



CLOSING THE GAP IN ABORIGINAL HEALTH OUTCOMES INITIATIVE



FINAL EVALUATION REPORT
January 2014

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Urbis's Public Policy team has received ISO 20252 Certification for the provision of public policy research and evaluation, social planning, community consultation, market research and communications research

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Executive Summary

The Victorian Closing the Gap in Health Outcomes Initiative (CtHG/the Initiative) is one component of the contribution by Victorian Government-funded health services and community organisations to the national efforts to close the gap in Indigenous disadvantage. The CtHG built on existing frameworks within Victoria to address Indigenous disadvantage, and was designed to strategically align with both national and state targets to reduce the disparity in health outcomes between Aboriginal and non-Aboriginal Victorians. The CtHG was established in 2009/10 and concluded in June 2013. The Koolin Balit – Directions for Aboriginal Health 2012-2022, launched in 2012, provides an ongoing framework for Victoria's efforts to improve health and wellbeing for Aboriginal Victorians.

Urbis was commissioned by the Victorian Department of Health to undertake the evaluation of the Closing the Gap in Health Outcomes initiative in Victoria, over the three-year period from 2010-2013. The evaluation focused on four key questions:

- how effectively the Initiative has been implemented in Victoria
- the extent to which the targets have been achieved
- whether current projects represent the most appropriate, effective and efficient means for achieving these goals
- the extent to which a community driven approach has been adopted and effective in the regional implementation of the initiative.

The findings of the evaluation have been reported regularly throughout the four-year funding period. This report is the final report of the evaluation, and provides a summative analysis of the 3-year concurrent evaluation conducted by Urbis, including recommendations for the future.

Previous reports have analysed activity at the project and regional level, and have concluded, with the evidence available to the evaluators, that the implementation of CtHG was making a considerable contribution towards the achievement of the agreed targets for the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (the NPA), and the targets set out in the Victorian Indigenous Affairs Framework 2010-2013 (VIAF). These reports should be read as a series of point-in-time reflections on the effect of Closing the Gap on improved service delivery. As such, this final report does not seek to repeat the analysis of project- and regional-level activity, but to focus on the extent to which the combination of state-wide and regional activities can be said to have contributed to the achievement of closing the gap in health outcomes for Aboriginal Victorians.

The next sections set out the summative analysis in response to the evaluation questions.

THE EFFECTIVENESS OF CTHG IMPLEMENTATION

Effectiveness in this evaluation is assessed by the evaluators, using all available data sources, and is based on evidence for tangible changes in service planning and the delivery of services, measurable improvements in Aboriginal Victorians' access to and uptake of health services, and measurable changes in lifestyle and behaviour risk factors among Aboriginal Victorians.

Using this definition, the evidence suggests that CtHG has been effective in strengthening the foundations within the service system of trust, organisational partnership, and information sharing, on which future improvements can be built.

Koolin Balit is the new framework under which Victorian health services will continue to build on the work undertaken through CtHG. CtHG has provided a strong foundation for the continued improvement of services to meet the needs of Aboriginal Victorians. It is reasonable to conclude that the four years of CtHG activity spent building the capital of trust, partnerships, cultural awareness and increased cultural competency, Aboriginal identification, clinical pathways and to a lesser extent monitoring systems, Koolin Balit is commencing from a strong base, where little momentum should be lost.

A number of indicators of effectiveness are evident across the state as a result of the overall body of investment and activity under CTHG. Regional governance groups, for instance, have reported improved health planning skills as well as improved relationships and communications across a range of health service organisations. In addition, regional health senior leaders within universal health services have reported a significant ongoing commitment from themselves and their services to maintaining a leadership focus on Aboriginal health in their service. This has been fostered particularly by the Statement of Intent and by the high profile given to key performance indicators for health services in improving Aboriginal health.

At the regional level, the effectiveness of the implementation has been influenced by the quality of the regional governance arrangements; the existing relationships between services and with the regional office of the Department of Health (as the lead agency); the regional vision for the Initiative; the extent of consultation between the region and ACCOs; and the personal leadership of senior executives in both ACCOs and universal services.

At the service delivery level, the evaluation team consulted with community members to inform the preparation of a number of case studies as part of the evaluation. This consultation indicated that in at least some areas there has been a change in individuals' own experience of health services as well as a greater sense of inclusion in health service planning and development. While not consistent across the state, in many areas community members have reported a greater sense of welcome and a greater ability to access universal health services. The ongoing identification and response to gaps in service delivery is a positive indicator that the Initiative is laying a foundation for ongoing quality improvement.

THE EXTENT TO WHICH THE STATED TARGETS HAVE BEEN ACHIEVED

The Victorian Indigenous Affairs Framework (VIAF) was in place before the signing of the NPA in 2008, and the revised VIAF in 2010 acknowledged the need to align targets with the national efforts to close the gap. Targets were outlined in the NPA, and targets were also defined in Victoria's implementation plan under the NPA. To a large extent, these targets are in alignment.

Progress has been made towards all of these targets. There is an extensive lag time for some of the targets, due to the timeframes of some data sets, and also due to the length of time required for change to be evident at a population level. In addition, changes in data, for instance an increase in rates of people attending hospital, may indicate a greater access to and willingness to attend universal health services, or an improvement in identification of Aboriginal clients, rather than any change in morbidity patterns. At this stage it is possible to say only that it is likely that these statistics indicate a positive move towards improved identification, access to and use of universal health services. A longer period of time to monitor the data will be required to make any substantive acknowledgment of closing the gap of morbidity or mortality.

THE EXTENT TO WHICH CTHG PROJECTS REPRESENTED THE MOST APPROPRIATE, EFFECTIVE AND EFFICIENT MEANS FOR ACHIEVING THE STATED GOALS

Projects funded under CtHG were many and varied. In part they built on existing state-wide investments, and augmented that investment to further the change agenda. Obvious examples of this are projects funded within the AHPACC and ICAP contexts. Others were new or pilot projects, and drew in external partners with state-wide roles, for example the Spectacle Subsidy Scheme, and to some extent the Workforce Strategy which worked in parallel with CtHG but was not originally funded under the Initiative. Other projects were more opportunistic, such as the Clinical Engagement Strategy which used existing clinical networks to leverage change in hospital contexts.

There is evidence that the regional delegation of funding was appropriate and effective in generating buy-in and participation in making Aboriginal health everyone's business. Efficiency in this context is difficult to measure. Potentially, the efficiency might have been increased through allocating more time for consultation and development at the early stage of the Initiative, when some regions reportedly struggled to undertake the planning process within the required timeframe. Equally, the state was constrained by Commonwealth timeframes, and the Aboriginal Health Branch itself was in its own establishment phase. Nevertheless, the location of responsibility at the regional and sub-regional level for planning, allocation,

monitoring and evaluation remains aligned with evidence of the efficacy of place-based strategies to address Aboriginal disadvantage.

The projects considered to be successful by stakeholders generally had the following characteristics:

- clear and visible leadership from CEOs and senior representatives of health services, both universal and Aboriginal community-controlled services
- consultation with, and ownership by, local Aboriginal leaders and community members
- investment of time and personal commitment into developing organisational relationships and partnerships between universal and Aboriginal community-controlled services
- flexibility to amend the project plan as required during the life of the project.

Capacity building has been an important feature at state-wide and regional levels. This has included capacity in cultural safety; in workforce skill; in health planning and in partnership engagement. In relation to partnerships, the delivery of health services has been changed where strong partnerships already existed, or where they are evolving because of effort under CTHG

THE EXTENT TO WHICH A COMMUNITY-DRIVEN APPROACH HAS BEEN ADOPTED AND EFFECTIVE IN THE REGIONAL IMPLEMENTATION OF THE INITIATIVE

A community-driven approach has been applied to varying degrees in different regions across the state. Regions where a community-driven approach was not as obvious tended to spend time building new relationships at a strategic level across universal and Aboriginal controlled health services. In these regions it is reasonable to conclude that as these relationships strengthen and as ACCHOs participate more in service planning in collaboration with universal health services, a community-driven approach will become more visible and effective in these regions over time as activities under Koolin Balit are established in the future.

On the whole, CTHG has raised the level of understanding within universal health systems of the need to consult with and engage Aboriginal community members and leaders in health service planning. This is by and large a new concept for universal health services as community consultation is not embedded in traditional service planning processes. It will be important to monitor through Koolin Balit the way in which the development of a community-driven approach influences the development and delivery of appropriate Aboriginal and universal health service in the future.

IMPLICATIONS FOR THE FUTURE

The Victorian approach was innovative and not replicated in other jurisdictions. The decision to distribute funding across all regions as well as to provide leadership for some state-wide investments meant a comprehensive approach was taken at both the state-wide population level, the regional level and through service providers, at the individual level of service provision. The innovation was, in part, based on evidence regarding successful approaches to improving Aboriginal health, recognising that the evidence base is not large regarding what works to improve Aboriginal health, while acknowledging the usual methods of increased investment in mainstream health had not delivered the outcomes sought. The investment sought to strike a balance between innovation, through locally driven place-based solutions, and evidence-based approaches. The implementation was largely true to its aims.

For this reason, it is clear that the approach which Victoria has taken, particularly in developing a long term vision for Aboriginal health in the state and policy frameworks to support that vision, is seeking to change the very system through which health services are delivered. A gradual change from traditional grants based funding to funding for outcomes is beginning to take place, with services increasingly required to demonstrate not just how funds were spent but what was achieved through their spending. While the implications of this change are not fully visible, it was notable that a greater number of participants in the 2013 consultations for the evaluation were expressing a view that this needed to be the direction for the future in order to realise tangible and sustainable change in Aboriginal health status.

One of the fundamental achievements of Closing the Health Gap, then, is the creation of service drivers through innovation, which are changing the focus of universal health services on providing health services that meet the needs of Aboriginal Victorians. This innovation has also benefitted Aboriginal community-controlled health services in providing a mechanism for greater engagement with universal health services and greater ability to negotiate service pathways for Aboriginal people. It is important to acknowledge that in many parts of the health system CtHG built on pre-existing commitment of individuals in community-controlled and mainstream health, and community leaders. The increase in engagement with Aboriginal communities and health services through regional governance and health service planning has provided a foundation of shared governance and ownership which should increase the capacity of services to continue to contribute to significantly improved health outcomes under Koolin Balit.

1 Introduction

1.1 BACKGROUND

In December 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Indigenous communities to 'Close the Gap' in Indigenous disadvantage (COAG, 2007). To achieve this target, a number of agreements, strategies and statements of intent were developed to provide the framework for the implementation of reforms.

Closing the Gap is a framework for action on disadvantage, which recognises that reducing Indigenous disadvantage requires a coordinated and sustained effort from all governments. The National Indigenous Reform Agreement (NIRA), endorsed by the COAG in 2008, commits all state and territory governments and the Commonwealth government to six ambitious 'Closing the Gap' targets.

One of the six targets COAG endorsed was to close the life expectancy gap between Indigenous and non-Indigenous Australians within a generation. In 2008, COAG's commitment to address this target was formalised in an historic \$1.57 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (the NPA). The NPA has been implemented alongside other National Agreements, including the National Healthcare Agreement, the National Disability Agreement, the Hospital and Health Workforce Reform National Partnership Agreement, the Preventative Health National Partnership Agreement and the Indigenous Economic Participation National Partnership Agreement.

The Victorian Closing the Gap in Health Outcomes (CtHG) Initiative is one component of Victoria's contribution to the national efforts to close the gap in Indigenous disadvantage. CtHG built on existing frameworks within Victoria to address Indigenous disadvantage, and was designed to strategically align with both national and state targets to reduce the disparity in health outcomes between Aboriginal and non-Aboriginal Victorians. CtHG was established in 2009/10 and concluded in June 2013.

Urbis was commissioned by the Victorian Department of Health to undertake the evaluation of the Closing the Gap in Health Outcomes initiative in Victoria, over the three-year period from 2010-2013. The evaluation has focussed on four key questions:

- how effectively the Initiative has been implemented in Victoria
- the extent to which the targets have been achieved
- whether current projects represent the most appropriate, effective and efficient means for achieving these goals
- the extent to which a community-driven approach has been adopted and effective in the regional implementation of the initiative.

The findings of the evaluation have been reported regularly throughout the three-year period, with a final report (this report) to be completed in January 2014.

In December 2012 an interim progress report was provided. The interim report identified risks or challenges to be addressed in the final six months of funding, and detailed achievements of the initiative to date.

This report is the final report of the evaluation, and synthesises the evaluation findings of all previous reports, as well as recent data, to provide an overarching summative analysis of the effectiveness, appropriateness and impact of Victoria's investment into closing the gap in Aboriginal health outcomes.

1.2 METHODOLOGY

The evaluation methodology was described in detail in the baseline report released in 2011, which included the evaluation framework and a discussion of methodological challenges. The evaluation has been conducted in-line with the requirements of the Human Research Ethics Committee (HREC), which provided approval for the consultation and data analysis activities.

The program logic for the evaluation, which guided the development of the evaluation framework, is presented in the table on the following page. This table outlines the implementation activities or early outputs, as well as short-, medium-, and long-term outcomes which were expected from the Closing the Gap investment.

The program logic was developed by Urbis in consultation with the staff from the Aboriginal Health Branch of the Department of Health and regional Departmental staff. In each year of the evaluation, the Urbis team has assessed the activities at state and regional levels according to the program logic, to analyse the extent to which the outputs of the investment align with the original intentions of the initiative.

The methodology was amended once, at the beginning on 2013, the final year of the evaluation. To increase the depth of data on regional activities, more project resources were invested in case studies on a series of regional projects. Case study extracts are referenced in the body of this report and available as a set in the companion report – Closing the Gap in Aboriginal Health Outcomes Initiative, Case Study Report.

TABLE 1 - CLOSING THE GAP IN HEALTH OUTCOMES IN VICTORIA: PROGRAM LOGIC MODEL

| IMPLEMENTATION ACTIVITIES | SHORT-TERM OUTCOMES (1-2 YEARS) | INTERMEDIATE OUTCOMES (BY 2013) | LONG-TERM OUTCOMES (POST-2013) |
|--|--|--|--|
| Develop Regional Implementation Plans in consultation with local communities | Regional Implementation Plans reflect local needs and priorities | Smoking rates among Aboriginal people are reduced by 20% by 2013 | The gap in life expectancy between Aboriginal and non-Aboriginal Australians is closed within a generation |
| Conduct needs analysis at the regional/local level | Local communities are engaged with the implementation of local initiatives | Health services are culturally safe and responsive, and Aboriginal health is a core part of health service design and delivery | The gap in mortality rates for Aboriginal children (under five years of age) has been halved within a decade |
| Establish governance structures to support the implementation of regional/local initiatives | Regional governance structures are effective and include community members | Aboriginal health services have increased governance and workforce capacity | |
| Provide pooled, flexible and capped funding to support local initiatives | Funding is appropriate and adequate to achieve local outcomes | The impact of chronic diseases among Aboriginal people is reduced | |
| Enhance existing and/or develop new state-wide initiatives addressing the five priority areas | State-wide initiatives linked to the five priority areas are enhanced or implemented | The patient journey and continuity of care experienced by Aboriginal people are improved | |
| Enhance existing and/or develop new regional/local initiatives addressing the five priority areas | Regional/local initiatives linked to the five priority areas are enhanced or implemented | There is increased multi-agency and cross-sectoral collaboration to deliver services to Aboriginal people | |
| Develop linkages and collaborative activities (e.g., ACCHOs, mainstream health service providers, private health service providers, services in child protection, youth justice, drug and alcohol and mental health) | Linkages and relationships between services are maintained and valued | There is improved access to quality health care services across the health care continuum for Aboriginal people | |
| Promote evidence-based practice and successful local initiatives | Collaborative initiatives are implemented | There is increased engagement with health services by Aboriginal young people | |
| Information regarding Closing the Health Gap programs/projects and outcomes are | Evidence-based practice and successful local initiatives are promoted and used to | Lessons learned through the process of improving health access and quality of care | |

| | | | |
|--|---|---|--|
| communicated with Aboriginal people and service providers | inform the development of local initiatives | for Aboriginal Victorians are shared and disseminated across regions and services | |
| Report the progress of implementation of Regional Implementation Plans | | Evaluations of state-wide and regional/local initiatives are conducted and findings are used to refine existing initiatives and inform future initiatives | |

1.2.1 DEFINITIONS

For the purpose of the evaluation, a number of improved care indicators or proxies were agreed as a means of defining what aspects of improved service delivery might be. These indicators are those for which population or service level data is available, or for which data was collected as part of the evaluation. These core indicators are shown in table 2, found in chapter 3.

The primary providers of services under the Victorian CtHG initiative are Victorian Government funded mainstream health services and Aboriginal community controlled health services (ACCHOs). For the purpose of this evaluation, we have defined mainstream health services as follows:

a service that aims to cater for the broad population in the provision of its services and programs (Department of Human Services 1998)

The definition of Aboriginal community controlled health services, according to the National Aboriginal Community Controlled Health Organisation (NACCHO), includes the following characteristics:

- “an incorporated Aboriginal organisation
- initiated by a local Aboriginal community
- based in a local Aboriginal community
- governed by an Aboriginal body which is elected by the local Aboriginal community
- delivering a holistic and culturally appropriate health service to the Community which controls it.” (NACCHO 2006)

In this report the term Aboriginal community controlled organisation (ACCO) is used to encompass both organisations with formal and established health services (ACCHOs), and those organisations which are not primarily health providers but are delivering some form of health related program.

A definition of ‘*effectiveness*’ in the context of CtHG might be the extent to which the implementation has produced a desired result. Using the phrase coined by CtHG itself, effectiveness would then be the extent to which the activities funded under CtHG have led Aboriginal health to become everyone’s business. Measures of this definition of effectiveness might be:

- levels of senior leadership engagement over time
- extent of shared understanding of common goals across universal and Aboriginal community controlled services
- levels of authentic partnership between services or programs.

For the purposes of the evaluation, the evaluation team considers *appropriateness* to be measured by the extent to which the investment addressed the service delivery principles agreed by COAG in 2008 and stated within the Victorian Indigenous Affairs Framework (VIAF) under principles for reform (DPCD, 2010). They are:

- **Priority** – programs and services should contribute to Closing the Gap by meeting targets endorsed by COAG while being appropriate to local community needs.
- **Indigenous engagement** – engagement with Indigenous men, women and children should be central to the design and delivery of programs and services.
- **Sustainability** – programs and services should be directed and resourced over an adequate period of time to meet the COAG targets.
- **Access** – programs and services should be physically and culturally accessible to Indigenous people recognising the diversity of urban, regional and remote needs.

- **Integration** – there should be the collaboration between and within governments at all levels and their agencies to effectively coordinate programs and services.
- **Accountability** – programs and services should have regular and transparent performance monitoring, review and evaluation.

Each of these principles informed the program logic and evaluation framework for the Victorian evaluation.

1.2.2 COMPARATIVE ANALYSIS

The lack of comparative data across jurisdictions, as well as the difficulty in comparing outcome data across regions (because regions invested in their own locally-identified priorities) means that assessing outcomes has been a challenge for the evaluation. The evaluation team has sought to mitigate this through analysing data at several levels:

- at the population level – considering agreed core indicators
- at the state-wide level – considering data from centrally-funded projects with a state-wide reach
- at the regional level – considering data from regional reports regarding the quantum of investment and activity across each region
- at the project level – considering data from consultations and case studies.

As there were differences in the way that each region implemented the Initiative, the evaluation team sought to learn from each region what worked well and what challenges were encountered and overcome. Elements of good practice or successful initiatives have been reported in previous reports where they have been identified through documentation review and stakeholder consultation. In addition, a series of case studies undertaken in the final year of the evaluation sought to highlight success stories and projects, which have had an impact on the health and wellbeing of the local community. Snapshots of the case studies have been included in this document to illustrate key points.

1.3 DATA

1.3.1 DATA SOURCES

The evaluation framework included a range of qualitative and quantitative data drawn from various sources, including data collected through:

- state-wide documentation and reports
- regional implementation progress reports
- review or evaluation reports of specific state-wide and regional initiatives
- existing administrative data sets (such as the VAED, VEMD and VPDC – accessed by the Department of Health and provided to the evaluators)
- consultations undertaken by the evaluators.

In developing the evaluation framework, a number of performance measures, benchmarks and indicators were also utilised:

- health related performance benchmarks and indicators as outlined in the *National Indigenous Reform Agreement (Closing the Gap)* (COAG, 2008)
- performance benchmarks and indicators as outlined in the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (COAG, 2009)
- performance indicators identified in the Victorian Implementation Plan for the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*

- health related performance indicators identified within the Victorian Indigenous Affairs Framework (VIAF).

Over the three years of the evaluation, more than five rounds of state-wide consultation were undertaken, with qualitative insights gathered from over 120 interviews with Department of Health staff in the central office, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), staff of non-government organisations (NGO) and Aboriginal community-controlled organisations (ACCO), universal and Aboriginal community controlled health service (ACCHS) providers, regional Department of Health staff, and community members.

The Department of Health provided public health data as they were available at the time of reporting each year. A baseline data reporting 2009 identified baseline data for a number of key health indicators, which were reviewed in 2012 and again in this final report in 2013.

1.3.2 DATA GAPS AND LIMITATIONS

The indicators identified in the evaluation framework were subject to a number of limitations, due to gaps in data sources or limitations in scale of the data. The following points are noteworthy.

- Publicly available data regarding the types of services provided through mainstream general practice is limited. This includes data regarding the types of services provided to Aboriginal people, which otherwise might have informed a perspective on whether access to primary healthcare services had increased over the period of the CtHG initiative.
- Nationally there is no agreed standard data collection or reporting mechanism for measuring service activity and clinical outcomes from different types of primary health care services. As many Aboriginal people access services through both mainstream general practices and through ACCHOs, it is not possible to assess accurately the extent to which Aboriginal people have increased their use of services overall.
- There continue to be gaps in the identification of Aboriginality across all health services, although this has reportedly improved over the course of the CtHG initiative.
- There are time lags in data availability, which affect the ability to track changes in service uptake and in clinical outcomes over the life of the evaluation.
- There is currently no data on the life expectancy of Aboriginal people in Victoria; this is due to the low numbers of reported Aboriginal deaths in the state.

We have sought to mitigate these limitations by: identifying indicators which could be collected annually; including qualitative data; and including some limited service data, aggregated by region.

1.3.3 THE QUESTION OF ATTRIBUTION

CtHG was one of a number of initiatives seeking to prevent, detect and manage chronic disease conditions amongst Aboriginal Australians in Victoria. Running parallel to the Initiative over the life of the program were several related programs:

- national Indigenous health programs targeting chronic disease and healthy lifestyle choices
- other Victorian Aboriginal health program or initiatives aimed at chronic disease and health promotion
- national (mainstream) strategies targeting smoking, lifestyle risk factors, and chronic disease conditions
- Victorian smoking, lifestyle risk factors, and chronic disease strategies.

Any of these initiatives and activities or combination of these and activities funded under CTHG could have had an impact on the health status of Aboriginal Victorians with or at risk of chronic disease. For that reason, attributing any changes to health outcomes at the regional or state-wide level purely to the *Closing the Gap in Health Outcomes Initiative* is problematic. At the same time, process and service delivery improvements may be able to be attributed to specific activities undertaken within the Initiative. These have been identified in previous evaluation reports where the evidence of attribution was clear, and are referred to again in the relevant sections of this report.

1.3.4 DATA ANALYSIS

The evaluation team used a number of methods to make sense of the range of data collected during the evaluation.

One approach was to use a contribution analysis framework for assessing the data. This approach, conceptualised by Mayne (1999), recognises that many programs are not able to measure their long-term goals either because of the timeframe involved or because of the many other activities and programs which may also contribute to the same outcome. Contribution analysis (CA) seeks to define the contribution which certain activities might make to the long-term outcomes, recognising that full attribution (ie, that A has led to B) may not be possible. As Lemire argues:

The aim of CA, then, is not to provide proof of a one-on-one, linear causal linkage between a program and its intended outcomes, nor is it to determine the exact contribution of the program. Rather the aim of CA is to provide evidence beyond reasonable doubt that the program to some degree contributed to the specified outcomes.(Lemire, 2010)

Much of the activity undertaken under the Closing the Health Gap Initiative at regional and state-wide levels focussed on health services improving their own processes and cross-sector relationships. The evaluation assessed the qualitative aspects of the Initiative, such as the extent to which communication and collaboration have improved between Indigenous health services and mainstream services; improvements to levels of cultural safety in health services; increases in cross-service care planning and coordination; improvements in transfer of care processes; and changes in the ways in which regional services work together in addressing locally-defined needs. Identifying and analysing the ways in which service delivery processes have improved as a result of the Initiative was a major focus of the evaluation.

The extent to which the Initiative made it easier for Aboriginal people to access services and receive the care they need was another key focus of regional and state-wide activities, and thus of the evaluation. The evaluation team recognised the difficulty of speaking with service users who may not be aware of the changes which are made internally within a health service. For that reason, we sought to include an Aboriginal community perspective in two distinct ways. First, we spoke with senior leaders within local Aboriginal community-controlled health services about the impact of CtHG-funded activities, and any changes in lifestyles and behaviours, which may have occurred through specific activities funded by CtHG. Secondly, we spoke with a small number of service users in the course of developing case studies regarding specific projects funded by CtHG. In addition, regional governance groups generally included Aboriginal members, from community-controlled services, mainstream services, or senior community members. Consultations with these governance groups were conducted each six months over the course of the evaluation.

1.4 THIS REPORT

The Victorian Closing the Health Gap in Health Initiative concluded in June 2013. This report is the final evaluation report for the Initiative and provides a summative analysis of the Initiative, its effectiveness, appropriateness, impact and outcomes.

Previous progress reports have separated the discussions of state-wide projects and regional projects. This final report provides a summative analysis of all activity funded under CtHG, and considers all activities under the headings of the five COAG priority areas. This report is structured as follows:

- Chapter 2 discusses the Victorian and national approaches to closing the gap in health, providing the policy context and structures supporting the CtHG Initiative
- Chapter 3 presents findings of the evaluation, under the headings of the five COAG priority areas
- Chapter 4 discusses key achievements, the impact of CtHG on system and structural changes, and lessons learned from the Initiative
- Chapter 5 provides a concluding analysis of the contribution made by CtHG to closing the gap, as well as responses to the four key evaluation questions, and recommendations for the future.

2 The Victorian approach to closing the health gap

2.1 THE NATIONAL POLICY FRAMEWORK

The National Indigenous Reform Agreement (NIRA) was signed in 2008, committed the Commonwealth, state and territory governments to attain six ambitious targets:

- closing the life expectancy gap within a generation;
- halving the gap in mortality rates for Indigenous children under five within a decade;
- ensuring all Indigenous four years olds in remote communities have access to early childhood education within five years;
- halving the gap for Indigenous students in reading, writing and numeracy within a decade;
- halving the gap for Indigenous people aged 20-24 in Year 12 attainment or equivalent attainment rates by 2020; and
- halving the gap in employment outcomes between Indigenous and non- Indigenous Australians within a decade (DPCD, 2010).

The NPA on Indigenous Health Outcomes, which came into effect on 1 July 2009, addressed two of the six targets:

- to close the gap in life expectancy within a generation
- to halve the gap in mortality rates for Indigenous children under five within a decade.

The NPA outlines five priority areas, which all states and territories must address as part of their contribution to the Closing the Gap agenda.

These priority areas are:

- **tackling smoking** – to assist Aboriginal people to quit smoking and in turn reduce the burden of tobacco related disease in Aboriginal communities.
- **primary health care services that can deliver** – to improve Aboriginal people’s experience and access to quality primary health care services.
- **fixing the gaps and improving the patient journey** – to improve Aboriginal people’s satisfaction with care provided by hospitals and their transition between hospital and other health care providers.
- **healthy transition to adulthood** – to improve the health of Aboriginal teenagers by promoting healthy lifestyle choices like nutrition and physical activity, and reducing the take up of high-risk behaviours such as smoking, alcohol abuse, substance misuse and unsafe sex.
- **making Indigenous health everyone’s business** – to increase the responsiveness of all health services to improve the health of Aboriginal people currently engaged in child protection, youth justice, drug and alcohol, and mental health services.

Under the NPA, the Commonwealth Government committed \$805.5 million over four years (2009-2013) to the Indigenous Chronic Disease Package (ICDP) to tackle chronic disease among Indigenous Australians.

The ICDP focused on three priority areas:

- tackling chronic disease risk factors – health promotion
- primary health care services that can deliver – increasing access to health services
- fixing the gaps and improving the patient journey – building the capacity of the health workforce.

The Commonwealth Implementation Plan under the NPA in Indigenous Health Outcomes expired in June 2013. However, the majority of ICDP measures have been consolidated into the new Aboriginal and Torres Strait Islander Chronic Disease Fund (outlined in the 2011 Budget) which provides an ongoing allocation of over \$220 million per year from 2013-14.

In July 2013 the National Aboriginal and Torres Strait Islander Health Plan (NATSIHP) was released. The Health Plan is a policy framework to guide policies and programs to improve Aboriginal and Torres Strait Islander health over the next decade until 2023. It replaces the National Strategic Framework for Aboriginal and Torres Strait Islander Health which expired in 2013 and will be used to guide future efforts to improve Aboriginal and Torres Strait Islander health and achieve the Closing the Gap targets (Australian Government Department of Health, 2013b).

2.2 THE VICTORIAN APPROACH TO CLOSING THE HEALTH GAP

In response to the NPA in Indigenous Health Outcomes, the Victorian government committed \$57.97 million over four years for state-wide initiatives, working with the Aboriginal community-controlled sector, key stakeholders and the greater community to help make Aboriginal health everyone's responsibility. Victoria adopted a unique approach to Closing the Health Gap in that much of the development, implementation, and execution of projects occurred at the local level through Closing the Health Gap committees in the eight Department of Health regions across the state. This approach recognised that regional and community ownership is central to any advances that are made to close the life expectancy gap.

The vision of the Closing the Health Gap Initiative (CtHG or the Initiative) in Victoria was articulated in the following statement:

By 2020 the Department of Health will have had a significant and measurable impact on improving the length and quality of the lives of Aboriginal Victorians. (Department of Health, 2011a)

The Department of Health proposes to achieve this vision through:

*working with Victoria's Aboriginal communities to improve Aboriginal health by providing leadership across government and engaging the health sector so **Aboriginal health becomes everyone's responsibility*** (Department of Health, 2011a – emphasis original).

The investment in regional activity reflects an important component of the approach taken to closing the health gap in Victoria, as 55 per cent of the state budget allocation for the overall Initiative was provided to the regions on a population basis. The regional investments were guided by a regional plan governed at the regional level. The remaining 45 per cent was invested in state-wide initiatives to introduce or augment activities in mainstream health settings, governed by the Aboriginal Health Branch within the Department of Health.

The Initiative was also linked to, and built on, other efforts to meet the targets set out in the 2010 Victorian Indigenous Affairs Framework, relating to life expectancy and child mortality.

2.2.1 ASSUMPTIONS GROUNDING THE VICTORIAN APPROACH

CtHG has been grounded, nationally and in Victoria, on the belief that only concerted, integrated whole-of-government efforts, working closely with Aboriginal communities, Aboriginal community-controlled health services, and other service providers would begin to change the entrenched levels of disadvantage experienced by many Aboriginal Australians.

The initiatives that Victoria will implement will not succeed unless there is Aboriginal community ownership and leadership. The Victorian Government has worked closely with the Aboriginal community to ensure community input has been central to the development and future implementation of these initiatives. (Department of Health, 2009:4)

The Victorian government will integrate with all levels of government, work collaboratively with government and non-government services, and be responsive to the needs of local Aboriginal communities and service providers. (Department of Health, 2009:5)

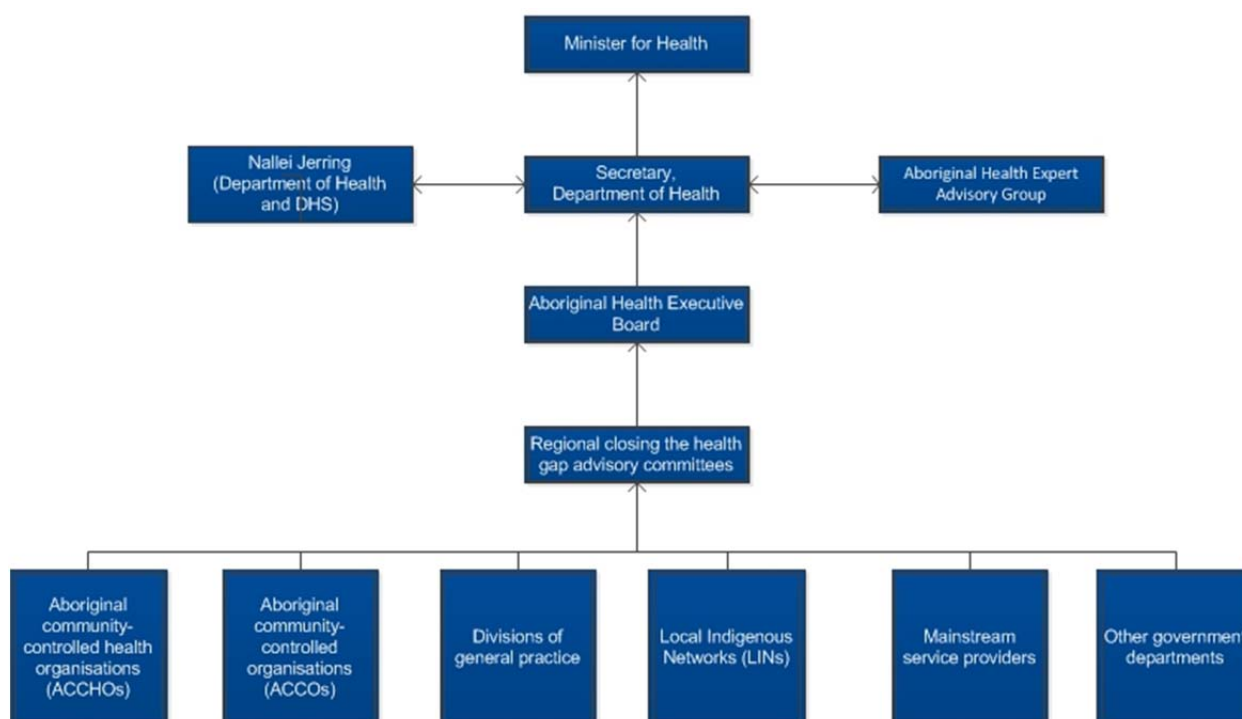
We recognise the Victorian Indigenous Affairs Framework 2010-2013 as a means for the Victorian Government to coordinate the effort of its departments and agencies to make significant progress in closing the gap and breaking the cycle of disadvantage. Central to achieving the objectives of this Framework is government's partnership with Victoria's Aboriginal people and communities. (DPCD, 2010:2)

Assumptions that underpinned the CtHG initiative in Victoria were that:

- the state has a role to play at the population health level, in providing large-scale initiatives to address systems and structures
- in order to respond to the specific needs of local communities, decision making needed to be brought closest to the service level
- it was essential to involve Aboriginal community-controlled health services in partnership with the universal health system to improve the access and quality of services for Aboriginal Australians.

2.2.2 STRUCTURE AND MANAGEMENT

The governance structure for during the funding period of Closing the Gap for Aboriginal Health is shown below.



A total to \$57.97million over four years was allocated to CtHG in Victoria. Victoria was unusual among states and territories for choosing to devolve a majority of its funds to the eight health regions across the state, proportionally allocated based on regional Aboriginal population. The funding therefore mirrored the regional and metropolitan Aboriginal population size, with slightly more being given to the five rural regions than to the three metropolitan regions.

All of the regions focussed initial activities on consultation at some level with local Aboriginal community-controlled services and local Aboriginal communities. Some regions gave a focus primarily to consulting with leaders of Aboriginal community controlled services while in other areas local community members were consulted to identify needs and assist with developing the regional plan.

All regions established some form of regional governance. The form of the governance structure varied according to the decisions made within the region, including: establishing closing the health gap advisory committees within existing Aboriginal planning groups; developing a closing the gaps steering committee under the governance of existing senior leadership structures; establishing an Aboriginal reference group

specifically focussing on making decisions regarding the closing the health gap investment; and regional advisory committees with sub-regional committees each charged with the implementation and oversight of local CTHG activities.

2.3 NATIONAL AND STATE TARGETS

The national and state targets that informed the development of Closing the Health Gap are summarised in table 1 below. These targets informed the development of Victoria's CtHG approach, and were incorporated into the evaluation framework for CtHG.

The five COAG priority areas provide an overarching framework for the NPA between governments. The NPA expected outcomes, and the Victorian NPA implementation plan, are designed to provide evidence to assess progress against the priority areas.

The VIAF was first developed in 2006, providing an authorising environment that pre-dated the national agreements on closing the gap. The most recent VIAF provided targets not only for 2013 but for 2018 and beyond, and incorporated not just health but other social indicators including housing, education and employment. Although developed independently of CtHG, the health targets are reasonably aligned with the NPA targets, and are in fact more specific than those arising from the NPA.

TABLE 2 – CLOSING THE GAP NATIONAL AND STATE TARGETS

| FIVE COAG PRIORITY AREAS | NPA EXPECTED OUTCOMES | VICTORIAN NPA IMPLEMENTATION PLAN (BY 2013) | VIAF 2010-2013 TARGETS (BY 2013) |
|---|---|---|--|
| Tackling smoking | <ul style="list-style-type: none"> ▪ Reduced smoking rate ▪ Reduced burden of tobacco-related disease for Indigenous communities | <ul style="list-style-type: none"> ▪ By 2013 reduce smoking among Aboriginal people by at least 20% from the current rate of 50-40% ▪ Reduce the burden of tobacco-related chronic diseases ▪ By 2023 halve the gap in number of Aboriginal women smoking during pregnancy | <ul style="list-style-type: none"> ▪ Reported smoking in pregnancy by Indigenous mothers will be reduced to 25% ▪ The proportion of Indigenous adults who are current smokers will reduce to 26% |
| Primary health care services that can deliver | <ul style="list-style-type: none"> ▪ Implementation of national best practice standards and accreditation processes for Aboriginal health services delivering primary health care ▪ Increased uptake of MBS-funded primary health care services by Aboriginal people ▪ Improved access to quality primary health care through improved coordination across the care continuum, particularly for people with chronic diseases and/or complex needs ▪ Provision of improved cultural security in services, and increased cultural competence of the primary health care workforce | <ul style="list-style-type: none"> ▪ Collaborate with key stakeholders to develop coordinated and integrated services ▪ Reduce the impact of chronic disease experienced by Aboriginal people ▪ Improve Aboriginal people's access to primary health care settings ▪ Develop and provide culturally competent primary health services ▪ Support local initiatives focussed on health promotion and chronic disease initiatives ▪ Build a flexible, culturally competent and cohesive health care workforce to provide care to Aboriginal people ▪ Strengthen management capability and clinician retention within ACCHOs | |

| | | | |
|--|---|--|--|
| <p>Fixing the gaps and improving the patient journey</p> | <ul style="list-style-type: none"> ▪ Reduced average length of stay in the long term ▪ Improved level of engagement between Aboriginal patients, referred care providers and primary level providers to deliver better follow up and referral processes ▪ Improved long-term stability in primary provider choice ▪ Improved patient satisfaction with the care and patient journey ▪ Reduced admissions and incomplete treatments for Aboriginal patients | <ul style="list-style-type: none"> ▪ Improve health outcomes for Aboriginal people in Victoria by improving the patient journey and supporting Aboriginal people accessing and moving between health care settings. Ensure seamless transition for Aboriginal patients moving and navigating between a various health care settings. ▪ Reduce the rates of Aboriginal patients leaving hospital against medical advice. ▪ Ensure hospitals and primary health care services have the capacity to deliver the coordination and continuity of care necessary to meet the needs of Aboriginal and Torres Strait Islander clients ▪ Develop culturally competent hospitals ▪ Improve coordination and follow up care of patient journey between hospitals and primary care settings | <ul style="list-style-type: none"> ▪ The proportion of Indigenous adults who are overweight or obese will reduce to 52% ▪ The proportion of Indigenous adults who do not meet healthy levels of vegetable intake will reduce to 87% ▪ The proportion of Indigenous adults who do not meet healthy levels of fruit intake will reduce to 58% ▪ The proportion of Indigenous adults who have healthy levels of physical activity will increase to 55% ▪ The separation rate for selected chronic conditions will be reduced to 43/1000 ▪ The rate of presentations due to alcohol consumption will be reduced to 12.6/1000 |
| <p>Healthy transition to adulthood</p> | <ul style="list-style-type: none"> ▪ Increased sense of social and emotional wellbeing ▪ Reduced uptake of alcohol, tobacco and illicit drugs ▪ Reduced rates of STIs ▪ Reduced hospitalisations for violence and injury ▪ Reduced excess mortality and morbidity among Aboriginal men | <ul style="list-style-type: none"> ▪ Positively impact on lifestyle choices of teenagers and young adults that their affect length and quality of life. ▪ Re-establish positive social norms and healthy behaviours amongst young Indigenous people. ▪ Reduce the take-up of high risk behaviours such as smoking, and provide improved referral and access to clinical and support services. | <ul style="list-style-type: none"> ▪ The Indigenous perinatal mortality rate will reduce to no more than 16/1000 births ▪ The percentage of Indigenous babies with birth weight below 2500g will decrease to 13% |

| | | | |
|---|--|--|--|
| <p>Making Indigenous health everyone's business</p> | <ul style="list-style-type: none"> ▪ Improved multi-agency, multi-programme and inter-sectoral collaboration and coordination to meet the needs of Indigenous families and communities ▪ Improved access to targeted early detection and intervention programs by high need Indigenous families ▪ Reduced waiting times for health services ▪ Reduction in early mortality | <ul style="list-style-type: none"> ▪ To re-engage the most disadvantaged families and individuals in Aboriginal communities in the health care system | |
|---|--|--|--|

From Victorian NPA Implementation Plan; VIAF 2010-2013; COAG NPA; Koori Health Counts!

2.4 NATIONAL CLOSING THE GAP OUTCOMES

Recent Closing the Gap figures released by the Australian Bureau of Statistics indicate that life expectancy for Aboriginal and Torres Strait Islander people has increased slightly (1.6 years in the past five years for men; 0.6 of a year for women). However, a significant gap between Indigenous and non-Indigenous life expectancy still remains (ABS, 2013). While there has been a decline in Indigenous mortality rates in the last decade, these rates continue to be twice the non-Indigenous rate. The rate of decline would need to accelerate dramatically if the Closing the Gap life expectancy target is to be met (Australian Health Ministers' Advisory Council, 2012). More promising, the target to halve the gap in national mortality rates for Indigenous children under five within a decade is likely to be met by 2018 if the downward trend continues (Australian Health Ministers' Advisory Council, 2012).

For many of the Closing the Gap initiatives across Australia, it is still too early for health outcome data to reflect the impact of the governments' investments. For example, any impact of smoking initiatives on mortality rates is not likely to manifest in mortality data until 2020 (Department of Health, 2013a).

Since the introduction of the National Partnership on Closing the Gap in Indigenous Health Outcomes there has been a significant increase in health assessments and chronic disease management items claimed through Medicare (Australian Health Ministers' Advisory Council, 2012). Evaluations of the federal government's Closing the Gap health initiatives suggest that the most successful initiatives nationally have been those under the health access measures (Ballie et al, 2013). For example, the ICDP has led to substantial increases in access to primary health care services and affordable medication. A key factor in the success of the health access measures has been the provision of additional Commonwealth government promotion of, and funding for, MBS Health Assessments for Aboriginal and Torres Strait Islander people and the subsidised PBS co-payments measure. Other notable achievements under the ICDP include the establishment of a new workforce focused on health promotion, improved access to specialist, allied health and coordinated approaches to health care, and improved understanding among General Practitioners of the needs of Aboriginal and Torres Strait Islander people (Ballie et al, 2013).

However, a lack of data has hindered the ability to measure the effectiveness of some of the ICDP measures. Problems with the quality and availability of data about Aboriginal and Torres Strait Islander health issues are well known (Australian Health Ministers' Advisory Council, 2012). These limitations include the quality of data on all key health measures including mortality and morbidity, uncertainty about the size and composition of the Aboriginal and Torres Strait Islander population and a lack of available data on other health-related issues such as access to health services. The Australian government has been working to improve the availability of quality Aboriginal and Torres Strait Islander health data and committed \$46.4 million over four years under the NIRA. The National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) engaged with key stakeholders, state and territory governments, the ABS and the AIHW to develop the key datasets required for NIRA Indigenous reporting, for example, mortality, morbidity, perinatal data and population estimates (Australian Health Ministers' Advisory Council, 2012). It will take some time before improvements in data capture lead to robust health data sets.

2.5 FUTURE DIRECTIONS

Since the implementation of the Victorian Closing the Health Gap Initiative the Victorian government launched its strategic directions for Aboriginal health over the next 10 years, *Koolin Balit: Victorian Government strategic directions for Aboriginal health 2012-2022* (Department of Health, 2013b). *Koolin Balit* is intended to follow on from the work of the CtHG Initiative, which finished in 2013.

Koolin Balit sets out what the Department of Health, together with Aboriginal communities, other parts of government and service providers, will do to achieve the government's commitment to improve Aboriginal health. It brings together Victoria's total effort in Aboriginal health in an integrated, whole of life framework based around a set of key priorities and enablers. *Koolin Balit* seeks to build on the work undertaken through CtHG, with a stated aim of making a significant and measurable impact on improving the length and quality of the lives of Aboriginal Victorians in this decade by focusing on six key priority areas:

- a healthy start to life
- a healthy childhood
- a healthy transition to adulthood
- caring for older people
- addressing risk factors
- managing illness better with effective health services (Department of Health, 2013b).

The Victorian government has identified three enablers that will help to provide a foundation for the key priorities, and support their achievement:

- improving data and evidence
- strong Aboriginal organisations
- cultural responsiveness.

Koolin Balit also builds on the Victorian Health Priorities Framework 2012-2022. Broader, whole-of-government strategies are outlined in the Victorian Aboriginal Affairs Framework 2013-2018.

3 Findings

This chapter discusses the achievements of activities funded under CtHG against the five COAG target areas:

- **tackling smoking** – to assist Aboriginal people to quit smoking and in turn reduce the burden of tobacco related disease in Aboriginal communities.
- **primary health care services that can deliver** – to improve Aboriginal people's experience and access to quality primary health care services.
- **fixing the gaps and improving the patient journey** – to improve Aboriginal people's satisfaction with care provided by hospitals and their transition between hospital and other health care providers.
- **healthy transition to adulthood** – to improve the health of Aboriginal teenagers by promoting healthy lifestyle choices like nutrition and physical activity, and reducing the take up of high-risk behaviours such as smoking, alcohol abuse, substance misuse and unsafe sex.
- **making Indigenous health everyone's business** – to increase the responsiveness of all health services to improve the health of Aboriginal people currently engaged in child protection, youth justice, drug and alcohol, and mental health services.

Early in the evaluation, core indicators were identified to provide a snapshot of the evidence base for change at the population level. Table 2 below provides a summary of the core indicators identified for the evaluation.

The 2012 update of the baseline data for CtHG in Victoria indicated a number of positive changes in service usage by Aboriginal Victorians across a range of health conditions, in particular in the following areas (all age categories):

- hospitalisations for injury/poisoning had decreased by 6.6/1000
- hospitalisations for circulatory disease had increased by 11.9/1000, although they decreased for Aboriginal Victorians over 50 years, by 23.7/1000.

A 2013 update of some indicators has identified the following changes:

- the rate of immunisation for five-year-olds has increased by 8.8 per cent to 91 per cent and the gap between rates of immunisation for Aboriginal and non-Aboriginal five-year-olds is now 0.6 per cent
- the rate of treatment for alcohol consumption has decreased for all life stages (adolescence, adulthood, and old age), while the rate for non-Aboriginal adults and older people increased, thus contributing to a small reduction of the gap
- the rate of treatment for all drugs excluding alcohol increased for Aboriginal Victorians at all life stages (adolescence, adulthood, and old age), as did the rate for non-Aboriginal Victorians at the same life stages.

It is not entirely clear what has driven changes in these figures. An increased rate of treatment for substance use may suggest that more people are accessing treatment, rather than an increase in substance use itself. Likewise, decreased hospitalisation rates may indicate that people are healthier, but it may also indicate that they are not accessing the services that they need. However, increased rates of immunisation are less open to interpretation and suggest that more children are having access to health checks and are getting immunised.

These results, and indeed all rates cited in this report, need to be treated with caution and would benefit from interrogation at the local service network level to ensure accurate interpretation.

TABLE 3 – CORE INDICATORS

| INDICATOR | RATIONALE | DATA SOURCE | BASELINE | 2012 | 2013 |
|--|--|--|---|--|---|
| Tobacco | | | | | |
| Smoking rate among Aboriginal adults | VIAF target: reduce proportion of Indigenous adults who are current smokers to 26% | VPHS Current smokers | 2008 32.8% | 2011 not yet available | |
| Smoking rate among Aboriginal pregnant women | VIAF target: reduce to 25% by 2013 | VAED (% of Aboriginal women admitted to hospitals from 1 month prior to delivery who were current smokers) | 2008/09 Aboriginal women 39% non-Aboriginal women 8% | 2010/11 Aboriginal women 38% non-Aboriginal women 6% 2011/12 Aboriginal women 34% Non-Aboriginal women 6% | 2012/13 Aboriginal women 36% Non-Aboriginal women 5% |
| Number of Aboriginal people accessing smoking cessation support and services | Considerable investment has been made into smoking cessation services through CthG | Regional implementation progress reports Quitline progress reports | n/a | 133 Aboriginal people accessed the Quitline service (financial year 2011-12) 146 clients reported to have accessed other smoking cessation support and services (from three regions, but data incomplete) | A further 180 people accessed the Quitline service in 2012/2013 |
| Workforce | | | | | |
| Increase in number of Aboriginal staff employed in mainstream public health services | Employment of Aboriginal people in health services is identified as an indicator of culturally appropriate services, and a state-wide employment target has been set as part of Karreeta Yirramboi | Reporting dependant on data recorded in regional progress reports. Consultation with health services The State Services Authority collects annual workforce data from Public Health Services | November 2010 85 Aboriginal staff 0.09% of health staff | June 2012 104 Aboriginal staff 0.10% of health staff | June 2013 131 Aboriginal staff 0.13% of health staff |

| INDICATOR | RATIONALE | DATA SOURCE | BASELINE | 2012 | 2013 |
|--|---|--|---|--|--|
| Clinical | | | | | |
| Evidence of increased hospital recording of Aboriginal identification | Indicator of improved use of identification question, and increased access to services | VAED separations, VEMD presentations (Public hospitals only) | 2008/09 VAED 13,241 VEMD 16,458 | 2011/12 VAED 19,055 VEMD 20,166 AIHW audit 2011 78% ¹ | 2012/13 VAED 18,035 VEMD 21,323 No update for audit. |
| Rates of discharge of Aboriginal people from hospital against medical advice | A reduction might indicate an improvement in cultural safety in hospitals, with more people willing to receive care there | VAED | VAED 2008/09 Public only N=236 (Total sep=13,241) Rate 1.8% Public and Private N=237 (Total sep=13,951 [†]) Rate: 1.7% | VAED 2010/11 Public only 278/16,622 = 1.7% Public and Private 279/19,320 = 1.4% | VAED 2012/13 Public only 281/18,035 = 1.6% Public and private 283/19,581 = 1.4% |
| Uptake of spectacles | | | | | |
| Uptake of subsidised spectacles among Aboriginal people | An indicator of the impact of the spectacles subsidy | Spectacles subsidy data (to be confirmed) | n/a | June 2012 2,473 subsidised spectacles dispensed (exceeding original target of 1,800) | July 2010-June 2013 4,199 pairs of spectacles through VASSS. |
| Infants | | | | | |
| Infant mortality rates | VIAF target: reduce Indigenous perinatal mortality to no more than 16/1000 | VPDC/AIHW | VPDC 2008 Babies of Aboriginal mothers 17.9 per 1000. Babies of non-Aboriginal mothers 7.9 per 1000. | VPDC 2009 Babies of Aboriginal mothers 22.8 per 1000. Babies of non-Aboriginal mothers 7.4 per 1000. | VPDC 2010 Babies of Aboriginal mothers 20.6 per 1000. Babies of non-Aboriginal mothers 8.1 per 1000. VPDC 2011 Babies of Aboriginal mothers 11.8 per 1000. Babies of non-Aboriginal mothers 7.3 per 1000. |

¹ Figures from the 2007 AIHW audit are not included because of differences in methodology which render any time-series comparisons invalid.

| INDICATOR | RATIONALE | DATA SOURCE | BASELINE | 2012 | 2013 |
|---|---|---|--|--|--|
| Rates of low birth weight | VIAF target 2013: decrease to 13% of Indigenous babies with birth weight below 2500g | VPDC | VPDC 2008 Babies of Aboriginal mothers 14.2% Babies of non-Aboriginal mothers 6.0% | VPDC 2009 Babies of Aboriginal mothers 12.1% Babies of non-Aboriginal mothers 4.5% | VPDC 2010 Babies of Aboriginal mothers 9.4% Babies of non-Aboriginal mothers 4.7% VPDC 2011 Babies of Aboriginal mothers 10.5% Babies of non-Aboriginal mothers 4.7% |
| Governance | | | | | |
| Number of MoUs or other formal agreements between universal health services and ACCHOs | While a number of services are developing stronger relationships across universal and community-controlled health services, evidence of formal partnership provides a foundation for improving services and systems to provide seamless care. | Regional progress reports, and consultation with stakeholders | n/a | Reportedly at least 22 formal MoUs between Victorian universal health services and ACCOs, and ten formal partnerships (consultation data: the true figure may be more). It should be noted that there are many more informal partnerships, which have not yet progressed to a formal, documented agreement | The level of collaboration and partnership has reportedly continued to grow. There are no new figures regarding numbers of MoUs or formal agreements. |
| Number and type of mechanisms for engagement of universal health services with Aboriginal community members | Increased engagement of Aboriginal people in universal services is a mechanism for making Aboriginal health everyone's responsibility | Consultation with state-wide and regional government stakeholders, VACCHO, health service providers | n/a | Varies across regions, some increase in Aboriginal health workforce, but primarily through CtHG governance structures | A number of mechanisms have been identified, including informal collaborations, MoUs, development of Reconciliation Action Plans, and community consultation. The development of 32 |

| INDICATOR | RATIONALE | DATA SOURCE | BASELINE | 2012 | 2013 |
|-----------|-----------|-------------|----------|------|---|
| | | | | | Aboriginal employment plans in Victorian public health services with 500 staff or more. |

3.1 TACKLING SMOKING

ACHIEVEMENTS:

- All ACCHOs are now smoke-free (national initiative); many ACCHO staff have quit smoking
- There is a small but steady decrease in the number of pregnant women reporting smoking in the last month of pregnancy since 2008
- Positive messages about quitting smoking are reportedly being received; more Aboriginal people are accessing the Quitline.

Quit smoking – the ACCO had good results with staff stopping smoking, and the ad campaign in the region was well received. The programs that have been most successful are the ones that are led by the ACCOs, and where mainstream has been involved too – smoking, etc. If ACCOs are not in the lead then the calibre is not as good. (ACCO)

Ambitious targets were set to reduce smoking rates among Aboriginal Victorians. The targets set in the NPA implementation plan stated that 'smoking rates among Aboriginal people are reduced by 20% by 2013'. The target stated in the VIAF was that 'smoking rates among Aboriginal people are reduced to 26% by 2013'. The expected outcome stated in the national partnership agreement through COAG was simply stated as 'reduced smoking rate'.

The data available at the time of writing does not provide a current indicator of smoking rates among Aboriginal adults in Victoria. The smoking rate among Aboriginal pregnant women has reduced from the baseline reported through the Victorian admitted episodes data set of 2008-09. The percentage of Aboriginal pregnant women who smoked at that time was recorded to be 39%. In 2011-12 that number reduced to 34% and 2012-13 figures are stated as a rate of 36%. This does seem to indicate a reduction, at least in the number of pregnant women smoking at the time they are admitted to hospital, although the figures remain substantially higher than for non-Aboriginal women (5% in 2012-2013).

Although the state-wide figures do not provide an overall estimation of the number of Aboriginal Victorians who smoke, or who have quit smoking, there is data available that suggest smoking rates among Aboriginal Victorians have reduced since the beginning of CtHG. Reportedly, one of the most significant initiatives influencing the change in smoking patterns has been the commitment of all Aboriginal community-controlled health organisations in Victoria to establish services as smoke-free environments. This has led not only to changed social practices in terms of people attending ACCHOs, who now are required to smoke outside the venue, but has also been matched by numbers of ACCHOs staff who have quit smoking and are therefore able to act as a role model and to encourage health service users to give up smoking as well.

Although this was a national initiative it has been supported by the corresponding investment within Victoria.

The Victorian Department of Health provided funding through CtHG to expand Quit Victoria's Aboriginal focussed program. This funding has provided an Aboriginal Quitline liaison role responsible for promoting the enhanced Quitline service in Victorian Aboriginal communities and establishing developing and reinforcing Quitline referral pathways. New resources have also been developed to promote the Quitline including social marketing pamphlets, the development of fact sheets and other promotion material which has been provided to the community. In addition, an Aboriginal research project officer is currently working through the Australian School Students for Alcohol and Drug (ASSAD) Survey on a pilot project which is taking place in Victoria and in Queensland schools to look at enhancing Aboriginal and Torres Strait Islander participation and to increase the survey's capacity to establish future prevalence estimates of tobacco smoking and substance abuse among school students.

The Aboriginal Quitline enhancement project was funded through CtHG and was established to improve the capacity of Quitline in Victoria to respond to the needs of Aboriginal callers. The Quit Victoria Aboriginal programs team have worked with a number of services to develop appropriate training resources and information for the community. Quitline activity as a result of Aboriginal callers between

2009-10 and 2012-13 has increased significantly with a 35% increase in the number of callers between 2011-12 and 2012-13. This has increased the percentage of the total contacts which are from Aboriginal callers from 1.19% to 1.73%.

Quit Victoria appointed two part-time Quitline counsellor positions in 2012-13 and in addition to providing cessation support these counsellors have also attended community events to promote the service (QUIT Victoria, 2013).

The state-wide expansion of the Aboriginal Quit Smoking program has also provided indications of health education and positive messages being received by Aboriginal people in Victoria. There have been a number of investments at the state and national level in health promotion and social marketing messages regarding smoking and quitting. These include campaigns funded within Victoria, such as the advertising campaign produced in the Gippsland Region, as well as national health promotion campaigns undertaken through the Commonwealth's investment in Indigenous chronic disease under Closing the Gap. The decision to mandate plain packaging for cigarettes may also have had an influence on the perception of smoking among Aboriginal people.

In the Grampians region, the ACCOs have all initiated smoking cessation programs. Ballarat and District Aboriginal Cooperative (BADAC) initiated a "Ditch the Dhurries" program to assist people to stop smoking. This was accompanied by a smoke-free policy within the ACCO, and the incorporation of smoking cessation messages into other programs such as mother and child groups. BADAC's practice nurses and chronic disease nurse continue to provide smoking cessation support to individuals. Goolum Goolum ACCO has also initiated a smoke-free policy and includes smoking cessation messages in its health promotion material. Budja Budja has done the same, and has sponsored 'no tobacco' days at the ACCO which were attended by community members. All ACCOs are providing NRT patches for service users who are trying to quit smoking.

3.2 PRIMARY HEALTH CARE SERVICES THAT CAN DELIVER

ACHIEVEMENTS:

- Increased capacity for health service delivery within ACCOs
- Increased engagement of ACCOs in regional health service planning and delivery
- Increased access to primary care through outreach services at gathering places
- Increase collaboration and workforce sharing across universal and Aboriginal community-controlled services.

CtHG is widely credited with increasing the level of engagement of ACCOs with universal health services, and increasing ACCOs' capacity to deliver health services.

The big lesson within CtHG was the building of relationships. There's better cultural awareness and understanding. We also thought we didn't have many Aboriginal people in our region but when you look at the figures it's actually above the state average as a percentage of the population – that brings it home and makes it more real. (PCP representative)

In addition, the greater focus on health promotion and engagement with the community has reported improved general health literacy among Aboriginal people, with a corresponding increase in health lifestyle changes, and better self-management.

Creating awareness among Aboriginal people themselves in terms of health, for example health check. It's shifted the focus to health and life expectancy. People are very motivated. (ACCO representative)

At the same time, a number of challenges remain. While the levels of health literacy may have improved, the extent to which this has translated to changed behaviour and improved health statistics is unclear. Respondents noted that behaviour changes take time, and are influenced by a number of other factors.

It's mixed. Looking across a plain of service delivery, there are some fertile spaces but mostly it's an arid plain. Particularly with men, and with the social determinants. Drugs and alcohol and violence are really diminishing the community. Men are drinking a lot. The fertile group: men need to gain a sense of worth, feel valued, they are not connected, they live in the shadowland, don't feel productive. The ability to be concerned about chronic disease is limited by the lack of connection to the community. It's difficult for men to get their health checked. The [ACCO] men's group is good. In the last round of CtHG funding they had some money left over and people agreed to support the local men's group. Men will come and help with practical things so that's a way of getting them involved. (hospital representative)

A number of regions sought to address chronic disease prevention and health promotion through educational opportunities including social marketing and community engagement strategies. Examples of this included Aboriginal health days such as Mallee District Aboriginal Services (formerly the Mildura Aboriginal Corporation) Aboriginal Health Day, which became a community gathering with games, health promotion booths, promotional material, and healthy food. The West Gippsland Community Health Service engaged with Ramahyuck District Aboriginal Corporation to hold an Aboriginal health event, including a sponsored walk through the town in which both Aboriginal and non-Aboriginal people participated. This long walk ended with a barbeque at the park with games and T-shirts and promotional materials, as well as healthy bush-tucker. EACH, a community health service in eastern metropolitan area held a men's health check day as a way of demonstrating commitment and relevance of the service to men.

We went to the leaders of the community. We presented them with the data, so we said 'here is the data here is the information' and then we asked them 'what do you think?' and what they said is 'we want a life-cycle approach, we want to engage with people on social determinants. You need to engage them and help them'. (regional director)

The Deliver Active and Healthy Lifestyle program was conceptualised, and is being delivered by, the Njernda Aboriginal Corporation. The program aims to reduce the rate of obesity and preventable hospitalisations among the local Aboriginal population.

The need for an Aboriginal gym was identified by community members who felt concerned that Aboriginal people were not accessing the gym in town because they did not feel comfortable and they could not afford it. A decision was made to establish an Aboriginal gym with no membership fees to encourage Aboriginal people in the Echuca area to exercise and improve their health outcomes.

The building was funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) and the equipment and training resourced through CTHG funding. The existing building had been under-utilised for some years, and community members felt that having well-funded structured programs and activities in the community would help to generate a sense of ownership of the building.

The gym was officially opened in 2012 and is situated at Baroona, a property owned by Njernda. Also on site is the Baroona Youth Healing Centre, an alcohol and substance abuse rehabilitation centre for young Aboriginal people.

In preparation for the gym to open, six local community members completed a Certificate III (Gym Instruction) in 2011, and went on to complete their Certificate IV, to become personal trainers. In 2012, a further three community members undertook the Certificate III (Gym Instruction) and three more started a Certificate IV (Personal Training). With three full-time staff the gym is open every week day.

The investment in the trainers and in the staff who are running the gym has potentially opened future employment pathways, and is likely to provide additional economic benefit to the individual and their family, beyond the health-orientated objectives of the gym.

There are over 100 members, and in excess of 150 people using the gym regularly, ranging in ages from 15-16 years to Elders. Early-joiners have promoted the gym, and encouraged others, including Elders, to become involved.

A range of activities and programs are contributing to the overall outcomes of the Deliver Active and Healthy Lifestyle program. The locally employed qualified instructors work with local community members of all ages to improve levels of physical fitness.

The gym's operating timetable and range of programs was developed in consultation with the community; and was also designed ensure access for different groups. The breadth of programs aims to engage everyone from young

children with high body mass indexes, to elderly people with chronic illnesses, such as diabetes.

The establishment of the gym and its associated programs, such as the ten-week weight loss challenge, has led to members of the local community becoming engaged in health-promoting activity. While specific health outcomes associated with participation have not yet been evaluated, the gym appears to have engaged community members in fitness and related programs, which may reasonably be thought to contribute to reducing risk factors in individuals if activity is sustained.

Ancillary benefits include the training and employment opportunity provided to community members who have completed training associated with instructing and training at the gym. This may ultimately increase the future employability of these individuals and may also open alternative career pathways in the fitness industry.

The co-location of the gym on the grounds of the Baroona Healing Program also means the gym offers value to young people involved in that residential program and may potentially contribute to the Healing Program's outcomes.

Many members of the community had never done any exercise (outside of walking) before the establishment of the gym. Since joining the gym people reported that they were developing muscle strength and were able to lift more weights. Other community members reported that attending the gym had helped them to lose weight and overcome injuries. Community members reported that the gym provided positive benefits to the young men in the community by helping to build their self-esteem and confidence. Attendance by young men was consistent and they appeared to enjoy the opportunity to work out with their friends.

3.3 FIXING THE GAPS AND IMPROVING THE PATIENT JOURNEY

ACHIEVEMENTS:

- Increase in number of partnerships and MoUs between ACCHOs and universal health services
- Increased levels of formal collaboration between universal and Aboriginal community-controlled services
- Increased access to spectacles through spectacle subsidy
- Increased reporting of Aboriginal identification
- Decreasing rates of Aboriginal people leaving hospital without treatment or against medical advice
- Greater number of integrated pathways to make it easier for Aboriginal people to access services
- Increase in number of services with Aboriginal employment plans, and increase in Aboriginal employment in health services across the state

3.3.1 GOVERNANCE AND WORKFORCE

The Statement of Intent signed by the Premier of Victoria in 2009 has reportedly had a significant impact on raising the awareness of cultural safety and the provision of services which are welcoming to Aboriginal people across the state. A number of hospital and health service CEOs have also signed the Statement, and many have displayed this statement publicly in their facilities.

It's changed a lot, although not as much as I would have hoped. I don't think people are aware of the complexity. The number of health services and hospitals... it's the sheer volume of organisation and staff in terms of introducing change (regional director)

A number of CtHG funded initiatives have had a focus on improving workforce capacity and governance arrangements in and around Aboriginal Health. This includes initiatives undertaken by universal health services as well as those undertaken within Aboriginal community controlled health organisations. The state-wide workforce initiative to increase Aboriginal employment within health services has had a significant influence in catalysing universal health services to increase their employment of Aboriginal people. This has included several successful initiatives to introduce Aboriginal specific traineeships in a variety of health related positions.

Our employment project has been the most significant activity for us. We have had 4 trainees, 1 completed early on and she's a gem, two are due to complete, and 1 dropped, but we think 3 out of 4 is a good result. We learned a lot through that process, we hadn't known how much would be required to make it successful. We are now absolutely committed to making it work. (hospital representative)

Governance arrangements have varied across the regions and have ranged from centralised collaborative advisory committees including senior members of both universal and Aboriginal community-controlled agencies; advisory groups consisting of senior leaders of Aboriginal community-controlled health services; and sub-regional level committees which include both universal and local Aboriginal community-controlled groups who report to a regional close the gap committee.

The effectiveness of governance arrangements across the regions has also varied. This has been influenced by the quality of communications and relationship between participating health services, as well as the style of leadership within the regional office, ACCHOs and other health services. Many examples have been reported where relationships have improved or have been developed as a result of the structures set up under CtHG, for instance in areas where local community health services have begun to collaborate with local Aboriginal community-controlled health services, or where local Aboriginal community groups have come together and built on existing relationships to create new opportunities to work together.

In many regions, relationships between universal and Aboriginal community-controlled services had been developing over many years. At a very basic level, CtHG has provided an 'authorising environment' for dialogue across services: The extent to which this becomes embedded in formal partnerships and integrated clinical pathways is an indication of the improved accessibility of services for Aboriginal people. As an example, recently when an Aboriginal patient was discharged from hospital with a prescription they could not afford to fill, the hospital and the ACCO CEOs agreed a mechanism for ensuring that the prescription was available to the patient.

The key message from the Aboriginal health conference is that we need to talk to people at the same level, from CEO to CEO. Before we were talking to the Aboriginal people, for instance I'd talk to the AHLO, but they don't have the authority. The Statement of Intent has put the message out there – put the focus on senior leadership rather than dealing with the AHLOs. I think it's the same with the other Aboriginal organisations, we have seen [ourselves] as the Aboriginal sector, and have worked very hard but could have stifled what we have done and ended up doing band-aid health. Now we are focussing more on wrap-around services. (ACCO representative)

Overall, it can be said that CtHG funding has enabled the strengthening of a network of relationships and collaborations that have led both to increased workforce capacity through training and employment, and to increased levels of collaboration between universal and Aboriginal community-controlled health services. It is notable as well that CtHG has engaged ACCOs in regional health service planning, decision making, and governance in a way which has not occurred before. It is anticipated that this strengthened network will be critical for the successful implementation of Koolin Balit.

Many formal MoUs and service agreements have been signed between universal and Aboriginal community-controlled services across the state, as reported in Table 2 above. These are most often the formalisation of relationships which have taken many years to develop, a process which may have begun well before the CtHG funding was released. Stakeholders have noted that the cumulative effect of CtHG, the Statement of Intent, the Statement of Priorities, the Aboriginal Inclusion Action Plans, and the VIAF (now VAAF) has been to create structural drivers for improving systems and processes within health services, as well as to improve communication and collaboration between universal and Aboriginal community-controlled services.

Critical success factors for productive partnerships have been identified as trust and respect, senior executive commitment from both ACCOs and universal health services, willingness to listen, patience, and open dialogue:

...overall the key element in [engaging] with Aboriginal Communities is to: LISTEN, TAKE TIME and BUILD RELATIONSHIPS and TRUST! (ACCO representative – emphasis original).

Closing the Health Gap and the Karreeta Yirramboi Victorian Aboriginal Public Sector Employment and Career Development Action Plan 2010-2015 are key drivers to increase Aboriginal employment in Victorian public health services. At the state level the department initiated a project to develop Aboriginal employment plans in Victorian public health services (32 in total) and secured funding for the work through the former Commonwealth Department of Employment, Education and Workplace Relations.

3.3.2 THE PATIENT JOURNEY

Improving the patient journey and particularly the access of Aboriginal Victorians to mainstream hospital services has been a focus of a number of projects. These include the maternity services project at Echuca in the LMR; the Aboriginal health transition officers at Goulburn Valley Health, North East Health, Albury Wodonga Health and Seymour Health, as part of the 'Client Journey' project in Hume Region; and the Improving Pathways to Hospital Care project in the North and West Region. The key element in projects such as the LMR and Hume initiatives appears to be the designation of a staff member to actively follow up a client or to meet with them at transition points to ensure that clients don't fall through the cracks and instead make it to the most appropriate service for treatment. The need for a dedicated individual to assist people to move through the health system has been noted by many people and more services are reportedly employing Aboriginal Hospital Liaison Officers (AHLOs), or bringing services out of the hospital into an ACCO, in order to make it easier for people to access care.

Funding to support clinical engagement projects was provided to health services to work with clinicians in developing strategies and clinical pathways to increase access to services for Aboriginal Victorians. Two examples of these are profiled below.

- An example of an evaluated project in the Southern Region was the 'Reaching Out Project', which aimed to provide intensive support to assist families to meet their healthcare needs. Children discharged from Southern Health would be provided with a documented personal plan, a health diary, information about resources and referrals to relevant ACCOs. Southern Health appointed two paediatric nurses to lead this project, one of whom was Aboriginal. Patient contacts (n=197) were monitored, and it was noted that as families began to trust the service there was a steady increase in the amount of support needs which were identified. These included transport, family support, referrals to other health services, and information. Southern Health worked closely with Bunurong Aboriginal Community Health, VACCA, the Medicare Locals, other ACCOs, and other children's health services in assisting families to access the services they needed. The project included a survey of nursing staff regarding their knowledge of Aboriginal culture. Educational sessions were planned for the future, and a clinical guideline implementation tool was developed for staff to use daily in monitoring a child's needs. The clinical guideline was reviewed by Bunurong as well as with Aboriginal families using the service before being finalised.
- The Aboriginal Cancer Care at Peter Mac (ACCAP) Project aimed to create a culturally appropriate cancer care pathway for Aboriginal people living with cancer, including effective links with community services. Project staff and a management committee were appointed, and the project began with a demographic analysis, and consultation with Aboriginal community groups and organisations. As with other health services, an early achievement of the project was the increase in visual cues acknowledging Aboriginal people and culture, with the Aboriginal and Torres Strait Islander flags raised in March 2012, and artwork commissioned from a Yorta Yorta artist, Vera Cooper. A resource guide was produced for staff, and project information was disseminated across the sector. As a result of the project, funding was secured for the appointment of an ongoing Aboriginal Health Engagement and Development Officer to develop organisational capacity to deliver services to Aboriginal patients and to build relationships with other Aboriginal health and community services. Models for integrating services have been developed, an Aboriginal health annual plan has been formed, and Peter Mac has set a goal to achieve the 1% employment target by 2015.

Other state-wide projects, such as the Quitline Program, noted in section 3.1, have demonstrated success in providing increased availability of support for Aboriginal people seeking to quit smoking. The Victorian Aboriginal Spectacles Subsidy Scheme (VASSS) have demonstrated that they are meeting a significant unmet need in the community, with VASSS providing over 4000 pairs of spectacles across Victoria by June 2013, far exceeding the original aim of the program, which was to provide 1800 visual aids in metropolitan Melbourne over three years (the program's early success led it to be extended across the entire state). The scheme also aims to achieve broader outcomes including increasing Aboriginal

uptake of primary eye care, identify vision-threatening eye disease, improve referrals, involve communities in eye health planning and increase awareness of eye health risks.

The Dhauwurd- Wurrung Elderly and Community Health Service Inc (DWECH) and Portland District Health (PDH) have through a formal partnership sought to deliver the Dhauwurd Wurrung's 'Delivering Deadly Services' in the Barwon South West region.

The aim of the DWECH- PDH partnership is to improve the health outcomes and experience for Aboriginal people in a manner that 'respects the reasonable wishes of the local Aboriginal community and acknowledges the history of inequality in health and inequity in health service access of the Aboriginal community'.

The partnership is underpinned by a formal MoU that was signed in September 2011. The partnership between DWECH and PDH underpins the success of the program

In 2009, Ochre Health was commissioned by OATSIH to undertake a review of clinical services at DWECH in Portland. Feedback from community members interviewed by Ochre Health found that very few Aboriginal people access Portland District Health due to poor impressions of the service, including that Aboriginal people may not receive the level of care they should. Local communities and Aboriginal health workers were also engaged and surveyed to understand access issues, aspirations and core principles of culturally relevant service delivery.

The research identified issues of service access between the Aboriginal community and the universal health services due to the absence of an AHLO or ICAP officer at PDH. The partnership between PDH and DWECH was formed because both organisations recognised that addressing the challenges requires a positive and collaborative working relationship to achieve the best care and health outcomes for Aboriginal people.

As a result of the partnership between the two organisations an Aboriginal Health Liason Officer position was established at PDH and cultural awareness training was developed and provided to workers in mainstream agencies across the area as well as for primary health care agencies in the area.

As a result of the CtHG investment, DWECH have six staff trained to provide the AHLO role, and further funding has been used to support 17 new Aboriginal students into clinical placements in PDH. This is the only program of its type in Victoria, and it has a target of reaching 450 clinical days for the students. To ensure that students feel culturally safe while on placement, DWECH is taking the lead and have established a specific training room and a class room for the students.

A cultural awareness program has been developed and delivered for new staff at PDH, including two modules: module 1 which includes a focus on self-identification training and module 2 which includes best practice self identification training

The 'Delivering Deadly Services' program has brought about a number of significant benefits for the community in Portland and the surrounding area. It has been reported that health service staff are more culturally aware and Aboriginal clients in Portland have reflected that their training has contributed to improved services in the hospital.

The CtHG investment funded the AHLO position, which has led to an increase in the presence of Aboriginal staff within the health organisations. From the perspective of the staff at DWECH, having more community members involved with mainstream workers and services is helping to build the bridges. Community members have also noted that changes to health services have made it easier for Aboriginal people to access a range of services. Communication between the health services has also led to easier pathways for Aboriginal clients. For example, one respondent noted that staff will ring ahead to other health practices to notify them that a client is coming, which meant when the client arrived everything was already set up for them and they did not need to repeat their story. The improved relationship between health staff and Aboriginal clients also facilitated easier access to services.

There is a perception amongst the Aboriginal clients interviewed that they have better access to mainstream organisations and health services in Portland and Heywood, with a better level of knowledge about service options held by mainstream service staff.

The Aboriginal Health Workforce Plan has provided an important catalyst for health services to increase the number of Aboriginal people employed within the health sector. One of the clinical engagement projects, undertaken by Dental Health Services Victoria (DHSV), has recruited six Aboriginal trainees, with four more identified to begin in 2013 and 2014. All trainees will become fully qualified dental assistants, with most seeking to continue to further study. DHSV has exceeded the Karreeta Yirramboi employment target, reaching 1.9% Aboriginal employment, and is completing an Aboriginal Employment Plan. Notably, DHSV has reported that the number of clients using their service has increased by 30% in 2012/2013, with a continual increase in client numbers in Melbourne and across Victoria since 2008. Whether this is due to increased identification, or increased number of service users, is unclear; however,

it is possible that the increase may be due to an increased focus on the visibility of Aboriginal people and culture within the DHSV, leading to an increasing number of service users who feel comfortable using the services, and identifying themselves as Aboriginal.

We did have the ED departures project and we saw a signification reduction in the numbers who left ED early, although it is hard to tell whether it was a result of CtHG. At the same time, we have developed better processes as a result of CtHG regarding tracking and communicating with people in ED so that is a direct result. We are using the Aboriginal HLO to communicate with people about other projects around the community. So they are not our projects but she is talking to inpatients about what is available in the community and what other services are doing. That's one way of sharing and spreading the information.
(hospital representative)

The 2013 update of the baseline data for CtHG in Victoria indicates continued change in regard to the rate of people leaving hospital emergency departments without treatment, which decreased by 1.9 per cent from 2009, and the rate of discharge against medical advice, which has decreased from 1.7/1000 to 1.4/1000. While it is difficult to know exactly why these figures are decreasing, it may be that Aboriginal people are experiencing greater support and assistance within the hospital environment.

In the hospital we have had an increase in Aboriginal inpatients, which might suggest that people are more comfortable being in hospital, and are less likely to think that it's a place to come to die. Fewer people are leaving ED early. (hospital representative)

The Aboriginal Employment in Universal Health Services initiative in Gippsland is part of a strategy to increase the participation of Aboriginal people in the health workforce. The CtHG funding built on existing commitments from the state and local government, and local hospitals to increase Aboriginal employment in universal health services. Hospitals and health centres in the Gippsland region committed to recruiting and retaining Aboriginal employees as part of meeting the objective of ensuring the full participation of Aboriginal peoples and their representative bodies in all aspects of addressing their health.

The specific aim of the CtHG Gippsland strategy is to reach 1% Aboriginal employment in health services, consistent with the Victorian Government's Aboriginal Employment Strategy (Karreeta Yirramboi), which has a target of 1% Aboriginal employment in the Victorian public sector by 2015.

All health services have established mechanisms to capture Indigenous status on personnel files to enable data collection for the annual surveys. It is important to note that it is not mandatory for services to ask for an applicant's Aboriginality in the recruitment and selection of staff.

Central Gippsland Health Service as part of this project, applied for funding in order to employ five trainees in allied health. They also received employee incentive funding from Commonwealth and State government programs designed to build the Aboriginal workforce

The first intake of Aboriginal Allied Health Assistant Training (AAHAT) commenced in 2011. The traineeships are delivered over an 18 month period with the trainees rotating through a number of allied health disciplines during this period. The trainees complete eight hours of formal online study each week provided through the Australian Institute of Flexible Learning (AIFL) in addition to their placements.

Upon completion, the trainees will receive a Certificate IV in Allied Health Assistance. The first round of trainees completed in January 2013 and the second in April 2013. Two of the trainees secured permanent work at CGHS following completion of the training.

A number of partnerships and agreements are in place (or are being established) which support the traineeship program. The Gippsland Closing the Health Gap Advisory Committee is responsible for developing and monitoring the performance of the Gippsland Indigenous Employment in Health Network or for appointing an auspice agency for the Network, which is intended to link with the traineeship program.

While some trainees reported getting off to a slow start and being out of practice with studying, the practical work, online learning and being able to draw on the assistance of people in the health service were found to be particularly useful and enjoyable. One trainee reported "it was hard to get into at first but once the practical work started it helped with the studies". Other challenges for the trainees included getting used to the more formal language and not being able to tell family members about other family and friends that were in the hospital.

It was reported that the traineeship had helped to build a sense of pride and helped to make trainees feel valued by other staff. For example, one trainee said "I feel proud when my daughter asks me what I have done at work... I want

to be a role model for my children". While another trainee said "I have learnt that I am stronger than I thought, emotionally stronger. Being in work has helped". Another benefit was that trainees were beginning to change their attitude towards their own health including increased nutrition and exercise, as well as improved sleep habits. Statements from trainees included "I have started to eat breakfast every morning and trying to do exercise at least once a week".

3.4 HEALTHY TRANSITION TO ADULTHOOD

ACHIEVEMENTS:

- A heightened focus on targeted health programs for young people
- Increased health literacy among young people, including nutrition and substance use
- Improved maternal and child care through better antenatal pathways

The healthy lifestyle initiative was very good. We have seen the results of people taking better care. (ACCO representative)

Previous observations about progress under this priority included the strong emphasis on health promotion and health screening for young people, and a particular focus on young women's health in some regions. Healthy living messages have been incorporated into multiple health promotion strategies, and young people continue to be central to these messages.

Young people are clearly on the agenda of ACCOs and CtHG committees across the state. A number of consultation respondents have identified that addressing the needs of Aboriginal children and young people is the key to closing the health gap. While assisting older people with their existing health needs may improve their health and wellbeing, ensuring that health promotion and illness prevention strategies are directed at children means that the next generation will live longer and healthier lives.

The priority placed on young people is also evident in the quantum of activity designed to engage young people in health issues, from health promotion and education on issues such as smoking and sexual health, health checks and general activity oriented to wellbeing. It can reasonably be expected that this activity will impact on at least some of those who participate, but it is only sustainable with continued funding. Additionally, the rationale for the selection of activity is often unspecified; for example, there is a great deal of health promotion activity underway, but little reference to planned strategies of activity or evaluation of the impact of the activity against objectives (if objectives are in place). Project activity of this nature is unlikely to have a positive long-term impact; and there is little evidence of systemic change in this domain, suggesting that all activity will cease with the end of CtHG funding.

Investment in additional service delivery positions in some regions is increasing access to services and there is some training that targets mainstream services in order to enhance the capability of staff to engage with young people. In addition to the ongoing health promotion activity, strategies designed to engage young people in decision-making and leadership roles is also evident. This is an area where evaluation is particularly important, as population data is unlikely to show an evident impact as a result of CtHG.

The 2012 update of the baseline indicators for CtHG in Victoria could suggest both that more young people are accessing treatment, and that lifestyle messages may be having an impact. The following data related to adolescents offers some examples of changes in service utilisation, although the reason for the changes is not clear from the data.

- The rate of hospitalisations for circulatory disease for adolescents has increased substantially, from 2.3/1000 to 4.8/1000, so that now more Aboriginal adolescents are being hospitalised than non-Aboriginal adolescents. In the absence of any identified widespread population-level cause, it is reasonable to assume that this is because more young people are being assessed and receiving treatment than before.

- The rate of notified cases of sexually transmissible infections for adolescents has increased from 4.5/1000 to 7.7/1000, while the rate for non-Aboriginal adolescents increased from 2.4/1000 to 3.4/1000. This is likely to result from greater identification of Aboriginality and from increased access to health services; however, due to the small numbers no conclusions can be reached from this change.

The 2013 update of baseline data indicates that the rate of alcohol treatments for adolescents has decreased by 16.3/1000 from 39.5 to 23.2/1000 over the four-year period from 2008/09 to 2012/13. It is not clear whether this decrease is because fewer people are seeking treatment or fewer people are requiring treatment. The gap in rates of Aboriginal and non-Aboriginal people seeking treatment has decreased from 36.5 to 20.5/1000.

While positive, these figures must be interpreted with caution and the extent to which they can be attributed to funded CtHG activities is unknown.

The expansion of the Student Health and Wellbeing Program at Worawa College in the EMR is a positive example of a modest investment to expand an existing service. Girls from around Victoria and Australia board at the College and, through the expanded nurse hours, are receiving an enhanced health service, addressing immediate needs as well as taking a preventative health focus. A further investment is planned in the coming year that will contribute to a full-time psychologist position at the College, which will address the mental health needs of the students. The position will complement the mental health first aid training undertaken by teachers and house parents. Worawa is reported to have capacity to continue the expanded model of service delivery after the CtHG funding is finalised.

Another EMR investment in expanding access crosses over into enhancing capability, with the funding of the Senior Aboriginal Youth Mental Health (Spiritual Wellbeing) Clinical Advisor. The high value of this investment continues to be reported, with ongoing positive engagement in both direct clinical work as well as strengthening the cultural competence of mental health, and alcohol and drug services. The role of the advisor is also viewed as valuable in terms of building crucial links between mainstream services and community.

The social and emotional wellbeing of young people in Robinvale is an identified priority and this has resulted in an investment in a number of activities such as re-establishing the Murray Valley Aboriginal Cooperative (MVAC) Board Youth Sub-Committee, involving young people in healthy lifestyle promotion and the development of a Festival for Healthy Living, which includes using arts and other media to deliver health messages. MVAC is also working on establishing the business case for a new gymnasium in partnership with a mainstream provider.

In the Hume Region, the Young Women's Health Project aims to address a number of priorities that focus on increasing access to sexual health and maternity health services; smoking cessation; and engagement in playgroup and parenting programs by young mothers. This strategy is supported by a Partnership Manager and a working party; however, because the appointed project officer has resigned, the work has been delayed. This is a factor commonly reported to be slowing progress of strategies.

In the Grampians Region, investment has been in the development of youth strategies by each ACCO, with BADAC in particular taking a focus on developing leadership skills in the context of cultural identity and strengthening self-esteem. In the LMR, ACCOs have been funded to expand their engagement with young people and are taking a range of approaches, including involvement of young people in planning for Swan Hill Aboriginal Service programs and services; establishing a youth sub-committee of the Murray Valley Aboriginal Cooperative Board; developing a calendar of events led by the youth leadership group at Mildura Aboriginal Cooperative; and holding a series of workshops that have been developed and delivered through Njernda.

Through the funding provided to the City of Greater Dandenong in the SMR, a steering committee will identify opportunities for young people to be involved in committees and other decision-making groups, and Elders engaged to support young people seeking these opportunities. Similarly in the EMR and SMR there is investment in building networks that are relevant to young people and that draw in Elders at the same time as engaging and consulting with young people.

A significant investment in the SMR covers a range of activities targeting young people, including health promotion initiatives, for example the Health Expo and Art Show. Similarly in Gippsland, significant funds

have been invested in a number of strategies concerned with healthy lifestyle changes, including nutritious food consumption, good oral hygiene, increased participation in healthy activity and delaying initiation of alcohol consumption. The extent to which the various strategies and the delivery is evidence-based is not reported. On the whole they are described as being delivered through community development activities that incorporate healthy lifestyle messages. The measures of success that will be used in any evaluation are not reported.

CtHG funds have also contributed to a broader social and emotional wellbeing strategy in Robinvale, which sees the Festival for Healthy Living model being rolled out in collaboration with all the key partners in the area.

Health promotion activity by all five ACCOs in the BSW will utilise the Deadly Choices Clips developed in partnership with the Geelong Cats Football Club. These and other social marketing tools have been developed to support smoking cessation strategies and promote preventative messaging around the protective factors of Aboriginal chronic disease such as oral health promotion, nutrition, physical activity and connection to culture.

Early funding was sought in Eastern region for an idea that had been mooted for several years previously, to create a Healesville Belonging Place. The theory was that creating a culturally safe place for the local Aboriginal community would bring people together for social and cultural activities, which could also provide an opportunity to provide health education and services within a central, culturally acceptable place. Funding of \$197,000 over three years was provided from CtHG.

The Belonging Place was originally designed to address the fourth CtHG priority 'Healthy Transition to Adulthood', but has become a place for all people, where Aboriginal community members can gather, seek assistance with a range of social and health issues, and find support and acceptance. The Belonging Place also seeks to work with non-Indigenous services to improve the cultural responsiveness in health service delivery, and to address risk factors that affect young people's health care.

Consultations with the local community suggest that the Belonging Place has ultimately been broadly successful in achieving these goals. Community members speak very positively about the Healesville Belonging Place and the impact that it has had on their lives. It is reported that the Belonging Place has helped people to make healthy lifestyle choices; has helped young people to learn about positive behaviour, gain life skills, and receive emotional and practical support; and has provided the Aboriginal community with a place where they can meet and feel culturally safe and strong. Those consulted for this evaluation consider that these benefits would not have been available to the community without CtHG funding.

It is reasonable to conclude that the CtHG investment into a culturally safe gathering place has contributed to increased social and emotional wellbeing for the Aboriginal community in Healesville, as well as increasing access to health promotion and lifestyle information, support for making healthy life choices, and information about health services.

3.5 MAKING INDIGENOUS HEALTH EVERYONE'S BUSINESS

ACHIEVEMENTS:

- Embedding Aboriginal health within health service commitments, through Statement of Intent, Statement of Priorities, Aboriginal Inclusion Plans and Reconciliation Action Plans
- Increased commitment to Aboriginal health at senior executive levels within universal services
- Increasing Aboriginal employment in mainstream public health services
- Investing in cultural competence training for staff of universal health services

CtHG is acknowledged by stakeholders across regions to have been the catalyst for important changes in health service delivery and health system planning.

The major change has also been in the mainstream health services; we've done a lot of work with Board chairs and CEOs at that level to talk to them about Aboriginal health. Examples – every health service has the flag, art work, and the number of people identifying as Aboriginal has increased in some places 100s of percent. They've done

cultural awareness and safety training in many many organisations, and many have signed the Statement of Intent. (regional director)

The biggest thing is that it's engaged mainstream with Aboriginal health. It's made us come together and make it everyone's business. (health service representative)

Probably the most visible impact of CtHG funding has been evident through visual changes in universal health services. As noted in previous evaluation reports, some of the first forms of engagement with local Aboriginal communities were flying the Aboriginal flag and adding Aboriginal artwork to the hospital environment. These actions reinforce the need to make universal health services welcoming and accessible for Aboriginal people.

Other visual cues to create a welcoming environment have included the provision of separate meeting rooms where Aboriginal families can meet together with a family member who is in hospital or can wait while a family member is receiving treatment; staff wearing name badges; the provision of pamphlets and brochures that are tailored for the Aboriginal audience; the employment of Aboriginal hospital liaison officers; and reception staff and frontline staff who are trained to welcome Aboriginal clients when they enter the door.

In many universal health services the employment of an Aboriginal health liaison officer or the expansion of an existing liaison officer role to include additional positions or traineeships has improved health services' capacity to assist Aboriginal people to navigate the health system. Under the state-wide Aboriginal health workforce project, other Aboriginal identified traineeship or training positions have been identified in a number of health services with the aim of increasing Aboriginal employment. Within the Department of Health, the target was set at 1.5% by 2013², and was reported by the Department to be 1.4% by 31 December 2013. It was reported to the evaluators that a number of health services had already exceeded this target. Overall, the Aboriginal health workforce was reported to be at 1.3% by June 2013, an increase from the 0.9% reported in 2009³.

The need for cultural education within universal health services has been recognised and all universal health services within the state have engaged with some form of cultural education training for staff. This is a substantial commitment for organisations that may have several thousand staff, and senior leaders have acknowledged that it will take time for a high level of cultural competence to be fully embedded within the organisation. However, as more staff are trained and the general culture of the system becomes more accepting and welcoming of Aboriginal people, it is expected that overall levels of cultural competence within organisations will improve. This is being monitored and measured through such activities as the cultural competence audit undertaken by Hume region. This audit is a facilitated process of assessing whether an organisation meets high standards of cultural competence, using a checklist of attributes and behaviours which are considered to demonstrate cultural competence within a health organisation.

It has been reported by Aboriginal community members and Aboriginal community organisations that the significant change in cultural safety has come about due to changes within universal health systems. A number of factors are considered to contribute to this change including:

- the signing of the state-wide Statement of Intent by the Premier of Victoria and subsequently by health service CEOs
- the visibility of Aboriginal health in hospital service performance indicators through, for instance, the Statement of Priorities
- investment in the development of opportunities for relationship building between ACCOs and universal services

² Department of Health (2011) Strategic directions on Aboriginal health: targeted issues. Available at: <http://www.health.vic.gov.au/search.htm?q=Aboriginal+workforce+target>

³ Department of Health (2013) SSA Workforce Data Collection, Indigenous Data Collection.

- the growing sense of genuine desire for active engagement across Aboriginal community controlled and universal health services.

It's changed a lot although not as much as I would have hoped. I don't think people are aware of the complexity. The number of health services and hospitals... it's the sheer volume of organisation and staff in terms of introducing change. (regional director)

The Improving Pathways to Hospital Care (IPHC) project was designed to improve the client journey between hospital and primary care services. The project assisted Northern Health (NH) and Western Health (WH) in the NWMR to implement an 'evidence based, culturally appropriate Aboriginal and Torres Strait Islander Continuous Quality Improvement (CQI) framework for acute health services'. The framework and the Aboriginal and Torres Strait Islander Quality Improvement Toolkit for Hospital Staff (AQITHS) supports health services to make improvements in Aboriginal health care, and endeavours to reinforce 'the Aboriginal voice at all stages of the CQI process'.

This project was piloted in St Vincent's Hospital and later established in two other hospitals in the region – the Austin and Royal Melbourne Hospitals. 300,000 was provided to this project for development and implementation, including the establishment of the project in two additional hospitals.

For the WH IPHC project, a proposal was developed for Aboriginal health governance and support structures within the hospital. The proposal includes an advisory committee made up of hospital executives and senior personnel and Aboriginal community members, an Aboriginal CQI working group (time limited) and AHLO Reference and Support Group (ongoing). All were to include a mix of internal and external hospital and Aboriginal community representatives, with a priority being to build organisational accountability.

A local resource kit focused on Aboriginal Health was developed by the AHLO at WH working with one of the project team members and an event planned for its launch.

At NH, one quality improvement initiative emerging from the IPHC approach has focused on reducing barriers and stressors associated with hospital attendance. Aboriginal patient attending hospital for their treatment receive assistance with travel, accommodation, meals, car parking, and medication costs to minimise stressors associated with hospital treatment. A second strategy includes improving access to medication and equipment at the point of discharge to improve continuity of care for patients who receive care from the Emergency Department.

Significant outcomes evident from this investment include an improvement in the profile of Aboriginal staff and their roles in the health services, and in the awareness and understanding of Aboriginal health care issues across health stakeholder groups. Importantly, these two outcomes have influenced attitudinal changes in the health care system, contributing to achievement the overall aim of the investment - to improve the systematic care of the client in their journey between hospitals and primary care services.

The IPHC project appears to have supported improvement in the profile of Aboriginal health at NH and WH, and has improved staff engagement at multiple levels. A specific focus of the project has been on embedding the notion that Aboriginal health is everyone's responsibility – to this end the projects have been able to engage a range of stakeholders outside of the AHLO programs areas including general hospital staff, quality departments and senior management.

4 Discussion

4.1 CONTRIBUTION OF THE CLOSING THE HEALTH GAPS INVESTMENT TO OUTCOMES

Lemire (2010:10) suggests that in many evaluations where there are challenges in attribution, *practical generalizability* can be considered to be a form of external validity. He defines *practical generalizability* as “the extent to which inferences and conclusions can support the local implementation of the program for other subjects, other times and other places or other settings.” Validity in this qualitative paradigm acknowledges that statistical generalizability is not possible where there are multiple influences contributing to an acknowledged outcome. In this instance, the use of contribution analysis can be helpful to provide a ‘plausible association’ (Mayne, 1999) linking input to outcome.

Applying *practical generalizability* to CtHG, the evaluation provides evidence that changes to the health system and to the access, availability and quality of services for Aboriginal people have been influenced by factors which can be attributed to the CtHG investment, and are potentially replicable in future program and service planning. These factors have been named repeatedly in previous evaluation reports and in previous chapters of this report, and include the following:

- Strong commitment from senior leadership in both universal and Aboriginal community-controlled health services, which is communicated to all levels of the organisation
- Organisational partnerships and collaborations which bring together universal and Aboriginal community-controlled health services for the purpose of providing integrated and seamless pathways for Aboriginal service users
- Ownership and engagement from Aboriginal community leaders and members, including transparent consultation mechanisms.

Lemire (2010) cites Mayne (nd) in defining the criteria for attributing causal influence:

- **Plausibility** - Is the theory of change plausible?
- **Implementation according to plan** - Was the program implemented with high fidelity?
- **Evidentiary confirmation of key elements** - To what extent are the key elements of the theory of change informed by or based on existing evidence?
- **Identification and examination of other influencing factors** - To what extent have other influencing factors been identified and accounted for?
- **Disproof of alternative explanations** - To what extent has the most relevant alternative explanations been disproved?

Using these criteria, we can conclude the following with regard to Victoria’s investment in CtHG:

4.1.1 THE LOGIC OF CLOSING THE HEALTH GAPS WAS PLAUSIBLE

Closing the Gap in Health Outcomes in Victoria has been grounded in a theory of change which posited that changing the health system to become more responsive to the needs of Aboriginal Victorians would change the gap in morbidity and mortality between Aboriginal and non-Aboriginal people in the state. CtHG was structured in such a way as to provide drivers for change at a number of levels across the system: universal community and tertiary health services; Aboriginal community-controlled health organisations and other organisations; within the community through improvements to health literacy and awareness; and through workforce development and education.

I didn't think other governments were as clearly committed in their budgets to CtHG. It was very clear we needed the Victorian approach. All the evidence says you have to have local ownership; communities have to be engaged, setting the agenda, working out priorities and

how to address them. The literature is so compelling, and demonstrates time and again that's what works best. It doesn't work in isolation, it has to be informed by evidence of what's likely to work; then construct [the project] in such a way as to meet the needs of community. Like tobacco – it complemented the Commonwealth investment – everyone knows what interventions work, but it had to have local ownership and adoption. The Commonwealth do ads, but at same time work is taking place locally. There's a transformation taking place in people's attitudes in smoking. When we started the conversations people kind of laughed, but by part-way through people were taking it seriously. The Co-op introduced its Smoke Free policy, and they had to go through a process with their Board and community to get it accepted. Now people don't smoke in the grounds at all. There's local ownership. (regional director)

There is a plausible association, based on reports from stakeholders and community members, to draw a direct line between the CtHG investment and improved system changes, such as increased partnerships, improved access to health services, and increased number of Aboriginal staff within universal health services.

4.1.2 CLOSING THE HEALTH GAPS WAS IMPLEMENTED WITH FIDELITY

The framework for CtHG provided flexibility for innovation in implementation, and indeed one of its greatest risks was the level of decentralised decision-making and accountability. By and large, the Initiative was implemented with fidelity as intended, with a number of state-wide programs funded to operate across the population, and a greater number of projects funded through devolved funding allocated by regions in consultation with local services and communities. Quantification of outcomes would have been enhanced by stronger monitoring at individual project level. Nevertheless, there is a recognition in regional offices of the Department of Health for the need to implement Koolin Balit as part of a change agenda, rather than as a grants program.

The enablers have been seeing the opportunity from increased resources. It's been about building levels of trust and collaboration, moving deeper into relationship. There's been a continued message from the Department and others, highlighting the importance of collaboration. From day 1 we were saying- it's not just a cash grab – which had been the approach previously...the discussion has moved it along to how we work together. It's not just the resources but it's about the conversation about what we need to achieve. (regional director)

4.1.3 CLOSING THE HEALTH GAPS CONTRIBUTES TO THE EXISTING EVIDENCE FOR WHAT WORKS

CtHG, and the COAG NPA, are contributing to the evidence base regarding what is known about the population-level health status of Aboriginal Australians, what is known about what has or has not worked in the past, as well as a strong theoretical and philosophical commitment to collaboration and consultation with Aboriginal communities and leaders (AIHW/AIFS 2012).

The Closing the Gap Clearinghouse Annual Report 2013 notes that relatively few evaluations of Closing the Gap programs have been able to report on outcomes, with most focussing on output measures (AIHW/AIFS 2013). The evaluation of the CtHG has sought to identify substantive outcomes, while recognising that most reporting from services and regions focussed on outputs. This is an area where Koolin Balit could usefully learn from the experience of CtHG, and ensure that services and organisations are clear from the outset what outcomes are to be achieved, how these will be measured, and how they will be reported.

It's been quite hard and within [some services] there is still a mindset about funding and where it goes. I would like to think it's moving from a program to a systems level approach. I think it's the only way forward but it will take a couple of go's to get it right. How can we stop that wastage and bring services together. It's a paradigm shift to see how we can get the outcomes [rather than outputs]. (health service representative)

The program was developed with input from the community, it had ownership, and it achieved its objectives very well. If there's a problem within the community, the solution needs to come from within, and CtG has facilitated this. (ACCO representative)

Consultation with stakeholders in each region has underlined the importance of building relationships of trust and cooperation across the community controlled and government-funded sectors. It is evident that one of the key lessons for universal services has been to find ways of creating dialogue and trust with community controlled services that place the priority on communication and respect. This has required universal services to operate differently, not make assumptions, and to be willing to do things differently. ACCOs have also been required to set aside perceptions, which may have been based on previous experiences, and have also been required to be willing to engage in open-minded dialogue and cooperation.

The extent to which lessons have been recorded and shared could be improved in the future at a state-wide level. This could include a number of mechanisms such as bringing people together to share information (eg the Aboriginal Health Conference), publications, and less formal avenues for discussion through email and video conference. Communication mechanisms that have been reported to be helpful are some of the regional governance structures, where they have worked well, and the state-wide meetings, when they are held.

The lessons learned are about the importance of listening to the community. (ACCO representative)

4.1.4 CLOSING THE HEALTH GAPS WAS NOT ALONE IN INFLUENCING ABORIGINAL HEALTH

Nationally and within Victoria, a number of other government programs have provided investment into addressing the health needs of Aboriginal people. These have included investments made under the COAG National Indigenous Reform Agreement in health, education, employment, and early childhood. In particular, investments by the Commonwealth Department of Health under Closing the Gap in smoking, improving access to primary care services (including ACCHOs), health promotion and social marketing, and workforce, have also had a significant influence on efforts in Victoria to improve the health status of Aboriginal people.

As noted in chapter 2, findings are emerging from the national ICDP evaluation that support the findings from Victoria, namely the importance of building relationships with services and engaging with Aboriginal communities and service users. Continuing national initiatives to improve the capacity of health and other social services to engage with Aboriginal people should provide ongoing support to Koolin Balit in its aims to achieve improved health and wellbeing for Aboriginal Victorians.

4.1.5 CLOSING THE HEALTH GAPS HAS SIGNIFICANTLY INFLUENCED HEALTH SYSTEM CHANGE

It's a good story. It's very pleasing - the transition that has occurred. To get a change like that in three years is pretty remarkable, because it's not easy to change behaviour, and [organisational] culture. (regional director)

Even given the extent of investment from the Commonwealth and other COAG-funded initiatives under Closing the Gap, it remains clear that the Victorian investment into CtHG has been the single greatest driver for changing the way in which health services address Aboriginal health. Commonwealth health investment has also funded significant projects across the state, and Closing the Gap investment in other policy areas – housing, education, employment – has also undoubtedly influenced the health and wellbeing of Aboriginal Victorians. However, the Victorian CtHG investment has been a catalyst for new discussions about changing the health system itself in ways which make the system more effective, accessible and welcoming for Aboriginal people.

CtHG has influenced system change through requiring regions to engage with both ACCOs and with communities; through mandating Aboriginal health as a priority for universal health services; through devolving responsibility for funding decisions and project planning to local regional committees; through providing an authorising environment for the development of new partnerships and the strengthening of existing partnerships, across universal and Aboriginal community-controlled health services.

Capacity building, building relationships and empowering local populations to be involved and take charge of partnerships: in the next couple of years that's where I would want to be investing so ACCOs are seen as equal players with health services. To have meaningful partnerships. (regional director)

Overall, the most substantial achievement of CtHG has been to 'make Aboriginal health everyone's business'. This has been achieved through structural drivers and through encouraging partnerships and collaboration across universal and Aboriginal community-controlled health services. Aboriginal health is clearly now 'on the agenda', as a stakeholder noted. While it will take time before this cultural and attitudinal shift translates into improved health data, a large majority of stakeholders believed that CtHG had influenced substantial cultural, behavioural and structural changes within the universal system.

5 Conclusions and learning

5.1 THE EFFECTIVENESS OF CLOSING THE HEALTH GAPS IMPLEMENTATION

Effectiveness in this evaluation is measured by the extent to which the cumulative results of the state-wide and regional investments into CtHG have resulted in perceivable improvements in Aboriginal Victorians' access to and uptake of health services, and perceivable changes in lifestyle and behaviour risk factors among Aboriginal Victorians.

Using this definition, the evidence suggests that CtHG has been effective in strengthening the foundations within the service system of trust, organisational partnership, and information sharing, on which future improvements can be built. It is reasonable to conclude that Koolin Balit could not be implemented without the four years of CtHG activity to build relationships between service providers, universal and Aboriginal community-controlled services, and others.

CtHG provides a strong foundation for the continued improvement of services to meet the needs of Aboriginal Victorians. Koolin Balit is the new framework under which Victorian health services will continue to build on the work undertaken through CtHG.

While many stakeholders have noted the importance of embedding drivers for change into the system, this is at an early stage for the health system as a whole, and there is room to further embed motivators for improving Aboriginal health into universal services as well as Aboriginal community-controlled health services. Some of these drivers for change are already being integrated into the system through Koolin Balit, the VAAF, and performance indicators for state-funded health services.

It was inevitable that with the large number of projects funded under CtHG (over individual 100 projects across eight health regions) not all of them would be equally successful, especially given varying needs and resourcing capacity across regions. This has indeed proved to be the case, with regions reporting lessons learned through initiatives which did not proceed as well as achievements gained through projects that were successful. Key elements of effective projects included:

- ground-up development, including consultation with Aboriginal community members and Aboriginal controlled health organisations
- senior stakeholder engagement (such as CEO commitment from both universal health service and Aboriginal community controlled health) and
- significant investment of time in building relationships across services where these relationship did not already exist.

A number of indicators of effectiveness are evident across the state as a result of the overall body of investment and activity under CTHG. Regional governance groups, for instance, have reported improved health planning skills as well as improved relationships and communications across a range of health service organisations. In addition, regional health leaders within universal health services have reported a significant ongoing commitment from themselves and their services to maintaining a leadership focus on Aboriginal health in their service. This has been fostered particularly by the Statement of Intent and by the high profile given to key performance indicators for health services in improving Aboriginal health.

Many of the projects which did not proceed also shared common elements, including insufficient planning and consultation with Aboriginal community members, inconclusive evidence base for the benefits for the project, and a lack of time and investment in building relationships across services and communicating aims of the project.

At the regional level, the effectiveness of the implementation has been influenced by the quality of the regional governance arrangements; the existing relationships between services and with the regional office of the Department of Health (as the lead agency); the regional vision for the Initiative; the extent of consultation between the region and ACCOs; and the personal leadership of senior executives in both ACCOs and universal services.

At the community level, consultation with community members has indicated that in at least some areas there has been a change in individuals' own experience of individual health services as well as a greater sense of inclusion in health service planning and development. While not consistent across the state, in many areas community members have reported a greater sense of welcome and a greater ability to access universal health services. ACCHOs have also reported the investment of CTHG has allowed them to negotiate greater access to services for their communities and to provide a greater range and availability of services within their own organisations. Universal health services have indicated that as a result of the efforts put into cultural competence training and greater education of staff, there is reportedly a greater awareness and understanding of the health needs of Aboriginal people. This is reflected in the ongoing identification of new opportunities for improved collaboration, such as improving client pathways beyond those planned at the outset of the Initiative. The ongoing identification and response to gaps in service delivery is a positive indicator that the Initiative is laying a foundation for ongoing quality improvement.

5.2 THE EXTENT TO WHICH THE STATED TARGETS HAVE BEEN ACHIEVED

The Victorian Indigenous Affairs Framework (VIAF) was in place before the signing of the NPA in 2008, and the revised VIAF in 2010 acknowledged the need to align targets with the national efforts to close the gap. Targets were outlined in the NPA, and targets were also defined in Victoria's implementation plan under the NPA. To a large extent, these targets are in alignment. (See table in section 2.3)

As noted in chapter 3, there has been progress made towards all of these targets. There is an extensive lag time for data on some of the targets, due to the timeframes of some data sets, and also due to the length of time required for change to be evident at a population level. In addition, changes in data, for instance an increase in rates of people attending hospital, may indicate a greater access to and willingness to attend universal health services rather than any change in morbidity patterns.

At this stage it is possible to say only that it is likely that these statistics indicate a positive move towards improved identification, access to and use of universal health services, and improved health status such as smoking and maternal access to services. A longer period of time to monitor the data will be required to make any substantive acknowledgment of closing the gap of morbidity or mortality.

The factor of time has consistently been raised by stakeholders in the change effort of CtHG. Both in terms of the time it takes to develop effective working arrangements and overcome a history of distrust, but also in terms of the depth of disadvantage and the entrenched nature of social determinants of health. This is reflected in this observation from a senior member of a community controlled health service:

The key lessons of [CtHG] are that it's going to take a long time. We need to see generational change, and more preventative work. When you push on one problem, another emerges. We need to stick in there because results don't happen overnight.
(ACCO)

Within this observation is the implication of consistency; consistency in effort, approach and leadership to enable change to be achieved.

5.3 THE EXTENT TO WHICH CLOSING THE HEALTH GAPS PROJECTS REPRESENTED THE MOST APPROPRIATE, EFFECTIVE AND EFFICIENT MEANS FOR ACHIEVING THE STATED GOALS

Projects funded under CtHG were many and varied. In part they built on existing state-wide investments, and augmented that investment to further the change agenda. Obvious examples of this are projects funded within the AHPACC and ICAP contexts. Others were more innovative, and drew in external partners with state-wide roles, for example the Spectacle Subsidy Scheme, and to some extent the Workforce Strategy, which worked in parallel with CtHG but were not originally funded under the Initiative. Other projects were more opportunistic, such as the Clinical Engagement Strategy which used existing clinical networks to leverage change in hospital contexts.

Overall there is evidence that the regional delegation was appropriate and effective in generating buy-in and participation in making Aboriginal health everyone's business. Efficiency in this context is difficult to measure. Potentially, the efficiency could have been increased through stronger support in the early planning stage of the Initiative when regions struggled at times to undertake the required planning process. Equally, the state was constrained by Commonwealth timeframes, and the Aboriginal Health Branch itself was in its own establishment phase. Nevertheless, the location of responsibility at the regional and sub-regional level for planning, allocation, monitoring and evaluation remains aligned with evidence of the efficacy of place-based strategies to address Aboriginal disadvantage.

The projects considered to be successful by stakeholders generally reflected the conclusions drawn by the 2011 Productivity Commission report on key indicators for overcoming Indigenous disadvantage. The lack of any of these factors can result in program failure.⁴

TABLE 4 – EVIDENCE OF SUCCESS FACTORS

| CTHG EVALUATION OBSERVATIONS OF SUCCESS FACTORS | PRODUCTIVITY COMMISSION OBSERVATIONS OF SUCCESS FACTORS |
|--|---|
| <ul style="list-style-type: none"> ▪ clear and visible leadership from CEOs and senior representatives of health services, both universal and Aboriginal community-controlled services ▪ investment of time and personal commitment into developing organisational relationships and partnerships between universal and Aboriginal community-controlled services | <ul style="list-style-type: none"> ▪ cooperative approaches between Indigenous people and government — often with the non-profit and private sectors as well |
| <ul style="list-style-type: none"> ▪ consultation with, and ownership by, local Aboriginal leaders and community members ▪ place-based approaches which devolve funding to the local level | <ul style="list-style-type: none"> ▪ community involvement in program design and decision-making — a 'bottom-up' rather than 'top-down' approach |
| <ul style="list-style-type: none"> ▪ engagement from government, non-government and community organisations | <ul style="list-style-type: none"> ▪ ongoing government support — including human, financial and physical resources |
| <ul style="list-style-type: none"> ▪ good governance, including clear accountability and reporting | <ul style="list-style-type: none"> ▪ good governance — at organisation, community and government levels |
| <ul style="list-style-type: none"> ▪ flexibility to amend the project plan as required during the life of the project. | |

Capacity building has been an important feature at state-wide and regional levels. This has included capacity in cultural safety; in workforce skill; in health planning and in partnership engagement:

Capacity building, building relationships and empowering local populations to be involved and take charge of partnerships: in the next couple of years that's where I would want to be investing so ACCOs are seen as equal players with health services. To have meaningful partnerships. (regional director)

In relation to partnerships, the delivery of health services has been changed where strong partnerships already existed, or where they are evolving because of effort under CtHG

⁴ SCRGSP (Steering Committee for the Review of Government Service Provision) 2011, *Overcoming Indigenous Disadvantage: Key Indicators 2011*, Productivity Commission, Canberra. p. 9.

The local approach indicated to ACCOs that [health services] wanted to engage with them; it adds a level of respect. We wouldn't have got the level of cooperation and collaboration without the local approach. It has built organisational trust in a way that a centralised approach wouldn't have done. It brings people together, builds up people's sense of responsibility, and has borne more fruit as a result, across the health system. (regional director)

5.4 THE EXTENT TO WHICH A COMMUNITY-DRIVEN APPROACH HAS BEEN ADOPTED AND EFFECTIVE IN THE REGIONAL IMPLEMENTATION OF THE INITIATIVE

A community-driven approach has been applied to varying degrees in different regions across the state. Regions where a community-driven approach was not as obvious tended to spend time building new relationships at a strategic level across universal and Aboriginal controlled health services. In these regions it is reasonable to conclude that as these relationships strengthen and as ACHHOs participate more in service planning in collaboration with universal health services, a community-driven approach will become more visible and effective in these regions over time as activities under Koolin Balit are established in the future.

The program [CtHG] was developed with input from the community, it had ownership, and it achieved its objectives very well. If there's a problem within the community, the solution needs to come from within, and CtHG has facilitated this. (ACCO)

It is important to note that the notion of a community-driven approach itself needs to be defined, and may be defined differently in different locations, and differently by Aboriginal and non-Aboriginal people. For most regions, community engagement included a consultation process at the beginning of Closing the Gap which then provided the basis on which Closing the Gap activities were developed. This may have included consultation with community members, or only with ACCHOs. The extent to which these consultation processes truly engaged the local community did influence the achievements within each region in terms of meeting Closing the Gap targets.

On the whole, CtHG has raised the level of understanding within universal health systems of the need to consult with and engage Aboriginal community members and leaders in health service planning. This is by and large a new concept for universal health services as community consultation is not embedded in traditional service planning processes. It will be important to monitor through Koolin Balit the way in which the development of a community-driven approach influences the development and delivery of appropriate Aboriginal and universal health service in the future.

5.5 IMPLICATIONS FOR THE FUTURE

The Victorian approach was innovative and not replicated in other jurisdictions. The decision to distribute funding across all regions as well as to provide leadership for some state-wide investments meant a comprehensive approach was taken at both the state-wide population level, the regional level and through service providers, at the individual level of service provision. The innovation was, in part, based on evidence regarding successful approaches to improving Aboriginal health, recognising that the evidence base is not large regarding what works to improve Aboriginal health, while acknowledging the usual methods of increased investment in mainstream health had not delivered the outcomes sought. The investment sought to strike a balance between innovation, through locally driven place-based solutions, and evidence-based approaches. The implementation was largely true to its aims.

For this reason, it is clear that the approach which Victoria has taken, particularly in developing a long term vision for Aboriginal health with supporting policy frameworks, is changing the very system through which health services are delivered. There is increasing local engagement in decision-making across universal and Aboriginal community-controlled services, in line with a place-based approach to needs assessment and service planning. A gradual change from traditional grants based funding to funding for outcomes is beginning to take place, with services increasingly required to demonstrate not just how funds were spent but what was achieved through their spending. While the implications of these changes are not fully visible yet, it was notable that a greater number of participants in the 2013 consultations for the evaluation were expressing a view that this needed to be the direction for the future in order to realise tangible and sustainable change in Aboriginal health status.

The innovation initiated through CtHG stretched the capacity of services to respond to the needs of Aboriginal service users and required changes of thinking at both the departmental level and the organisational level as services learned to focus on outcomes rather than outputs. It is important to acknowledge that in many parts of the health system CtHG built on pre-existing commitment of individuals in community-controlled and universal health and community services. The increase in engagement with Aboriginal communities and health services through regional governance and health service planning has provided a foundation of shared governance and ownership which should increase the capacity of services to continue to contribute to significantly improved health outcomes under Koolin Balit.

One of the fundamental achievements of Closing the Health Gap Initiative, then, is the creation of service drivers through innovation, which are changing the focus of universal health services on providing health services that meet the needs of Aboriginal Victorians. This innovation has also benefitted Aboriginal community-controlled health services in providing a mechanism for greater engagement with universal health services and greater ability to negotiate service pathways for Aboriginal people.

The CtHG investment provided both authority and impetus for change. Senior leaders in both mainstream and community-controlled services identified the importance of this impetus in prioritising resources, leadership effort and workforce to address the gap in Aboriginal health outcomes.

In strengthening the authorising environment and challenging individuals and organisations to address the health disparities which exist across Victoria, CtHG has initiated a level of system growth and reform which is building momentum and should, if continued in line with a corresponding monitoring within a performance management framework, make a significant contribution to closing the gap in health outcomes for Aboriginal people in Victoria.

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