health physician and academic general practitioner who is Associate Professor of General Practice and Rural Medicine with the College of Medicine and Dentistry at James Cook University. She is currently Consultant Public Health Physician to the Queensland Aboriginal and Islander Health Council and has nearly 30 years' experience working for Aboriginal community-controlled health services (ACCHS) in remote Australia as well as for the National Aboriginal Community Controlled Health Organisation in Canberra as their Public Health Medical Officer. She spent 14 years working in remote Australia, with 7 years as a clinician in ACCHSs in the Kimberley region of Western Australia, and over 30 years in regional and remote Australia.

She has led the development of clinical practice guidelines (National Guide to a Preventive Health Assessment for Aboriginal and Torres Strait Islander peoples, now in 3rd edn), and was editor and author of *Aboriginal Primary Health Care: An evidence-based Approach* (3rd edition, published by Oxford University Press) shortlisted and 'highly commended' in the Australian Awards for Excellence in Educational Publishing in 2008. She has led multicenter award-winning research specializing in community-based participatory research and is current leading the evaluation of the *Integrating Pharmacists within Aboriginal Community Controlled Health Services (ACCHSs) to improve Chronic Disease Management* (IPAC) project. The project is funded by the Australian Government Department of Health, under the Pharmacy Trials Program (Tranche 2) funding as part of the 6th Community Pharmacy Agreement (6CPA).

Submission:

The Productivity Commission (PC) Issues paper is well written, comprehensive, and explores important gaps in the systems and processes currently used by government departments to evaluate policy and programs affecting Aboriginal and Torres Strait Islander peoples. Guidance is needed to reduce adhoc and unsystematic approaches to evaluation that lack any significant oversight by Aboriginal representative bodies. Moreover, evaluation is often considered late in program/project development which significantly limits the range of evaluation methodologies to be used. This results in poor quality data and missed opportunities for more robust evaluation. The following are a few suggestions that may inform the development of an Indigenous Evaluation Strategy:

1. The PC has correctly identified that the vast majority of Australian Government funding that goes towards providing services to Aboriginal peoples and Torres Strait Islanders is spent through mainstream programs and services (page 5). Yet, even when funding is predominantly directed to mainstream health services as occurred with the Council of Australian Governments (COAG) National Indigenous Reform Agreement (November 2008) for strategies designed to close the gap in Aboriginal and Torres Strait Islander people's life expectancy, **mainstream health services were evaluated the least**. This evaluation gap needs to change.

2. It is well established that the ACCHS sector is often significantly overburdened by the volume of data and reports it is required to generate in order to inform evaluation of programs that have funding sourced from Australian and State/Terr Governments. On average, a single ACCHS had 22 program contracts that required reporting against for evaluation and accounting purposes [*Overburden Report, 2009 by CRCAH and Flinders Univ*]. In 2008, the Office of Aboriginal and Torres Strait Islander Health within the Department of Health reported that "*ACCHSs have borne a heavy reporting burden, in excess of any other primary health care provider, and that this is likely to be a cause for inefficiency, not to mention potential frustration for organisations*" (OATSIH Issues Paper, 2008). Recognition of this burden led to attempts to streamline reporting for evaluation purposes through the development of the national Key Performance Indicators (nKPIs). Whilst the ACCHS sector now have established systems where de-identified and aggregated patient data can be ethically sourced to evaluate programs, mainstream service providers (such as government health services, and private general practices) in receipt of government program funding to close the gap in Aboriginal health disparities, do not. **An Indigenous Evaluation Strategy can help guide the evaluation of programs where Australian Government funding is directed through mainstream service providers, to ensure these initiatives are better evaluated and accountable to Aboriginal and Torres Strait Islander representative bodies.**

3. The Indigenous Evaluation Strategy should guide the prioritisation of programs needing evaluation from those that may not require this. **Large-scale, new programs, pilot programs, and programs of particular State/Territory or national significance should be evaluated.** Evaluation planning should be established at the time of program development and not after the program has been piloted or established (which is the approach usually adopted by government departments).

4. **Program evaluation should be fit for purpose**. If the aim of the evaluation is to examine outcomes in the quality of care, the measures must be recognised indicators of the quality of care. If the outcomes are to inform national activity, nationally recognised measures should be used. If outcomes pertain to clinical activity, the measures must be evidence-based. An example of how this approach can be challenge is the national nKPI performance (and continual quality improvement) monitoring that is mandated through the Indigenous Australians Health Programme (IAHP). This ongoing IAHP evaluation is welcomed by the ACCHS sector but it places a heavy data reporting burden on ACCHSs above that imposed on any other stakeholder. It is important to guard against 'policy creep' as evaluation demands impose more and more burdens on ACCHSs. In recent years, the ACCHS sector has had to guard against nKPI expansion and unnecessary interference in clinical delivery. In the desire for more data, the principles and goal of the evaluation are easily undermined. For example, in an effort to generate more nKPI data from ACCHSs on 'risky drinking' behaviour, the Department of Health recommended the exclusive use of a particular clinical assessment tool (AUDIT-C) above other tools, when the exclusive use of this tool was not consistent with National Guidelines. The need for data to evaluate programs should not influence nor drive clinical activity.

4. The Indigenous Evaluation Strategy **should include principles that require evaluation plans to be established at the same time as project/program development**. This is identified as an important indicator of evaluation quality in the PC issues paper (page 28). The IPAC project is an example of this type of approach. The IPAC project is a tripartite project with an inbuilt evaluation based on the study design that is prospective, quasi-experimental, pragmatic, participatory and includes an economic analysis. The project is evaluating the impact of pharmacists integrated within ACCHSs as team members. The project partners include the National Aboriginal Community Controlled Health Organisation (NACCHO), the Pharmaceutical Society of Australia (PSA) and James Cook University (JCU). However in general, most

evaluations are not often planned from the outset especially for programs and services meant for Aboriginal and Torres Strait Islander peoples. **This needs to change so that early evaluation plans are developed in partnership with Aboriginal representative bodies, for programs delivered through any health service provider.** Early planning has significant benefits not only to enhance program evaluation but also to enable the use and development of the best measures and to collect agreed data that might otherwise not have been collected. Data gaps are a significant barrier to evaluation, but these factors can be planned for and an appropriate methodology selected to be fit for purpose even with data constraints (page 35 issues paper). **This will also ensure that principles regarding ethical approval of evaluation projects are carefully considered from the start (**page 33 PC issues paper). This is not currently considered carefully enough by program evaluators.

5. **Evaluation methodologies should recognise a variety of methods and be context-specific**. It is unrealistic to expect randomised controlled trial (RCT) methodology if this evaluation method is not acceptable nor feasible (page 14 PC issues paper]. The criteria for feasibility is also context - specific in that **Aboriginal stakeholder priorities should guide the optimal selection of methods, just as costs do**. For example, the Medical Services Advisory Council (MSAC) expects gold standard evaluation methodology when this may not be feasible in Aboriginal contexts, and even if it was, may be unlikely to reflect real world outcomes and afford possibilities for generalisation of the policy being investigated. An Indigenous Evaluation Strategy can help to reorientate these unrealistic expectations from bodies such as MSAC. Unrealistic evaluation standards may also hinder programmatic innovation. Rather, the aim should be to plan early and build the right type of evaluation methodologies for programs at the time of their development. There are many examples of high-quality evaluation methods using customised data collection methods so that the program reduces data reporting burdens,[1] including RCT study designs where these are carefully planned and feasible.[2] Again, the evaluation methods should be fit for purpose.

6. **Evaluation methodologies can better incorporate Aboriginal and Torres Strait Islander perspectives** using appropriate qualitative methods, guided by Aboriginal representative stakeholders. There are many examples of this. Evaluation timeframes will need to be extended because developing the right method and process often takes longer than what is currently expected by government departments. These are challenges, but there is an increasing body of expertise within NACCHO Affiliates and within certain Universities of how to undertake the right type of context-specific program evaluations. [See below]

7. Importantly, data ownership (governance) issues are critical to establish trust in evaluation methodologies. The **Indigenous Evaluation Strategy should identify Aboriginal data governance protocols as a priority**, but these are currently lacking (page 41). These need to be developed. Guidance for their development can be sought from NACCHO and Affiliates. Such protocols underpin the development of trust in the Strategy.

8. The Strategy should provide guidance on **using new models to undertake Indigenous program evaluations**. These models include partnerships between Aboriginal representative bodies such as the Queensland Aboriginal and Islander Health Council (QAIHC) and Universities. This partnership model refers to **Academic Health Centres** as agencies that can combine stakeholder expertise with robust scientific methods to better evaluate programs. For example,

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[1] Couzos S, Nicholson AK, Hunt JM, Davey ME, May JK, Bennet PT, Westphal DW, Thomas DP. Talking About The Smokes: a large-scale, community-based participatory research project. Med J Aust. 2015 Jun 1;202(10):S13-9.

2 Couzos S, Lea T, Murray RB, Culbong M. 'We are not just participants- we are in charge': the NACCHO ear trial and the process for Aboriginal community-controlled health research. Ethn Health. 2005 10(2):91-111

the north Qld region's highly distributed health care system is united through membership of the **Tropical Australian Academic Health Centre** (TAAHC), a partnership between five Hospital and Health Services (Cairns and Hinterland, Mackay, North West, Torres & Cape, and Townsville), the Northern Queensland Primary Health Network (NQPHN) and James Cook University (JCU), including the Australian Institute of Tropical Health and Medicine (AITHM). This partnership is currently working to engage the QAIHC into this partnership. The aim of TAAHC is to use the skills of partners organisations to respond to the health service and program evaluation needs identified by partners and stakeholders.[3]

9. The PC issues paper identifies that **evaluation results must be able to be shared in a way that allows findings to feed into policy development** (pages 29 and 35). This is critically important. Aboriginal representative bodies like NACCHO and QAIHC have been concerned that program evaluation plans, updates, and findings are not disseminated to member services that contributed to the evaluation. **The Evaluation Strategy should include principles and guidance around dissemination and release of evaluation findings to stakeholders**. This is vital for transparency and trust, program innovation, and research translation. Australian Government Departments (such as Health) can impose excessive controls over the release of program evaluation findings including restricting any information release whatsoever about the evaluation under way. The lack of guidance on these matters means that departmental staff interpret these restrictions in an ad hoc way and can be extremely restrictive and cautious depending on personalities. There have been situations where departmental staff have inserted clauses into contracts to restrict evaluators and peak Aboriginal representative bodies from sharing evaluation-related information. **If the evaluation operates under a community-based participative action framework, this means that sharing information on the overall aims, the evolving experiences and outcomes of the evaluation is a core activity that should be conducted on an ongoing basis.** Co-learning and proactive information dissemination throughout the evaluation process are core activities.[4] These activities should not be viewed as promotion or business activities (as they have been interpreted by departmental staff). Sharing information supports stakeholder engagement in the evaluation process and in the program itself. Departmental contract clauses that limit the sharing of information regarding program evaluations need to be reviewed. **The Indigenous Evaluation Strategy should provide guidance to government departments to support the sharing of information about program evaluation throughout all phases of the evaluation**. This is important when the sharing of information is considered in the community interest and/or would facilitate peer review to benefit the project evaluation.

10. Further consultation on the Indigenous Evaluation Strategy is warranted and QAIHC is happy to work with the Commission to support facilitated group consultation workshops.

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[3] Edelman A, Taylor J, Ovseiko PV, Topp SM. "'Academic' is a dirty word": Intended impact pathways of an emerging academic health centre in tropical regional Australia. *Int J Health Plann Manage*. 2019;34(1):e661–e678. doi:10.1002/hpm.2681. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6559162/

[4] Israel BA, Schulz AJ, Coombe CM, Parker EA, Reyes AG, Rowe Z, Lichtenstein RL. Community-based participatory research. Urban Health. 2019 Apr 4:272.