14. What is needed to make sure Aboriginal and Torres Strait Islander people are equal partners with governments and can make shared decisions on issues that are important to us? (Say as much as you like, there is no word limit)

Mainstream approaches, including procurement contestability, have failed to deliver outcomes for Aboriginal and Torres Strait Islander peoples. Focusing investment, wherever possible, through well-governed and accountable community-controlled services is, therefore, fundamental to achieving significant improvements in outcomes. For instance, primary health care delivered through Aboriginal Community Controlled Health Services (ACCHSs) is known to be significantly more effective than that offered through mainstream/government services, particularly concerning access to services and the prevention, detection, and treatment of chronic disease.

Indigenous-led Models for Regional Funding and Decision Making to Close the Gap is an example of a partnership arrangement that allows Aboriginal and Torres Strait Islander people to be equal partners with governments in making shared decisions on issues that affect them.

The COAG 2018 Closing the Gap Special Gathering has noted that the best progress made over the last ten years has been in areas where the Indigenous community has led the design and implementation of programs from the beginning. Accordingly, it demands from the government a community-led, strengths-based strategy, underpinned by principles of empowerment and self-determination so that Indigenous people can move 'beyond surviving to thriving'.

For instance, as part of its *System of Care*, the IUIH has demonstrated unprecedented efficiency and effectiveness in closing the health gap faster in South East Queensland (SEQ), through a regional governance model - where empowered Indigenous leadership has been the proactive agent of change, and the fundamental lever in rebalancing the government-community relationship to effect real change. In addition to health outcomes, significant improvements in linked CTG targets such as Indigenous employment rates have been achieved through an integrated regional model.

Further information on the IUIH System of care is articulated in the recently published article "Building a regional health ecosystem: a case study of the Institute for Urban Indigenous Health and its *System of Care*" in the Australian Journal of Primary Health's special Indigenous issue, accessible at https://www.publish.csiro.au/PY/issue/9445.

Summary findings of a recent external review (Nous Group) of the IUIH System of Care can also be accessed at http://www.iuih.org.au/Blog/ArticleID/7056.

Notwithstanding these achievements, there remain significant and systemic barriers to current funding and decision-making arrangements that need to be addressed to achieve the required acceleration and transformational changes still required to close the gap. The magnitude of the challenge is such that it requires a foundational restructuring of the current funding and decision-making architecture.

It is therefore critical that the governments commit to giving priority to:

- Providing opportunities for opt-in trials of reformed financial and decision-making arrangements, including through Indigenous-led Regional Funding and Decision Making models
- These trials would include funds-pooling of targeted (Commonwealth and State) Indigenous funding, and prorated mainstream funding, for use by regional Indigenous commissioning bodies

with shared and devolved decision making authority to prioritise need and respond with tailored regional solutions – calibrated to their context
- Under these trials, the significantly increased regional flexibility in funding decisions would be matched by enhanced accountability regarding outcomes and evidence and
- These trials would have principles consistent with, but not necessarily requiring opt-in to, the specific *Empowered Communities* initiative. Regional entities such as the IUIH should be able to negotiate with the government a preferred future state, tailored to their context and concerning their scope of responsibilities and achievements to date.

16. What do you think we should measure which would show action is being taken in this area? (Say as much as you like, there is no word limit)

Brand et al. (2016)[1] observe that a trend by government to increasingly fund and or rely on mainstream providers in its funding allocations puts at risk the community controlled sector's capacity to close the gap and undermines the work and successes of these critical providers.

If the gap is to close, funding should be prioritised to services that can deliver the best outcomes for Indigenous people; This should include assignment of ACCHSs as First Choice providers for Commonwealth funded health services for Indigenous people unless it can be clearly shown that alternative arrangements can produce better outcomes in quality of care and access to services. The same approach could be replicated in other sectors, such as housing, legal, employment, etc.

Such a First Choice provider policy could be embedded in the new National Agreement on Closing the Gap, Commonwealth Grant Rules and Primary Health Networks (PHN) and other commissioning guidelines, and reflect the success, for example, of the recently implemented Australian Government Indigenous Procurement Policy. The Government funders and their commissioning agents such as PHNs would then be required to report to the Joint Council on Closing the Gap against the measures and targets set in a preferred provider policy and associated guidelines.

17. Is there anything else you would like to say about arrangements between Aboriginal and Torres Strait Islander people and the government on closing the gap? (Say as much as you like, there is no word limit)

A recalibration of focus in the design, delivery, and evaluation of government programs is required which:

- recognises the centrality of culture in best practice
- invokes an accountability architecture which promotes and rewards performance and outcomes (rather than a focus on the program implementation and evaluation process itself)
- builds Indigenous perspectives and leadership into the design and delivery of all parts of the policy/program cycle and at all levels (national, state and local/regional) as a necessary precursor to improving outcomes for Aboriginal and Torres Strait Islander peoples.

[1] Brand E, Bond C, Shannon C (2016) Urban Indigenous Health: Opportunities and Challenges in South East Queensland (University of Queensland Poche Centre for Indigenous Health: Brisbane, Qld)

It is considered that the capacity of government programs to make an effective contribution to closing the gap will depend on reforms such as these. Accordingly, the IUIH suggests the following broad principles for consideration for inclusion in the new National Agreement on Closing the Gap:

1. Aboriginal Community Controlled Health Services as First Choice Providers of health and aged care services and programs aimed at closing the gap – this same principle could apply to other sectors
2. Indigenous-led service planning and design, commissioning and decision making about investment at a regional level for initiatives aimed at closing the gap
3. Enhanced accountability and evidence-base to Close the Gap and to measure impact and outcomes.

19. Which service do you think it is most important for a community-controlled organisation to deliver and can you tell us why? (Say as much as you like, there is no word limit)

The IUIH considers that Aboriginal and Torres Strait Islander people should lead the design and implementation of health and social services affecting their people and communities.

The evidence points to ACCHSs demonstrating more effective service delivery and better health and social outcomes for Indigenous people. Linked CTG employment targets are also vastly improved, with significantly higher Indigenous employment rates achieved by community-controlled organisations.

The National Community Controlled Health Organisation (NACCHO, 2018)[2] cites the evidence which shows that ACCHSs are 23% better at attracting and retaining Indigenous clients than mainstream providers and at identifying and managing the risk of chronic disease. Indigenous people are more likely to access care if it is through an ACCHS and patients are more likely to follow chronic disease plans, return for follow up appointments and share information about their health and the health of their family. ACCHSs are also more cost-effective, providing greater health benefits per dollar spent. The lifetime health impact of interventions delivered by ACCHSs is 50% greater than if these same interventions were delivered by mainstream health services, primarily due to improved Indigenous access (Vos et al., 2010)[3].

For example, related independent research (SAHMRI, 2016)[4] of the IUIH's programs reported that an analysis of MBS data and the IUIH patient data showed that, compared to SEQ mainstream providers, the IUIH:

- provides 2.6 times the number of Nurse/Aboriginal Health Worker (AHW) follow-up services (Item 10987) to a Health Check (Item 715)
- provides 1.4 times the amount of Practice Nurse or AHW follow-up services (Item 10997) to a General Practice (GP) Management Plan (Item 721) or Team Care Arrangement (Item 723)

[2] National Aboriginal Community Controlled Health Service (NACCHO) (2018) Key Facts – Why ACCHS are needed. Available at https://www.naccho.org.au/wp-content/uploads/Key-facts-1-why-ACCHS-are-needed-FINAL.pdf [Verified 22/08/2019]

[3] Vos, T. et al. Assessing Cost-Effectiveness in Prevention (Final Report 2010); Ong, K. S. et al

[4] South Australian Health and Medical Research Institute (SAHMRI) – Wardliparinga Unit (2016) Evaluation of IUIH Connect program (completed Jan 2016) and Evaluation of IUIH Care Coordination and Supplementary Services program in SEQ (Completed May 2016),

- is 32 times more likely to provide selected case conferences (Items 735, 739, 743) for every Standard GP Consultation (Item 23) they provide
- is 4.24 times more likely to provide a GP Management Plan (Item 721) or Team Care Arrangement (Item 723) for every Standard GP Consultation (Item 23) they provide.

The above research study (SAHMRI, 2016) also evaluated the PHN funded, and the IUIH administered Coordinated Care and Supplementary Services (CCSS)[5] . The evaluation found that channelling these funds through PHNs have not been administratively efficient, but instead has added cost and complexity to program implementation. The review further concluded that: "the only substantive source of inefficiency was in relation to the margin retained by the Primary Health Network (PHNs) … (and) allocative efficiency would be improved if these funds were allocated to the IUIH CCSS instead of retained as margins ….." The review estimated that these PHN retained funds equated to an amount of $232,469 per annum, which could have provided care for an additional 33 clients per month. The evaluators also estimated that the additional administrative costs to the IUIH in having to manage four separate contracts with the PHNs were in the order of $75,000 annually.

A model for regional funding and decision making is also fundamentally different to the current program centered approach, where government policies and programs are often designed with a focus on a particular issue (e.g. reducing smoking rates) instead of focusing holistically on a person and its family and a community context as whole (e.g. improved access to an integrated regional system of care). Subsequently, the contemporary government programs are often found to be of limited success in changing the overall impact within the complex societal and community environments.

Mainstream approaches, including procurement contestability, have failed to deliver outcomes for Indigenous people. Focusing investment, wherever possible, through well-governed and accountable community-controlled services is, therefore, fundamental to achieving significant improvements in outcomes. As noted, primary health care delivered through ACCHSs is known to be significantly more effective than that obtained through mainstream/government services, particularly concerning access to services and the prevention, detection, and treatment of chronic disease.

20. Which community-controlled services should be made stronger? You can list as many as you like, and please also tell us why they should be made stronger. (Say as much as you like, there is no word limit)

See comments above in response to question number 19.

21. What can governments do to help Aboriginal and Torres Strait Islander community-controlled organisations grow and be strong? (Say as much as you like, there is no word limit)

There is a risk that the current funding and commissioning arrangements of health services, including through the Primary Health Networks (PHNs):

- are out of step with the principles of an Indigenous-led reform process

[5] Now incorporated into the ITC program

- are not evidence-based and undermine the effectiveness of Indigenous health expenditure to close the gap and
- increase the potential for inefficiency and fragmentation in the health system.

The Queensland Productivity Commission (QPC, 2017)[6]finds that 'to make material progress, evidence suggests the current decision-making model for service delivery must move closer to the people it serves. Transferring decision-making closer to communities is more likely to:

- meet community needs and priorities
- empower people to have greater control over their lives
- create incentives for providers to be more responsive and drive innovation and efficiencies in service delivery and
- be more effective in improving outcomes and wellbeing'.

Further, the QPC report concludes that 'Although grant funding and contracting arrangements aim to ensure accountability, manage risk and encourage competition, the system does not appear to facilitate the outcomes it aims to achieve. Short-term grant funding and methods of contracting leads to rigidity in program delivery (as opposed to focusing on the needs of the individuals or place) and high administration costs. It contributes to uncertainty and is a barrier to long term planning and innovation to meet better service user needs and build local capability.'

In the health sector, the Commonwealth government is, however, increasingly using the PHN network to be its commissioning agent of choice with targeted Indigenous funding. In addition to the IUIH's Integrated Team Care (ITC) program, this includes the recent transition of substantial levels of targeted Indigenous mental health, substance use and suicide prevention funding from direct contracting arrangements with ACCHSs (and other NGOs) to the PHNs.

While there is an acknowledgement of the role of a commissioning model to advance health system reforms at a regional level, there are concerns about the efficacy of some of these commissioning arrangements as they apply to Indigenous health. These concerns relate to the procurement strategies adopted by PHNs, including market-driven and competitive tendering processes for targeted Indigenous funding.

While there are some examples where PHNs have acknowledged ACCHSs, including the IUIH, as preferred providers when making commissioning decisions in relation to Indigenous-specific funding, the degree of sophistication across PHNs is highly variable, and there isn't a consistent commissioning framework which is guided by the recognition that Indigenous health outcomes will be achieved when Indigenous people control them, and that commissioned service delivery will be a strengths-based approach reflecting the United Nations Declaration on the Rights of Indigenous Peoples.

The current commissioning approach by some PHNs is also not aligned with the Australian Government's *National Aboriginal and Torres Strait Islander Health Plan* (2013-2023), which

[6] Queensland Productivity Commission (2017) Summary Report of Service Delivery in Remote and Discrete Aboriginal and Torres Strait Islander Communities

acknowledges the unique contribution of ACCHSs in delivering holistic, comprehensive and culturally appropriate health care to meet closing the gap targets.

22. Which mainstream services should be transferred to community control? (Say as much as you like, there is no word limit)

See comments above about regional Indigenous-led commissioning models.

24. What do you think we should measure which would show action is being taken in this area? (Say as much as you like, there is no word limit)

See comments above about the assignment of ACCHSs as First Choice providers for Commonwealth funded health services for Aboriginal and Torres Strait Islander people.

25. Is there anything else you would like to say about making Aboriginal and Torres Strait Islander community-controlled organisations stronger? (Say as much as you like, there is no word limit)

Continuity of Medicare Income Generation for Aboriginal Community Controlled Health Services (ACCHSs) to Close the Gap is paramount.

Aboriginal and Torres Strait Islander people are currently not benefiting from the same levels of universal access to Medicare as non-Indigenous Australians. The targeted health grant funding is insufficient to provide the level of service responses required to accelerate closing the health gap. Hence, supplementation of health grant funding through Section 19:2 Directions under the Health Insurance Act is providing valuable and flexible Medicare income streams for ACCHSs to meet this funding shortfall and to increase Medicare access by Indigenous Australians.

It is therefore critical that the government commit to giving priority to providing certainty to the ACCHS sector of continuing Medicare income generation availability under Section 19:2 arrangements to meet closing the gap targets.

27. What are some things that would stop you from using a mainstream service? (Say as much as you like, there is no word limit)

N/A as this is a submission form an organisation and not form an individual.

28. What are some of the things that mainstream services and governments can do to work better with Aboriginal and Torres Strait Islander people? (Say as much as you like, there is no word limit)

Enhanced accountability and evidence-based framework to Close the Gap and to measure the impact are required. Closing the gap requires the further building of the evidence-base to inform policy and practice, particularly in urban settings where the majority of Australia's Indigenous population live. This requires the governments to give priority to:

- Developing enhanced opportunities for knowledge translation of policies and practices which are demonstrating evidence in closing the gap. This should include the re-establishment of a CTG clearinghouse.
- Ensuring that National Health and Medical Research Council (NHMRC) and other Commonwealth-funded research organisations have a stronger focus on research aimed at assessing the

effectiveness of service models in achieving outcomes, including across mainstream and community-controlled providers.

- Ensuring all funding agreements with both mainstream and community-controlled providers have an additional allocation, over and above that required for service delivery, to support the collection of data and evaluation of outcomes about meeting CTG objectives at community/regional levels. Such data and evaluation of outcomes should then be reported to the Joint Council on Closing the Gap, together with the recommending remedial actions where the outcomes are under-achieved.
- Ensuring that centralised data collection portals are of high quality and accessible to ACCHSs to support program monitoring and evaluative efforts. There are examples where this is not currently the case, such as the Australian Nurse Family Partnership Program (ANFPP).
- Ensuring that economic and social impact evaluation principles are intrinsic to building the evidence base about 'what works,' including to ensure value for money in delivering programs for Indigenous Australians. Incorporating these principles would also maximise the benefits of health care spending and help overcome regional variations in access.
- Ensuring the recently re-established and emerging Closing The Gap national partnership agreements include transparent performance monitoring arrangements for both targeted and mainstream funding for Indigenous health services and programs. Indigenous participation must be central to these arrangements to ensure effective community-led accountability of investment, outcomes, and evidence in meeting CTG refreshed goals. The enhanced role of the Productivity Commission will support this performance monitoring effort.
- Establishing a national Indigenous Research Future Fund dedicated to accelerating best practice in achieving CTG goals. This could be based on the National Medical Research Future Fund.

29. How can Aboriginal and Torres Strait Islander people be involved in the development, design, and implementation of mainstream services? (Say as much as you like, there is no word limit)

See previous comments in response to questions 14, 16 and 17 above.

31. What do you think we should measure which would show action is being taken in this area? (Say as much as you like, there is no word limit)

See response to question 28 above.

32. Is there anything else you would like to say about how mainstream services can be improved for Aboriginal and Torres Strait Islander people? (Say as much as you like, there is no word limit)

Establishing funding criteria for mainstream services which require:

- A recalibration of focus to recognise the centrality of culture as best practice including to affirm a systems-level approach to building cultural competency, which does not rely solely on cultural training but aims to embed culture in all aspects of mainstream organisations' governance, community engagement/reciprocity, continuous quality improvement (CQI) and service planning domains.
- Establishing an accountability architecture for mainstream programs that is commensurate with performance reporting requirements of Aboriginal Community Controlled Organisations.

- Demonstration that mainstream service models are evidence-based in terms of delivering outcomes for Indigenous clients.
- Setting targets and monitoring mechanisms which ensure access by Indigenous clients to all mainstream programs is consistent with Indigenous population levels and need. This also includes, more broadly, identifying closing the gap targets in the aged care and disability domains.

Cultural Accountability Framework

Providing culturally safe care remains an imperative for health practitioners if better health access and outcomes for Indigenous people are to be realised, including in relation to the capacity of the mainstream services and programs to improve the quality of services for Indigenous patients.

The *National Aboriginal and Torres Strait Islander Health Plan 2013 - 2023* highlights the centrality of culture in the health of Indigenous people. Specifically, the plan points to how culture can influence Indigenous people's decisions about when and why they should seek health services, their acceptance of treatment, the likelihood of adherence to treatment and follow up, and the likely success of prevention and health promotion strategies.

Ensuring that health services and providers are culturally competent will lead to more effective health service delivery and better health outcomes.[7] In this context, ACCHS are making a unique contribution to the delivery of best practice health care for Indigenous people - care which is intrinsically characterised by a strong cultural integrity framework[8].

The ACCHS model affirms the recurring evidence that Indigenous people will access services and actively engage in, and benefit from, health-improving, independence promoting and capacity building behaviours when they are culturally connected to community-controlled providers and can develop trusting relationships with Indigenous staff.

Equally important for ACCHS is that all aspects of care planning and delivery are designed and operate from an Indigenous worldview, where:

- concepts of holistic health and wellbeing are recognised in health practice
- Indigenous knowledge, values, beliefs and cultural needs inform clinical decisions, pathways and ongoing care and
- Cultural identity, cultural connection/responsibility to family/community and cultural healing represent the critical success factors in supporting goal attainment and improved health and wellbeing, including in the prevention and management of chronic disease.[9]

This importance of cultural integrity in health practice has been elevated as a priority in the Council of Australian Government's (COAG) recent refresh of the Closing the Gap agenda, and also affirmed by the Australian Health Ministers' Advisory Council (AHMAC) in its National Aboriginal and Torres Strait

[7] National Aboriginal and Torres Strait Islander Health Plan 2013-23.

[8] The AMA, in its *2018 Indigenous Report Card*, noted that ACCHSs are better at the critical issue of access, attracting and retaining Aboriginal and Torres Strait Islander clients, and result in better health outcomes than mainstream services

[9] Parmenter J et al. Chronic disease self-management programs for Aboriginal and Torres Strait Islander people: Factors influencing participation in an urban setting. *Health Promot J Austral*. 2019;00:1–8. https ://doi.org/10.1002/hpja.256. Findings from this study (IUIH's *Work it Out* chronic disease self-management program) indicate that key features of program design based on a culturally responsive approach influences participation and can contribute significantly to closing the health disparity gap.

Islander Health Standing Committee (NATSIHSC) refresh of the *Cultural Respect Framework 2016-26.* Through this framework, all governments have agreed to embed cultural respect and responsiveness across all health systems.

Translation of this framework into routine clinical practice remains, however, a significant challenge in mainstream settings, where a cultural misalignment continues to manifest in in the form of systemic barriers of access and health benefit.

Underscoring this challenge, the *Medical Journal of Australia* recently (2019) published the outcomes of a cluster randomised control trial of 56 general practices in Sydney and Melbourne designed to examine whether a cultural respect framework improved clinically appropriate anticipatory care for Indigenous patients in mainstream general practice and the cultural respect levels of medical practice staff. In this trial, despite a year-long practice-based cultural respect program (Ways of Thinking and Ways of Doing) applied to the intervention group — including a workshop and toolkit of scenarios, with advice from a cultural mentor, and guided by a partnership of Indigenous and general practice organisations — the program failed to increase Indigenous health check rates (MBS Item 715), recording of chronic disease risk factors or cultural quotient scores for staff, compared to a control group of general practices.[10]

Of equal concern, a November 2018 joint Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and Royal Melbourne Institute of Technology (RMIT) survey found continuing high levels of racism in the health sector, including 88% of respondents experiencing racism from nurses and 74% experiencing racism from GPs[11].

This accentuates the earlier Australian Department of Health's *My Life My Lead Consultation Report* findings that systemic racism and a lack of cultural capability, cultural safety and cultural security remain barriers to health system access. The *My Life My Lead* report further notes that racism makes people sick and that constructive and systemic action addressing its causes and effects is required to deliver significant positive impacts on health and broader life outcomes for Indigenous Australians.[12] A more structured cultural accountability framework is considered a necessary response to this challenge. Apropos this challenge, and in what is hopefully a precursor to further reform, we have now seen, for the first time, the inclusion of six new actions in the National Safety and Quality Health Service (NSQHS) Standards (second edition) that specifically address the needs of Indigenous people.

Launched at COAG in August 2018, the NATSIHSC developed actions cover areas that are considered to have the biggest impact on improving the health outcomes for Indigenous Australians. An NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health provides practical guidance and case studies to assist health services to meet these actions - which build on the 'usual' cultural training requirement to take a more systemic approach by embedding cultural competency into the

[10] Liaw ST et al. 2019. Cultural respect in general practice: a cluster randomised controlled trial. *Medical Journal of Australia* **210,** 263-268

[11] As reported by NACCHO https://nacchocommunique.com/2018/11/14/naccho-aboriginal-health-and-racism-vicvotes-vaccho_org-survey-finds-86-per-cent-of-aboriginal-and-torres-strait-islander-people-living-in-victoria-have-personally-experienced-racism-in-a-mainstrea/

[12] My Life My Lead Consultation Report 2017, Commonwealth Department of Health

governance, community partnership, needs assessment, CQI and service design domains of the health organisation.

Incorporating these actions in the Standards means that mainstream health services will, from 1 January 2019, need to demonstrate that they are being addressed to pass their assessments. This will help to ensure, for example, that formalised arrangements are in place which requires demonstration of community engagement by mainstream organisations to support the planning and delivery of effective services.

It is considered that other programs and services can also significantly benefit from such an approach, with the NSQHS Indigenous standards providing a useful framework to drive the changes required to build cultural competency across all mainstream programs

Performance Accountability Framework

The ACCHS sector in SEQ has contributed to resourcing significant continuous quality improvement capability within IUIH Network which has seen IUIH's National Key Performance Indicator (nKPI) data achieve a range of best practice results, make significant progress towards meeting the National Aboriginal and Torres Strait Islander Health Implementation Plan's 2023 nKPI targets[13] and deliver validated better health outcomes, including narrowing of the health gap[14].

The efficacy of government programs to achieve similar improvement outcomes in the mainstream sector is, however, in question. For example, there is a quantum differential standard of performance monitoring between mainstream GP practices and the community controlled sector, with only 233 organisations nationally (mainly ACCHSs) regularly (six-monthly) reporting against the COAG agreed set of 28 nKPIs. For the remaining majority of practices, there is no real CQI accountability in terms of demonstrating continuous improvement outcomes for Indigenous clients. This also highlights a major program misalignment with the government's related efforts to close the gap through its 2023 Implementation Plan nKPI targets[15].

For instance, the Commonwealth *Practice Incentive Program Indigenous Health Incentive* (PIP IHI) has been an effective incentivisation instrument within the ACCHS sector. In the case of IUIH, this has manifest in the way PIP IHI payments, together with MBS income, have made a critical contribution to expanding service reach through the rollout of new clinics – ensuring substantially increased numbers of Indigenous people can now access culturally safe and best practice care[16].

Additionally, the PIP IHI has contributed to resourcing significant continuous quality improvement capability within IUIH Network which has seen IUIH's National Key Performance Indicator (nKPI) data achieve a range of best practice results, make significant progress towards meeting the

[13] Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013 to 2023

[14] According to an independent study by Latrobe University, IUIH is closing the health-adjusted life expectancy (HALE) gap 2.3 times faster than predicted trajectories

[15] Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-23

[16]. Since 2009, IUIH Network clinics have increased from 5 to 20; regular Indigenous IUIH clients has increased from 8,000 (16% of the Indigenous population in SEQ) to 33,000 (approximately 45% of the Indigenous population), with an average of 9,000 new clients per annum

Implementation Plan's 2023 nKPI targets[17] and deliver validated better health outcomes, including narrowing of the health gap[18].

The efficacy of the PIP IHI to achieve similar improvement outcomes in the mainstream sector is, however, questioned. For example, the current PIP IHI payment structure is applied equally to both ACCHS and mainstream practices without adequately taking into account inherent and fundamental differences and performance expectations. In the case of ACCHSs, the PIP IHI builds on an already evidence-based and best practice model by supporting its extension and continuous improvement - including within a robust benchmarking and monitoring regime (e.g. nKPI reporting). Mainstream practices, on the other hand, start from a significantly lower threshold in terms of cultural acuity, their capacity to provide the levels of holistic comprehensive primary health care required, and their lack of any obligations to report against performance measures and health outcomes.

It is recognised that not all Indigenous people can access ACCHSs and that it is important to have improvement initiatives which can also support mainstream services and programs[19]. A substantive redesign of the current program development and evaluation processes is, therefore, required if objectives of government programs are to be realised, adequately measured and a return on investment demonstrated.

Government programs need to be operating within and evaluated against a monitoring framework which can support relevant trend analysis, benchmark against best practice and monitor continuous quality improvement. For instance, monitoring regimes such as nKPIs, including through benchmarking and target setting, can be instrumental in meeting these objectives and drive real change. Recent Australian Institute of Health and Welfare (AIHW) data (published July 2019)[20], for example, showed that favourable changes were observed for 20 of the 23 nKPIs for which comparable data were available from June 2017 to June 2018. Also, the AIHW data showed that the mean results for nKPI reporting organisations were markedly better for health checks and 1.75 times better than the national results for both General Practitioner Management Plans (GPMP) and Team Care Arrangements (TCA) items for Indigenous Australians.

Accordingly, establishing a suitable accountability architecture for all mainstream programs which is commensurate with relevant performance reporting requirements of ACCHSs and ACCHOs is deemed a priority.

Access and Equity Framework

At a minimum, all mainstream programs should be required to report levels of access by Indigenous clients. Importantly, this should include relevant identification of Indigenous clients and the setting

[17] Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013 to 2023

[18] According to an independent study by Latrobe University, IUIH is closing the health-adjusted life expectancy (HALE) gap 2.3 times faster than predicted trajectories

[19]. For example, the latest AIHW data indicates only 50% of the Indigenous population nationally are accessing ACCHSs. https://www.aihw.gov.au/reports/indigenous-australians/nkpis-indigenous-australians-health-care-2018/contents/nkpi-descriptions

[20] AIHW, 2019 National Key Performance Indicators for Aboriginal and Torres Strait Islander Primary Health Care: Results to June 2018 Cat. no: IHW 211 https://www.aihw.gov.au/reports/indigenous-australians/nkpis-indigenous-australians-health-care-2018/contents/an-overview-of-nkpi-results-to-june-2018

and reporting against targets which are consistent with the Indigenous population levels and need to ensure that equity of access is a priority.

Currently, there isn't consistent transparency and accountability in this regard. For example, mainstream providers who are successful in the Aged Care Approval Rounds (ACAR) in terms of funding for Indigenous places are subsequently not held to account in terms of their performance against Indigenous client numbers. Similarly, there are no accountabilities for NDIS providers to ensure equitable access by Indigenous clients.

Accordingly, IUIH advocates for the inclusion of Indigenous access targets as deliverables within service contracts and the consideration of global closing the gap targets in the aged care and disability sectors.

35. Are there any draft targets you really support? (Say as much as you like, there is no word limit)

The IUIH advocates for a rethink of the current headline CTG health targets concerning the use of Life Expectancy as a preferred measure. For example, Health Adjusted Life Expectancy (HALE) is considered a superior measure to Life Expectancy. This is because HALE extends the concept of life expectancy by also considering the time spent living with disease and injury. It reflects the length of time an individual can, on average, expect to live in full health. This provides a better understanding of whether people are spending more years in good health or more years living with illness. The IUIH contends that reducing premature mortality is not enough if people are going to live longer but in states of ill health and disability.

In the context of closing the gap, the inclusion of HALE is therefore considered a much better measure to use in terms of a CTG target. At present, the crude measure of life expectancy does not highlight or provide capacity for targeted measurement of, the significant disease burden and health gap which Indigenous Australians are experiencing through disease and ill health. The non-fatal component of the Indigenous burden of disease, for example, represents approximately half (47.1%) of the total disease burden. For particular diseases, it is much higher. Mental disorders, hearing, and dental conditions are examples of conditions that are not being systematically measured under current close the gap targets because of their low contribution to mortality. Yet the impact of these conditions can be a quality of life, education and employment outcomes.

36. Are there any draft targets you really do not agree with? (Say as much as you like, there is no word limit)

See the response to question 35 above.

37. Are there any other targets you think should be included? If yes, can you tell us about those targets and why they should be included? (Say as much as you like, there is no word limit)

The IUIH advocates for the inclusion of specific targets for addressing mental health needs and for addressing urban Indigenous disadvantage to Close the Gap. The IUIH also advocates for the inclusion of global closing the gap targets in the aged care and disability sectors.

Addressing Urban Indigenous Disadvantage to Close the Gap

The IUIH advocates for giving priority to addressing urban Indigenous disadvantage to close the gap, including:

- Examining the need for increased funding of, and access to, community-controlled health services for urban Indigenous Australians, relative to disease and disability burden and projected population growth and
- Examining the need for allocating specific infrastructure funding to support enhanced service accessibility in urban settings, including expanded clinic development.

The IUIH sees the rapid urbanization of the Indigenous population as an emergent priority for closing the gap. Efforts to address Indigenous health disadvantage require a refocus on urban settings. Proximity to mainstream primary care has not translated into health equity, with the majority of the Indigenous burden of disease (73%) remaining in urban areas and urban Indigenous people continuing to face significant barriers in accessing comprehensive and culturally appropriate care.

The IUIH has strategically responded to these challenges in South East Queensland (SEQ) – home to Australia's largest and equal fastest growing Indigenous population. The IUIH has developed a new regional and systematised model – a regional health 'ecosystem' – for how primary care is delivered and intersects with the broader health system. Through intentional action which strengthens the self-efficacy of community, The IUIH *System of Care* has achieved real gains for the Indigenous population of the region and can provide similar improvements in health access and outcomes in the other regions.

Before the IUIH, there was limited research that examined the continuing and significant disadvantage experienced by urban Indigenous Australians (Eades *et al*. 2010).[21] This was mainly due to the misconception that urban Indigenous populations enjoyed easy access to, and were benefiting from, 'mainstream' health services. The contrary reality was that proximity to mainstream services in urban settings had not translated into better health outcomes for Indigenous people. This was due to a high degree of inequity, geographical dispersion and segregation, with urban Indigenous people typically residing in isolated, outer suburban areas, characterised by low socioeconomic status and limited employment opportunities (Brand *et al*. 2016).[22]

These barriers have been magnified due to the rapid urbanisation of Australia's Indigenous population, with 79% of Indigenous Australians now living in urban areas (Australian Bureau of Statistics 2017).[23] Nationally, the urban Indigenous population is growing faster than those in remote areas and far outpaces the overall non-Indigenous urban population growth.

[21] Eades S J, Taylor B, Bailey S, Williamson A B, Craig J C, Redman R (2010) The health of urban Aboriginal people: insufficient data to close the gap. Medical Journal of Australia 193, 521-524

[22] Brand E, Bond C, Shannon C (2016) Urban Indigenous Health: Opportunities and Challenges in South East Queensland (University of Queensland Poche Centre for Indigenous Health: Brisbane, Qld)

[23] Australian Bureau of Statistics (2017) Census of Population and Housing: Reflecting Australia - Stories from the Census, Aboriginal and Torres Strait Islander Population 2016, cat no 2071.0 (ABS: Canberra, ACT) Available at http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20Population%20Article~12 [Verified 31 January 2019]

Besides, access to culturally appropriate healthcare remains out of reach for the vast majority of urban Indigenous Australians (Liaw *et al.* 2019).[24] Compared to ACCHSs in remote areas that were reaching 97% of their potential Indigenous population, in 2015 ACCHSs were only reaching 26% of Indigenous people living in major cities (Australian Institute of Health and Welfare 2017).[25]

These access challenges have corresponded to poor health outcomes for urban Indigenous Australians (Eades *et al.* 2010). While remote Indigenous populations generally experience higher rates of disadvantage relative to urban Indigenous populations (Carson *et al*. 2018)[26], the overall health gap is weighted to urban settings. Given the overwhelming proportion of the Indigenous population is in non-remote areas, nearly three-quarters of the total national Indigenous burden of disease (using Disability Adjusted Life Years, DALY) and the Indigenous health gap (DALY Gap), is associated with urban areas (73% and 74% respectively) (Australian Institute of Health and Welfare 2016).[27]

The implications for program development are clear. While there is no denying the health need in remote communities, policies and funding appropriations that are not impacting the highest number of Indigenous people and the most considerable burden of disease, will also not deliver progress to close the gap. Similarly, there is an imperative to ensure adherence to the refreshed CTG focus on evidence-based policies and programs.

As noted, urban Indigenous Australians are accessing evaluated best-practice care, as delivered through community-controlled health services, at only half the national rate. This is mostly a factor of a lack of available and accessible comprehensive and culturally appropriate care in these urban settings, where the majority of the Indigenous population reside. As the recent CTG Special Gathering has advocated, this situation must be redressed through Indigenous empowerment and self-determination which manifests in community-led solutions, not a continued reliance on mainstream service responses for urban Indigenous Australians. There must be an investment in 'what works.'

Addressing Indigenous Mental Health Needs to Close the Gap

The IUIH advocates that the governments commit to giving priority to addressing mental health needs, including:

- Examining the benefits of consolidating Indigenous mental health, suicide prevention, social and emotional wellbeing (SEWB) and substance use funding back under the Commonwealth Department of Health to support preferred service delivery through ACCHSs and more effective partnerships with the mainstream service sector and
- Examining the benefits of adding appropriate mental health Closing the Gap targets, supported by proper prevalence monitoring and adequate funding to address needs.

[24] Liaw ST, Wade V, Furler JS, Hasan I, Lau P, Kelaher M, Xuan W, Harris MF (2019) Cultural respect in general practice: a cluster randomised controlled trial. Medical Journal of Australia 210, 263-268

[25] Australian Institute of Health and Welfare (2017) National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care: results from June 2016. National key performance indicators for Aboriginal and Torres Strait Islander primary health care series no. 4. Cat. no. IHW 177 (AIHW: Canberra, ACT)

[26] Carson E, Sharmin S, Maier A, Meij J (2018) Comparing indigenous mortality across urban, rural and very remote areas: A systematic review and meta-analysis. International Health 10, 219-227

[27] Australian Institute of Health and Welfare (2016) Australian Burden of Disease Study: Impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no. 6 Cat. No. BOD 7 (AIHW: Canberra, ACT)

The mental health needs of Indigenous people require particular attention in the context of closing the gap refresh. Nationally, mental and substance use disorders were responsible for 19% of the total disease burden and 14% of the health gap experienced by Indigenous Australians in 2011, making it the disease group contributing most to the burden of disease and injury and the second largest contributor to the gap in total burden. It was also the leading cause of non-fatal burden, accounting for more than one-third (39%) of all Years Lived with Disability (YLD) When looking at remoteness categories, mental disorders make up an even higher contribution to the Indigenous burden in urban areas compared to remote areas. For example, in Major Cities, mental disorders contribute to 25% of the total disease burden (DALY)[28], almost double that in remote areas. (AIHW, 2016).

Current funding and commissioning arrangements are not supporting efficient and effective mental health, social and emotional well-being (SEWB) and substance use service responses for Indigenous people, due to fragmented responsibilities across government agencies, and mainstream commissioning arrangements and decisions which are not conducive to community-led solutions.

As reported in the *5th National Mental Health and Suicide Prevention Implementation Plan* (Department of Health, 2017a)[29] Aboriginal and Torres Strait Islander adults are almost three times more likely to experience high or very high levels of psychological distress than other Australians, are hospitalised for mental and behavioural disorders at nearly twice the rate of non-Indigenous people, and have twice the rate of suicide than that of other Australians. The breadth and depth of such high levels of distress on individuals, their families, and their communities is profound.
The high rates of chronic disease in Aboriginal and Torres Strait Islander peoples mean that many people are likely to experience coexisting physical and social/emotional health problems. Meeting Closing the Gap targets will require simultaneous action to address chronic disease and mental illness in Indigenous people, families, and communities. Despite having a greater need, Indigenous people have lower than expected access to mental health services and professionals. In 2012–2013, the most common Closing the Gap service gaps reported by ACCHSs related to mental health and social and emotional wellbeing services (Department of Health, 2017a).

This is compounded with the Commonwealth government increasingly using the PHN network to be its commissioning agent of choice with targeted Indigenous mental health funding. In addition to issues outlined earlier regarding this approach, there are examples of PHNs having a preference for funding mainstream mental health services to deliver 'universal' mental health treatment services which include Indigenous people rather than a targeted approach through ACCHSs. This results in:

- mainstream service models which are less appropriate, less likely to be utilised, and less likely to be effective and
- ACCHSs which are insufficiently resourced to deal with the significant numbers of patients with SEWB, mental health, and substance issues at their clinics.

It also has to be noted that ACCHSs are generally funded for SEWB programs (preventive mental health), rather than for clinical treatment mental health services, which is more what they are dealing with on a day to day basis.

[28] Note that in SEQ, mental disorders contribute to up to 30% of the Indigenous disease burden
[29] Department of Health (2017a). Fifth National Mental Health and Suicide Prevention Plan, Implementation Plan, Department of Health, Canberra

Most Aboriginal and Torres Strait Islander peoples want to be able to access services where the best possible mental health and social and emotional wellbeing strategies are integrated into a culturally capable model of health care. This approach needs an appropriate balance of clinical and culturally informed mental health system responses, including access to traditional and cultural healing.

Aboriginal and Torres Strait Islander peoples embrace a holistic concept of health, which inextricably links mental and physical health within a broader concept of social and emotional wellbeing. A whole-of-life view, social and emotional wellbeing recognises the interconnectedness of physical wellbeing with spiritual and cultural factors, especially a fundamental connection to the land, community, and traditions, as vital to maintaining a person's wellbeing (Department of Health, 2017a).

Mental health service access challenges were again highlighted in the recent *My Life My Lead* consultations undertaken by the Commonwealth Department of Health (2017).[30] The consultation report reiterated the importance of culturally valid understandings in shaping the provision of services and guiding the assessment, care, and management of mental disorders for Indigenous people. The report identified inpatient and specialist services as often the least culturally safe for Indigenous people accessing mental health care. Fear of accessing inpatient services is often compounded by people having a lack of support due to dislocation from family and country. In the absence of community-controlled inpatient services, it is, therefore, critical for the Commonwealth to invest in strategies to improve the cultural capability of those services.[31]

The impact of intergenerational trauma and social and economic disadvantage at individual, family and community levels also continues to challenge the mental and physical health and wellbeing of Aboriginal and Torres Strait Islander peoples, who can present to mental health services with a complex and interrelated mix of problems.

To meet this need in the culturally and holistic way described, Aboriginal and Torres Strait Islander leadership, including ACCHSs, must have an integral role in the design and delivery of an appropriately responsive mental health and well-being service system for Indigenous people.

Unfortunately, the current mental health funding framework is not conducive to best supporting this principle. Where mental health, social and emotional well-being and substance use funding should be given to directly to ACCHSs to ensure that comprehensive and integrated care models can be efficiently delivered, an entirely inefficient and fragmented program arrangement is in place.

Following the previous machinery of government changes, mental health, social and emotional well-being, suicide prevention and substance use responsibilities and funding are now split between the Department of Health and the Department of the Prime Minister and Cabinet. Further, specific mental health appropriations for Indigenous people are directed through Primary Health Networks (PHNs) to

[30] Department of Health (2017). My Life My Lead - Opportunities for strengthening approaches to the social determinants and cultural determinants of Indigenous health: Report on the national consultations

[31] For instance, the state-run Statewide Specialist Aboriginal Mental Health Service (SSAMHS) in Perth is an example of a culturally capable specialist mental health service; this model potentially could be expanded into a community controlled model in partnership with an ACCHS.

commission, which adds an inefficient additional layer of administration at best, and at worst, the risk of further service fragmentation through PHN 'market-driven' procurement practices.

Aged Care

The way aged care services are redesigned and delivered for Indigenous Peoples will be key to ensuring alignment with the refreshed Closing the Gap principles and priorities.

Sadly, this is not yet the everyday reality for the majority of Indigenous Elders – who are the fastest-growing Indigenous cohort yet continue to experience serious barriers in accessing and navigating the current aged care system. Although these systemic barriers have recently been highlighted by the Aged Care Royal Commission, the current iteration of the Closing the Gap reforms have yet to acknowledge this as a priority.

Accordingly, IUIH advocates:

- Indigenous-led re-design of the aged care system, including culturally safe service navigation/assessment pathways, and a reinterpretation of the concepts of person centred care and client choice/control from Aboriginal terms of reference
- Building the capacity of and contracting Indigenous community-controlled organisations on a preferred provider basis to deliver aged care programs for Indigenous Elders, including integration with health care and supported by business models which incorporate block funding
- Incorporation of mandatory Indigenous number or percentage targets of aged care clients, commensurate with Indigenous population levels and also acknowledging the higher level of need of Indigenous Elders.

The barriers experienced by Indigenous Elders manifest in several ways, including:

- The significant disparities that exist for Indigenous Elders to gain equitable participation and access to the full range of aged care programs that are available in Australia. This is particularly evident in relation to addressing their higher and more complex health and social needs. For example these include, but are not limited to Indigenous Australians are 2.3 times as likely to die early or live with poor health compared to non-Indigenous Australians [Australian Institute of Health and Welfare]; Indigenous Australians are 2.1 times as likely to have a profound/severe core activity limitation than non-Indigenous Australians [Australian Institute of Health and Welfare]; Indigenous Australians are likely to experience dementia at 3 to 5 times the rates of non-Indigenous Australians [Australian Institute of Health and Welfare]; and Indigenous Australians are 2.7 times more likely to live in disadvantaged areas compared to non-Indigenous people based on the SEIFA Index of Relative Socio-Economic Advantage and Disadvantage [ABS]
- The lack of culturally safe service choices for Indigenous Elders. This is most evident in a significant deficit of Indigenous-led aged care providers in Australia who can best provide the essential foundational cultural enablers of trust and respect. This is further compounded by the continuing cultural barriers manifest in the mainstream system and the lack of any real performance measures or targets which would ensure accountability of mainstream providers to prioritise Indigenous need and demonstrate cultural attunement and competence and
- The lack of government aged care funding and program agility to match the pace and location of Australia's rapidly growing and ageing Indigenous population. This is particularly evident in the urbanisation of the Indigenous population, which represents one of the most striking demographic trends since Indigenous populations were first counted. For example, 79% of Indigenous people now live in urban areas, with the largest cohort (41%) of Indigenous people living in major urban cities over 100,000 (ABS), yet funding is not commensurate with this need. The fastest-growing Indigenous populations are in these major urban cities, with population decline or slowed growth in remote and very remote regions. However, proximity to mainstream services has not translated into better health or aged care access and outcomes for urban

Indigenous Australians, with 73% of the total Indigenous burden of disease and 74% of the total health gap in urban areas [Australian Institute of Health and Welfare]. The Indigenous 50+ year's intercensal growth between 2011 and 2016 was the fastest-growing Indigenous age cohort (39%)

- double that of the non-Indigenous aged population growth rate (20%) in this period [ABS]. Whilst the total Indigenous population is projected to grow by 59 per cent between 2011 and 2031, the Indigenous population aged 65 and over is projected to grow by 200 per cent. [CAEPR Indigenous Population Project. 2011 Census Papers. Paper 14: Population Projections].

Tellingly, the raft of recent aged care reforms, including through the Living Better Living Longer initiatives, have not yet delivered particularly well for Indigenous people in terms of addressing these challenges. Despite well-intentioned, key design elements of these reforms (including Consumer Directed Care, person centred care, MyAgedCare portal, ACAT/RAS, service navigation and fees/funding structures) requires substantial recalibration and reframing from Aboriginal Terms of Reference, before they can begin to be impactful for Indigenous Elders and their families.

By contrast, IUIH, as an example, has turned the tables on the usual reform paradigm and implemented a completely new aged care model, delivering what is considered to be unprecedented national results in its South East Queensland footprint. For example, since its establishment in 2009, the numbers of Indigenous people regularly accessing comprehensive health care from IUIH has increased from 8,000 to 35,000, and the number of Indigenous Elders accessing the Institute's aged home care and support services has increased from 48 to over 1800. The Institute is now considered to be Australia's largest single Provider of community-controlled community aged care.

Fundamentally, IUIH's success has occurred not because the government wished it to happen. It was not a response to an aged care reform strategy or policy. It happened because its communities determined it should. It was community-controlled and Indigenous designed and driven – every step of the way.

This has been the key driver in the cultural shaping and design of IUIH's aged care model – a model which is recognised by both government and the sector as best practice, and one which is considered has significant potential for adaptability and replicability nationally. For example, NACCHO has, in its October 2019 submission to the Royal Commission on Aged Care Quality and Safety, recommended that to better support Indigenous Elders, "the Australian Government increase its investment in integrated primary health and aged care exemplified by IUIH" - submission AWF.001.04347 accessible at https://agedcare.royalcommission.gov.au/submissions/Pages/read-published-submissions.aspx#N

IUIH's model is characterised by:

- Cultural integrity: The model affirms the recurring evidence that Indigenous people will access services and actively engage in, and benefit from, health-improving, independence promoting and capacity building behaviours when they are culturally connected to community-controlled providers and can develop trusting relationships with Indigenous staff. Equally important is that all aspects of care planning and delivery are designed and operate from an Indigenous worldview. For example, in contrast to a deficit discourse, the development and implementation of aged care plans are strength-based: with cultural identity, connection to family/community and cultural healing critical success factors supporting goal attainment and increased independence. Similarly, the modality of service delivery is framed around how 'mob' engages with each other and their support workers – which often is reflected in collectivism, ways of belonging and family-centric, rather than an individualistic focus
- Integrated and holistic care: The above cultural integrity framework is enhanced through the extensive additional wrap-around services which the model can offer clients. Operating from the premise of a 'one-stop-shop' for all clients, there is no wrong door to access a full range of primary/specialist health, family, social, community and aged care services

- Service Navigation: Based on a foundation of cultivated cultural trust and respect, the model places a premium on and invests in proactively supporting clients in seamless navigation of the aged care system
- Business model: Operating under a unique service delivery and financial arrangement, client co-contributions are eliminated as a barrier to access
- Accountability: Accountability to community is considered the essence of community control, with key delivery metrics and outcomes supported through robust performance monitoring mechanisms and
- Targeted investment: Resources are commissioned to ensure priority needs are appropriately targeted, including tailored responses to the rapid Indigenous population growth in urban areas.

The imperative to urgently reshape the aged care system for Indigenous Elders has recently been highlighted in the Royal Commission into Aged Care Quality and Safety's Interim Report (released October 2019). The Royal Commission acknowledged the contributions made by IUIH - whom the Commission called as an expert witness - and drew on this contribution to formulate its Interim Report conclusions.

In relation to Indigenous Elders, the Royal Commissioners committed to further explore the following to inform recommendations in its final report:

- more accessible aged care assessment pathways
- integration of aged care with other services, such as primary health, mental health and disability services, including services provided by Aboriginal Community Controlled Health Organisations and other existing Aboriginal health and community organisations
- greater provision of Aboriginal and Torres Strait Islander-specific services in cities and regional areas and
- ways to support aged care services to be staffed and managed by Aboriginal and Torres Strait Islander people.

These important reform areas and the need to include aged care participation targets are also key areas of focus for the Closing the Gap reform agenda.

Further details of IUIH's Royal Commission witness statement (Exhibit 5-28 – WIT.0162.0001.0001, Statement of Matthew Moore) and testimony transcript (Perth Hearing, 26 June 2019, Matthew Moore) can be accessed at https://agedcare.royalcommission.gov.au/hearings/Pages/default.aspx

National Disability Insurance Scheme (NDIS)

IUIH calls for the Australian Government to commit to giving priority to:

- Indigenous-led re-design of the NDIA Indigenous engagement processes, including to support contracting Indigenous community-controlled organisations on a preferred provider basis to undertake Local Area Coordinator (LAC) functions and
- Implementation of a targeted investment strategy that incorporates mandatory Indigenous number or percentage targets, commensurate with the estimated Indigenous NDIS participant rate and also the higher level of need of Indigenous people with a disability.

The NDIS has the potential to significantly enhance access, choice and control for disabled persons through customising and personalising annual Service Plans to reflect individual goals. However, systemic design flaws in the National Disability Insurance Agency's (NDIA) Indigenous investment and engagement strategies put this potential at risk for Indigenous clients. In particular, functional and siloed constraints inherent in the current NDIS model present barriers to culturally appropriate access to, and navigation of, the NDIS including concerning community/region-specific and tailored support from Local Area Coordination (LAC) services.

Further, while the evidence supports Indigenous community-controlled organisations as being best placed to address these barriers, this is currently not being supported by the NDIA at a systems-wide level – an approach that is also misaligned with the principles of the Closing the Gap Refresh agenda.

As a first step in addressing these barriers, the NDIA has recently funded IUIH to undertake a pilot project of national significance in relation to trialling a radically different pathway of NDIS access navigation for Indigenous people, including culturally safe support processes to apply for NDIS eligibility assessment, NDIS plan preparation and plan lodgement. The outcome of this trial - which effectively replaces the current ineffectual LAC process - will make an important contribution to the wider Closing the Gap reform agenda and is considered essential to informing the Closing the Gap partnership agreement architecture going forward.

38. Is there something that you would like to add about the Closing the Gap targets? (Say as much as you like, there is no word limit)

See response to question 37 above.