

**KPMG
National Monitoring and
Evaluation of the
Indigenous Chronic
Disease Package:
Final Evaluation Summary
Report**

June 2014



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National Monitoring and Evaluation of the Indigenous Chronic Disease Package: Summary Report (2009-2013)

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Glossary

Acronyms	Descriptions
ABS	Australian Bureau of Statistics
AGPN	Australian General Practice Network
AHS	Aboriginal health service
AHW	Aboriginal Health Worker
AIHW	Australian Institute of Health and Welfare
ATSIOW	Aboriginal and Torres Strait Islander Outreach Worker
CDSM	Chronic Disease Self Management
CtG scripts	Closing the Gap (relates to scripts dispensed through the PBS Co-payment measure of the ICDP)
EQHS/EQHS-C	Establishing Quality Health Standards and Establishing Quality Health Standards Continuation
GP	General Practitioner
HPF	Health Performance Framework
ICDP	Indigenous Chronic Disease Package
IHPF	Indigenous Health Partnership Forum
MBS	Medicare Benefits Schedule
MSOAP	Medical Specialist Outreach Assistance Program
NACCHO	National Aboriginal Community Controlled Health Organisation
NAGATSIHID	The National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data
NGO	Non-government organisation
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentives Program



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Acronyms	Descriptions
SBO	The (previous) State Based Organisations representing Divisions of General Practice
STO	The previous State or Territory offices of the (former) Department of Health and Ageing
VET	Vocational Education and Training
WHO	World Health Organisation

Main messages

These main messages identify the key implications for decision makers from the evaluation of the Indigenous Chronic Disease Package (ICDP). Chapter 6 of this report identifies specific lessons and opportunities for further consideration.

The ICDP represented the Commonwealth's contribution to the National Partnership Agreement on Closing the Gap in Indigenous health outcomes.¹ The ICDP put forward a comprehensive, multi-faceted strategy designed to enhance the focus of the primary health care system around preventive health and effective chronic disease management.

- The ICDP mobilised considerable effort to address key areas of weakness in the primary health care system. This has resulted in many primary health care organisations embedding the features of effective chronic disease management and prevention in every day practice, and communities also being more empowered to focus on prevention. However, it will take time for these changes to deliver impacts on chronic disease incidence, prevalence and mortality.
- Both the community controlled and mainstream sectors have important roles in addressing the chronic disease burden that is faced by Aboriginal and Torres Strait Islander people. The ICDP rightly invested in capacity and capability building in both sectors, and contributed to improving collaboration between the two sectors. Future policy should continue to focus on building the capacity of both sectors and create incentives and opportunities for the two sectors to work together.
- There was a concern early on that the ICDP as a national policy was being imposed at the local level with little flexibility. Not all organisations recognised its overall design and complementary nature. Over time some organisations began to appreciate the synergies which allowed them to tailor the package to suit their environment and meet local needs. Future complex initiatives need a communication and support strategy that assists organisations to leverage the opportunities in order to maximise the outcomes for their community.
- Getting the balance right in terms of the degree of prescription and flexibility within program parameters is not easy, however can empower health services to effectively accommodate programs in a way that also takes account of varying levels of organisational capability. It also enables the design of programs to be honed during the implementation phase so that they can be effectively implemented in local contexts.

¹ On 1 July 2014, the Indigenous Australians' Health Program was established consolidating four existing funding streams including the Aboriginal and Torres Strait Islander Chronic Disease Fund which had replaced the ICDP. The majority of the original ICDP measures are continuing under the new program.

- The ICDP enabled some primary health care organisations to focus on preventive public health for the first time, while for others the dedicated support enabled them to further build on their existing preventive health workforce capability. This will have lasting impacts in terms of helping reorient organisations to be more focussed on prevention, in the recognition that most chronic disease conditions are preventable.
- Preventive health seeks to change long term, entrenched behaviours, which are often influenced by a range of complex environmental and social issues. Primary health care organisations need to be supported to build the skills of the ICDP preventive health workforce to effectively address the complex determinants of lifestyle choices and risk behaviours.
- The paucity of existing evidence about effective health promotion approaches meant that there was a limited evidence base available for the preventive health teams and the local community campaigns. There is a need to systematically build and share relevant evidence to maximise the effectiveness of preventive health strategies for Aboriginal and Torres Strait Islander Australians, in order to support targeted investment in the future.
- Many primary health care organisations in the mainstream and Aboriginal health sectors made important changes to some patient care practices, but were not always able to embed these changes in day to day operations. These organisations and others that have yet to take up the opportunities created through the ICDP, need to be encouraged and supported to take a systematic approach to chronic disease prevention and management as part of core, comprehensive primary health care.
- The ICDP implemented a number of broad based strategies such as the Practice Incentives Program (PIP) Indigenous Health Incentive to improve patient care and management practices. These strategies need to focus more on demonstrable improvements to patient outcomes. This will require stronger policy levers that encourage general practices and Indigenous health services to appropriately and effectively meet the chronic disease care needs of Aboriginal and Torres Strait Islander people.
- Primary health care organisations participating in the ICDP often struggled to collect the clinical data essential for patient care and/or the information necessary to know whether their activities were having an impact in their communities. More needs to be done to support these organisations to develop the capability to collect the information necessary for ongoing monitoring and continuous quality improvement.
- The ICDP introduced a range of new workforce elements whose roles and training needs have continued to evolve. Support strategies are now required to ensure the sustainability and effectiveness of this workforce such that the improvements enabled through the new positions are embedded in the current system.
- Implementation of the ICDP illustrated that leadership, and organisational capacity to build linkages and partnerships, are critical enablers. Future programs should incorporate capacity building and opportunities to foster leadership from the design phase throughout implementation and beyond.



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- The efforts enabled through the ICDP to date have helped create the necessary momentum to reorient the primary health care system to be better attuned to the health care needs of Aboriginal and Torres Strait Islander people at risk of or experiencing chronic disease. Building on this momentum will support sustainable change and the spread of this new orientation across the service system.

Executive Summary

This is a summary report on the evaluation of the Indigenous Chronic Disease Package (ICDP). The evaluation was commissioned by the Department of Health (the department) and undertaken by KPMG with support from Winangali² and Baker IDI³.

The full report comprises:

- Volume 1 and its appendices which provide details of the evaluation of each measure that makes up the ICDP and the evaluation of the whole of package.⁴
- Volume 2, referred to as the ICDP impact on Patient Journey and Service Availability report, which provides the details of the evaluation findings in relation to a selected number of sites where the ICDP was operating.⁵

The reader is also referred to the Sentinel Sites Evaluation reports.⁶ In 2010, the department contracted Menzies School of Health Research (Menzies) to undertake a place-based monitoring and formative evaluation of the ICDP through the Sentinel Sites Evaluation to inform ongoing refinements in the design and implementation of the package. These reports have been used to inform this evaluation in addition to other activities undertaken by this⁷ evaluation.

Context

Chronic disease contributes about 80 per cent of the mortality gap between Aboriginal and Torres Strait Islander Australians and other Australians aged 35-74 years.⁸ Aboriginal and Torres Strait Islander people experience risk factors associated with chronic disease at higher rates than other Australians and experience death from chronic disease earlier than other Australians.

² [Winangali](http://winangali.com.au/) is an independent Indigenous consultancy specialising in engaging with Aboriginal and Torres Strait Islander markets whose staff assisted with community consultations, <<http://winangali.com.au/>>

³ [Baker IDI Heart and Diabetes Institute](http://www.bakeridi.edu.au) is an independent medical research facility. <www.bakeridi.edu.au>

⁴ KPMG 2014, National Monitoring and Evaluation of the Indigenous Chronic Disease Package: Final Report (2014), Australian Government Department of Health, Canberra.

⁵ KPMG 2014, National Monitoring and Evaluation of the Indigenous Chronic Disease Package Volume 2: ICDP Impact on Patient Journey and Service Availability (2014), Australian Government Department of Health, Canberra.

⁶ Menzies School of Health Research 2013, [Sentinel Sites Evaluation Final Report February 2013](http://www.healthinonet.edu.edu.au/key-resources/bibliography/?lid=26320), prepared for the former Australian Government Department of Health and Ageing <<http://www.healthinonet.edu.edu.au/key-resources/bibliography/?lid=26320>>.

⁷ Australian Institute of Health and Welfare. [Access to health services for Aboriginal and Torres Strait Islander people](http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737418951). Canberra: AIHW, 2011. (Cat. No. IHW 46.), viewed May 2014, <<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737418951>>.

⁸ Australian Institute of Health and Welfare. [Contribution of chronic disease to the gap in mortality between Aboriginal and Torres Strait Islander people and other Australians](http://www.aihw.gov.au/publicationdetail/?id=10737418878). Canberra: AIHW, 2011. (AIHW Cat. No. IHW 48.), viewed Oct 2013, <<http://www.aihw.gov.au/publicationdetail/?id=10737418878>>.

In spite of the high level of chronic disease and other morbidity among Aboriginal and Torres Strait Islander people, historically they have been lower users of a range of acute health care services than other Australians and their use of primary health care services such as MBS services is similar to that of other Australians. While they make use of the mainstream general practices in addition to Aboriginal Health Services (AHSs), historically not all general practices have provided culturally sensitive and appropriate services.

The Indigenous Chronic Disease package

The ICDP put forward a comprehensive multi-faceted strategy, comprised of 14 measures which aim to enhance the capacity of the primary health care system around preventive health and effective chronic disease management. The ICDP focused on:

- tackling chronic disease risk factors;
- earlier detection, improved management and follow up of chronic diseases in primary health care; and
- expanding the Aboriginal and Torres Strait Islander workforce and increasing the capability of the health workforce to deliver effective care.

The Commonwealth contributed \$805.5 million to the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes over four years (2009 to 2013).

The evaluation

The evaluation commenced in July 2011 and had multiple rounds of data collection and reporting. The final round of primary data collection activities was completed by May 2013. The evaluation served two broad purposes. Firstly, together with other mechanisms deployed by the department, the evaluation provided the department with information on implementation progress through two monitoring reports. Secondly, the evaluation assessed the effectiveness of the ICDP and in doing so considered the appropriateness of the ICDP and synergies that it created.

The evaluation used a mixed-methods methodology that involved analysis of primary and secondary data as well as quantitative data collection and analysis.

Key Findings

The ICDP has improved the capacity, capability and responsiveness of the primary health care service system to meet the needs of Aboriginal and Torres Strait Islander people

This has resulted in an increase in the use of essential health services by Aboriginal and Torres Strait Islander people, with more people being supported to adopt healthier life styles and more people being able to manage their chronic disease better. Importantly, the ICDP is addressing the factors that account for why chronic disease contributes to about 80 per cent of the mortality gap for Aboriginal and Torres Strait Islander people. It has increased the focus on health promotion and preventive health that has resulted in community members now seeking more help to, for example, quit smoking. It has increased the use of services which help with earlier identification of chronic disease and with referral to specialist services, and it has improved the management and coordination of care for some people with a chronic condition.

The ICDP has made progress in addressing some of the systemic issues that ultimately will determine the extent to which the gap in life expectancy will be reduced

The ICDP has improved the cultural responsiveness of many mainstream general practices although much more needs to be done. The ICDP has reduced barriers, such as financial, transport and cultural barriers, that Aboriginal and Torres Strait Islander people face in trying to use primary health care services, and it has improved the capacity of the community controlled sector to support and empower its community to take action to reduce the prevalence of chronic disease.

While there is some evidence that this could reduce the incidence of chronic disease and reduce mortality rates associated with chronic disease, it will take time before there is any demonstrable whole of population impact.

The ICDP has built momentum to orient the primary health care system to evidence-based chronic disease management and to embed preventive health in all aspects of the system

There are opportunities and an imperative to improve the effectiveness of the current investments that include:

- modifying the PIP Indigenous Health Incentive practice improvement incentives so that they are more explicitly linked to demonstrable quality and practice improvement outcomes;
- better integration of the new workforce types into the existing workforce;
- increasing the accountability of all primary health care organisations to embed preventive health in all aspects of their operations; and
- more actively and systematically building and sharing evidence in order to maximise the effectiveness of preventive health strategies for Aboriginal and Torres Strait Islander people.

There is also an imperative to continue with the focus of building strong organisations in both the mainstream and Aboriginal health sectors including leadership, technical capability and strong governance that requires continued support from peak bodies and leaders in Aboriginal and Torres Strait Islander health; and for a greater focus on addressing the underlying complex social issues that often prevent people from focusing on their physical health.

The ICDP has created an expectation amongst the community and a demand for help and services

The momentum towards prevention and effective chronic disease management that the ICDP has created needs to be supported for it to be embedded into the system. It is important that future policy considers how best to capitalise on this momentum and that it addresses the subsequent increasing demand for services that is now occurring.

1 Context

In 2008 the Council of Australian Governments joined in a National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes.^{9,10} This agreement was particularly intended to contribute to the target of closing the gap in life expectancy between Aboriginal and Torres Strait Islander people and other Australians within a generation.¹¹ Accordingly, the ICDP focused on the major causes of premature death within the Aboriginal and Torres Strait Islander population, relative to other Australians.

The overall agreement was to direct \$1,577 million to this objective, with the Commonwealth contributing \$805.5 million.¹² The Commonwealth contribution was implemented through the ICDP.^{13 14}

While the ICDP was a major Commonwealth expenditure package, it represented a relatively modest increment to the Australian Government's total Aboriginal and Torres Strait Islander health expenditure. For example, in 2010-2011 ICDP expenditure represented 13 per cent of the Commonwealth's total Aboriginal and Torres Strait Islander health expenditure.

The primary health care system is made up of three overlapping and intersecting components. These are ongoing Commonwealth investment in Aboriginal and Torres Strait Islander primary health care that consists of grant based funding of Aboriginal and Torres Strait Islander specific health services; Commonwealth funding through MBS, PBS and the Practice Incentives Program; and state and territory government investment in Aboriginal and Torres Strait Islander primary health care through for example, funding state run Aboriginal health services (AHSs).

⁹ Council of Australian Governments October 2009, [National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan, Jurisdiction: Commonwealth](http://www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-health-outcomes/all_states_IP.pdf). COAG, Canberra, viewed 8 May 2014, <http://www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-health-outcomes/all_states_IP.pdf>.

¹⁰ Council of Australian Governments [n.d.], [Closing the Gap in Indigenous Disadvantage](http://www.coag.gov.au/closing_the_gap_in_indigenous_disadvantage) (website), COAG, viewed 8 May 2014 <http://www.coag.gov.au/closing_the_gap_in_indigenous_disadvantage>.

¹¹ *ibid.*

¹² Council of Australian Governments 2008, [National Partnership Agreement on Closing The Gap in Indigenous Health Outcomes](http://www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-health-outcomes/national_partnership.pdf), COAG, Canberra. Available at <http://www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-health-outcomes/national_partnership.pdf>.

¹³ Council of Australian Governments October 2009, [National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan, Jurisdiction: Commonwealth](http://www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-health-outcomes/all_states_IP.pdf). COAG, Canberra, viewed 8 May 2014, <http://www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-health-outcomes/all_states_IP.pdf>.

¹⁴ While the NPA expired on 30 June 2013, the Commonwealth continued its contribution through the, Aboriginal and Torres Strait Islander Chronic Disease Fund (ATSICDF). From 1 July 2014 four separate funding streams including the ATSICDF were consolidated the Indigenous Australians' Health Program. The majority of the ICDP measures are continuing under the new arrangements.

1.1 The Aboriginal and Torres Strait Islander life expectancy gap

In the period from 2005 to 2007, the gap in life expectancy between Aboriginal and Torres Strait Islander people and other Australians resulted in 1,523 potential years of life lost per 10,000 Aboriginal and Torres Strait Islander people.¹⁵ The substantial majority of that difference (79.7 per cent) was attributable to chronic diseases, and most was specifically attributable to the following six disease groups:

- heart diseases;
- diabetes;
- diseases of the liver;
- chronic lower respiratory disease;
- cerebrovascular diseases; and
- cancers.¹⁶

Aboriginal and Torres Strait Islander people also experience death from chronic disease earlier than other Australians. This can be seen from two key facts. In terms of mortality rates, 35 to 44 year old Aboriginal and Torres Strait Islanders have the highest increased likelihood of premature death compared to other Australians (5.0 times more likely for males and 5.4 times more likely for females).¹⁷ The next highest age groups with increased likelihood of premature death were for 25 to 34 year olds and 45 to 54 year olds. As well as this premature mortality, chronic diseases were responsible for around three quarters of potential years of life lost in the 35 to 54 Aboriginal and Torres Strait Islander age group.

As well as high rates of premature mortality from chronic diseases, in 2008-09 Aboriginal and Torres Strait Islander people also were more than eight times as likely to experience a potentially preventable hospital episode for a chronic disease than were other Australians.¹⁸

There are a number of behavioural risk factors that are associated with the chronic diseases most strongly affecting Aboriginal and Torres Strait Islander mortality. Each of the six chronic diseases listed above is linked to one or more of the following behavioural risk factors: tobacco smoking; physical inactivity; alcohol misuse; poor nutrition; and obesity.¹⁹

¹⁵ Australian Institute of Health and Welfare May 2011, *Contribution of chronic disease to the gap in adult mortality between Aboriginal and Torres Strait Islander and other Australians*, AIHW, Canberra, cat. no. IHW 48.

¹⁶ *ibid.*

¹⁷ Australian Institute of Health and Welfare 2011, *The health and welfare of Australia's Aboriginal and Torres Strait Islander people, an overview 2011*, AIHW, Canberra, cat. no. IHW 42.

¹⁸ *ibid.*

¹⁹ Australian Institute of Health and Welfare March 2012, *Risk factors contributing to chronic disease*, AIHW, Canberra, cat. no. PHE 157.

Aboriginal and Torres Strait Islander people experience these risk factors at higher rates than other Australians^{20,21} which contributes to the elevated chronic disease morbidity and mortality experienced by this population.

This elevated mortality and morbidity from chronic disease for Aboriginal and Torres Strait Islander people occurs in a world where many chronic diseases are becoming more prevalent. Rates of chronic disease are increasing in Australia and in many parts of the world.²² In 2005 the World Health Organization (WHO) described the growth in chronic diseases as “looming epidemics ... that for the foreseeable future will take the greatest toll in deaths and disability”.²³

1.2 The chronic disease challenge

In Australia, chronic diseases impact heavily on the use of health services and contribute to major funding pressures on the health care system. Chronic diseases are the leading causes of death and disability in Australia, result in hospitalisation that is otherwise preventable and the burden of these conditions can be high for sufferers, their families and carers.

This worldwide growth in chronic disease is driven by increased prevalence of four main behavioural risk factors: tobacco smoking, physical inactivity, alcohol use and poor nutrition.²⁴ Moreover, these risk factors are more likely to occur in poor and socially disadvantaged countries and communities.²⁵

The greatest reductions to the burden from chronic disease will come from prevention and population wide activities, such as health promotion and education.²⁶ Nonetheless, early detection and effective treatment of chronic disease are also needed to reduce the impact of chronic diseases for those people who develop them, their families and their communities.

²⁰ Britt H & Miller GC (eds.) 2009, *General practice in Australia, health priorities and policy 1998 to 2008*, Australian Institute of Health and Welfare, Canberra, General practice series, no. 24. cat. no. GEP 24.

²¹ Australian Bureau of Statistics 11 April 2006, *National Aboriginal and Torres Strait Islander Health Survey 2004-05*, ABS, Canberra, cat. no. 4715.0.

²² Australian Institute of Health and Welfare March 2012. *Risk factors contributing to chronic disease*, AIHW, Canberra, cat no. PHE 157.

²³ World Health Organisation 2005, *Preventing chronic diseases: a vital investment: WHO global report*, WHO Press, Geneva.

²⁴ World Health Organisation 2011, *Global status report on noncommunicable diseases 2010*, WHO Press, Geneva.

²⁵ World Health Organisation 2002, *Innovative care for chronic conditions: building blocks for action: global report*, WHO Press, Geneva.

²⁶ World Health Organisation 2011, *Global status report on noncommunicable diseases 2010*, WHO Press, Geneva.

There are a number of challenges associated with responding to this increasing burden on health systems:

- Chronic disease is preventable yet not directly in control of health professionals, as the risk factors primarily relate to behaviours of individuals and to the environments within which they live.
- Prevention of complications and exacerbations of chronic disease relies on early detection and action. The WHO advocates active prevention as a necessary part of every health care interaction.²⁷
- Effective chronic disease management requires a different approach to traditional services organised around an episodic model of care designed to deal with acute problems. In particular, it requires ongoing monitoring of the condition and ongoing involvement of the patient, the community in which they live and the health care workers with whom they interact.
- Patients with chronic disease need to be active partners in the management and treatment of their condition. The role of behavioural risk factors in causing and exacerbating chronic disease makes this essential.
- These patients also need to be supported beyond the clinic and into their home, working and community environments. Successful management of chronic conditions requires services and support from, and within, their communities.²⁸
- Care for chronic conditions requires integration to ensure continuity across settings and providers, as well as over time. This is needed to ensure the necessary services are both accessible to the patient and available when the patient needs them.
- Advanced communication abilities, behaviour change techniques, patient education, and counselling skills are necessary in helping patients with chronic disease. Providers with these skills do not necessarily require medical qualifications and experience. A trained workforce of health care workers with a health promotion and illness prevention focus provides an efficient and effective means to support patients and improve long term outcomes.²⁹

1.3 The chronic disease challenge for Aboriginal and Torres Strait Islander people

Effective chronic disease management requires significant changes from health care systems as well as among communities and the individuals within them. This is particularly true for Aboriginal and Torres Strait Islander people in Australia, where chronic disease is

²⁷ World Health Organisation 2002, *Innovative Care for Chronic Conditions: Building Blocks for Action: Global Report*, WHO Press, Geneva.

²⁸ *ibid.*

²⁹ *ibid.*

such a large contributor to the gap in life expectancy between this population group and other Australians.

In spite of the high level of chronic disease and other morbidity among Aboriginal and Torres Strait Islander people, historically they have been lower users of some acute health services compared to other Australians³⁰ and their use of primary health care services such as general practice type MBS services is similar to that of other Australians.³¹ This low level of primary care services relative to need in turn results in high use of hospital services, including emergency departments and outpatient clinics, by Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander people use mainstream general practices as well as AHSs (both community controlled and state/territory funded services). However, historically not all general practices have provided culturally 'sensitive and appropriate services.'³² This can range from providers displaying bias or discrimination³³ to simply failing to identify their Aboriginal and Torres Strait Islander patients, resulting in that person not having access to relevant MBS, PBS, immunisation and other services.

Contributing to this situation is the fact that for many general practices, Aboriginal and Torres Strait Islander patients are a small proportion of their patient population. This has made it challenging for such practices to develop the necessary competence in Aboriginal and Torres Strait Islander health. Effectively responding to the prevalence of chronic disease in the Aboriginal and Torres Strait Islander population relies on meeting these challenges.

On average, Aboriginal and Torres Strait Islander people experience greater levels of social and economic disadvantage than other Australians. For example, they are more likely to experience lower household income, live in single parent families and to have left school at year nine or lower, while also being less likely to have access to a motor vehicle.³⁴ The WHO and the Australian Institute of Health and Welfare (AIHW) have both reported that

³⁰ Council of Australian Governments October 2009, [National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan, Jurisdiction: Commonwealth](#), COAG, Canberra, viewed 8 May 2014, <http://www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-health-outcomes/all_states_IP.pdf>.

³¹ Australian Institute of Health and Welfare 2011, [Access to health services for Aboriginal and Torres Strait Islander people](#). Cat. No. IHW 46. Canberra: AIHW, viewed May 2014, <<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737418951>>.

³² *ibid.*

³³ Abbott P, Dave D, Gordon E & Reath J 2014, 'What do GPs need to work more effectively with Aboriginal patients? Views of Aboriginal cultural mentors and health workers', *J Australian Family Physician*, vol. 43, no. 1, pp 58-63. <<http://www.racgp.org.au/afp/2014/januaryfebruary/aboriginal-cultural-mentors/>>.

³⁴ Australian Institute of Health and Welfare 2011, *Aboriginal and Torres Strait Islander Health Performance Framework 2010: detailed analyses*, AIHW, Canberra, cat. no. IHW 53.

such disadvantaged populations are more likely to experience chronic disease risk factors and, consequently, experience greater illness and mortality from chronic disease.^{35,36}

Such social disadvantage can also make it harder to respond to chronic disease. For example, lower educational attainment means Aboriginal and Torres Strait Islander people will often have low levels of health literacy and lack the knowledge required to negotiate complex pathways through the health system. This presents a challenge to building the health literacy needed for Aboriginal and Torres Strait Islander people with chronic disease to self manage their condition. In addition to health literacy, a key requirement to effectively self manage chronic disease is the confidence to carry out the behaviours needed to self manage, as well as a personal belief that one is able to self manage their condition. This all points to the importance of treatment and support services being provided in ways and settings that are familiar, non-threatening and culturally safe.

The cultural competency of a primary health care organisation or the health system more broadly impacts on Aboriginal and Torres Strait Islander people's access to health care, the quality and effectiveness of the care that is received, and disparities in health outcomes.³⁷

An orientation to the delivery of culturally competent care requires health professionals and organisations to have an explicit and defined set of core values and principles that value and embrace diversity, actively seek to manage the dynamics of difference as well as acquire and embed cultural knowledge while adapting to different cultural contexts. Underpinning this is an ongoing commitment to reflecting, learning and adapting in order to improve the cultural competency of their work.

The Aboriginal and Torres Strait Islander population is also highly dispersed, with large parts of that population living in both large and small communities in remote and very remote areas. More than one in five Aboriginal and Torres Strait Islander people live in these areas and more than one in five live in outer regional parts of Australia.³⁸ The fact that Aboriginal and Torres Strait Islander communities are often dispersed within large general populations also exacerbates the challenges the health system faces in terms of enabling a connected patient journey.³⁹

³⁵ World Health Organisation 2005, *Preventing chronic diseases: a vital investment: WHO global report*, WHO Press, Geneva.

³⁶ Australian Institute of Health and Welfare March 2012, *Risk factors contributing to chronic disease*, AIHW, Canberra, cat no. PHE 157.

³⁷ Lau P., Pyett P., Burchill M., Furler J., Tynan M., Kelaher M., Liaw S. 2012, 'Factors influencing access to urban general practices and primary health care by Aboriginal Australians – A qualitative study', *AlterNative: An International Journal of Indigenous Peoples*, 8(1), 66-84.

³⁸ Australian Bureau of Statistics 2014, [Census 2011: RA by INGP counting persons by place of usual residence. Table Builder Basic](http://abs.gov.au/websitedbs/D3310114.nsf/home/About+TableBuilder) (website), ABS, Canberra, viewed 18 May 2014 <<http://abs.gov.au/websitedbs/D3310114.nsf/home/About+TableBuilder>>.

³⁹ In 2011, one sixth of the Aboriginal and Torres Strait Islander population were dispersed among large communities of 50,000 or more people and where the Aboriginal and Torres Strait Islander population comprised less than 2.5% of the community's population.

2 Overview of the ICDP

The ICDP aimed to reduce the incidence of preventable chronic disease and improve outcomes for Aboriginal and Torres Strait Islander people with chronic disease through 14 measures across three elements:⁴⁰

- Tackling chronic disease risk factors;
- Improving chronic disease management and follow up care; and
- Workforce expansion and support.

Appendix A provides further information about the 14 measures in terms of their aim, originally planned approach and underlying rationale. These areas of focus and the individual measures were deliberately chosen to address the challenges discussed in the previous chapter and were based on commissioned research.⁴¹ The ICDP was progressively rolled out from 1 July 2009 although some preparatory work commenced prior to this date. Some of the measures were implemented in a short period of time, such as the PBS Co-payment measure, while others were rolled out over two to three years, such as funding of the preventive health teams.

2.1 Tackling chronic disease risk factors

Health risk factors contribute significantly to the burden of chronic disease and high smoking rates are particularly a concern for Aboriginal and Torres Strait Islander people.⁴² Other significant impacting factors are sedentary lifestyles⁴³, inadequate intake of fruits and vegetables⁴⁴ and obesity.⁴⁵

ABS 2014. [Census 2011: RA by INGP counting persons by place of usual residence. Table Builder Basic](http://abs.gov.au/websitedbs/D3310114.nsf/home/About+TableBuilder) (website), viewed 18 May 2014 <<http://abs.gov.au/websitedbs/D3310114.nsf/home/About+TableBuilder>>.

⁴⁰ See Council of Australian Governments n.d., [National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plans](#), viewed September 2012.

⁴¹ Ipsos-Eureka Social Research Institute and Winangali 2010, *Developmental Research to Inform the Local Aboriginal and Torres Strait Islander Community Campaigns to Promote Better Health*, prepared for the former Department of Health and Ageing, Canberra.

⁴² Australian Health Ministers' Advisory Council 2011, *Aboriginal and Torres Strait Islander Health Performance Framework Report: 2008*, AHMAC, Canberra.

⁴³ Australian Health Ministers' Advisory Council 2011, *Aboriginal and Torres Strait Islander Health Performance Framework Report: 2004-05*, AHMAC, Canberra.

⁴⁴ *ibid.*

⁴⁵ *ibid.*

Effective health promotion is considered critical and one way in which improved health can be achieved, particularly in the area of chronic disease. Health promotion can support increased self empowerment, self efficacy and behaviour change.⁴⁶

Prevention – as a key element of comprehensive primary health care delivery – is also considered critical in addressing chronic disease and other poor health experienced by Aboriginal and Torres Strait Islander people.

The ICDP funded organisations to establish new regionally-based preventive health teams across Australia and funded healthy lifestyle community campaigns in over 200 communities. The health teams focused on reducing smoking and improving the healthy lifestyles and were mostly established in AHSs while the campaigns were run by a diverse range of community-based organisations that included AHSs, other Aboriginal community controlled organisations and Medicare Locals.

The range of activities undertaken by the preventive health teams and through the local community campaigns varied considerably and generally fall into three categories:

- a broad range of social marketing activities such as media events and production and distribution of multi-media materials;
- small group based programs that varied from participatory sessions such as learning bush tucker skills and community gardens to support groups for smoking cessation; and
- community events, such as health expos and school visits.

2.2 Improving chronic disease management and follow up care

As discussed in the previous chapter, Aboriginal and Torres Strait Islander people, including those with chronic disease, experience lower levels of access to primary health care than other Australians, leading to increased use of acute health care services. This is particularly true for chronic disease, with around 79 per cent of all hospital admissions for Aboriginal and Torres Strait Islander people linked to a chronic condition.⁴⁷ Improved access to health services, including to providers, medicines and testing, is thus considered essential to improve both prevention and chronic disease management.

A literature review undertaken to inform the design of the ICDP suggested that some Aboriginal and Torres Strait Islander people were likely to believe that if the body is currently not experiencing significant illness then there is no need for concern. This attitude may impact upon patterns and levels of service access.⁴⁸ This underlines the importance of

⁴⁶ Mikhailovich K, Morrison P & Arabena K 2007, 'Evaluating Australian Indigenous community health promotion initiatives: a selective review', *Rural and Remote Health*, vol.7, p.746.

⁴⁷ Australian Health Ministers' Advisory Council 2011, *Aboriginal and Torres Strait Islander Health Performance Framework Report: 2006-08*, AHMAC, Canberra.

⁴⁸ Ipsos-Eureka Social Research Institute & Winangali 2010, *Developmental Research to inform the Local Indigenous Community Campaigns to Promote Better Health*, prepared for the Australian Government former Department of Health and Ageing, Canberra.

the ICDP aiming to increase access to chronic disease preventive health care, such as health checks. Health checks were seen as one way in which health problems can be picked up early as well as increasing the frequency of patients' engagement with the chronic disease preventive health care system.⁴⁹

The high levels of social and economic disadvantage in the Aboriginal and Torres Strait Islander population (see previous chapter) make the cost of services a barrier for many people.⁵⁰ Evidence suggested that lack of cultural accessibility was another barrier.⁵¹ Consequently, the measures in this area of the ICDP were designed to address these barriers of affordability and (cultural) accessibility.

Consistent with the evidence underlying effective treatment and care for people with chronic disease⁵² these measures also aimed to put in place key elements of effective services. These included focusing on chronic disease self management and health literacy, appropriate service referrals, support for patients to navigate the service system, ongoing patient follow up and the involvement of multidisciplinary teams.

The ICDP adopted a comprehensive approach to encourage greater uptake of health checks and the provision of follow-up care, with incentives for general practices to improve the coordination of health care for Aboriginal and Torres Strait Islander people with or at risk of chronic disease. Greater support was also provided for Aboriginal and Torres Strait Islander people to actively participate in their own health care, with improved access to medicines, multidisciplinary follow up care, specialist care and allied health services. Organisations involved in these measures included AHSs, individual general practices, Medicare Locals, workforce agencies, and community pharmacies.

2.3 Workforce expansion and support

Leading up to the commencement of the ICDP, the Aboriginal and Torres Strait Islander health workforce had grown more slowly than the mainstream health workforce.⁵³ There was also recognition of issues concerning the attraction and retention of workers in

⁴⁹ Harris M 2008, *The role of primary health care in preventing the onset of chronic disease, with a particular focus on the lifestyle risk factors of obesity, tobacco and alcohol*, Centre for Primary Health Care and Equity, University New South Wales, Sydney.

⁵⁰ Lexchin J & Grootendorst P 2004, 'Effects of prescription drug user fees on drug and health services use and on health status in vulnerable populations: a systematic review of the evidence', *Int J Health Serv*, vol. 34, pp. 101-122.

⁵¹ Gruen R & Bailie R 2004, 'Specialist clinics in remote Australian Aboriginal communities: where rock art meets rocket science', *Journal of Health Services Research & Policy*, vol. 9.

⁵² New South Wales Health 2010, *Chronic Care for Aboriginal People Model of Care*, New South Wales Government Department of Health, Sydney.

⁵³ Australian Health Ministers' Advisory Council 2011, *Aboriginal and Torres Strait Islander Health Performance Framework Report, 2006*, AHMAC, Canberra.

Aboriginal and Torres Strait Islander health.⁵⁴ Accordingly, measures in this focus area aimed to enhance and increase the Aboriginal and Torres Strait Islander health workforce.

In designing suitable measures, evidence suggested that a focus on recruiting Aboriginal and Torres Strait Islander workers would lead to increased engagement with health services by the Aboriginal and Torres Strait Islander population.⁵⁵ In addition, there was an understanding that strengthening this workforce would lead to improved outcomes across other areas, such as employment and economic participation. Measures focusing on recruitment and retention adopted evidence-based strategies, including culturally appropriate recruitment methods⁵⁶ as well as ensuring availability of training, support and mentoring.⁵⁷

Another factor influencing the design of measures in this component of the ICDP was that around 60 per cent of Aboriginal and Torres Strait Islander people obtained their primary care through mainstream health services.⁵⁸ As discussed in the previous chapter, inadequate delivery of culturally competent services by mainstream providers had been identified as a barrier for Aboriginal and Torres Strait Islander people accessing these services. Accordingly, the measures in this focus area also aimed to enhance this aspect of mainstream general practice.

The ICDP funded a national campaign to attract, train and support the primary health workforce, as well as providing for additional Aboriginal and Torres Strait Islander Outreach Workers (ATSIOWs), health professionals, practice managers, project managers, nursing scholarships, registrar training posts and nurse clinical placements. Funding was provided to AHSs, Medicare Locals, peak bodies and workforce agencies. Indigenous specific clinical practice and decision support guidelines were also developed to assist health professionals in tackling the key conditions that contribute to the gap in life expectancy.

⁵⁴ Australian Institute of Health and Welfare 2010, *Aboriginal and Torres Strait Islander health services report, 2008-09, OATSIH Services Reporting: Key results*, AIHW, Canberra, cat. no. AIHW 31.

⁵⁵ Smith J, O'Dea K, McDermott R, Schmidt B & Connors C 2006, '[Educating to improve population health outcomes in chronic disease: an innovative workforce initiative across remote, rural and Indigenous communities in northern Australia](#)', *Rural and Remote Health*, vol. 6, no. 606, pp.1-15. Available at <<http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=606>> (registration required).

⁵⁶ Watson C & Harrison N 2009, *New South Wales Aboriginal Mental Health Worker Training Program: Implementation Review*, New South Wales Health and the Cooperative Research Centre for Aboriginal Health, New South Wales.

⁵⁷ Hunter BH 2010. *Pathways for Indigenous school leavers to undertake training or gain employment. Resource Sheet no. 2*, produced for Closing the Gap Clearinghouse, AIHW, Canberra, and AIFS, Melbourne.

⁵⁸ Information provided by the Australian Government former Department of Health and Ageing.

3 The evaluation

In July 2011, the department engaged the following consortium of independent consultants⁵⁹ to undertake the monitoring and evaluation of the ICDP:

- KPMG, the lead evaluator;
- Winangali, an Indigenous communication firm, to support the community consultations for the evaluation; and
- Baker IDI Heart and Diabetes Institute, to lead the health economics components of the evaluation.

3.1 Purpose and objectives of the evaluation

The purpose of the evaluation was to monitor and appraise the implementation and impacts of both the ICDP as a whole and the measures that comprise the ICDP. The objectives were to assess the:

- consistency of the implementation of the ICDP with the implementation plans;
- extent to which the package and individual measures are consistent and coordinated with, and complementary to, each other and the ICDP aims (synergies among the measures);
- appropriateness of the ICDP to the target population and stakeholder needs in terms of stakeholder awareness, appreciation and satisfaction with the activities undertaken under the ICDP; and
- effectiveness of the ICDP in achieving the expected early results and in progressing towards achieving medium and long term outcomes.

A more focussed evaluation of the *Local Indigenous Community Campaigns to Promote Better Health* measure was also undertaken concurrently with this evaluation.

3.2 Evaluation approach

This national monitoring and evaluation was part of a broader strategy deployed by the department which also included:

- the development of a monitoring and evaluation framework; and
- the Sentinel Sites Evaluation project.

The ICDP Monitoring and Evaluation Framework⁶⁰ was developed by independent consultants, and published in 2010. The Framework guided the Sentinel Sites Evaluation

⁵⁹ A fourth organisation, IPSOS Australia, was to have been involved in one aspect of the evaluation which did not occur as a result of a change in the focus of the evaluation.

⁶⁰ Urbis 2013, *Indigenous Chronic Disease Package Monitoring and Evaluation Framework, September 2010, Volumes 1, 2 and 3*, Australian Government Department of Health and Ageing, Canberra.

and this evaluation. The Framework is based on a program logic approach and identifies activities, outputs and expected results for each of the individual measures and the package as a whole over different time periods. Outputs are relevant to a 'one year' (and ongoing) time period, early results are relevant to a 'two to four years' time period, medium term results are relevant to a 'four to 10 years' time period, and longer-term results are relevant to a time period 'greater than 10 years'. For each result, the Framework outlines key evaluation questions, the relevant indicators, data sources and timing of data collection.

The Sentinel Sites Evaluation conducted by the Menzies School of Health Research was a place-based evaluation undertaken in 24 selected sites. It was mainly formative in nature and served two purposes:

- to inform on the implementation of the package, and identify barriers and facilitators to effective implementation as well as early outcomes at the local level; and
- to provide this national evaluation with additional local data.

The national evaluation was both formative and summative. The formative evaluation activities monitored the progress of individual measures against their expected early results. The summative evaluation assessed the effectiveness of the ICDP in achieving its expected early outcomes and the likelihood of achieving expected longer term outcomes.

3.3 Methods and data sources

The evaluation used a mixed methods approach to gather and analyse data that involved qualitative as well as quantitative data. These included data obtained through consultations, surveys and the collation of secondary data sources. Consultations facilitated assessment of the implementation of the ICDP and the impact from different perspectives, and consisted of:

- community site visits, which included interviews and focus groups with organisations that received ICDP funding, providers that interacted with ICDP measures, and Aboriginal and Torres Strait Islander community members;
- consultations with national and jurisdictional stakeholders in the government, non-government and community controlled sectors;
- interactions with a broad range of stakeholders, most notably people employed under the ICDP, through attendance at key events such as national conferences for the ICDP funded workforce; and
- consultations with departmental staff responsible for the implementation and ongoing management of the measures (measure managers).

Many stakeholders had a further opportunity to contribute through separate evaluation surveys developed for each of the ICDP funded workforce groups and ICDP funded organisations.

Secondary data sources included PIP Indigenous Health Incentive data, MBS and PBS data, data available based on the Health Performance Framework (HPF), hospital morbidity data, jurisdictional activity data, national health surveys, and ICDP program data. Relevant documents and literature were also reviewed, and the Sentinel Sites Evaluation provided an important source of secondary data.

Analysis and reporting was undertaken at two levels: the individual measure level; and the whole of ICDP level. A range of methods were employed to analyse the large and varied data collected. At the measure level the evaluation used qualitative synthesis methods, such as criterion-based assessment, and statistical methods including regression and inferential statistics.

Modelling was undertaken to test the plausibility of effect and an attribution and contribution analysis was used to consider the current and future contribution of the ICDP to its identified outcomes, and the extent to which the changes observed could be attributed to the ICDP. These methods were applied to inform the evaluation of individual measures and the whole of ICDP. Case studies, bringing together information about particular topics of interest, were used for both measure specific and multiple measure analysis.

Patient journey and service system analysis took a whole of ICDP view, and considered the impacts of the ICDP on the patient experience and service system.

3.4 Strengths and limitations

The comprehensive nature of the overall evaluation approach and scope of this evaluation appropriately reflects the scale and complexity of the task. Investment in the complementary components – development of a detailed monitoring and evaluation framework, the Sentinel Sites Evaluation, and this national evaluation – provided an opportunity for robust and informative evaluation to take place. The formative aspects of both the Sentinel Sites Evaluation and this evaluation played an important role in strengthening the ICDP during implementation and supporting achievement of the desired outcomes.

One of the key strengths of this evaluation was the very broad range of data collection and analysis mechanisms with regard to:

- the large number and range of stakeholders who had opportunities to provide input through multiple mechanisms such as site visits, consultations and surveys; and
- the opportunities to examine the individual measures, and the ICDP as a whole, from different angles by utilising the varied data sources and analysis techniques.

This was particularly important given some of the limitations of the evaluation, specifically in relation to data sources. Examples of limitations include gaps in collection and reporting of program data necessary to address evaluation questions and inherent limitations associated with external data sources (such as the absence of an Aboriginal and Torres Strait Islander status in the MBS data) which restricted analysis. These limitations reflect the need to balance between generating and accessing data to inform monitoring and evaluation activities and imposing burdensome collection and reporting requirements on service providers.

Linked to these limitations, a key challenge for the summative evaluation was to determine the contribution of the ICDP to any observed change in key outcome indicators in the context that:

- positive historical trends existed for many of these indicators; and
- there are many other state/territory and national initiatives and programs operating with similar aims to those of the ICDP.

Accordingly, the evaluation used a theory of change approach to assess the likelihood of an ICDP effect. The theory of change methodology comprised an assessment of:

- the plausibility of an effect which was based on an assessment of the following:
 - Was there an evidence basis for the measure to suggest that it could be effective if implemented appropriately?
 - Was the measure implemented in accordance with the design?
 - Were the external factors upon which the success of the measure was dependent in place?
- implementation progress to determine the extent to which each measure was operating to achieve its reach and was effective in deploying its strategies intended for its target audience;
- the strength and reliability of available evidence; and
- the potential impact of other initiatives that could influence the intended outcome.

The above steps provided a basis for assessing the likelihood of the ICDP making a contribution to any observed changes in key outcome indicators. Where possible the contribution of the ICDP was quantified. In many cases, the lack of robust data for many of the key indicators made it difficult to measure the indicator, let alone assess whether there had been any change since the implementation of the ICDP.

As it was not possible to directly measure the contribution of the ICDP and of other potential influences, the evaluation first accounted for the effects of known external factors (such as historical trends) leaving a residual or unexplained change to a key indicator. The evaluation then formed a view on the likely contribution of the ICDP based on the strength of the plausibility of an effect.

4 Results

4.1 Progress with implementation

The ICDP was designed to address weaknesses in the current primary health care system as well as encourage systems change by complementing as well as leveraging off existing initiatives. The evaluation found that most components of the ICDP were successfully implemented and that many of its operations are now well established and will continue to evolve.

The pre-existing Indigenous Health Partnership Forums (IHPFs) in each state and territory provided guidance and advice to the department, particularly early in the ICDP's implementation. At the time the IHPFs included representation from the department, state and territory governments and the National Aboriginal Community Controlled Health Organisation (NACCHO) state or territory affiliate. In some cases the then State Based Organisation (SBO) of the Divisions of General Practice⁶¹ was also represented on the IHPF. In broad terms the Partnership Forums provide a mechanism for the partners to undertake joint planning and work to improve access to services as well as monitor progress and activities in relation to Aboriginal health in each jurisdiction.

A number of national peak bodies were also involved in one of two ways. Some peak bodies participated in technical reference groups or advisory groups. Others were selected as recipients of ICDP funding to deliver an aspect of ICDP. In some cases, peak bodies fulfilled both roles, such as NACCHO and the Australian General Practice Network⁶² (AGPN).

The specific findings are:

The ICDP implementation occurred largely as planned and nearly all components are now fully operational

This is a significant achievement given the:

- scale and diversity of the ICDP, which involved a large number of stakeholders;
- considerable collaboration required at national, state and local levels across the mainstream and AHS sectors;
- need to respond quickly to early implementation experiences; and
- need to make changes in response to external influences such as the new health care reforms.

⁶¹ SBOs and the Divisions of General Practice were no longer funded with the advent of Medicare Locals in 2011. ICDP funding was instead diverted to the Australian Medicare Local Alliance and to individual Medicare Locals.

⁶² The AGPN was effectively replaced by the newly created Australian Medicare Local Alliance in 2011.

The ICDP implementation has resulted in:

- deployment of a large, new workforce (direct employment of 521.3 FTE as at December 2013), and expansion of the existing workforce in all states and territories;
- active engagement of over 200 communities in strategies focussing on chronic disease risk factors;
- active participation by a large number of AHSs and general practices in initiatives to improve the management of patients with a chronic condition; and
- mobilisation of a range of national initiatives that provide support to primary health care organisations and their staff to enhance their service delivery.

Only two aspects of the ICDP experienced significant implementation delays or required substantial adjustment late in the evaluation period. These were, the delay in the development and launch of the Clinical Practice and Decision Support Guidelines (C5) and the redevelopment of core components of the Chronic Disease Self Management training measure (B4). Thus, the evaluation could not assess these aspects of the ICDP.

The ICDP has been responsive to implementation lessons, due to its supporting infrastructure and extensive collaboration between a range of stakeholders

The department established an operational infrastructure that enabled the ICDP to be responsive to implementation lessons as they arose. Mechanisms to monitor implementation and quickly identify when changes were needed operated throughout the evaluation period. These included reference groups, the Indigenous Health Partnership Forums, learnings from the Sentinel Sites Evaluation, this evaluation, and feedback obtained from the department's program managers. The department used information obtained through these mechanisms to modify some aspects of the ICDP's design and operations in order to strengthen its effectiveness.

Examples included:

- streamlining administrative requirements, making it easier for patients and providers to participate in the new initiatives (e.g. the process for patients wanting to register in the PIP Indigenous Health Incentive);
- modifying eligibility criteria so that more patients could access the ICDP initiatives (e.g. Care Coordinators and financial subsidies such as Closing the Gap (CtG) scripts);
- expanding the scope of services available (e.g. expanding the outreach programs to include allied health professionals, general practitioners (GPs) and nurses in urban areas); and
- restructuring some parts of the ICDP (e.g. merging the urban and rural outreach programs into a single program).

Funded organisations also made changes to both their models and operations as they learnt what was working and what was not working so well. This reflects the willingness of these organisations to change and respond quickly to emerging issues. Local responsiveness was possible due to the flexibility the department had built into funding contracts. While there was a view early on in the implementation that the ICDP was an

imposed national policy, in due course funded organisations began to appreciate that there was considerable flexibility that allowed them to develop local approaches in line with local priorities.

The evaluation found that the changes made by the department and funded organisations in response to implementation lessons were necessary and have enhanced the potential effectiveness of the ICDP.

The ICDP implementation galvanised a large number of national and local stakeholders into a concerted and cooperative approach to improving services for Aboriginal and Torres Strait Islander people

The department used existing national and local structures to involve a large range of organisations in implementing the ICDP. The opportunity to be involved throughout the implementation and the shared commitment of these organisations to closing the gap resulted in close cooperation at the national and local level. Most notably, there were examples of the mainstream and the AHS sectors sharing resources and collaborating to improve services. Some Medicare Locals, as fund holders, proactively engaged AHSs to take on aspects of the ICDP that they could have retained (such as employment of a Care Coordinator). There were examples of NACCHO affiliates providing support to ICDP staff employed in the mainstream sector and not just to the equivalent staff employed in the AHS sector (such as mentoring support for Outreach Workers). This closer cooperation strengthened the ICDP's implementation.

It took time for host organisations and the new workforce to get established

The ICDP funded a number of new workforce roles including the preventive health teams, Aboriginal and Torres Strait Islander Outreach Workers and Care Coordinators. The department anticipated that it would take time to establish this new workforce, and implemented strategies to assist in the establishment phase. For example:

- distributing the funding for the new workforce in tranches over three years to gradually build up to the full workforce complement; and
- funding a number of initiatives to support development of the workforce in anticipation that it would take time for the host organisations to recruit and then orient the staff to their roles.

Implementation experiences indicated it was not only recruitment and training that took time. Once the staff were in place, it also took time for other organisations and the community to understand these new roles and for the staff to effectively engage with the community and service providers. For example:

- community organisations funded to develop and implement campaigns reported that it took them longer than they anticipated often because of the time it took to engage other parties in their campaigns; and
- health workers such as the Care Coordinators reported that it took considerable time to set up referral processes with general practices.

Many of those involved in the setup of operations reported that it took longer than expected to become fully operational.

The ICDP successfully involved a large number of health care providers from the AHS and mainstream health sectors

The ICDP provided incentives for primary health care services and individual specialist providers to become involved in various closing the gap strategies. The effectiveness of the ICDP was heavily dependent on these organisations and individuals wanting to participate, and actively becoming involved in the strategies. The evaluation found that the ICDP signed up a large number of service organisations and individual specialist providers. This resulted in some providing services for the first time and others increasing their focus on providing services to Aboriginal and Torres Strait Islander people. Specifically:

- approximately 83 per cent of AHSs and 44 per cent of general practices had signed up to the PIP Indigenous Health Incentive (as at November 2012); this measure aims to improve the delivery of chronic disease management services to Aboriginal and Torres Strait Islander people;
- approximately 96 per cent of community pharmacies had been involved in the PBS Co-payment subsidy measure (up to June 2012) that aims to reduce the financial barrier to purchasing medicines;
- by the end of November 2012, 3,097 general practices were registered for the PIP Indigenous Health Incentive which represented approximately 44 per cent of general practices in Australia;
- about one third (30.6 per cent) of all GPs prescribed at least one CtG script in the six months ending December 2012; and
- more than 1500 medical specialists and other providers of outreach services participated in the outreach programs (as at December 2012), with many doing so for the first time.

There is still scope to expand the level of participation while noting that some general practices and pharmacies do not have Aboriginal and Torres Strait Islander patients or are not able to participate because of the eligibility requirements (particularly small practices).

Community organisations welcomed the opportunity to develop their own, tailored community strategies to address chronic disease risk factors

The department had an overwhelming response from community organisations eager to develop and implement local community campaigns. These campaigns arose from a grass roots approach to preventive health that empowered and enabled community organisations to develop local solutions focused on local priorities. Community organisations were encouraged to develop partnerships with other organisations, including primary health services, as a strategy to build local capacity and enhance community members' access to local health services. It has created an expectation in some communities that the campaign activities would continue even though ICDP funding was for a fixed period. Other organisations, recognising the fixed nature of ICDP funding, reported that they were seeking alternative funding sources to build upon what they were able to implement through the ICDP.

4.2 Impacts on the health service system

The ICDP was designed to improve the capacity, capability and responsiveness of the primary health care service system to meet the needs of Aboriginal and Torres Strait Islander people. The evaluation found the ICDP has made progress with this objective although there are still opportunities, and in some cases an imperative, to further enhance these services.

Primary health care organisations have increased capacity and enhanced capability to provide appropriate services to Aboriginal and Torres Strait Islander people at risk of or with a chronic condition

The ICDP made a considerable investment in expanding the health workforce of the Aboriginal health and mainstream sectors that resulted in the direct employment of 521.3 (as at 31 December 2012) full time equivalent (FTE) staff. In addition, more of the existing workforce is providing services to Aboriginal and Torres Strait Islander people in areas of need. Specifically there was:

- an addition of more than one hundred (102.7 FTE) Care Coordinators working in the AHS and mainstream sectors by December 2012;
- an increase in the number of CtG script prescribers, from 2,940 in December, 2010 to 12,598 in December 2012;
- an increase in the number of GPs providing at least one Health Assessment, from 1,824 to 3,058 between August quarter 2010 and November quarter 2012 (a 68 per cent increase);
- over one hundred and twenty (124.7 FTE) Aboriginal and Torres Strait Islander Outreach Workers in the AHS and mainstream sectors, and 87.8 FTE Indigenous Health Project Officers by March 2013; the establishment of preventive health teams in 38 regions (154 FTE) by December 2012, and funding to 72 organisations to implement locally generated and delivered health promotion initiatives (Local Community Campaigns);⁶³
- an increase in various types of health care professionals providing services to Aboriginal and Torres Strait Islander people; and
- an increase in the number of specialist medical providers and allied health specialist providing services to Aboriginal and Torres Strait Islander people on an outreach basis for the first time or expanding their service provision.⁶⁴

⁶³ With additional teams in place during 2013.

⁶⁴ Based on interviews and surveys to assess whether the outreach programs have attracted new specialists to provide services; the actual increase is not quantifiable.

This increased capacity of both the mainstream and the AHS sectors to provide chronic disease management and preventive health services to Aboriginal and Torres Strait Islander people has also had other benefits. These benefits⁶⁵ include:

- new positions such as Care Coordinators and Outreach Workers have reduced the burden on GPs and other clinicians, increasing their capacity to provide additional clinical services to Aboriginal and Torres Strait Islander people;
- improvements in referral processes have improved the efficiency of primary health care services and reduced the time they need to invest in non-clinical activities;
- reductions in patient no shows have reduced the effort required to recall and remind patients of their appointments; and
- a dedicated preventive health workforce has focused the organisations on effectively engaging and supporting communities to address risk factors.

The ICDP has also enhanced the capability of primary health care organisations through:

- dedicated training opportunities for existing staff, such as: chronic disease self management training for 718 people⁶⁶; cultural awareness training for 6,184 general practice staff, 75 nurse professional development scholarships and 112 nurse clinical placement scholarships awarded in 2012 and additional GP registrar posts (an increase of 30 in 2012 compared to 2011);
- dedicated training opportunities for ICDP funded staff such as the preventive health teams and outreach workers;
- providing all staff in primary health care organisations with ready access to a rich array of resources that assist with chronic disease management through the creation of the Australian Indigenous Clinical *InfoNet*;
- increased access to education from specialist outreach providers – medical specialists often provided on the job education and mentoring of clinicians in local primary health care practices which led to increasing knowledge of ‘best practice’, referral and service options, and the latest innovations/procedures. This training was open to all host organisation staff, not just staff whose positions were funded under the ICDP, and provided an opportunity to expand the training experience of AHWs, support staff, existing practice managers and clinical staff in the AHSs and community health centres; and
- infrastructure grants to seven AHSs in four states to support their expansion of service delivery.

⁶⁵ The evaluation is not able to quantify the magnitude of these benefits. These findings are largely based on interviews with stakeholders and case studies.

⁶⁶ 718 people (including 212 Aboriginal Health Workers (AHWs), 220 nurses, 82 allied health staff and 40 GPs among others) had received chronic disease self management training as at April 2013.

The establishment of new workforce types has created a need for ongoing skill development as these new roles continue to evolve. The evaluation found that staff employed in these new roles generally valued the training supports offered but there are training gaps which, together with other factors, have caused some staff turnover. This issue, together with the broader implications in terms of future workforce development, is discussed in chapter 6.

Some general practices are more attuned to the cultural needs of Aboriginal and Torres Strait Islander people

Many general practices were providing services to Aboriginal and Torres Strait Islander people but not necessarily ensuring that they operated in a culturally competent manner. The ICDP implemented a set of complementary initiatives to encourage and support practices to be more focused on cultural aspects of patient need. These initiatives included:

- the requirement for two staff (including one GP) from general practices that have signed up to the PIP Indigenous Health Incentive to undertake cultural awareness training;
- the recruitment of:
 - Indigenous Health Project Officers to support general practices to change their procedures to ensure that they provide culturally competent services to Aboriginal and Torres Strait Islander people;
 - Outreach Workers to assist patients to access services; and
 - Care Coordinators to provide GPs with an easier referral pathway for their patients and assist patients to access mainstream services.

The evaluation found that as a result, some general practices are more responsive to the needs of their Aboriginal and Torres Strait Islander patients. Specifically, some general practices have:

- established processes to identify the Aboriginal and Torres Strait Islander status of their patients in a more culturally sensitive way;
- educated their staff on the use of appropriate language;
- changed their appointments process to be more flexible and therefore responsive to the needs of their Aboriginal and Torres Strait Islander patients such as allowing for 'walk-in' appointments and family appointments;
- modified their practices to make it easier for patients to register under the PIP Indigenous Health Incentive;
- improved their patient recall and reminder systems; and
- improved their referral processes.

The evaluation is not able to quantify the extent of these enhancements and considers that this is very much a work in progress outcome as not all general practices have fully embraced the need to change their patient management procedures, while others are still working through the practical steps to change these procedures. There was a perception from some stakeholders that the cultural awareness training requirements within the ICDP

were inadequate, particularly for providers participating in the PIP Indigenous Health Incentive, both in terms of not all providers undertaking the training and that the minimum training requirement itself was not sufficient.

Community organisations are more oriented towards and are taking a more integrated approach to preventive health

Organisations participating in the preventive health components of ICDP clearly had a level of commitment to preventive health. For some organisations, the ICDP simply but importantly enabled them to consolidate and/or expand their existing efforts. For others, the ICDP enabled them to move from a programmatic approach to a whole-of-organisation approach to preventive health. They did this through a mix of practical, structural and organisational cultural changes including:

- the allocation of additional resources to develop health promotion materials;
- integrating staff employed under ICDP with other existing staff in the organisation or other existing programs being delivered by the organisation;
- aligning and/or strengthening the vision and mission of the organisation with the role and goals of the preventive health teams;
- linking the activities of the preventive health teams, often across multiple areas within the organisation; and
- providing support to the teams from multiple levels of the organisation, and particularly from higher levels of management.

The extent to which preventive health became integral to, and was integrated within, an organisation depended on the prior experience of the organisation in preventive health, the extent to which organisational leaders viewed this as important and how quickly and effectively the teams themselves could establish internal working relationships. There is still a tendency in some organisations to manage the teams and their activities as distinct programs, partly because of a perception that it is easier to do it this way. Thus, there is still considerable scope for the preventive health teams to link more with the clinical teams in their organisations and for organisations to make the role of the teams more integral to the whole of the organisation.

The requirement for AHSs to have a smoke free workplace policy aimed to encourage a whole of organisation approach to preventive health.

*'As professional health workers we need to set an example if we wish to tackle chronic disease and close the gap. We cannot educate our people and tell people to quit smoking and here we are smoking. It is about internally let's work together [to quit] and ... then take message to community and roll it out.'*⁶⁷

The main challenges facing AHSs with the implementation of this policy were:

- low levels of organisational experience or capacity to implement such policies; and
- resistance from managers and staff to make changes within the workplace.

The evaluation found that the teams had an important role in assisting their organisations to implement this policy requirement, but they still faced considerable challenges to gain management support to enforce the policy.

Organisations have enhanced capacity and capability to develop and implement preventive health programs

For many primary health care organisations, this was the first time they had a dedicated workforce to specifically provide preventive health activities in the community to supplement any programs and activities they may have offered on their premises. In other cases, the establishment of the teams enabled existing activities to be undertaken in a more structured and strengthened form, and there were some organisations that used ICDP funding to continue existing activities.

There was a transfer of knowledge and skills from the preventive health teams to other health workers in the same organisation and the teams were able to leverage external resources. Thus the impact of the ICDP on the participating organisations reached beyond the immediate benefits of the direct investment in a new workforce.

New and enhanced existing partnerships between primary health care services and other community organisations strengthened the local focus on preventive health

Partnerships were often intrinsic in the development and implementation activities of the preventive health teams and local community campaigns. The type of partner organisations and the nature of the partnerships, varied from the funded organisation accessing external expertise during the development phase to cooperation around increasing referral and access to healthy lifestyle supports. For example, many of the community organisations implementing healthy lifestyle campaigns, and those funded to set up regional preventive health teams, partnered with local health services whose staff participated in community events and facilitated referrals to the health service for follow up health assessments. These relationships were critical enablers but also increased the possibility of sustaining some aspects of the campaign after grant funding had been expended. The teams also liaised with a range of other organisations including state and territory health departments to ensure coordination of efforts within a region. Nearly all of the preventive health teams were

⁶⁷ Menzies School of Health Research 2013, *Sentinel Sites Evaluation Final Report February 2013*, prepared for the Australian Government former Department of Health and Ageing, Canberra, p. 50.

working formally with other organisations or informally with staff in other organisations to create synergies and to support a consistent approach to preventive health locally.

4.3 Impacts for Aboriginal and Torres Strait Islander people

The primary aim of the ICDP is to close the gap in life expectancy by ensuring that Aboriginal and Torres Strait Islander people have ready access to preventive health and chronic disease management services. The evaluation found that Aboriginal and Torres Strait Islander people have benefited from the ICDP, resulting in a reduction in risk factors for some individuals and improved access to chronic disease management services. The evaluation was not able to quantify the extent of these impacts or assess the extent to which organisations were successful in reaching those most 'hard to reach'.

The ICDP targeted the priority needs of Aboriginal and Torres Strait Islander people and substantially reached those in need of support

The ICDP targeted barriers that constrained people's access to existing health services as well as expanding the availability of services. There is no single measure of reach for the ICDP, given the varying nature of its activities and whom they targeted. At the broadest level, the evaluation found that:

- over 12,000 people in more than 200 communities actively participated in local community campaigns and many others engaged in preventive health activities through the efforts of the preventive health teams funded by the ICDP;
- approximately 63 per cent (79,758) of Aboriginal and Torres Strait Islander people over the age of 15 and living with a chronic disease were registered at least once (between 2009 and 2012) by a primary health care organisation participating in the PIP Indigenous Health Incentive;⁶⁸
- PIP IHI patient registrations continue to increase with 23.8 per cent more registrations in 2012 compared to 2011;
- at least one in four Aboriginal and Torres Strait Islander people (145,167) received a PBS Co-payment subsidy between 2009 and 2012 when having their medications dispensed;
- in 2011-12 there were 27,561 care coordination services provided nationally and 9,319 Supplementary Services were purchased.⁶⁹ through the Care Coordination and Supplementary Services measure;
- there was a rapid increase in the outreach specialist and allied health services in regional and remote areas under the MSOAP-ICD program, with approximately 600

⁶⁸ This estimate is derived from modelling rather than direct measurement.

⁶⁹ Menzies School of Health Research 2013, *Sentinel Sites Evaluation Report June 2011*, prepared for the former Department of Health and Ageing, Canberra, p. 308.

patient contacts per month during 2010-11 which increased to 5,449 patient contacts per month by December 2012.

Community attitudes about the inevitability of illness are changing

A significant challenge for the health workers engaged in the preventive health components of the ICDP has been changing community acceptance of chronic disease as a fait accompli. Helping Aboriginal and Torres Strait Islander people to identify chronic diseases as potentially avoidable is a key step to increasing participation in preventive health activities and utilisation of acute health services to help prevent the onset and progression of chronic disease. The ICDP has made inroads but still has a long way to go to shift the views of the community about the inevitability of chronic disease:

'Lots of people now think it's normal to be healthy which is a big shift.' (preventive health team member).

Many Aboriginal and Torres Strait Islander people who participated in preventive health activities demonstrated a clear understanding of what it means to be healthy, and expressed confidence at their ability to manage their own lifestyle.

'[Our] family and friends who live with chronic disease die too young, and must change their lifestyle to survive' (participant).

The importance of leveraging a community rather than just an individual approach to changing attitudes is illustrated by a group of community members who proactively supported and encouraged each other to exercise and eat well, ensuring that they all 'live longer'. Some of the women reported applying their knowledge and skills at home in the interest of improving their family's health. There was a real sense that participants, in particular those who engaged in events and programs, believed themselves to be 'agents of change', in charge of their own health and wellbeing. The challenge now is to build upon this momentum.

'People looked at you, what you were wearing, and judged you because you didn't fit in. It [the gym now] offers a comfortable environment for all people. We never had anything like this before and now we do, and we feel confident that we can do it.' (community member).

Individuals are better supported in their attempts to adopt more healthy lifestyles

'The [group program] brings people together. Because of this people can see that others in the group are doing healthy things, and this motivates them to make changes to their own lives.' (community member).

For individuals to successfully adopt healthy lifestyle behaviours, it is important for them to feel supported by the community, family and peers. The ICDP developed such supports through:

- the delivery of community-based events and programs specifically designed to encourage family and peer groups to participate in preventive health activities;

- the use of champions within local communities in campaigns and activities, where community identities acted as role models within their community and encouraged individuals to participate in ICDP healthy lifestyle activities; and
- the preventive teams conducting group support sessions, often in partnership with other organisations, for people wanting to change aspects of their lifestyles.

Community members contributing to various evaluation activities often reported that they valued these supports, for example, in terms of them feeling more comfortable to participate in various activities. This is consistent with the views of clinicians who for example reported that ‘there has been increased interest from patients seeking support to quit smoking’⁷⁰. This in turn is likely to have contributed to an increase in the use of smoking cessation medicines.⁷¹

‘One big benefit is building connections with people who are like you and want to make changes to their life as well’. (community member).

Increased participation in preventive health activities and use of related supports has resulted in some individuals changing their behaviour by adopting healthier lifestyles

‘[Through the preventive health team] I got help from a dietician to develop a healthy eating program...working with the group helps me to stay on track because I know how to eat better. I can see other people trying to be healthy too and this is motivating’. (community member).

The adoption of healthy lifestyles often requires major changes to health behaviours that may be addictive, such as smoking and alcohol consumption, or strongly habitual, such as poor exercise and nutrition. As such, behavioural changes may not only take significant time to achieve, but also may require a large number of attempts before the desired outcomes are realised. Due to the short period of time that many ICDP measures had been operating, it was not expected that significant changes to health behaviours would be identified during the evaluation period. However, stakeholders did report a number of positive signs that some participants were actively attempting to adopt healthy lifestyles. For example, one in three program managers reported behavioural changes in the target audience based on personal observations and involvement with the target audience. Reported changes related to:

⁷⁰ Menzies School of Health Research 2013, *Sentinel Sites Evaluation Report June 2011*, prepared for the Australian Government former Department of Health and Ageing, Canberra, p. 61.

⁷¹ There was a 74.1 per cent increase in the dispensing of tobacco cessation medicines to Aboriginal and Torres Strait Islander people who had ever registered in the PIP Indigenous Health Incentive or where such medications had been supplied to AHSs through S100 RAAHS (from 22,008 to 38,326) between the 24 month period preceding the start of the ICDP (July 2008 to June 2010) and the 24 months post the ICDP’s implementation (January 2011 to December 2012). This compares to an increase of 21.1 per cent over the same period for Aboriginal and Torres Strait Islander people who had never registered in the PIP Indigenous Health Incentive.

- changes in diet, consumption of sugary beverages;
- increased physical activity;
- increased visits to clinics or other health professionals to seek help in modifying risk behaviours; and
- smoking cessation.

In addition, research evaluating the effectiveness of the 'Break the Chain' national campaign showed that the target audience had reduced their level of smoking.⁷²

Many of those involved in delivering preventive health programs were cautious in suggesting that the ICDP had made a definitive change simply because of the time it will take and the level of ongoing support required before there is a demonstrable reduction in risk factors.

Aboriginal and Torres Strait Islander people are making more use of services that lead to earlier identification of a chronic condition and improved assessment of their needs

The cumulative effect of a number of complementary aspects of the ICDP measures has led to an increase in the use of services that are important in terms of the early identification of chronic conditions and their related risk factors. They have also resulted in improved assessment of patient need in relation to the ongoing management of their chronic condition. Two broad strategies were built into the design of the ICDP:

- initiatives that directly encouraged and supported a patient to make greater use of their primary health care services such as the role of Outreach Workers and the preventive health teams, and incentivising and supporting primary health care practices to register patients; and
- initiatives that increased the capacity of primary health care services to undertake the relevant assessments such as incentive payments and restructuring of MBS item numbers, funding for additional staff and an increase in the provision of clinical specialist outreach services.

Specifically, the evaluation found that, as a result of these ICDP activities and other factors external to ICDP, there has been an 85 per cent increase in the number of Aboriginal and Torres Strait Islander Health Assessments (MBS Item 715) between 2010 and 2012.⁷³ This

⁷² [Orima Research 2012](#),

<[http://www.quitnow.gov.au/internet/quitnow/publishing.nsf/Content/A61C40086BCE07F8CA257A0D001F1207/\\$File/NPAP%20Health%20Tobacco%20Social%20Marketing%20Campaign%202012.pdf](http://www.quitnow.gov.au/internet/quitnow/publishing.nsf/Content/A61C40086BCE07F8CA257A0D001F1207/$File/NPAP%20Health%20Tobacco%20Social%20Marketing%20Campaign%202012.pdf)>.

⁷³ 2012 calendar compared to 2010 calendar year.

was largely driven by an increase in GPs now providing this service, with a trend break coinciding with the ICDP's commencement.⁷⁴

In addition, the increased use of outreach specialist services has contributed to improved initial and ongoing assessment of patients' conditions, given that assessment was an important component of the care delivered by these providers. The benefits to the individual are perhaps best reflected by the views of an Aboriginal and Torres Strait Islander person:

'We have many doctors in the community. Some doctors are hard to get into and others are easy. Now more people go to the doctor early'. (community member).

The management of individuals with a chronic condition has improved but significant challenges for patients and providers remain

The ICDP adopted a multi-faceted strategy to improve the management of people with a chronic disease. This included:

- encouraging GPs to apply best practice management in terms of developing and then periodically reviewing care plans for their patients, and within a team care environment;
- supporting GPs and the patient through the creation of a focused care coordination workforce;
- encouraging and supporting patients to make more use of their health service and encouraging general practices to be more culturally safe for patients to visit; and
- increasing the skills of the workforce to apply self management models of care with their patients.

The benefits to the patient of this multi-faceted approach are illustrated through the experiences of these community members:

'In the past I didn't go to my appointments. I didn't want to wait for the train, and then travel for 40 minutes when I was feeling sick. I also didn't really see the point in my appointments – why should I go to the hospital when I'm not sick? I was thinking. When [the ATSIOW] started, she said she could drive me to the hospital. This was really helpful. Then I found out about [the Care Coordinator], she organised my appointments for me, and came into the appointments to help me understand the doctor. She also explained that I need to go to the appointments. I realised that I needed to go there to prevent [my condition] getting worse.'

'I used to go to the local doctor but the doctor didn't really explain what my medicines were for. Sometimes I went to the pharmacy to get my medicines, but because I didn't know what they were for I didn't take them or forgot to take them. Now that [the Care Coordinator] is around, they can come to the doctors with me and explain what the medicine is for. They also remind me to take my medicines which is good.'

⁷⁴ Use of this item in 2012 was 44 per cent greater than expected when compared to the historical trend prior to the implementation of the ICDP.

There appears to have been some improvement in the coordination and management of patients as a result of these initiatives. Specifically:

- PBS Co-payment subsidy beneficiaries increased their use of medicines, with Aboriginal and Torres Strait Islander people aged between 0 and 14 years having higher than expected use of PBS medicines in 2012, with between 25 and 33 per cent of this increase being attributable to the ICDP. Similarly, people between the ages of 15 and 54 years had higher than expected use of PBS medicines, with between 13 and 21 per cent of the increase being attributable to the ICDP.
- The number of MBS health assessments for Aboriginal and Torres Strait Islander People increased from 59,259 in calendar year 2010 to 109,849 in calendar year 2012. This is an 85 per cent increase and translates to approximately 19 per 100 Aboriginal and Torres Strait Islander people having received a health assessment in 2012.
- In 2010, 6,049 MBS follow up services were provided by nurses and Aboriginal Health Workers compared with 39,977 in 2012 (a 561 per cent increase).
- The utilisation of MBS allied health items increased three fold from a low base of 0.2 services per 100 Aboriginal and Torres Strait Islander people the November quarter 2010, to 0.6 allied health services per 100 in November quarter 2012.
- GP Management Plans (GPMP) increased by 152 per cent between 2008 and 2012 for Aboriginal and Torres Strait Islander people registered under the PIP Indigenous Health Incentive (EverIHI patient). As a result, while about one in eight EverIHI patients had a GPMP in 2008, one in three had a GPMP in 2012.
- Patients receiving services through the Care Coordination and Supplementary Services measure increased steadily from the implementation of the measure. Individual patients receiving Care Coordinator services increased from 3,208 in just one quarter (October to December) of 2011 to 4,994 over the same period in 2012 (an increase of 56 per cent).
- The number of MSOAP-ICD services⁷⁵ grew from a zero base in 2009-10 to 1,330 services provided in 2011-12, building to 1,564 for 2012-13. The number of patient contacts rose to 5,449 per month by December 2012 from a zero base in 2009-10, with additional specialist outreach services occurring in urban areas.⁷⁶
- Stakeholders reported that individual patients were accessing services that they otherwise may not have used because of the efforts of Care Coordinators and support from the Outreach Workers. Survey respondents also indicated that patients were

⁷⁵ Information on the number of providers was not collected for the MSOAP-ICD program.

⁷⁶ For urban services definitive individual patient service data was not available due to differences in service definitions and reporting.

receiving more coordinated care⁷⁷, a view which is similar to the findings of the Sentinel Sites Evaluation.⁷⁸

- There was some evidence that the quality of the services provided to Aboriginal and Torres Strait Islander people had improved.⁷⁹

Consequently, the ICDP assisted people who had a chronic disease to reduce the onset of complications.

'If I don't take my meds, I'll get sick even though I don't feel sick until it's too late. I need to go see the foot doctor because I have to make sure I'm not at risk of getting my foot removed'.(community member).

There are however, some challenges that need to be addressed in future policy considerations. These are:

- insufficient capacity in the system to help individuals to deal with the range of complex social and personal issues they face in their daily lives that are often barriers to addressing their clinical needs;
- the capacity constraints of Care Coordinators, many of whom appear to have full caseloads;
- the still relatively low use by some primary health care services of the 'care coordination related MBS items' that are being promoted through the PIP Indigenous Health Incentive;
- improving referral protocols to ensure that GPs refer patients in need of more intensive coordination and support; and
- ensuring organisational buy in to the use of self management models of care and related to this, ensuring that the models are able to be applied in everyday practice.

⁷⁷ Ninety four per cent of Care Coordinators who responded to the ICDP evaluation survey (2013) agreed with this statement.

⁷⁸ Eighty nine per cent of health care professionals interviewed (28) in 2012 compared to only 27 per cent of interviewees (22) in 2011.

⁷⁹ Eighty seven per cent of Care Coordinators who responded to the ICDP evaluation survey (2013) agreed with this statement as did eighty six per cent of health care professionals interviewed by the Sentinel Sites Evaluation in 2012.

5 Overarching evaluation objectives

This chapter addresses the overarching evaluation objectives and in doing so, draws from the evaluation findings in the previous chapter. The objectives of the evaluation were to assess the:

- consistency of the implementation of the ICDP with the implementation plans;
- extent to which the package and individual measures are consistent and coordinated with, and complementary to, each other and the ICDP aims (synergies among the measures);
- appropriateness of the ICDP to the target population and stakeholder needs in terms of stakeholder awareness, appreciation and satisfaction with the activities undertaken under the ICDP; and
- effectiveness of the ICDP in achieving the expected early results and in progressing towards achieving medium and long term outcomes.

As the first two objectives are interrelated they are addressed together.

5.1 Consistency of the implementation and design synergies

The ICDP was implemented successfully. It deployed a significant new workforce and initiated a large number of new programs and initiatives in an ambitious timeframe. This is a testimony to the commitment of a large number of organisations that collaborated at the national, regional and local levels. There were a number of design and operational changes made during the formative stages of the implementation that have strengthened the ICDP. These changes reflect the effectiveness of the monitoring mechanisms that the department had in place that allowed it to identify and respond to implementation issues early. It also reflected the support from the sector to make sure that ICDP was operating effectively in a changing environment.

The different aspects of the ICDP were designed and operated to be internally complementary and to complement existing initiatives and policies. The evaluation found that as a consequence:

- the level of participation of primary health care services was greater than what might have otherwise occurred;
- the effectiveness of some measures was strengthened; and
- the benefits to Aboriginal and Torres Strait Islander people were more than would otherwise have been the case.

The complementary nature of different aspects of the ICDP and the benefits for patients are many and varied including:

- it led to a more team-based approach to care with GPs being supported by Care Coordinators and both being supported by other health workers specifically funded by ICDP which meant that patients were better supported through the care process;
- it supported those mainstream general practices who wanted to make substantial changes to the cultural appropriateness of their practice so that Aboriginal and Torres

Strait Islander patients felt more respected and comfortable to use a mainstream practice; and

- the new workforce groups were well supported with more ready access to a range of resources, training opportunities and mentorship from national leaders.

The ICDP was able to effectively leverage from other policies and initiatives that enhanced its effectiveness. This included:

- the Establishing Quality Health Standards (EQHS) initiative that meant that, as AHSs became accredited, they could then participate in the PIP Indigenous Health Incentive;
- the use of NACCHO and its Affiliates to support various initiatives meant that the ICDP benefited from their reach into and understanding of the AHS sector;
- the existing priority to encourage GP registrars to undertake their vocational training in AHSs provided a strong platform to meet the target for the number of additional registrars to gain this experience; and
- the use of workforce agencies that had considerable experience in contracting medical specialist providers meant that they were able to quickly implement the rural outreach program.

The use of these existing mechanisms (organisations, policies and payment structures) facilitated both the implementation of the ICDP and provided an effective platform from which it could operate.

There are opportunities to streamline some aspects of the ICDP and strengthen other aspects by leveraging other initiatives. These are discussed in chapter 6.

5.2 Appropriateness

The appropriateness of the ICDP was assessed in terms of:

- the extent to which it targeted population needs; and
- the level of awareness, appreciation and satisfaction with the activities undertaken under the ICDP.

The evaluation established that the ICDP is delivering a range of evidence-based solutions that address priority individual and community need. The ICDP was designed to, and successfully, focused on the needs of individual patients and communities and on factors that impact on their ability to access services critical to effective chronic disease management.

A key feature which supported this aspect of appropriateness was the use of evidence to inform the design and operations of the ICDP. A range of evidence was used to inform design and on-going refinement of the ICDP such as literature, commissioned research and feedback obtained through monitoring processes. Many measures were the subject of refinements throughout the evaluation period. In each case the evaluation found that these refinements strengthened the measure and enhanced the focus on addressing priority needs.

Further, some aspects of the ICDP measures required funded organisations to undertake a needs assessment in order to ensure that local implementation addressed specific and locally relevant needs.

Importantly, when one considers the factors that underlie why chronic disease accounts for about 80 per cent of the mortality gap for Aboriginal and Torres Strait Islander people, the evaluation found that the ICDP:

- had an important focus on prevention which produced an overwhelming response from communities to participate in related programs that then created a demand from individuals for assistance to address risk factors such as smoking;
- increased the capacity of primary health care organisations to detect chronic disease and associated risk factors earlier and meet the care needs of people with a chronic illness; and
- provided extensive support to Aboriginal and Torres Strait Islander people to access these services and for them to feel more comfortable to use the services.

The level of awareness of the ICDP grew over time within the community and amongst primary health care services. For example, there was a high level of awareness and uptake of CtG scripts under the PBS Co-payment subsidy initiative and broad level awareness of opportunities for Aboriginal and Torres Strait Islander people to get support with healthy life style activities. The community often was not able to differentiate an ICDP funded activity from other similar initiatives, but this was not important to and did not affect their use of services.

Initially, many service providers were not aware of or did not understand the full relevance of key aspects of ICDP. They were aware, for instance, of the particular component of the ICDP with which they were directly involved but less aware of the complementary nature of the various measures. While this did improve over time, the evaluation found that there remained gaps in the knowledge of some service providers about the complementary aspects of the ICDP. This finding has implications for the development of future communication strategies which need to empower organisations to more clearly understand their role in ensuring that the measures function in a complementary way so that the expected system impacts can be realised.

It was clear that the various stakeholders involved in the ICDP were largely satisfied with its operations and that patients appreciated the additional support they received. There was some initial tension amongst the community controlled sector (and in some cases this continued) with the level of funding being provided to the mainstream sector but there were also examples of where this was supported from within the community controlled sector. The ICDP investment in both sectors was found to be appropriate given the importance of supporting and enhancing the community controlled sector while also providing effective culturally appropriate services through the mainstream sector. Focusing on strengthening both the Aboriginal and Torres Strait Islander community controlled and the mainstream sectors was and should remain a priority. Importantly, the ICDP created further opportunities for collaboration between AHS and mainstream service providers.

5.3 Effectiveness of the ICDP

The previous chapter presents the key findings on the ICDP's impacts. This section assesses the ICDP's effectiveness in relation to the key issues that are critical to reducing the prevalence and impact of chronic disease for Aboriginal and Torres Strait Islander people. As discussed in chapter 1, the ICDP was designed to address these issues within the context that all health systems are struggling with the challenges of chronic disease, and thus its aim is to improve the health service system's capacity and capability to meet the needs of Aboriginal and Torres Strait Islander people.⁸⁰ The range of specific measures implemented through the ICDP will take time to achieve impacts on chronic disease incidence, prevalence and mortality and these measures alone are unlikely to be sufficient to meet the Closing the Gap mortality and longevity targets.

The evaluation has found that as a result of the ICDP:

- Aboriginal and Torres Strait Islander people have more effective support to access health services;
- Aboriginal and Torres Strait Islander people with complex care needs have more support and guidance available to manage their health;
- there is a greater focus on prevention and earlier action within the health system;
- coordination and monitoring of care provision have improved; and
- the cultural competency of some health care providers has improved.

While the evaluation is not able to quantify the benefits for Aboriginal and Torres Strait Islander people, it has found that these service improvements have resulted in:

- **Increased use of health services** – the ICDP both expanded the availability of services for chronic disease prevention and management, and reduced financial and other barriers (including transport and cultural barriers), leading to improved access to services. Community members' awareness of available services and supports also increased over time. This resulted in increases in the use of medicines, specialist services, care planning and the provision of follow up services related to the care plan, and diagnostic services relating to the detection of chronic disease. There are some aspects of the original design of the ICDP that limited the access that Aboriginal and Torres Strait Islander people had to services. The department addressed some of these issues, for example, by modifying eligibility requirements or administrative processes. However, there are still opportunities for further improvement. For example, CtG scripts are only able to be issued by GPs who comply with specific practice requirements resulting in some patients not being able to easily access a CtG script. Opportunities for improvement are discussed in chapter 6.

⁸⁰ The effectiveness of the ICDP is assessed in terms of the extent to which these early expected outcomes have been achieved noting that targets were not set for individual outcomes.

'Early on, a lot of doctors didn't know about CtG scripts. Some of them weren't interested in providing them ether. One of my friends told me about them and I thought, that sounds pretty good. My doctor wasn't part of the program [PIP Indigenous Health Incentive] but I asked them to sign up, and they did. Now I can afford my medication.' (community member).

- **Improved patient care** – the ICDP led to an enhanced focus on Aboriginal and Torres Strait Islander health, improved coordination of care and, in some cases, improved the quality of care. In the mainstream sector, this was largely a result of general practices being able to provide more culturally appropriate services. The combined effects of various ICDP measures has resulted in some practices being more aware of cultural sensitivities in providing care to their patients; improving their procedures so that they are more attuned to the preferences of Aboriginal and Torres Strait Islander people; and being more appreciative of and making more use of the Outreach Workers and Aboriginal Health Workers to assist them in the care of their patients. In the community controlled sector, the increase in use of services has largely occurred as a result of the AHSs now having additional capacity to provide the level of service required for quality care. There are some issues that still need to be addressed including the need to further enhance the cultural competency of general practices; workforce capacity constraints which mean that not all patients in need of care coordination for example, have ready access to this service; and there is a need to focus on ensuring the quality use of medicines.
- **Some individuals are now better able to manage their chronic condition** – many more Aboriginal and Torres Strait Islander people are being supported to focus on their health and associated risk factors, and take action to address and take responsibility for their health issues. While there was a general level of awareness of chronic disease risk factors when the ICDP was first implemented, the ICDP supported the translation of this knowledge into increased skills and motivation to change behaviour. The ICDP also had some focus on building the capacity of patients to self-manage their chronic condition with support from health workers and clinical staff, and enabled some individuals to take more control over their health and use of the health system. The approach to improving chronic disease self management was changed substantially in the latter stages of the evaluation period. In particular there were modifications to the tools and the training program and most importantly, a requirement was introduced for organisations whose staff were being trained, to make a commitment to implement chronic disease self management. It is too early for the evaluation to determine if the new approach will be successful.

These early results are encouraging and suggest that progress is being made towards the achievement of medium to longer term outcomes that would contribute to closing the gap in life expectancy. Further, the evaluation has established that the package of measures:

- has progressed many of the factors that are critical to the success of its individual measures which leads to the overall conclusion that the ICDP should make a contribution to the expected longer term outcomes which is also supported by qualitative evidence of these outcomes;
- is delivering a range of evidence-based solutions that address priority individual and community need;
- is dealing with systemic issues that have historically constrained access that Aboriginal and Torres Strait Islander people have to services critical to their health care;
- has engineered change at the community and health service system level and increased the capacity of communities and that of the existing health care system that is sustainable and thus have longer term benefits;
- has enabled existing health services to better leverage other strategies and initiatives focusing on Aboriginal and Torres Strait Islander health which is critical for the longer term given the significant investments being made through the broader health care system – the role of the ICDP goes beyond its own investments in new services; and
- has the flexibility that allows local organisations to adapt the various national initiatives to meet local needs.

This further gives confidence that these measures will make progress to achieve the longer term outcomes that are critical to closing the gap in life expectancy.

The challenge is how to embed these improvements in the health service system so that there can be lasting benefits for patients.

6 Lessons and opportunities

There are a range of lessons and opportunities that arise from the experiences of stakeholders involved in such a vast and complex initiative such as the ICDP. These have implications for the implementation of future similar strategies; options to strengthen the preventive health and the chronic disease management measures; workforce development; and on-going monitoring and support.

6.1 Implementation of future strategies

It takes time for organisations less experienced in preventive health to implement new initiatives

The organisations with a history in preventive health were able to more quickly implement their programs and campaigns, mostly because the ICDP enabled them to continue with what they were already doing or to expand upon existing programs. Others needed help and guidance and additional time to recruit staff, develop programs and engage with their communities. The national supports provided were critical during this development period, and many of the teams still require such supports.

Future programs need to:

- ensure that the timeframes for implementation are adequate, recognising that often there is a developmental phase; and
- consider what national supports could be made available to local organisations.

Supportive structures are required to ensure implementation success

The ICDP included a number of structures that supported implementation at the national, regional and local levels. These were instrumental to the successful implementation of the ICDP. They enabled implementation issues to be identified early and responded to quickly. Given that many aspects of the ICDP will continue to evolve, these supports remain important to sustaining the long term success of closing the gap strategies. They include:

- national workshops that enable new workforce groups to come together to share knowledge and foster innovative solutions; and
- the role of national leaders and peak bodies in supporting local initiatives.

Ongoing effort is needed in order to progress beyond implementation to embed best practice preventive health and chronic disease management. Encouraging providers to take a systematic approach to chronic disease prevention and management, incorporating key aspects of chronic disease prevention and management into the role of the existing workforce, supporting effective use of clinical systems and improving referral are some ways to ensure this happens.

Stakeholders need to understand the complementary nature of a multi-faceted strategy in order to realise the full potential impact of the strategy

The ICDP was a multi-faceted strategy with many components designed to complement each other. During the early stages of implementation few stakeholders outside of the department understood the full nature of the ICDP other than those components in which they were directly involved. While this improved over time, not all organisations funded under or affected by the ICDP fully realised the potential synergies that could be gained from the complementary nature of the various ICDP components. Therefore, future policy initiatives of the magnitude and complexity of the ICDP should have a communication strategy that establishes stakeholder understanding from the outset. Such a communication strategy could include:

- clear articulation of the linkages intended in the design of the initiative;
- practical examples of how organisations can capitalise on the complementary nature of the components;
- change agents from within the various service sectors that can advise health services on how to realise potential synergies from within the initiative and leverage off other existing policy initiatives; and
- national workshops and on-line forums.

The ICDP implementation had elements of such a strategy such as national workshops the preventive health teams but not as part of a complete and coherent communication strategy and often as a reaction to implementation issues.

6.2 Strengthening preventive measures

Preventive health needs to be seen as an integral part of comprehensive primary health care and requires strong leadership for there to be an optimal focus on this part of the care continuum

Some organisations compartmentalised the preventive health components of ICDP, while others took the opportunity to shift the thinking within their organisation to a position where preventive health was seen as a central aspect of organisational activity. The extent to which organisations have integrated preventive health into their core business as a result of the ICDP was found to be influenced by:

- the funded organisation's previous experience and existing capability in preventive health;
- leadership and support from within the funded organisation; and
- the extent to which funded organisations actively leveraged the ICDP measures to build health promotion and preventive health capacity across the organisation.

Strong leadership positively influenced the level of enthusiasm across the organisation and facilitated an ongoing focus on the delivery of health promotion activities, even when there were competing pressures to focus on other organisational goals, such as the delivery of clinical care. Where this new orientation was embraced by organisational and community

leaders (this was not the case in all organisations), it was easier for the teams to ‘sell’ their messages to other staff and community members. Where strong leadership was not evident, preventive health teams did not feel as empowered and/or were more likely to consider that their efforts were not as valued by the organisation.

There is a need to further consider strategies that can assist primary health care organisations to embed a preventive health focus as part of their core business.

Individuals require ongoing support to sustain healthy lifestyles

Many of the campaigns and preventive health teams experienced challenges in achieving sustained participation of individuals in lifestyle activities. According to staff this was often linked to the existence of other significant pressures people were managing in their personal lives. Many of the teams reported that they were increasingly asked to provide more direct and targeted supports. However, these services were beyond the role and sometimes the skills of the workers in the teams.

‘What we need is Aboriginal quit smoking programs with counsellors and people who can help you through the process [of quitting].’ (community focus group, urban location)

These challenges emphasise the need for community organisations including primary health care organisations to develop effective partnerships with other agencies that can provide direct support to those wanting to make changes in their daily lives. They also emphasise the need for long term programs:

‘I have a store room full of flip charts, posters and resources ... The investment in resources doesn’t make the difference, it is about long-term projects that have stable workforce, which is hard in a remote context, to engage community so it can carry on through workforce turnover, and is an approach that the community wants.’⁸¹

Preventive health work has to address the underlying complex health and social issues

The ICDP-commissioned research⁸² identified, and evaluation stakeholders reported, that while there is a general level of awareness within the community of the links between risk factors and chronic disease, this awareness alone is not sufficient to make inroads into making lifestyle changes. There is a complex mix of social issues and personal factors that act as barriers to behaviour change for some community members.⁸³ There is now an

⁸¹ Menzies School of Health Research, *Sentinel Sites Evaluation Report February 2013*, prepared for the Australian Government former Department of Health and Ageing, Canberra, p. 89.

⁸² Ipsos-Eureka Social Research Institute & Winangali 2010, *Developmental Research to inform the Local Indigenous Community Campaigns to Promote Better Health*, prepared for the Australian Government former Department of Health and Ageing, Canberra.

⁸³ Gador-Whyte A, Wakerman J, Campbell D, Lenthal S, Struber J, Hope A & Watson C, 2014, ‘Cost of best-practice primary care management of chronic disease in a remote Aboriginal community’, *Medical Journal of Australia*, 200 (11), pp 663-666.

opportunity for all of the preventive health teams to go beyond their awareness-raising role to incorporate an enhanced focus on the development and implementation of locally relevant strategies that assist in addressing specific barriers, and support community members to begin making lifestyle changes.

It is critical that health promotion approaches used are also fully attuned with Aboriginal and Torres Strait Islander views about health and accessing services. This expanded role needs to include strategies that:

- build health literacy, assisting community members to move beyond general awareness of risk factors to development of the detailed understanding, knowledge and (where relevant) skills that support a healthier lifestyle;
- specifically address barriers by working in a collaborative and coordinated manner with other agencies and organisations that focus on particular social issues and provision of supports; and
- target those in the community who have the greatest level of need.

This expanded role would need to be supported by a specific workforce development strategy to provide team members with the necessary skills to support their work.

'People around here have had bad experiences with workers threatening to take their kids away, so they sometimes avoid health workers. But now that the workers are involved with the AMS more, more people are willing to try their healthy living programs. Lots of Aboriginal people go to the gym now or go to the elders program to get healthy. Word is spreading about these things' (community worker).

Linking individual community members to other services is important to sustain participation

Many organisations funded to implement community campaigns recognised that the time limited campaigns may not be sufficient to achieve sustainable changes in lifestyle behaviour. Similarly, the preventive health teams recognised that they had limited capacity to assist all individuals wanting to change their lifestyles. Consequently, some organisations incorporated strategies into their activities and programs to link individual community members with other services and organisations that could help them to address chronic disease risk factors. This was supported through partnerships that funded organisations already had, or put in place, to support their preventive health initiatives. These partnerships also increased the potential sustainability of the activities themselves. It is important that all organisations have strategies that:

- link individuals participating in their preventive health programs with other relevant existing support services;
- develop linkages with other like-minded or complementary service organisations; and
- support individual community members to access these other services and organisations.

6.3 Strengthening chronic disease management measures

Broad-based strategies are not sufficient on their own to drive the practice change required to benefit patients

The ICDP embarked upon a number of broad-based strategies to improve patient care and patient management practices. These included the PIP Indigenous Health Incentive and various mechanisms to encourage primary health care organisations to implement various components of practice associated with this incentive (such as MBS Health Assessments and the provision of follow up services required by a patient). While many organisations signed up to the base incentive, approximately 30 per cent did not then attract any of the patient-specific outcome payments.

Moreover these patient specific outcome payments are only indirectly linked to actual outcomes. They reflect a prescribed level of service that the practice provided to the patient which in some cases could include general health services.

To drive practice change in future activities, consideration needs to be given to:

- whether incentives continue to be broadly available or targeted to those primary health care organisations that have demonstrated their capacity to work effectively to improve outcomes;
- linking available incentives more explicitly to quality practice requirements and demonstrable outcomes for patients such as Quality Use of Medicine requirements⁸⁴, and
- exploring additional policy levers that could be used to require demonstrable improvements to patient care practices that are culturally competent.

There is a need to embed the key features of the ICDP in existing structures and systems

The ICDP focused on key aspects of the chronic disease pathway, and deployed discrete strategies to generate improvements in the pathway, for example, Care Coordinators, Outreach Workers and training in formalised and prescriptive models of chronic disease self management for staff in primary health care organisations. These strategies added valuable capacity to the existing system. Where they are perceived to be and remain as separate components to the core system, there is a risk that they function in an isolated way and continue to be seen as an add-on function. Some but not all organisations embedded key aspects of the measures such as best practice chronic disease management care models into their existing operations and team structures.

Therefore, consideration needs to be given to how to embed these critical chronic disease management functions into the core way that the current system operates. This would

⁸⁴ [Quality Use of Medicines \(QUM\)](http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-quality.htm) is one of the central objectives of Australia's National Medicines Policy, <<http://www.health.gov.au/internet/main/publishing.nsf/Content/nmp-quality.htm>>.

support sustainability and achieve benefits for more patients. A strategy to embed these features into the existing primary health care system could consider:

- how the care coordination function could be embedded in the role of practice nurses and Aboriginal Health Workers;
- requirements that clinical staff involved in the management of patients with a chronic disease have core competencies in chronic disease management including assisting patients to self-manage;
- inclusion of an outreach support function in the expected role of community based primary health care organisations;
- requirements that primary health organisations with a systems integration role⁸⁵ prioritise making the system work for people with a chronic condition; and
- inclusion of cultural competence as a core requirement of general practice accreditation.

An important and separate consideration is what funding is required to achieve this system wide enhancement.

An integrated approach to building the capacity of individuals to manage their own health is required

The ICDP included various components that directly or indirectly aimed to build the capacity of an individual to manage their health. These included training health staff to use a formal model of chronic disease self management (CDSM), the activities of Outreach Workers and Care Coordinators in supporting individuals with a chronic disease and the activities of the preventive health teams in encouraging and supporting individuals to adopt healthier life styles. These components operated in relative isolation from each other. The CDSM training program was developed and implemented without sufficient consideration of the new workforce roles and activities. Organisations funded to employ people in these new roles were not always aware of the training opportunities. Many staff assisting individuals with their self management were not in a position to be trained or, if trained, to apply the full CDSM model. Therefore, consideration should be given to how best to support primary health care services to embed chronic disease self management approaches in every day practice.

Team-based models of care are essential and can operate across the service system

The ICDP encouraged and supported a team-based care approach to the management of patients. This included:

- encouraging the use of formal team care arrangements through the MBS;
- improving access to a range of specialists to provide care for patients;

⁸⁵ Currently the role of Medicare Locals but to transition to the newly announced Primary Health Organisations.

- supporting the GP and the patient across the range of health care professionals involved in the continuum of care; and
- building stronger linkages across organisations involved in the delivery of care to the one individual.

The evaluation found that any single measure is unlikely to be sufficient and that strategies that simultaneously operate at the patient, practitioner and organisational level are necessary to facilitate effective team-based care. The ICDP also demonstrated that team-based care can operate effectively across the diversity of provider organisations.

However, there are ongoing challenges that need to be addressed:

- Aboriginal and Torres Strait Islander patients often have complex social issues, and the absence of services to assist with these issues impedes their capacity to engage in or benefit from services aimed at managing their chronic disease.
- GPs need to be encouraged and supported to refer patients to Care Coordinators. While referrals continued to increase, a sustained effort is needed to both broaden the number of GPs engaged in referrals and embed the referral pathway.
- Care Coordinators need support for administrative tasks so that they can focus more on patient care needs and/or the administrative requirements that they must comply with should be streamlined. For example, the time needed to comply with the administrative requirements of the supplementary services funding has reduced their capacity to coordinate the clinical aspects of the care plan.
- Closer working relationships between general practices and AHSs are important for patients who choose to obtain services from both sectors. There remains a level of concern amongst AHSs about the expanded role of the mainstream sector and sometimes the lack of engagement by individual general practices with AHSs.

While these challenges reflect the current fragmented nature of the primary health care system, they also reflect the need for a more mobilised and concerted effort by various players within the system to ensure that it can work seamlessly from the patient perspective and ensure that the patient is fully supported to navigate it.

6.4 Workforce development

The preventive health workforce needs ongoing support and development

Participation in the preventive health components of the ICDP was a new experience for some organisations and staff. This required considerable effort to develop the skills of the staff involved in the programs. For those organisations with some history in preventive health, their workforce still required development. The evaluation also found that staff employed into ICDP-designated roles required ongoing development regardless of their level of preventive health experience because of the complexity of the issues they were addressing. As more is understood about what needs to be done to effectively focus on the underlying complex issues that often are barriers to individual community members adopting healthier lifestyles, the strategies that the workforce will need to develop will evolve and are likely to be more complex. All this points to a workforce that will need to be

supported with resources, skill development and a structured career pathway if they are to be retained in preventive health work.

A workforce strategy is required that is responsive to the evolving roles of the new workforce and also supports the broader primary healthcare workforce

The ICDP created workforce roles that were either new in function (for example, Outreach Workers) or formalised an informal role being undertaken by the existing workforce (that of care coordination). These workforce roles evolved during the period of the evaluation. This has implications for the development needs of staff in these new positions and for existing staff who undertake similar functions.

For example, the Outreach Worker positions were designed to have entry-level skills, partly as a strategy to encourage community members into these positions and through this build local capacity, and partly because of the role expected of these workers. In practice, staff with existing relevant qualifications were often recruited to these positions. This had implications for their role, professional development expectations and how they functioned within their organisations.

In contrast, while Care Coordinators were qualified health care professionals, they did not always have the broader knowledge and experiences required to fulfil their new role. For example, not all had knowledge of the community controlled sector and experience in how to engage this sector; not all had experience in managing patients with complex care needs. Moreover, in both cases, having ready access to training and clear options for career development were enablers to retaining staff and resulted in retention issues when not present.

These ICDP experiences highlight that a workforce development strategy is required that builds the competencies of the primary health care workforce so that preventive health and chronic disease management are core capabilities and the strategy offers genuine career progression. Ongoing professional development and genuine career progression are critical to recruitment and retention of a highly skilled Aboriginal and Torres Strait Islander health workforce. In particular, for health professionals and non-clinical staff involved in primary health care the focus should be on:

- building their skills to extend their areas of expertise and scope of practice, for example in preventive health, patient self management and care coordination; and
- establishing a competency based career pathway from entry level to tertiary qualified positions, and supporting individuals to build a career in Aboriginal and Torres Strait Islander health according to their own capacities and desires within the existing service system.

In addition, consideration should be given to reviewing the roles and functions of the Aboriginal and Torres Strait Islander health workforce (including the Care Coordinators) to create a simplified and clearly articulated workforce structure to avoid role confusion and exacerbating issues arising from an already fragmented service system.

6.5 Monitoring and support

Establishing an evidence base to support people in the field is valuable, but further active and systematic generation of evidence is required

A number of inherent challenges were evident in the implementation of the preventive health components of ICDP. One related to the paucity of evidence about effective Aboriginal and Torres Strait Islander specific prevention initiatives that could be adopted by local teams. The department commissioned research⁸⁶ and consulted with experts and leaders in the field to ensure that as far as possible, the ICDP was evidence-based in terms of its design. In addition, the teams were well supported by being provided with resource materials that they used as information sources. This resulted in the implementation of a range of activities that were well supported and valued by those in the field. However, less was known or understood about, for example, strategies that would be effective in engaging groups and individuals to take action to change actual behaviours.

Preventive health strategies that help facilitate behaviour change need to be grounded in a strong understanding of the complexities of the social and environmental determinants of lifestyle choices and risk behaviours. They also need to take into account local context as this often shapes community attitudes towards healthy behaviours. This poses challenges for building and utilising evidence-based approaches. Thus, flexibility is needed in order to be responsive to local needs and contexts, which means that what works in one location is not automatically transferable to another.

Future programs on preventive health for Aboriginal and Torres Strait Islander people would benefit from undertaking a more in depth analysis of potential models and approaches that could be developed and used to both build and maximise the uptake of effective health promotion approaches in community settings using ground up approaches. As part of this it will be important to the develop and monitor strategies that can better harness existing evidence such that this can more easily translate into the approaches that local teams can use.

Future programs should also consider including strategies into program implementation that can build the evidence base, for example, through the use of developmental evaluation approaches. The evaluation found that there was little emphasis on self-evaluation that would enable those implementing local campaigns to know whether they were achieving their sought objectives. Results from self-evaluations would add to the available evidence about what works, what does not and the circumstances in which this occurs. Thus, consideration should be given to:

- a greater emphasis on building self-evaluation into program requirements to benefit those wanting to implement new initiatives;

⁸⁶ Ipsos-Eureka Social Research Institute & Winangali 2010, *Developmental Research to inform the Local Indigenous Community Campaigns to Promote Better Health*, prepared for the Australian Government former Department of Health and Ageing, Canberra.

- encouraging continuous quality improvement in both preventive health and chronic disease management through the ongoing development of quality improvement frameworks, such as the work being undertaken by the department in relation to the potential development of a National Continuous Quality Improvement Policy Framework;
- ensuring that the reporting requirements of funded organisations are more focused on outcomes than processes; and
- establishing effective learning supports that, will, over time, facilitate the building, sharing and utilisation of evidence-based preventive health approaches at a systems level and in a way that empowers local workers, organisations and communities.

Success creates further demand for services and this should be monitored and planned for

The evaluation found that the ICDP has raised expectations within the community, and created a demand for services. While the ICDP included strategies to address increased demand, there is a risk that, as ICDP gains greater penetration, it will create a level of demand that could strain the capacity of both existing services and the ICDP-funded workforce. There was evidence of this already occurring. For example, some Outreach Workers reported that the help they had provided to individual patients had spread through word of mouth, creating a level of demand that could not be met in a sustainable manner. Some Care Coordinators reported increasingly spending an inordinate amount of their time trying to source more services from a limited pool of available providers.

Currently, there is no strategy for monitoring either the potentially increasing demand for services or the availability of existing services to address this demand. As the ICDP continues, it is important to consider how best to monitor the nature and level of demand and the matching of service availability, and to develop the necessary strategies to address any identified gaps in services.

The collection of data to support patient care is a challenge but one that ultimately benefits the patient

The ICDP evaluation and particularly the Sentinel Sites Evaluation demonstrated the challenges that primary health care services face in collecting the clinical and other patient-related data that is important to ongoing patient care. The Sentinel Sites Evaluation attempted to build organisational capacity to collect relevant data from a number of designated locations and provide a rich set of clinical data for the evaluation. This was largely unsuccessful due to the perennial system challenges related to collecting this data routinely, despite this data being essential to the ongoing care of the patient.

This evaluation supports the view of the Sentinel Sites Evaluation that states in its summary report that “this points to a clear need to build competence in the design, development and effective use of information systems to support delivery of high-quality chronic illness care, including capability for ongoing evaluation and improvement at local and regional levels”.

7 Conclusions

The evaluation found that the ICDP has enhanced the health care service system resulting in a demonstrated increase in access to services relevant to improved chronic disease management and there are early signs of benefits for individual patients. Furthermore, the evaluation found that the ICDP is helping some individual patients with their own capacity to manage their illness and supporting communities to address chronic disease risk factors within their communities. While the evaluation was not able to determine the extent of these impacts, the evidence shows that the reach of the ICDP is expanding and with this, so should its impacts.

It took time to establish the mechanisms such as new funding arrangements and new types of workforce that were important to create the momentum for a reorientation of the primary health care system. This momentum needs to continue in order for health services to reach a state of maturity in which prevention and effective chronic disease management are embedded in their practices.

The ICDP was able to capitalise upon existing initiatives and strengthen links with various components of the current primary health care service system. This is important as the ICDP does not exist in a vacuum. It is a strategy that has strengthened the current service system and enhanced the system's capability to focus more on health promotion and prevention as well as to better respond to the needs of people with a chronic illness.

Specifically, the ICDP has:

- made a difference to reducing barriers to access to services and care through observed changes related to specific measure activities such as CtG scripts; the work of Outreach Workers and Care Coordinators; cultural awareness training provided to mainstream providers; and the provision of additional specialist clinical outreach services;
- made a difference to the capacity of the workforce and health system to supply additional services and care; and
- enabled some improvements to the quality of chronic disease management and to increasing the use of services that are important for effective management although there is considerable scope to improve this aspect of the ICDP.

It was not feasible to assess the impact of the ICDP on chronic disease incidence, prevalence and mortality, given that it will take time for these impacts to be achieved and given the gaps in available data. However, the evaluation has established that the ICDP:

- has progressed many of the factors that are critical to the success of its individual measures which leads to the overall conclusion that the ICDP should make a contribution to the expected longer-term outcomes;
- is delivering a range of evidence-based solutions that address priority individual and community need;
- is dealing with systemic issues that have historically constrained access that Aboriginal and Torres Strait Islander people have to services that are critical to their health care;
- has generated change at the community and health service system level and created some sustainable capacity that should have longer-term benefits;

- has enabled existing health services to better leverage other strategies and initiatives focusing on Aboriginal and Torres Strait Islander health which is critical for the longer-term given the significant investments being made through the broader health care system – the role of the ICDP goes beyond its own investments in new services;
- has the flexibility that allows local organisations to adapt the various ICDP measures to meet local needs; and
- has added to the momentum for primary health care services to have a greater focus on preventive health and effective chronic disease management.

The evaluation has established that many aspects of the ICDP are important if the gap in life expectancy between Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians is to be closed but it is likely to take considerable time. There are opportunities and an imperative to further improve some aspects of the package to ensure that:

- primary health care organisations in both the mainstream and Aboriginal health sectors embed preventive health and chronic disease management in all of what they do on a daily basis, rather than see this as a ‘program add on’; some need continued support to achieve this reorientation;
- the focus is on outcomes not processes which will require, for example, reconsideration of how incentive payments are designed and used;
- there is a sustainable workforce model that in the longer-term integrates key functions of chronic disease management in the existing workforce rather than have a proliferation of workforce types; primary health care services will need the resources to embed this expanded function; and
- there is capacity and the capability for all primary health care organisations to support individuals with the range of complex social and personal issues that often are barriers to patients being able to focus on their illness and are also determinants of health.

The evaluation demonstrated that the leadership shown from peak bodies, individual champions and local organisations was instrumental to drive change, and that effective partnerships are necessary to overcome challenges and create synergies to maximise success. It is necessary that there is an ongoing focus on building strong organisations in both sectors including leadership, technical capability and strong governance that requires continued support from peak bodies and leaders in Aboriginal and Torres Strait Islander health.

The achievements of the ICDP are encouraging given the complexity of the challenge of addressing the prevalence and impact of chronic disease, not only for Aboriginal and Torres Strait Islander people, but for all populations. Health services face increasing levels of chronic disease and this requires a remodelling of their health care systems, which are presently oriented to provide episodic rather than the integrated, patient centred care appropriate to chronic disease management. This type of system level change is by necessity incremental rather than transformative, and the ICDP can be viewed as an important step in that process.

Appendix A: The ICDP Measures

A.1 Summary of the measures

Table 1: Measures in the ICDP

Priority Area	Key	Measure
Tackling chronic disease risk factors	A1	National Action to Reduce Indigenous Smoking Rates (subsequently merged with measure A2 to form the Regional Tackling Smoking and Healthy Lifestyle Team measures)
	A2	Helping Indigenous Australians Reduce Their Risk of Chronic Disease (subsequently merged with measure A1 to form the Regional Tackling Smoking and Healthy Lifestyle Team measures)
	A3	Local Indigenous Community Campaigns to Promote Better Health
Improving chronic disease management and follow up care	B1	Subsidising PBS Medicine Co-payments
	B2	Higher Utilisation Costs for MBS and PBS
	B3	Supporting Primary Care Providers to Coordinate Chronic Disease Management (subsequently split in to B3a: PIP Indigenous Health Incentive and B3b: CCSS program)
	B4	Improving Indigenous Participation in Health Care through Chronic Disease Self Management
	B5	Increasing Access to Specialist and Multidisciplinary Team Care (subsequently split into measure B5a: Urban Specialist Outreach Assistance Program (USOAP) and measure B5b: Medical Specialist Outreach Assistance Program – Indigenous Chronic Disease)
	B6	Monitor and Evaluate the Closing the Gap Chronic Disease Initiative
Workforce expansion and support	C1	Workforce Support, Education and Training
	C2	Expanding the Outreach and Service Capacity of Indigenous Health Organisations

Priority Area	Key	Measure
	C3	Engaging Divisions of General Practice to Improve Indigenous Access to Mainstream Primary Care (subsequently renamed as Improving Indigenous Access to Mainstream Primary Care Program)
	C4	Attracting More People to Work in Indigenous Health
	C5	Clinical Practice and Decision Support Guidelines

Table 2: Focus of ICDP on the chronic disease management pathway

Chronic disease management focus of the ICDP	Type of strategy	ICDP Measures
Detection	Encourage and support Aboriginal and Torres Strait Islander people to connect with and use their primary health care service	C2 and C3
Detection	Encourage and support primary health care providers to increase detection activities	C1, C2, C3, and B3a
Health needs assessment	Increase capacity of primary health care organisations and specialists to undertake needs assessments	B2, C1, C2, C3, B3a and B5
Health needs assessment	Encourage primary health care providers to apply best practice needs assessment protocols	B2 and B3a
Health needs assessment	Reduce barriers that patients face in accessing health needs assessment services	B3a, C2 and C3
Service provision	Improve referrals to secondary care services	B3a, B3b, B5, C2 and C3
Service provision	Increase capacity and capability of primary health care providers to provide	B2, B3a, B5, B4 and B5

Chronic disease management focus of the ICDP	Type of strategy	ICDP Measures
	services	
Service provision	Encourage best practice service provision	B2, B3a, B4 and B5
Coordination and care management	Increase capacity and capability to coordinate care	B3a, B3b, B4, B5, C1, C2 and C3
Coordination and care management	Encourage best practice care management	B2, B3a, B4 and B5

A.2 Detailed description

The descriptions in the following pages have been reproduced from the Commonwealth's Implementation Plan for the ICDP.⁸⁷ They describe the measures as originally conceived and designed. A number of the measures have undergone changes and have continued to evolve since this time.

A.3 Priority Area – Tackling chronic disease risk factors

A.3.1 Measure A1 – National Action to Reduce Indigenous Smoking Rates

Aim

Reduce the Indigenous smoking rate and the burden of tobacco related chronic disease for Indigenous communities.

Approach

- National formative research to determine culturally appropriate tobacco action campaign activity.
- Fund up to three national conferences/workforce meetings to share best practice and innovation.

⁸⁷ COAG October 2009, [National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan, Jurisdiction: Commonwealth](http://www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-health-outcomes/all_states_IP.pdf). Australian Government, Canberra, viewed 8 May 2014, <http://www.federalfinancialrelations.gov.au/content/npa/health_indigenous/ctg-health-outcomes/all_states_IP.pdf>.

- Develop a national Indigenous tobacco action training program for health workers and community educators.
- Authority list Nicotine Replacement Therapy on the PBS for Indigenous Australians.
- Coordinate program evaluation.

Commonwealth to fund, and work with, state and territory governments and NGOs to:

- Establish a national network of tobacco action coordinators.
- Implement local strategies including media placement.
- Consult and engage with local communities.
- Sponsor community events and establish quit smoking role models and ambassadors.
- Provide workforce training and support units.
- Enhance Quitline to provide culturally sensitive services.
- Train health and community workers to deliver tobacco action programs.
- Implement targeted tobacco cessation programs.

Rationale

- If the smoking rate among Indigenous Australians was reduced to the rate of the non-Indigenous population, the overall Indigenous burden of disease would fall by around 6.5%, and save the lives of around 420 Aboriginal and Torres Strait Islander people per year. This equates to an additional four extra years of life expectancy.
- Evidence from New Zealand in reducing Maori smoking rates and learnings from community projects funded under the Indigenous Tobacco Control Initiative will inform this priority area.

A.3.2 Measure A2 – Helping Indigenous Australians Reduce Their Risk of Chronic Disease

Aim

Assist Indigenous Australians to reduce their risk of chronic disease and better manage their conditions and lifestyle risk factors through the adoption of healthy lifestyle choices.

Approach

This element forms a continuum with measure B4 to effectively reduce the impact of chronic disease.

Commonwealth to fund, and work with, state and territory governments and NGOs to:

- Recruit and train over 105 Indigenous healthy lifestyle workers to deliver programs or activities that target the key lifestyle contributors to chronic disease.
- Deliver programs or activities to 25,000 individuals and families, particularly targeting those who are considered to be at high risk of developing a chronic disease.

Rationale

- Many chronic diseases can be prevented or delayed through intervention, effective management and lifestyle change.
- Access to affordable chronic disease lifestyle risk reduction programs is a barrier to good health outcomes for Indigenous Australians. Significant ongoing personalised support is needed to encourage self management of lifestyle risk factors and prevent chronic disease.

A.3.3 Measure A3 – Local Indigenous Community Campaigns to Promote Better Health

Aim

Improve Indigenous Australians' awareness of, and access to, health measures to better promote their health and wellbeing.

Approach

Undertake a research program to inform community level communication activity. Facilitate partnerships to develop community- oriented approaches to health promotion. Review partnership models and actions to guide state and territory extension activities. Commonwealth to fund, and work with, state and territory governments and NGOs to:

- Partner with communities to develop local-level information and communication activities.
- Implement local strategies, including media placement.

Rationale

- The World Health Organization's Ottawa charter recommends a five pronged approach for health promotion, including public awareness campaigns.
- Health promotion is an important factor in reducing risk factors at the population level.

A.4 Priority Area – Improving chronic disease management and follow up care

A.4.1 Measure B1 – Subsidising PBS Medicine Co-payments

Aim

Improve access to and quality use of Pharmaceutical Benefits Schedule (PBS) medicines for Indigenous Australians with chronic disease or chronic disease risk factors who attend a participating general practice or Indigenous health service in a non-remote area.

Approach

- Contract suitable funds holders to manage funds to address cost barriers for eligible Indigenous Australians with chronic disease or chronic disease risk factors.

Rationale

- Remote area initiatives supporting access to PBS medicines (through Section 100 mechanisms) have increased access to the PBS, and this initiative will provide similar improvements for non-remote areas.
- Cost barriers to services are a major reason why Indigenous Australians do not access health care.
- It is predicted that making medicines more accessible to Indigenous Australians results in higher medication compliance amongst those with chronic disease.

A.4.2 Measure B2 – Higher Utilisation Costs for MBS and PBS

Aim

Provide increased funding to the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) to meet expected increased utilisation costs by Indigenous Australians accessing those parts of the ICDP designed to promote access to medical services.

Approach

- Expand the number of MBS follow up items (MBS item 10987) for Practice Nurses and AHWs from five to 10 services per client per annum.
- Meet the costs of the anticipated increased uptake of MBS health checks, chronic disease management and allied health professional service items.

Rationale

- MBS expenditure for Indigenous people is estimated to be 45% of the non-Indigenous average, and PBS expenditure is estimated at 51% of the non-Indigenous average.
- For other Australians, use of health services rises with level of illness. People with one significant medical condition have a usage of MBS and PBS about four times the nation average, and expenditure rises up to 12 times the average for people with five conditions.

A.4.3 Measure B3 – Supporting Primary Care Providers to Coordinate Chronic Disease Management

Aim

Encourage general practices to provide better health care for Indigenous Australians and improve the continuity of care for those with chronic health conditions

Approach

- Develop and implement the Practice Incentives Program (PIP) Indigenous Health Incentive to provide incentives to accredited general practices and Aboriginal health services to improve the provision of care to Indigenous Australians. Contract suitable

funds holders to manage a flexible pool to provide care coordination and a range of supports to individual patients participating in an eligible Chronic Disease Management Program (CDMP).

Rationale

- Primary care payment schemes that combine salary or capitation with fee- for-service payments provide better overall incentives for care coordination with increased effectiveness when fee-for-service payments specifically remunerate coordination activities.
- Encouraging practices to provide a target level of care promotes continuity of care, which has been shown to improve patient outcomes.

A.4.4 Measure B4 – Improving Indigenous Participation in Health Care through Chronic Disease Self Management

Aim

Support Indigenous Australians to better manage or self manage their chronic disease

Approach

This element forms a continuum with measure A2.

Commonwealth to fund, and work with, state and territory governments and NGOs to:

- 400 workers trained to deliver chronic disease self management support programs.
- The training will provide the competency-based skills appropriate to support lifestyle change and self management skills in Aboriginal and Torres Strait Islander people who have established chronic disease or who are at risk of developing a chronic disease.
- The trained workforce will deliver chronic disease self management sessions or activities to 50,000 Indigenous individuals and families with established chronic disease or who are at high risk of developing a chronic disease.

Rationale

- Many chronic diseases can be prevented and/or progress delayed through intervention, effective management and lifestyle change.
- Access to affordable chronic disease risk reduction/self management programs is a barrier to good health outcomes for Indigenous Australians. Significant ongoing personalised support is needed to encourage self management of lifestyle risk factors to prevent chronic disease or to slow its progression

A.4.5 Measure B5 – Increasing Access to Specialist and Multidisciplinary Team Care

Aim

Increase access to specialist and multidisciplinary team follow-up care for Indigenous Australians

Approach

- Create flexible funds pools to provide access to specialists for Indigenous Australians participating in the CDMP. Provide specialist outreach services in urban areas for Indigenous Australians.
- Expand the Medical Specialist Outreach Assistance Program (MSOAP) to target services to rural and remote Indigenous communities by supporting the introduction of multidisciplinary health professional outreach teams consisting of specialists, GPs and allied health professionals.

Rationale

- Many Indigenous Australians cannot afford the specialist and allied health services they need to manage their chronic disease.
- Workforce shortages, waiting times and the lack of available services have been reported as barriers to Indigenous Australians accessing services when needed.
- Service providers face financial disincentives in delivering outreach services to Indigenous Australians living in remote and very remote communities.

A.4.6 Measure B6 – Monitor and Evaluate the Closing the Gap Chronic Disease Initiative

Aim

Monitor and evaluate the Closing the Gap Chronic Disease initiative

Approach

Develop and implement an overarching Monitoring and Evaluation framework including:

- Monitor progress through up to 32 sentinel sites, national survey data, and the rollout of a web based system for Key Performance Indicator data;
- Conduct an independent evaluation.
- Analyse and report on data collected by the AIHW, MBS, PBS and other sources.
- In consultation with the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) and jurisdictions, support the improvement of Indigenous identification in vitals and health administrative datasets.

Rationale

Good quality data is vital for monitoring progress on closing the gap in Indigenous health.

A.5 Priority Area – Workforce expansion and support

A.5.1 Measure C1 – Workforce Support, Education and Training

Aim

Build the Indigenous health workforce through education and training initiatives

Approach

- Fund the development and delivery of education and training to Aboriginal and Torres Strait Islander Outreach Worker (ATSIOWs).
- Provide 38 additional GP registrar training posts in Indigenous health services.
- Expand the Nursing Scholarship to include 50 continuing professional education scholarships per annum for nurses working in Aboriginal Medical Services. Expand the Nursing Clinical Placement Program.

Rationale

- The provision of training through the vocational education and training (VET) sector is a recognised method of providing accredited training to Indigenous Australians.
- Providing exposure to Indigenous health for GPs and nurses in a cross discipline environment is regarded by the World Health Organization as world's best practice.

A.5.2 Measures C2 and C3 – Expanding the Outreach and Service Capacity of Indigenous Health Organisations and Engaging Divisions of General Practice to Improve Indigenous Access to Mainstream Primary Care

Aim

Increase the capacity of Indigenous and mainstream health organisations to provide better continuity of care for Indigenous people with chronic and complex health conditions

Approach

- Fund accredited Indigenous health services to recruit and employ ATSIOWs and Practice Managers to encourage Indigenous Australians to access health services, work with services to resolve barriers that impact on attendance and improve service capacity to deliver regular health checks.
- Fund additional health professionals in rural and remote Indigenous health services to meet the expected increase in demand for services and provide resources to support additional housing/clinic upgrades.
- Fund the Divisions of General Practice to recruit and employ ATSIOWs and Project Officers to support increased access to mainstream care options by Indigenous Australians, better manage Indigenous health needs and increase collaboration between general practice and Indigenous health services.

Rationale

- Using ATSIOWs to increase access to health care is a model that has demonstrated success in Australia when well supported by the health system.
- A similar approach has also been used in the Maori health sector in New Zealand.

A.5.3 Measure C4 – Attracting More People to Work in Indigenous Health

Aim

Generate interest and encourage more health professionals to work in Indigenous health

Approach

- Undertake a market research program exploring the attitudes, barriers and expectations of current and potential health professionals and other workers regarding employment in Indigenous primary health care services, including the Aboriginal community controlled sector.
- Resource development will include concept testing with appropriate target audiences.
- Develop and implement a national Indigenous health recruitment campaign to build a health workforce to work in primary health care organisations that provide services for Indigenous Australians.

Rationale

- The availability of other disciplines to participate in team care contributes to the gap between optimal and current practice.

A.5.4 Measure C5 – Clinical Practice and Decision Support Guidelines

Aim

Ensure health service providers have access to relevant and culturally appropriate information to improve decision making processes and inform management options for Indigenous Australians

Approach

- Coordinate activities across the department to ensure that mainstream clinical practice and decision support guidelines include Indigenous specific information when they are to be updated.
- Review existing Indigenous chronic disease clinical practice and decision support guidelines.
- Develop and disseminate Indigenous specific clinical practice and decision support guidelines for chronic disease prevention and primary care management.