

National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan

Jurisdiction: Commonwealth

Table of contents

1 BACKGROUND AND CONTEXT 3

2 NATIONAL REFORMS 6

2.1 National minimum service standards 6

2.2 Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets .. 6

2.3 Infrastructures to support transitions and linked records between primary, in-patient and specialist services..... 6

2.4 Workforce..... 6

2.5 Cultural Security..... 7

3 IMPLEMENTATION PLAN..... 8

**3.1 KEY FOR NPA PERFORMANCE BENCHMARKS REFERRED TO IN IMPLEMENTATION PLAN
TEMPLATE 8**

3.2 KEY TO MEASURES IN THE IMPLEMENTATION PLAN..... 9

4 RISK MANAGEMENT..... 24

5 REVIEW AND EVALUATION 24

**6 APPENDIX A: NATIONAL INDIGENOUS REFORM AGREEMENT’S SERVICE DELIVERY PRINCIPLES FOR
INDIGENOUS AUSTRALIANS: 25**

6.1 Priority 25

6.2 Indigenous engagement 25

6.3 Sustainability 25

6.4 Access 26

6.5 Integration 26

6.6 Accountability..... 26

7 APPENDIX B: NATIONAL PRINCIPLES FOR INVESTMENTS IN REMOTE LOCATIONS 28

8 APPENDIX C: ACRONYMS 29

9 REFERENCES..... 30

1 BACKGROUND AND CONTEXT

On 20 December 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Aboriginal and Torres Strait Islander communities to achieve the target of closing the gap on Indigenous disadvantage. COAG committed to closing the life expectancy gap between Indigenous and non-Indigenous Australians within a generation; halving the mortality gap for children under five within a decade; and halving the gap in reading, writing and numeracy within a decade.

Subsequently, on 20 March 2008 the Prime Minister and other key Indigenous and non-Indigenous stakeholders jointly signed a Statement of Intent to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by the year 2030.

Six ambitious targets for closing the gap between Indigenous and non-Indigenous Australians across urban, rural and remote areas were agreed to by COAG in March 2008:

- to close the gap in life expectancy within a generation;
- to halve the gap in mortality rates for Indigenous children under five within a decade;
- to ensure all Indigenous four years olds in remote communities have access to early childhood education within five years;
- to halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade;
- to halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020; and
- to halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

On 29 November 2008, COAG agreed to an historic \$1.6 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (the NPA) to specifically address the first of the COAG Closing the Gap targets – to close the gap in life expectancy within a generation. The Commonwealth will contribute \$805.5 million over four years to address three priority areas in the NPA - *Tackling Smoking*, *Primary Health Care Services That Can Deliver*, and *Fixing The Gaps And Improving The Patient Journey*. State and territory governments will contribute to all priority areas of the NPA. The NPA will be implemented consistent with the National Indigenous Reform Agreement, and will complement activities in other National Partnership Agreements.

National Indigenous Reform Agreement

The National Indigenous Reform Agreement (NIRA) provides the overarching framework for the six targets across the Indigenous specific National Partnership Agreements, and is underpinned by key performance indicators and benchmarks. These performance indicators and benchmarks will be used to monitor progress through annual public reporting and analysis by the COAG Reform Council from 2009-10. To ensure consistency across the development of National Partnership Agreements, COAG has agreed service delivery principles for Indigenous Australians (see Appendix A) and principles for investment in remote locations (see Appendix B). These principles are a guide for all COAG reforms, and all governments are expected to take these principles into account in designing policies and providing services.

Other National Partnership Agreements

The NPA will also be implemented in the context of, and consistent with, other National Partnership Agreements covering a range of reform areas, including Indigenous economic participation, remote Indigenous housing, Indigenous early childhood development, Indigenous remote service delivery, preventive health, and hospital and health workforce.

The Burden of Disease for Aboriginal and Torres Strait Islander people

The Commonwealth's Implementation Plan under the NPA is based on evidence that shows Aboriginal and Torres Strait Islander people experience a burden of disease two and half times that of non-Indigenous Australians.ⁱ Chronic diseases and associated risk factors are responsible for about two-thirds of the life expectancy gap between Indigenous and non-Indigenous Australians.ⁱⁱ Aboriginal and Torres Strait Islander people are more likely to die from these conditions than non-Indigenous Australians with the same condition: 1.5 times more likely to die from cancer; 12 times more likely to die from diabetes.ⁱⁱⁱ Tobacco smoking alone is responsible for 20% of all deaths for Aboriginal and Torres Strait Islander people.^{iv}

Good quality care for people with chronic disease generally involves multiple health care providers across multiple settings (for example, Aboriginal and Torres Strait Islander primary health care services, general practice, community health, hospitals, specialists, allied health professionals, etc.) and the engagement of the client and their families in the self-management of their condition.^v Primary health care is fundamental to the prevention, early detection and management of chronic diseases and their risk factors^{vi} and the primary health care provider typically plays a central role in the coordination of care.

The Commonwealth Government provides universal access to high quality primary care and medicines for all Australians through the Medicare system and the Pharmaceutical Benefits Scheme (PBS). However, for Indigenous Australians, Medicare Benefits Schedule (MBS) per capita expenditure is estimated to be 45% of the non-Indigenous average, and Pharmaceutical Benefits Scheme (PBS) per capita expenditure is estimated at 51% of the non-Indigenous average.^{vii} For non-Indigenous Australians, use of health services rises with the level of illness. People with one significant medical condition have a usage of

MBS and PBS about four times the national average, and expenditure rises up to 12 times the average for people with five conditions.^{viii}

The low usage of primary health care by Aboriginal and Torres Strait Islander people, relative to need, has resulted in over-utilisation of hospital services. In 2004-05 Indigenous Australians were more than twice as likely to visit casualty/outpatients as non-Indigenous Australians.^{ix}

Primary health care services for Aboriginal and Torres Strait Islander people

Mainstream general practice is a significant source of care for a large number of Aboriginal and Torres Strait Islander people, however, anecdotal reports suggest a relatively small proportion of private general practitioners provide sensitive and appropriate services for their Indigenous patients. There is some evidence that few mainstream general practitioners currently identify which of their patients are Aboriginal and Torres Strait Islander. Therefore they are not in a position to offer the additional MBS, PBS and immunisation programs available.^{x,xi} For most general practices, unlike Aboriginal community controlled health services, Aboriginal and Torres Strait Islander people remain a small proportion of their clients, which makes developing expertise in Aboriginal and Torres Strait Islander health challenging.

Aboriginal community controlled health services play an important role as the major provider of health care for Aboriginal and Torres Strait Islander people in remote areas of Australia, and as the usual source of care for a third of Indigenous Australians overall. These services are controlled by the local community and have significant expertise in Aboriginal and Torres Strait Islander health. They offer services in addition to primary medical care and remain the service of choice for many Aboriginal and Torres Strait Islander people. However, the relatively small number of services nationally limits their accessibility for Aboriginal and Torres Strait Islander people.

State and territory government funded primary health and community services, as well as other non-government organisations, also deliver primary health care and other health services for many Aboriginal and Torres Strait Islander people.

Commonwealth Government programs for Aboriginal and Torres Strait Islander people.

To compensate for the shortfall in MBS expenditure, the Commonwealth government provides funding for health programs specifically for Aboriginal and Torres Strait Islander people. In the 2008-09 Budget, the Commonwealth Department of Health and Ageing provided funding of more than \$663 million for health programs specific to Aboriginal and Torres Strait Islander people, including new Indigenous specific Medicare items, hearing services, aged care, population health and prevention programs. This takes into account funding of \$529 million, through the Aboriginal and Torres Strait Islander Health program, including grant funding to Aboriginal community controlled health organisations and other health services to provide high quality, coordinated primary health care, substance use, and social and emotional well-being services for Aboriginal and Torres Strait Islander people.

The Commonwealth contribution to the NPA builds upon a series of other important investments the Commonwealth has made that specifically address the health of Aboriginal and Torres Strait Islander people.

The second COAG-agreed target – to halve the gap in mortality rates for Indigenous children under 5 years within a decade – recognises the importance of early childhood development in closing the gap in Indigenous health outcomes. On 2 October 2008, the Council of Australian Governments made a commitment of \$564 million in joint Commonwealth and state and territory funding over six years for the National Partnership Agreement on Indigenous Early Childhood Development. This investment will increase access to antenatal care, teenage reproductive and sexual health services, and child and maternal health services; and establish 35 Children and Family Centres across Australia that offer early learning, child care and family support programs. It builds upon work to establish home visiting services for at-risk Aboriginal and Torres Strait Islander children up to 8 years of age through the Australian Nurse Family Partnership program. It also builds on and the Healthy for Life program, which provides funding to Indigenous health services to increase attendance rates for antenatal care; increase adult and child health checks and follow-up; improve best practice service delivery for people with chronic conditions; and, where appropriate, increase the capacity of services to address men's health issues.

In 2004-05, 10% of Aboriginal and Torres Strait Islander children aged 0-14 years were reported as having ear or hearing problems compared with 3% of other Australian children. Hearing loss can lead to linguistic, social and learning difficulties and behavioural problems in school, which reduce educational achievements that have life-long consequences for employment, income, and social success.^{xii} Blindness was around one-and-a-half times more common for Indigenous than for non-Indigenous people.^{xiii} On 26 February 2009, the Prime Minister announced new funding of \$58.3 million over four years to expand services in the management of ear and eye problems. This measure will lead to better health, education and employment outcomes for Indigenous Australians and assist in closing the gaps in these areas.

As well as ongoing funding for primary health care services nationally, the Commonwealth Government continues to support coordinated delivery of primary care services and better health for Aboriginal and Torres Strait Islander people living in the Northern Territory, with a focus on children's health. The Enhanced Health Service Delivery Initiative will continue to improve the way services are delivered in the Northern Territory through ongoing reform, the regionalisation of services, and increasing the number of additional health professionals through the Remote Area Health Corps.

In December 2007, the Commonwealth announced an additional \$49.3 million for drug and alcohol treatment services for Aboriginal and Torres Strait Islander people. The measure builds on the earlier COAG commitment of funding for drug and alcohol treatment and rehabilitation services for Aboriginal and Torres Strait Islander people across Australia, particularly in

regional and remote areas, and includes drug and alcohol treatment and rehabilitation services to support the Cape York Welfare Reform. States and territory governments have also committed to complementary investments in drug and alcohol services to support the initiative.

Commonwealth Government investment in primary health care, allied health and specialist services, particularly in rural and remote areas, also supports the delivery of health care for Aboriginal and Torres Strait Islander people.

The Commonwealth implementation plan

The activities in this Commonwealth implementation plan have a focus on improving the capacity of all primary health care services to better manage chronic disease for Aboriginal and Torres Strait Islander people. These initiatives will be delivered through a range of Indigenous and non-Indigenous health services, including Aboriginal community controlled health services, state and territory government Indigenous specific health services, general practice and other government and non-government organisations that provide primary health care to Aboriginal and Torres Strait Islander people.

The Commonwealth's implementation plan has three main elements:

Tackle chronic disease risk factors

Many of the chronic diseases affecting Indigenous Australians have common risk factors. Modifying risk behaviour and decreasing the prevalence of these risk factors can prevent or delay the onset of chronic disease and improve outcomes for those who are already unwell. Measures in this priority area will tackle chronic disease risk factors including smoking, poor nutrition and lack of exercise, and deliver community education initiatives to reduce the prevalence of these risk factors in Aboriginal and Torres Strait Islander populations. It will provide Indigenous tobacco campaign activities, a new tobacco action workforce, a health promotion workforce, healthy lifestyle programs and improved access to smoking cessation services by Aboriginal and Torres Strait Islander people.

Improve chronic disease management and follow-up care

The Medicare Benefits Schedule currently provides for routine health checks and chronic disease management items, however, the use of these by health service providers and the uptake by Indigenous Australians is limited. This measure will deliver a comprehensive approach to chronic disease management that seeks to encourage greater uptake of health checks and the provision of follow-up care in a coordinated, accessible and systematic manner. Incentives will be provided to encourage general practices to improve the coordination of health care for Aboriginal and Torres Strait Islander people, including best practice management of patients with chronic disease. Greater support will also be provided for Aboriginal and Torres Strait Islander people to actively participate in their own health care, in addition to improved access to affordable medicines, multidisciplinary follow up care and specialist general practice and allied health services for Indigenous Australians with a chronic disease.

Workforce expansion and support

The capacity of the primary care workforce in Indigenous and mainstream health services will be expanded to increase the uptake of health services by Aboriginal and Torres Strait Islander people. Measures include a national recruitment campaign to attract, train and support health workforce; additional staff such as Indigenous Outreach Workers, health professionals, practice managers and project managers; and additional nursing scholarships, registrar training posts and nurse clinical placements. Indigenous specific clinical practice and decision support guidelines will also be developed to assist health professionals in tackling the key conditions that contribute to the gap in life expectancy.

2 NATIONAL REFORMS

The five reforms identified below reflect system-level changes to support combined efforts to close the gap in Indigenous health outcomes. A number of these reforms are being pursued through mechanisms outside of the National Partnership Agreement, while others rely upon joint and/or complementary activity by the Commonwealth and state and territory governments through the NPA. Further detail on specific activities to address national reforms is embedded within the implementation plan.

2.1 National minimum service standards for all organisations providing primary health care services to Aboriginal and Torres Strait Islander populations

Accreditation frameworks are an explicit statement of the expected level and quality of care to be provided to patients by health services and are a means of assessing the performance of these services.

- Through the 2007-08 Budget measure *Establishing Quality Health Standards*, the Australian Government is providing support to Aboriginal and Torres Strait Islander community controlled health services to prepare for, and achieve, clinical and/or organisational accreditation under National Standards applicable to the broader Australian health care system.
- To further promote and uphold the accreditation of services as a minimum standard for primary health care service delivery, eligibility to participate in the Practice Incentives Program (PIP) Indigenous Health Incentive (*Primary Health Care Services That Can Deliver - B3*) will be dependent on service accreditation.
- Work to implement minimum service standards for all health organisations providing care for Aboriginal and Torres Strait Islander people will be aligned with the work program of the Australian Commission on Safety and Quality in Healthcare, specifically the development of a set of national safety and quality standards for accreditation across the Australian health care system.

2.2 Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets

Addressing quality issues in data reporting, including accuracy and coverage, is necessary to inform the evidence base and monitor progress against COAG targets and performance indicators.

- The performance indicators included in this National Partnership Agreement are also reflected in the National Health Care Agreement, the National Indigenous Reform Agreement and the National Aboriginal and Torres Strait Islander Health Performance Framework. These performance indicators, disaggregated by Indigenous status, will be used as the basis for reporting progress against COAG targets and will assist in building the evidence base to inform improved care coordination and service delivery for Aboriginal and Torres Strait Islander people.
- The Commonwealth government, in consultation with NAGATSIHID and jurisdictions, will support the improvement of Indigenous identification in vitals and health administrative datasets (*Primary Health Care Services That Can Deliver - B6*).

2.3 Infrastructures to support care transitions and linked records of Aboriginal and Torres Strait Islander patients between primary, in-patient and specialist services

A shared electronic health record is an important systemic opportunity to improve the quality and safety of health care in Australia.

- The Commonwealth and state and territory governments will progress work towards shared electronic health records compliant with the national standards and guidelines of the National eHealth Transition Authority (NeHTA), including data collection and linked admission and discharge information between primary, in-patient and specialist services.

2.4 Workforce: increase the number of Aboriginal and Torres Strait Islander people in the health workforce, and reform and improve the supply of the health workforce generally including the adoption of complementary workplace reforms.

The limited availability of a culturally competent workforce to provide health care to Aboriginal and Torres Strait Islander people is the single biggest risk to achievement of the objectives of the reforms under the NPA. Commonwealth activities will build upon complementary efforts being progressed through all National Partnership Agreements and include:

- New nursing scholarships and the training and support of Aboriginal and Torres Strait Islander people as Indigenous Outreach Workers to strengthen career pathways into the health system for Indigenous Australians (*Fixing the Gaps and Improving the Patient Journey - C1*).
- Additional training positions for general practice registrars in Indigenous health services and a national campaign to encourage health professionals to work in Aboriginal and Torres Strait Islander health (*Fixing the Gaps and Improving the Patient Journey - C1 & C4*).

These measures build upon existing and complementary Commonwealth and national activities such as:

- Support for the Indigenous health workforce and initiatives to encourage more Aboriginal and Torres Strait Islander people to take up careers as health professionals through funding of \$19 million over three years for the National Indigenous Health Workforce Training Plan.
- Working through the Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG) to oversee the implementation of the National Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework (*The Yellow Book*) and respond to the recommendations of *A blueprint for action: Pathways into the health workforce for Aboriginal and Torres Strait Islander people* - developed by AIDA and Launched by the Minister for Health and Ageing on 10 July 2008 together with NIHEC. This is congruent to the National Training Plan.
- Scholarships and mentoring for Aboriginal and Torres Strait Islander students of health-related disciplines through Rotary and the Puggy Hunter Memorial Scholarship Scheme.
- Funding of \$1.1 billion over four years to address Health Workforce Reform. This National Partnership Agreement includes initiatives to improve health workforce capacity, efficiency and productivity across the health sector primarily through improving clinical training; facilitating more efficient workforce utilisation; improving international recruitment efforts; and effective and accurate planning of health workforce requirements.

2.5 Cultural Security: Improved cultural security in health service delivery in all organisations providing care to Aboriginal and Torres Strait Islander people.

To ensure health services are respectful of, and responsive to, the needs of Aboriginal and Torres Strait Islander people, targeted investment is required to improve the quality and cultural security of health service delivery, and to address systemic discrimination in the health system, where it is found to exist.

- Indigenous Outreach Workers will be employed and trained to expand and support the role of Aboriginal and Torres Strait Islander people in community outreach, liaison and health advocacy and to encourage and support Aboriginal and Torres Strait Islander people to access and navigate the health system. (*Fixing the Gaps and Improving the Patient Journey – C1, C2 & C3*).
- Indigenous specific clinical practice and decision support guidelines for the management of chronic disease prevention and primary care management will be developed and Australian healthcare guidelines will include Indigenous specific information to improve the quality of service delivery for Aboriginal and Torres Strait Islander people (*Fixing The Gaps and Improving the Patient Journey – C5*).
- All training and education provided for health professionals, health and community workers, health promotion officers etc, will be culturally sensitive.
- The Commonwealth Government is also working with the Royal Australian College of General Practitioners to explore options for incorporating cultural safety as a module within their clinical standards for general practice.

3 IMPLEMENTATION PLAN

3.1 KEY FOR NPA PERFORMANCE BENCHMARKS REFERRED TO IN IMPLEMENTATION PLAN TEMPLATE

Priority Area	Key	Performance benchmarks
Tackle smoking	S1	Number and key results of culturally secure community education/ health promotion/ social marketing activities to promote quitting and smoke-free environments.
	S2	Key results of specific evidence based Aboriginal and Torres Strait Islander brief interventions, other smoking cessation and support initiatives offered to individuals.
	S3	Evidence of implementation of regulatory efforts to encourage reduction/ cessation in smoking in Aboriginal and Torres Strait Islander people and communities.
	S4	Number of service delivery staff trained to deliver the interventions.
Primary health care services that can deliver	P1	Number of Indigenous specific health services meeting national minimum standards.
	P2	Number of Aboriginal and/or Torres Strait Islander people receiving a MBS Adult Health Check.
	P3	Number of new allied health professionals recruited.
	P4	Increased effort to refocus own purpose outlays in primary care to prioritise core service provision and evidence-based Indigenous health regional priorities.
	P5	Improved patient referral and recall for more effective health care, and in particular, chronic disease management.
	P6	Improved/new IT systems operational to support interface between systems used in primary health care sector and other parts of the health system.
	P7	Evidence of implementation of cultural competency frameworks across the applicable health workforce.
Fixing the gaps and improving the patient journey	F1	Number of new case managers/ Indigenous liaison officers (referred to as Indigenous Outreach Workers in the Commonwealth Implementation Plan) recruited and operational.
	F2	Number of culturally secure health education products and services to give Indigenous people skills and understanding of preventative health behaviours, and self management of some chronic health conditions.
	F3	Key results of strategies to improve cultural security of services and practice within public hospitals.
	F4	Increased percentage of Aboriginal and/or Torres Strait Islander people with a chronic disease with a care plan in place.
	F5	Percentage of Aboriginal and Torres Strait Islander people participating in rehabilitation programs intended to reduce hospitalisation of people with chronic disease.
	F6	Increased number of culturally appropriate transition care plans/procedures/best practice guidelines to reduce readmissions by (percentage/proportion).
	F7	Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets.

3.2 KEY TO MEASURES IN THE IMPLEMENTATION PLAN

Priority Area	Key	Measure
Smoking	A1	National Action to Reduce Indigenous Smoking Rates
	A2	Helping Indigenous Australians Reduce Their Risk of Chronic Disease
	A3	Local Indigenous Community Campaigns to Promote Better Health
Primary health care services that can deliver	B1	Subsidising PBS Medicine Co-payments
	B2	Higher Utilisation Costs for MBS and PBS
	B3	Supporting Primary Care Providers to Coordinate Chronic Disease Management
	B4	Improving Indigenous Participation in Health Care through Chronic Disease Self Management
	B5	Increasing Access to Specialist and Multidisciplinary Team Care
	B6	Monitoring and Evaluation
Fixing the gaps and improving the patient journey	C1	Workforce Support, Education and Training
	C2	Expanding the Outreach and Service Capacity of Indigenous Health Organisations
	C3	Engaging Divisions of General Practice to Improve Indigenous Access to Mainstream Primary Care
	C4	Attracting More People to Work in Indigenous Health
	C5	Clinical Practice and Decision Support Guidelines

PRIORITY AREA: Tackle smoking

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
<p>Reduce the Indigenous smoking rate and the burden of tobacco related chronic disease for Indigenous communities. (A1)</p> <p><i>Joint Initiative with state and territory governments.</i></p>	<ul style="list-style-type: none"> ▪ 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. ▪ Develop a national Indigenous tobacco action training program for health workers and community educators. ▪ Authority list NRT on the PBS for Indigenous Australians. ▪ Coordinate program evaluation. <p>Commonwealth to fund, and work with, state and territory governments and NGOs to:</p> <ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ 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. 	<p>Mental Health and Chronic Disease Division and Business Group (DoHA) in partnership with state and territory governments, Indigenous and non-Indigenous health and community organisations.</p>	<p>2009-10</p> <ul style="list-style-type: none"> ▪ Partnership, program and funding arrangements agreed with jurisdictions. ▪ National formative campaign research undertaken. ▪ National Coordinator appointed. ▪ Funding provided for enhanced culturally sensitive services delivered by Quitline. ▪ Regional tobacco action coordinators recruited to cover 20 sites. <p>2010-11</p> <ul style="list-style-type: none"> ▪ Strategic campaign framework and resources delivered to state and territory governments. ▪ Regional tobacco action coordinators recruited to cover an additional 20 sites. ▪ Up to 200 workers trained. ▪ National Workshop conducted. ▪ Regional campaign grants and sponsorship awarded. <p>2011-12</p> <ul style="list-style-type: none"> ▪ Workforce education program developed. ▪ Additional 400 workers trained. ▪ Regional tobacco action coordinators recruited to cover an additional 17 sites. <p>2012-13</p> <ul style="list-style-type: none"> ▪ 1st National Conference. ▪ 2nd National Workshop. ▪ Additional 400 workers trained. ▪ Evaluation commences. 	<p>Benchmark: S1</p> <p><i>Measurement:</i></p> <ul style="list-style-type: none"> ▪ Number of tobacco action coordinators. <p><i>Measurement:</i></p> <ul style="list-style-type: none"> ▪ Number of Indigenous participants in smoking cessation and support activities. <p>Benchmark: S4</p> <p><i>Measurement:</i></p> <ul style="list-style-type: none"> ▪ Number of health workers and community educators trained in smoking cessation. 	<p>Commonwealth funding: 2009-10: \$4.23m 2010-11: \$19.83m 2011-12: \$35.40m 2012-13: \$41.14m Total: \$100.61m</p>

PRIORITY AREA: Tackle smoking

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
<p>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 (A2). <i>Joint initiative with state and territory governments.</i></p> <p>This element forms a continuum with <i>Helping Indigenous Australians improve their self management of established chronic disease (B4)</i> to effectively reduce the impact of chronic disease.</p>	<ul style="list-style-type: none"> Train health and community workers to deliver tobacco action programs. Implement targeted tobacco cessation programs. <p>Commonwealth to fund, and work with, state and territory governments and NGOs to:</p> <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Many chronic diseases can be prevented or delayed through intervention, effective management and lifestyle change.^{xiv} 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.^{xv} 	<p>Mental Health and Chronic Disease Division, DoHA in partnership with state and territory governments, Indigenous and non-Indigenous health and community organisations.</p>	<p>2009-10</p> <ul style="list-style-type: none"> Nationally recognised and accredited core competencies and training program developed for delivery by the VET sector or other appropriate education and training organisation - February 2010. Training and service provision funding agreements in place - March 2010. Recruitment of healthy lifestyle workers commences - April 2010. Training of healthy lifestyle workers commences May 2010. <p>2010-11</p> <ul style="list-style-type: none"> Up to 42 positions funded and trained. 2,500 sessions/activities delivered. <p>2011-12</p> <ul style="list-style-type: none"> A further 30 positions funded and trained. A further 7,500 sessions/activities delivered. <p>2012-13</p> <ul style="list-style-type: none"> A further 33 positions funded and trained, totalling 105 over 4 years. 	<p>Benchmark: S4 Measurement:</p> <ul style="list-style-type: none"> Number of healthy lifestyle workers funded and trained. Number of healthy lifestyle sessions and activities conducted. Number of participants in healthy lifestyle sessions and activities. 	<p>2009-10: \$2.25m 2010-11: \$7.34m 2011-12: \$10.60m 2012-13: \$17.34m Total: \$37.53m</p>

PRIORITY AREA: Tackle smoking

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
<p>Improve Indigenous Australians' awareness of, and access to, health measures to better promote their health and wellbeing (A3). <i>Joint Initiative with state and territory governments.</i></p>	<ul style="list-style-type: none"> ▪ Undertake a research program to inform community level communication activity. ▪ Facilitate partnerships to develop community-orientated approaches to health promotion. ▪ Review partnership models and actions to guide state and territory extension activities. <p>Commonwealth to fund, and work with, state and territory governments and NGOs to:</p> <ul style="list-style-type: none"> ▪ Partner with communities to develop local-level information and communication activities. ▪ Implement local strategies, including media placement. 	<ul style="list-style-type: none"> ▪ The World Health Organization's Ottawa charter recommends a five pronged approach for health promotion, including public awareness campaigns.^{xvi} ▪ Health promotion is an important factor in reducing risk factors at the population level.^{xvii} 	<p>Business Group (DoHA) in partnership with state and territory governments, Indigenous and non-Indigenous health and community organisations.</p>	<ul style="list-style-type: none"> ▪ A further 15,000 sessions/ activities delivered, totalling 25,000 over 4 years. <p>2009-10</p> <ul style="list-style-type: none"> ▪ Undertake research program. ▪ Community partnership programs developed. <p>2010-11</p> <ul style="list-style-type: none"> ▪ Community partnership programs undertaken. ▪ Interim evaluation. <p>2011-12</p> <ul style="list-style-type: none"> ▪ Communications framework and resources provided to state and territory governments, ▪ Ongoing community engagement, partnerships, and communications activities. <p>2012-13</p> <ul style="list-style-type: none"> ▪ Ongoing community engagement, partnerships, and communications activities. ▪ Program evaluation. 	<p>Benchmark: S1</p> <p><i>Measurement:</i></p> <ul style="list-style-type: none"> ▪ Number and type of targeted activities undertaken. ▪ Number and type of culturally appropriate information resources developed. ▪ Description of dissemination of information undertaken. 	<p>2009-10: \$2.24m 2010-11: \$8.35m 2011-12: \$6.04m 2012-13: \$6.07m Total: \$22.70m</p>

PRIORITY AREA: Tackle smoking

<p>Internal Governance and Management</p>	<p>The Commonwealth will coordinate and manage the implementation of its initiatives in this priority area through an overarching internal coordination committee supported by a Program Management Committee and specific working groups as required. These committees will comprise of Departmental officers who will meet as required to ensure effective internal coordination.</p>
<p>Linkages and Coordination</p>	<p>The Commonwealth will work to jointly implement the initiatives within this priority area in partnership with state and territory governments, the Aboriginal and Torres Strait Islander community controlled health sector and the broader health and community sector.</p> <p>Indigenous Health Partnership Forums (HPF) in each jurisdiction will provide advice on priorities and opportunities for integrated activity at a regional level. Membership of the HPF currently includes Commonwealth, state and territory government and the Aboriginal community controlled health sector, and will be expanded to include other health providers/stakeholders relevant to the implementation of these initiatives.</p> <p>At a national level, coordination across governments will also be provided through existing Commonwealth whole-of-government arrangements, including the Secretaries Group on Indigenous Affairs, as well as engagement with state and territory governments through NATSIHON, AHMAC and AHMC.</p>
<p>Community/ Stakeholder Involvement</p>	<p>The National Indigenous Health Equality Council (NIHEC) will provide advice on key policy issues and community engagement strategies to the Department and to the Minister for Health and Ageing.</p> <p>Indigenous Australians will be formally involved in the development, implementation and monitoring of the Tackle Smoking initiatives through participation in technical reference groups as required to advise on the development and implementation of initiatives under this priority area. Membership will include representatives of Indigenous and non-Indigenous health organisations, subject matter experts and state and territory governments.</p>

PRIORITY AREA: Primary health care services that can deliver

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
<p>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 (B1).</p>	<ul style="list-style-type: none"> Contract suitable funds holders to manage funds to address cost barriers for eligible Indigenous Australians with chronic disease or chronic disease risk factors. 	<ul style="list-style-type: none"> 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.^{xviii} It is predicted that making medicines more accessible to Indigenous Australians results in higher medication compliance amongst those with chronic disease.^{xix} 	<p>Pharmaceutical Benefits Division, DoHA.</p>	<p>2009-10</p> <ul style="list-style-type: none"> Program governance arrangements established. Information technology support rolled out. Training and education materials developed. <p>2010-11</p> <ul style="list-style-type: none"> Co-payment assistance commences. <p>2011-12</p> <ul style="list-style-type: none"> Ongoing program implementation. <p>2012-13</p> <ul style="list-style-type: none"> Ongoing program implementation. 	<p><i>Measurement:</i></p> <ul style="list-style-type: none"> Numbers and locations of people accessing medicines through the program. Number of practices, Indigenous health services and community pharmacies participating in the program. 	<p>2009-10: \$4.74m 2010-11: \$18.74m 2011-12: \$27.75m 2012-13: \$37.48m Total: \$88.70m</p>
<p>Provide increased funding to the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) to meet higher utilisation costs by Indigenous Australians accessing complementary programs in this Plan (B2).</p>	<ul style="list-style-type: none"> Expand the number of MBS follow up items (MBS item 10987) for Practice Nurses and AHWs from 5 to 10 services per client per annum. Provide additional funding for the anticipated increased uptake of MBS health checks, chronic disease management and allied health professional service items. 	<ul style="list-style-type: none"> 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.^{xx} 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.^{xxi} 	<p>Medical Benefits Division, DoHA.</p>	<p>2009-10</p> <p>Legislation amended to increase the cap on services for Practice Nurse/AHW follow up items.</p> <p>2010-11</p> <p>Ongoing program implementation.</p> <p>2011-12</p> <p>Ongoing program implementation.</p> <p>2012-13</p> <p>Ongoing program implementation.</p>	<p>Benchmark: P2</p> <p><i>Measurement:</i></p> <ul style="list-style-type: none"> Take up rates of Indigenous MBS health checks. Number of Indigenous clients accessing the CDMP. Additional Practice Nurse/AHW services, including item 10987. 	<p>2009-10: \$6.35m 2010-11: \$20.22m 2011-12: \$49.57m 2012-13: \$64.26m Total: \$140.40m</p>

PRIORITY AREA: Primary health care services that can deliver

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
Encourage general practices to provide better health care for Indigenous Australians and improve the continuity of care for those with chronic health conditions (B3).	<ul style="list-style-type: none"> Develop and implement the Practice Incentives Program (PIP) Indigenous Health Incentive to provide incentives to accredited general practices 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). 	<ul style="list-style-type: none"> 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.^{xxii} Encouraging practices to provide a target level of care promotes continuity of care, which has been shown to improve patient outcomes.^{xxiii} 	Primary and Ambulatory Care Division, and Medical Benefits Division, DoHA.	<p>2009-10</p> <ul style="list-style-type: none"> Business rules agreed with Medicare Australia Implementation commences May 2010. CDMP fund holders contracted. <p>2010-11</p> <ul style="list-style-type: none"> Ongoing program implementation. <p>2011-12</p> <ul style="list-style-type: none"> Ongoing program implementation. <p>2012-13</p> <ul style="list-style-type: none"> Ongoing program implementation. 	<p>Benchmark: P1</p> <p><i>Measurement:</i></p> <ul style="list-style-type: none"> Number of PIP practices signed on to the incentive. Number of practices receiving payments for registering patients. <p>Benchmark: P5</p> <p><i>Measurement:</i></p> <ul style="list-style-type: none"> Number of Indigenous clients registered with a PIP practice for chronic disease management. Number of care coordination services to Indigenous clients. 	<p>2009-10: \$7.02m</p> <p>2010-11: \$9.67m</p> <p>2011-12: \$37.30m</p> <p>2012-13: \$61.09m</p> <p>Total: \$115.08m</p>
Support Indigenous Australians to better manage or self manage their chronic disease (B4). <i>Joint initiative with state and territory</i>	Commonwealth to fund, and work with, state and territory governments and NGOs to: <ul style="list-style-type: none"> 400 workers trained to deliver chronic disease self management support programs. 	<ul style="list-style-type: none"> Many chronic diseases can be prevented and/or progress delayed through intervention, effective management and lifestyle change.^{xxiv} Access to affordable chronic disease risk reduction/self management programs is a barrier to good health 	Mental Health and Chronic Disease Division, DoHA, in partnership with state and territory	<p>2009-10</p> <ul style="list-style-type: none"> Nationally recognised and accredited core competencies and training program developed for delivery by the VET sector or 	<p>Benchmark: P5</p> <p><i>Measurement:</i></p> <ul style="list-style-type: none"> Number of workers provided with chronic disease self 	<p>2009-10: \$1.17m</p> <p>2010-11: \$2.71m</p> <p>2011-12: \$6.01m</p> <p>2012-13: \$8.68m</p> <p>Total: \$18.56m</p>

PRIORITY AREA: Primary health care services that can deliver

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
<p>governments.</p> <p>This element forms a continuum with <i>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 (A2)</i></p>	<ul style="list-style-type: none"> 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. 	<p>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.^{xv}</p>	<p>governments, Indigenous and non-Indigenous health and community organisations.</p>	<p>other appropriate education and training organisation - February 2010.</p> <ul style="list-style-type: none"> Training and service provision funding agreements in place - March 2010. Commencement of chronic disease self management support training April 2010. Commencement of delivery of chronic disease self management sessions or activities May 2010. <p>2010-11</p> <ul style="list-style-type: none"> Up to 100 workers trained. 5,000 lifestyle sessions or activities delivered. <p>2011-12</p> <ul style="list-style-type: none"> A further 150 workers trained. A further 15,000 sessions or activities delivered. <p>2012-13</p> <ul style="list-style-type: none"> A further 150 workers trained, totalling 400 over 4 years. A further 30,000 sessions or activities delivered, totalling 50,000 over 4 years. 	<p>management support training.</p> <ul style="list-style-type: none"> Number of participants in chronic disease self management sessions or activities. 	

PRIORITY AREA: Primary health care services that can deliver

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
<p>Increase access to specialist and multidisciplinary team follow-up care for Indigenous Australians (B5).</p>	<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ Many Indigenous Australians cannot afford the specialist and allied health services they need to manage their chronic disease.^{xxvi} ▪ Workforce shortages, waiting times and the lack of available services have been reported as barriers to Indigenous Australians accessing services when needed.^{xxvii} ▪ Service providers face financial disincentives in delivering outreach services to Indigenous Australians living in remote and very remote communities. 	<p>Primary and Ambulatory Care Division, DoHA.</p>	<p>2009-10</p> <ul style="list-style-type: none"> ▪ MSOAP guidelines enhanced following consultation with key stakeholders. ▪ Communities/chronic conditions identified for MSOAP support. ▪ MSOAP service plans finalised and approved from Jan 2010. ▪ Outreach commences to urban services from May 2010. ▪ Flexible funds pools holding arrangements available from May 2010. ▪ MSOAP service delivery commences from May 2010 <p>2010-11</p> <ul style="list-style-type: none"> ▪ Ongoing program implementation. <p>2011-12</p> <ul style="list-style-type: none"> ▪ Ongoing program implementation. <p>2012-13</p> <ul style="list-style-type: none"> ▪ Ongoing program implementation. 	<p><i>Measurement:</i></p> <ul style="list-style-type: none"> ▪ Number of Indigenous clients receiving specialist and allied health care in urban areas through this measure. ▪ Number of services provided by multidisciplinary health professional outreach teams in rural and remote Indigenous communities. 	<p>2009-10: \$7.12m 2010-11: \$9.85m 2011-12: \$23.14m 2012-13: \$30.68m Total: \$70.78m</p>

PRIORITY AREA: Primary health care services that can deliver

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
<p>Monitor and evaluate the Closing the Gap Chronic Disease initiative (B6).</p>	<p>Develop and implement an overarching Monitoring and Evaluation framework including:</p> <ul style="list-style-type: none"> ▪ 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; and ▪ In consultation with NAGATSIHID and jurisdictions, support the improvement of Indigenous identification in vitals and health administrative datasets. 	<ul style="list-style-type: none"> ▪ Good quality data is vital for monitoring progress on closing the gap in Indigenous health. 	<p>Office for Aboriginal and Torres Strait Islander Health with other DoHA areas, the ABS and AIHW.</p>	<p>2009-10</p> <ul style="list-style-type: none"> ▪ Monitoring and Evaluation framework developed. <p>2010-11</p> <ul style="list-style-type: none"> ▪ Ongoing implementation. <p>2011-12</p> <ul style="list-style-type: none"> ▪ Ongoing implementation. <p>2012-13</p> <ul style="list-style-type: none"> ▪ Ongoing implementation. 	<p>Benchmark: F7</p> <p><i>Measurement:</i></p> <ul style="list-style-type: none"> ▪ Monitor progress in improving Indigenous health data. 	<p>2009-10: \$14.98m 2010-11: \$15.78m 2011-12: \$6.73m 2012-13: \$2.44m Total: \$39.94m</p>

PRIORITY AREA: Primary health care services that can deliver

<p>Internal Governance and Management</p>	<p>The Commonwealth will coordinate and manage the implementation of its initiatives in this priority area through an overarching internal coordination committee supported by a Program Management Committee and specific working groups as required. These committees will comprise of Departmental officers who will meet as required to ensure effective internal coordination.</p>
<p>Linkages and Coordination</p>	<p>Indigenous Health Partnership Forums (HPF) in each jurisdiction will provide advice on priorities and opportunities for integrated activity at a regional level. Membership of the HPF currently includes Commonwealth, state and territory government and the Aboriginal community controlled health sector, and will be expanded to include other health providers/stakeholders relevant to the implementation of these initiatives.</p> <p>At a national level, coordination across governments will be provided through existing Commonwealth whole-of-government arrangements, including the Secretaries Group on Indigenous Affairs, as well as engagement with state and territory governments through NATISHON, AHMAC and AHMC.</p>
<p>Community/ Stakeholder Involvement</p>	<p>The National Indigenous Health Equality Council (NIHEC) will provide advice on key policy issues and community engagement strategies to the Department and to the Minister for Health and Ageing.</p> <p>Indigenous Australians will be formally involved in the development, implementation and monitoring of the Primary Health Care Services That Can Deliver initiatives through participation in technical reference groups as required to advise on the development and implementation of initiatives under this priority area. Membership will include representatives of Indigenous and non-Indigenous health organisations, subject matter experts and state and territory governments.</p>

PRIORITY AREA: Fixing the gaps and improving the patient journey

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
Build the Indigenous health workforce through education and training initiatives (C1).	<ul style="list-style-type: none"> ▪ Fund the development and delivery of education and training to IOWs. ▪ 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. 	<ul style="list-style-type: none"> ▪ The provision of training through the vocational education and training (VET) sector is a recognised method or 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. 	Workforce Division, DoHA.	2009-10 <ul style="list-style-type: none"> ▪ Funding agreements in place with RTOs, nursing organisations and GPET. ▪ Training resources developed. ▪ IOW training and support commences. ▪ 38 registrar training posts. 2010-11 <ul style="list-style-type: none"> ▪ 1st IOW workshop/conference held. ▪ Annual allocation of nursing scholarships. ▪ Continuation of IOW training and support. ▪ 38 registrar training posts. 2011-12 <ul style="list-style-type: none"> ▪ Annual allocation of nursing scholarships. ▪ Continuation of IOW training and support. ▪ 38 registrar training posts. 2012-13 <ul style="list-style-type: none"> ▪ 2nd IOW workshop/conference held. ▪ Continuation of IOW training and support. ▪ Annual allocation of nursing scholarships. ▪ 38 registrar training posts. 	<i>Measurement:</i> <ul style="list-style-type: none"> ▪ Number of IOWs trained per year. ▪ Number of nursing scholarships provided each year. ▪ Number of nursing clinical placements per annum. ▪ Number of GP registrar placements each year. 	2009-10: \$4.81m 2010-11: \$4.41m 2011-12: \$4.06m 2012-13: \$4.47m Total: \$17.74m
Increase the capacity of Indigenous and mainstream health organisations to provide better	<ul style="list-style-type: none"> ▪ Fund accredited Indigenous health services to recruit and employ IOWs and Practice Managers to encourage Indigenous Australians to 	<ul style="list-style-type: none"> ▪ Using IOWs to increase access to health care is a model that has demonstrated success in Australia when well supported by the health system. <small>xxviii xxix xxx</small> 	Office for Aboriginal and Torres Strait Islander Health, DoHA.	2009-10 <ul style="list-style-type: none"> ▪ 71 positions recruited (IOWs, practice managers, and health professionals.) ▪ 80 project officers in 	Benchmark: F1 <i>Measurement:</i> <ul style="list-style-type: none"> ▪ Number of IOWs, Practice 	2009-10: \$23.91m 2010-11: \$37.14m 2011-12: \$39.21m 2012-13: \$42.88m Total: \$143.14m

PRIORITY AREA: Fixing the gaps and improving the patient journey

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
continuity of care for Indigenous people with chronic and complex health conditions (C2 and C3).	<p>access health services, work with services to resolve barriers that impact on attendance and improve service capacity to deliver regular health checks.</p> <ul style="list-style-type: none"> 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 IOWs 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. 	<ul style="list-style-type: none"> A similar approach has also been used in the Maori health sector in New Zealand.^{xxxi} 	Primary and Ambulatory Care Division, DoHA.	<p>Divisions of General Practice recruited.</p> <ul style="list-style-type: none"> Capital works projects to accommodate additional positions funded. Three NIHEC meetings conducted. <p>2010-11</p> <ul style="list-style-type: none"> 83 additional positions recruited (IOWs, practice managers, and health professionals). Capital works projects to accommodate additional positions funded. <p>2011-12</p> <ul style="list-style-type: none"> 41 additional positions recruited (IOWs, practice managers, and health professionals). <p>2012-13</p> <ul style="list-style-type: none"> 47 additional positions recruited (IOWs, practice managers, and health professionals). 	<p>Managers, and other health professionals funded.</p> <ul style="list-style-type: none"> Divisions network project officers funded. 	
Generate interest and encourage more health professionals to work in Indigenous health (C4).	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> The availability of other disciplines to participate in team care contributes to the gap between optimal and current practice.^{xxxii} 	Business Group, DoHA.	<p>2009-10</p> <ul style="list-style-type: none"> Market research program conducted. <p>2010-11</p> <ul style="list-style-type: none"> Public relations program established. Campaign strategy finalised. 	<p><i>Measurement:</i></p> <ul style="list-style-type: none"> Number of tertiary education seminars conducted. Website usage data. Number and 	<p>2009-10: \$2.28m</p> <p>2010-11: \$1.68m</p> <p>2011-12: \$1.75m</p> <p>2012-13: \$1.44m</p> <p>Total: \$7.15m</p>

PRIORITY AREA: Fixing the gaps and improving the patient journey

What are we aiming to do?	How will we do it?	Why are we doing it?	Who will do it?	When will it be done?	How will we check progress?	What is the cost?
	<ul style="list-style-type: none"> 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. 			<ul style="list-style-type: none"> Recruitment campaign commences. Distribution of information products. Ongoing implementation. 2011-12 Ongoing implementation. 2012-13 Ongoing implementation. 	<p>type of culturally relevant information products disseminated to health professionals, schools and universities.</p>	
<p>Ensure health service providers have access to relevant and culturally appropriate information to improve decision making processes and inform management options for Indigenous Australians (C5).</p>	<ul style="list-style-type: none"> Coordinate activities across DoHA 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. 	<ul style="list-style-type: none"> Existing mainstream clinical practice and decision support guidelines for the management of chronic disease do not adequately address needs for Indigenous people. Good quality guidelines can lead to improved patient care and clinical governance.^{xxxiii} 	<p>Office for Aboriginal and Torres Strait Islander Health and other DoHA areas.</p>	<p>2009-10</p> <ul style="list-style-type: none"> Consultation with experts commences. Coordination across DoHA. <p>2010-11</p> <ul style="list-style-type: none"> Indigenous specific clinical practice and decision support guidelines developed and disseminated. <p>2011-12</p> <ul style="list-style-type: none"> Coordination across DoHA. <p>2012-13</p> <ul style="list-style-type: none"> Coordination across DoHA. 	<p><i>Measurement:</i></p> <p>Clinical practice and decision support guidelines developed and disseminated.</p>	<p>2009-10: \$1.61m</p> <p>2010-11: \$1.53m</p> <p>2011-12: \$ nil</p> <p>2012-13: \$ nil</p> <p>Total: \$3.14m</p>

PRIORITY AREA: Fixing the gaps and improving the patient journey

<p>Internal Governance and Management</p>	<p>The Commonwealth will coordinate and manage the implementation of its initiatives in this priority area through an overarching internal coordination committee supported by a Program Management Committee and specific working groups as required. These committees will comprise of Departmental officers who will meet as required to ensure effective internal coordination.</p>
<p>Linkages and Coordination</p>	<p>Indigenous Health Partnership Forums (HPF) in each jurisdiction will provide advice on priorities and opportunities for integrated activity at a regional level. Membership of the HPF currently includes Commonwealth, state and territory government and the Aboriginal community controlled health sector, and will be expanded to include other health providers/stakeholders relevant to the implementation of these initiatives.</p> <p>At a national level, coordination across governments will be provided through existing Commonwealth whole-of-government arrangements, including the Secretaries Group on Indigenous Affairs, as well as engagement with state and territory governments through NATISHON, AHMAC and AHMC.</p>
<p>Community/ Stakeholder Involvement</p>	<p>The National Indigenous Health Equality Council (NIHEC) will provide advice on key policy issues and community engagement strategies to the Department and to the Minister for Health and Ageing.</p> <p>Indigenous Australians will be formally involved in the development, implementation and monitoring of the Fixing The Gaps and Improving The Patient Journey initiatives through participation in technical reference groups as required to advise on the development and implementation of initiatives under this priority area. Membership will include representatives of Indigenous and non-Indigenous health organisations, subject matter experts and state and territory governments.</p>

4 RISK MANAGEMENT

A detailed risk management plan will be developed and incorporated into project plans for each initiative in the Commonwealth's package.

As an overview, some of the broader contextual demands and risks which may affect implementation of this multifaceted package of initiatives would include:

- Less than optimal coordination and cooperation between the Commonwealth and state/territory governments could result in duplication of effort, misdirected investments and gaps in service delivery;
- A complex package of initiatives such as this will demand clear communications, effective mechanisms for consultation and collaboration at national, jurisdictional and regional levels, and a spirit of cooperation with all levels of government, health services and Indigenous communities;
- Health sector capacity especially workforce shortages across all areas of the health sector, in particular within the Indigenous health sector, could impact on staffing new services and programs for Aboriginal and Torres Strait Islander peoples in some regions;
- A strong commitment to ensuring local Aboriginal and Torres Strait Islander community engagement will be required to facilitate appropriate services are delivered to those who need them most, and importantly to secure community ownership and participation;
- Local information and advice for Aboriginal and Torres Strait Islander peoples about the new services, programs and supports will be critical to raise awareness and improve access and take-up of new initiatives;
- Mainstream health services, including general practices, will need to be receptive to the complex health needs of Aboriginal and Torres Strait Islander peoples and be committed to improving their cultural competency in delivering key services and programs;
- It will also be vital to ensure that our new initiatives are rigorously monitored and evaluated, to ascertain as soon as possible what areas are working well, and what may need modification or redesign; and
- Broader financial constraints for some state/territory government agencies may limit their capacity to fulfil all their NPA commitments, resulting in service gaps and loss of momentum in the national health system reforms needed to improve health outcomes for Aboriginal and Torres Strait Islander peoples.

The Commonwealth is committed to delivering on its goals to close the gap in Indigenous health outcomes, including closing the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation. We will be actively managing these and other risks and challenges that may emerge in the coming years, including through the multiple partnership/consultation arrangements with states/territories, other key stakeholders and Aboriginal and Torres Strait Islander communities, the multi-layered coordination mechanisms, regional planning processes, and the monitoring and evaluation framework outlined in this implementation plan.

5 REVIEW AND EVALUATION

A monitoring and evaluation framework will be developed to provide a valid and reliable assessment of the success of the Commonwealth package. Key stakeholders will also be involved in developing the evaluation strategy.

The Health Performance Framework provides a comprehensive set of information on chronic disease outcomes and health system performance that will be utilised for the evaluation. Additional data will also be required to monitor specific outputs of the initiatives in this implementation plan where these collections do not already exist.

An independent evaluation will commence in 2012-13 and will use data from the Aboriginal and Torres Strait Islander Health Performance Framework, National Healthcare Agreement, Medicare, Commonwealth reports against this implementation plan, results of evaluations of the specific components of the chronic disease package, as well as other data sets.

6 APPENDIX A: NATIONAL INDIGENOUS REFORM AGREEMENT'S SERVICE DELIVERY PRINCIPLES FOR INDIGENOUS AUSTRALIANS:

Service Delivery Principles for Indigenous Australians are detailed within the COAG National Indigenous Reform Agreement. Implementation of this Plan will align with these Service Delivery Principles as described below:

6.1 Priority

Programs and services should contribute to Closing the Gap by meeting the targets endorsed by COAG while being appropriate to local community needs.

The package of measures outlined in this implementation plan will work specifically to address the first COAG-agreed target of closing the life expectancy gap within a generation. Measures focus on the prevention and better management of chronic disease, which accounts for some two thirds of the premature deaths among Indigenous Australians. These initiatives will address chronic disease risk factors, including smoking, and improve access to primary health care, multidisciplinary follow up care and specialist services. In addition, the Commonwealth will be working to build the capacity of the health workforce to provide coordinated, culturally responsive care for Aboriginal and Torres Strait Islander people.

Health Partnership Forums will be a primary vehicle to plan and prioritise areas for investment on a jurisdictional and regional level and for the integration and coordination of Commonwealth and state and territory government initiatives under the NPA. Initiatives outlined in the Commonwealth implementation plan will allow for flexibility in the implementation of national programs so that they can be tailored to meet the needs of local communities.

6.2 Indigenous engagement

Engagement with Indigenous men, women and children and communities should be central to the design and delivery of programs and services.

Multi-layered stakeholder engagement will inform the development and implementation of the Commonwealth package.

The Commonwealth is working with the National Indigenous Health Equality Council (NIHEC) on key policy issues affecting measures under the package. As a principle advisory body to the Commonwealth Health Minister, NIHEC will be consulted and informed regarding the key strategic directions of the package.

This strategic national advice will be supported by advice from technical reference groups established to inform the work of specific measures. The groups will comprise members of key Aboriginal and Torres Strait Islander health representative organisations and other key health representative bodies.

Regional and local level planning will be informed by ongoing engagement with Aboriginal and Torres Strait Islander people and health organisations, including through existing Indigenous Health Partnership Forums comprising Departmental, state and territory government and Aboriginal community controlled health sector representatives.

6.3 Sustainability

Programs and services should be directed and resourced over an adequate period of time to meet the COAG targets.

Closing the gap in life expectancy between Indigenous and non-Indigenous Australians requires a substantial increase in resources, including investment in effective primary health care services in all parts of Australia.^{xxxiv} This investment needs to be strategic to maximise efficiency and effectiveness and ensure sustainability over time. A phased approach to implementation will allow larger and better equipped general practices and Indigenous health services opportunities to drive reforms while capacity is built in other areas. Results of formative assessments and ongoing monitoring of performance will provide opportunities for quality improvement and will inform implementation more broadly.

The package has a focus on building the capacity of Indigenous health services so that they are able to better access and utilise program and funding models, such as access to Australian healthcare financing

systems including Medicare and the Practice Incentives Program, to ensure greater sustainability of these services in the longer term.

It also provides for targeted recruitment and retention strategies to secure a strong workforce in Aboriginal and Torres Strait Islander health into the future.

Through this NPA, the Commonwealth, working in partnership with state and territory governments, the health sector and Aboriginal and Torres Strait Islander communities, will lay the foundations for sustainable health system reforms.

6.4 Access

Programs and services should be physically and culturally accessible to Indigenous people recognising the diversity of urban, regional and remote needs.

Initiatives in this implementation plan take into consideration access issues relating to geographic location, and physical and cultural appropriateness of service delivery. Measures to improve the cultural security of all organisations providing health care to Aboriginal and Torres Strait Islander people include: the development of Indigenous specific chronic disease clinical practice and decision support guidelines and the inclusion of Indigenous components in mainstream clinical guidelines; flexible delivery of programs and services tailored to the needs of local communities; and the delivery of culturally sensitive training for health professionals and health workers providing care to Aboriginal and Torres Strait Islander people. Encouraging Aboriginal and Torres Strait Islander people into the health workforce as Indigenous Outreach Workers within Indigenous health organisations and general practices is a means to assist Aboriginal and Torres Strait Islander people to better access and navigate health care services. In addition, Aboriginal and Torres Strait Islander people will have improved access to affordable medicines, multidisciplinary follow up and specialist services in urban, regional and remote areas.

6.5 Integration

There should be collaborations between and within Governments at all levels and their agencies to effectively coordinate programs and services.

Implementation of this National Partnership Agreement will utilise and build upon existing Commonwealth arrangements for whole-of-government collaboration, such as the Secretaries' Group on Indigenous Affairs, to ensure integration of these measures with existing programs and new reforms being progressed through COAG.

The Commonwealth will continue to work with state and territory governments, including through the National Aboriginal and Torres Strait Islander Health Officials Network, to integrate Commonwealth initiatives with complementary activities by state and territory governments.

Commonwealth initiatives are designed as a complementary package of measures to improve access to health services for Aboriginal and Torres Strait Islander people on a regional level. Indigenous Health Partnership Forums, comprising Commonwealth, state and territory government and Aboriginal community controlled health sector representatives will be instrumental in ensuring appropriate coordination and integration of measures at jurisdictional and regional level.

These structures will bring together the broad range of organisations and levels of government involved in delivering health services to Aboriginal and Torres Strait Islander people to ensure a collaborative and integrated approach to the implementation of the NPA.

6.6 Accountability

Programs and services should have regular and transparent performance monitoring, review and evaluation.

The Commonwealth package includes an overarching monitoring and evaluation framework that will provide regular and transparent performance monitoring, review and evaluation using performance measures endorsed by COAG to meet the close the gap targets. Progress against the NPA will be reported annually through to the Australian Health Ministers Conference through the Australian Health Ministers Advisory Council. Targets for each of the initiatives in this implementation plan will also be reported against to measure effectiveness and indicate progress made.

The Commonwealth will provide a detailed report on an annual basis to state and territory governments and Aboriginal and Torres Strait Islander organisations against the benchmarks and timelines as detailed in this implementation plan.

Reporting requirements for the NPA will be in accordance with the provisions in Schedule C of the Intergovernmental Agreements on Federal Financial Relations.

7 APPENDIX B: NATIONAL PRINCIPLES FOR INVESTMENTS IN REMOTE LOCATIONS

In addition the following principles should also be considered in any investment in remote locations, as detailed in the COAG National Indigenous Reform Agreement.

National principles for investments in remote locations include:

- a) remote Indigenous communities and remote communities with significant Indigenous populations are entitled to standards of services and infrastructure broadly comparable with that in non-Indigenous communities of similar size, location and need elsewhere in Australia;
- b) investment decisions should aim to: improve participation in education/training and the market economy on a sustainable basis; and reduce dependence on welfare where possible; and promote personal responsibility, engagement and behaviours consistent with positive social norms;
- c) priority for enhanced infrastructure support and service provision should be to larger and more economically sustainable communities where secure land tenure exists, allowing for services outreach to access by smaller surrounding communities, including:
 - i. recognising Indigenous peoples' cultural connections to homelands (whether on a visiting or permanent basis) but avoiding expectations of major investment in service provision where there are a few economic or educational opportunities; and
 - ii. facilitating voluntary mobility by individuals and families to areas where better education and job opportunities exist, with higher standards of service.

8 APPENDIX C: ACRONYMS

AIDA	Australian Indigenous Doctors Association
AHMAC	Australian Health Ministers Advisory Council
AHMC	Australian Health Ministers Conference
ATSIHWG	Aboriginal and Torres Strait Islander Health Workforce Working Group
CDMP	Chronic Disease Management Program
CDSM	Chronic Disease Self Management
COAG	Council of Australian Governments
CRANA	Council of Remote Area Nurses of Australia Inc.
DoHA	Department of Health and Ageing
GPET	General Practice Education and Training
HPF	Indigenous Health Partnership Forums
IOW	Indigenous Outreach Worker
MBS	Medicare Benefits Schedule
MSOAP	Medical Specialist Outreach Access Program
NATSIHON	National Aboriginal and Torres Strait Islander Health Officials Network
NAGATSIHID	National Advisory Group On Aboriginal and Torres Strait Islander Health Information and Data
NGO	Non-Government Organisation
NIHEC	National Indigenous Health Equality Council
NRT	Nicotine Replacement Therapy
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentives Program
RCNA	Royal College of Nursing Australia
RTO	Registered Training Organisation
VET	Vocational Education and Training

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