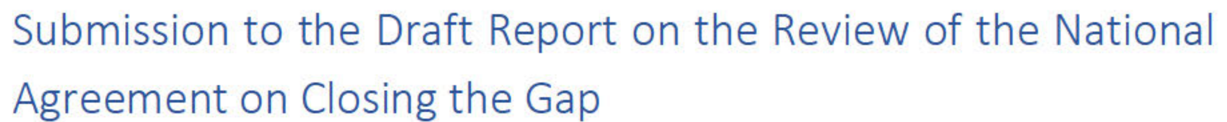

Submission to the Draft Report on the Review of the National Agreement on Closing the Gap

Institute of Urban Indigenous Health (IUIH) Network, October 2023

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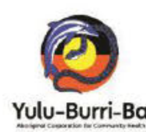

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About IUIH

The Institute for Urban Indigenous Health Ltd (IUIH) is one of Australia's largest Aboriginal and Torres Strait Islander Community Controlled Health Organisation (ATSICCHO). With an operating budget of around $150 million, IUIH leads the planning, development, and regional delivery of comprehensive primary health care, wellbeing, and social support services for Aboriginal and Torres Strait Islander people in the South East Queensland (SEQ) region.

IUIH was established in 2009 by its four founding Member Organisations:

- Aboriginal and Torres Strait Islander Community Health Service (ATSICHS) Brisbane Limited
- Kalwun Development Corporation Limited (Kalwun Health Service)
- Kambu Aboriginal and Torres Strait Islander Corporation for Health (Kambu Health)
- Yulu-Burri-Ba Aboriginal Corporation for Community Health (Yulu-Burri-Ba).

Since then, IUIH has established the Moreton Aboriginal and Torres Strait Islander Community Health Service (MATSICHS) and operates a clinic in Goodna. Together, these entities comprise the IUIH Network (see Attachment A). Each ATSICCHO in the Network retains its own governance, with IUIH acting as the regional lead or backbone of the Network.

The SEQ region represents one of the largest and fastest-growing Aboriginal and Torres Strait Islander populations in Australia. Based on 2021 Census data, SEQ is home to around 40% of Queensland's and 11.3% of Australia's Aboriginal and Torres Strait Islander people. In the five years between the 2016 and 2021 Census, the Aboriginal and Torres Strait Islander population in SEQ grew from 78,390 to 110,858, representing an increase of 32,468 people (41%).[i]

The IUIH System of Care (ISoC), an evidence-based, family-centred model of care that connects clients to an integrated network of services through a 'one-stop-shop' approach, has delivered unprecedented improvements in health access and outcomes.

Since the establishment of IUIH in 2009, the number of clinics across the Network has grown from five (5) to 19, and there has been a 381% increase in regular client numbers (from 8,000 in 2009 to 38,464 in 2022) and a 3,264% increase in annual Health Assessments (from 550 in 2009 to 18,500 in 2022).[ii]

The ISoC is also demonstrating best practice improvements in closing the gap targets. For example, IUIH's Birthing in Our Communities (BiOC) program delivers a unique model of Indigenous-led maternity care that has closed the gap in preterm birth rates and birth weights whilst costing less than standard care.[iii] In addition, the IUIH Network is making significant contributions to education, training and employment targets through our student and trainee pathways and the employment of over 1,500 people.[iv] This reflects our understanding of the interdependencies of health and employment and the benefits of a highly integrated regional model.

Executive Summary

The *National Agreement on Closing the Gap* ('National Agreement') is a commitment between Australian governments at the national, State and Territory levels and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations. It represents a collaborative effort to address the entrenched disparities faced by Aboriginal and Torres Strait Islander people, committing governments to work in partnership with Indigenous people in making policies to close the gap.

The IUIH Network understands the importance of collaborative effort. Establishing IUIH and the IUIH Network was a contemporary renewal of traditional ways of belonging, when for thousands of years, Aboriginal clans, tribes and communities across SEQ had come together to achieve shared goals. As a Network, we lead a SEQ First Nations Health Equity (FNHE) partnership with the Mater Health Service, the Hospital and Health Services (State Government) and Primary Health Networks (Australian Government) in our region. Through the SEQ FNHE Strategy[v], we look to accelerate efforts to close the gap and achieve health equity through system-level reforms, including key priorities in increasing investment in the community-controlled sector and data sharing, and that align well with the National Agreement priority areas.

The IUIH Network welcomes the Productivity Commission's review of the National Agreement. Through this submission, we seek to offer an urban Aboriginal and Torres Strait Islander perspective to assess progress on the National Agreement.

The IUIH Network is in broad agreement with the Commission's draft report. The experiences of the IUIH Network working with State and Australian Government agencies strongly align with the Commission's observations as to the challenges that have arisen in the implementation of the National Agreement, in particular, that:

- Governments are not adequately and promptly delivering on their closing-the-gap commitments.
- Progress on implementing the Priority Reforms has been inadequate and reflects a business-as-usual approach.
- It is not clear that governments have fully grasped the scale of change required to their systems, operations and ways of working to effect and achieve the improvements needed to close the gap.
- Government actions continue to contradict the commitments in the National Agreement, do not reflect the priorities and perspectives of Aboriginal and Torres Strait Islander peoples, particularly at the local and regional levels, and, in some cases, exacerbate disadvantage and discrimination.
- There is a strong need to improve accountability and transparency mechanisms in implementing the National Agreement across all government organisations, primarily to cater to unique and specific needs and priorities at the local and regional levels.

We place particular emphasis on the following factors that continue to stand in the way of meaningful progress in closing the gap:

- The inadequate focus and investment by governments on the needs of urban Indigenous communities, where the majority of Aboriginal and Torres Strait Islander Australians live.

- The failure of Government agencies at both state and national levels to embed the Closing the Gap Agreement commitments in all aspects of their portfolios, with a tendency to focus only on Aboriginal and Torres Strait Islander programs and investment.
- The reluctance of governments to prioritise genuine community-driven engagement mechanisms over current top-down approaches.
- The tendency of governments to operate at a national, jurisdictional, or 'place-based' level, overlooking the opportunities for change through regionally driven reforms. For example, empowering national Indigenous-bodies to undertake 'commissioning' replicates the top-down, 'one-size fits all', centralised commissioning approaches of governments and fails to realise the benefits of regional, population-based and community-controlled commissioning that can leverage scale, capacity and capability while retaining the connection to local communities.
- The reluctance of governments to value and collaborate with Aboriginal and Torres Strait Islander Community Health Organisations (ATSICHOs) and other Aboriginal and Torres Strait Islander Community Controlled Organisations (ACCOs) as equal partners.
- The resistance by governments to share meaningful data with Aboriginal and Torres Strait Islander communities and ACCOs.
- The failure to incorporate critical indicators and targets of health and wellbeing in the National Agreement, particularly Health Adjusted Life Expectancy (HALE), mental health, aged care and disability.

The SEQ region is a microcosm of the issues facing Aboriginal and Torres Strait Islander communities around Australia, revealing the significant challenges to overcoming the disadvantage faced by Aboriginal and Torres Strait Islander people, most of whom live in urban areas.

The efforts of the IUIH Network are a case study of how a unique place-based and integrated regional response to the health disparity in urban Indigenous populations is delivering significantly improved access and outcomes. Over time, the IUIH Network response is designed to provide greater efficiency and return on government investment by reducing service duplication and administrative overheads and re-investing such savings in direct service delivery.

The IUIH Network supports the National Agreement Priority Reform Areas as essential to recognising the disparity in life outcomes between Indigenous and non-Indigenous people and committing to address the structural barriers to self-determination for Aboriginal and Torres Strait Islander Australians.

At the heart of the National Agreement is that governments must change how they engage and work with Aboriginal and Torres Strait Islander people in genuine partnership. The draft report on the implementation of the National Agreement highlights the slow progress being made to remove those barriers.

Within our submission, the IUIH Network shares our experiences working with all levels of government, including where things could be improved and where, through Community Controlled leadership, we have been able to drive positive collaboration and progress in SEQ.

Summary of the IUIH Network's Response to Information Requests

Information Request 1: Effectiveness of policy partnerships

- The IUIH Network experiences daily the policy barriers impacting the lives of the mob in our region. The progress of national policy partnerships has been slow and largely invisible. These partnerships need a stronger connection to the community-controlled sector.
- Shared decision-making needs to occur at the lowest level possible, and there needs to be a greater focus on how to effect this in urban areas where most Aboriginal and Torres Strait Islander people live. Support is required to expand urban place-based partnerships under the National Agreement.
- The IUIH Network would welcome specific resourcing to ACCOs to support strategic engagement with government, to contribute to or lead national, jurisdictional, regional, and local policy partnerships, and to sustain engagement with and accountability to our community.
- Shared decision-making should not just occur at Indigenous-specific, national policy partnerships or through place-based partnerships under the National Agreement, but at whole-of-population ('mainstream') partnerships where the weight of advice from the community-controlled sector should be equivalent to the disadvantage experienced by Aboriginal and Torres Strait Islander people.
- Importantly, to ensure ACCOs can participate as equal partners, resourcing should support ACCOs in obtaining independent advice or expertise of the type that is readily available within government agencies.

Information Request 2: Shifting service delivery to Aboriginal community-controlled organisations (ACCOs)

- Increasing investment in ACCOs has been slow and not at the pace required to achieve the close the gap targets. Transparent and measurable reporting of the investment available and the investment transitioning at a regional level to ACCOs is required (see also recommendation 5).
- Increasing investment in ACCOs must be accompanied by adequate additional funding to build organisational capacity and to meet the actual cost of delivering services and programs in an integrated, culturally appropriate and wholistic manner.
- Government procurement processes need to recognise ACCOs as preferred providers and 'best value for money' for government-funded services to Aboriginal and Torres Strait Islander people.
- The design of funding programs and associated contracts need to give ACCOs control over defining service and program outcomes and be sufficiently flexible to meet community needs and respond to changing priorities.
- Through the National Agreement, Commonwealth and State and Territory Governments should commit to regional community-controlled commissioning arrangements at a whole-of-systems level.
- At a minimum, Commonwealth and State and Territory Governments should transition needs assessment, priority setting and service planning responsibilities, such as those currently undertaken by Primary Health Networks and Queensland Hospital and Health Services, to ACCOs.

Information request 3 Transformation of government organisations

- ACCOs are well positioned to support government organisations to address institutionalised racism and to change organisational cultures, priorities, and ways of operating, as demonstrated through the SEQ First Nation Health Equity Strategy, which includes IUIH leading development of an anti-racism campaign to be rolled out across all Hospital and Health Services in SEQ.

Information Request 4: Indigenous data sovereignty and Priority Reform 4

- The IUIH Network strongly agrees that there has been a lack of progress against Priority Reform 4 – Shared Access to Data and Information at a Regional Level. The IUIH Network supports clarifying Indigenous data sovereignty as the objective of this priority reform.
- However, clarifying data sovereignty as the objective should not impede an accelerated effort by governments to ensure that data currently collected on services provided to Aboriginal and Torres Strait Islander people can be reported (disaggregated) by Indigenous status and for consistent geographical regions – such as ABS Statistical Area 4. This is still required as part of a commitment to and transition to Indigenous data sovereignty.

Information Request 5: Legislative and policy change to support Priority Reform 4

- The experience of the IUIH Network is that barriers to data sharing tend to be academic and technical rather than genuine legislative barriers.
- The IUIH Network supports legislative and/or policy change to enable the sharing of data with Aboriginal and Torres Strait Islander communities and ACCOs. However, the IUIH Network notes these changes would need to be communicated clearly and repeatedly within government agencies. The onus must not be on communities and ACCOs to educate public servants and to advocate and agitate where data is not forthcoming.

Information Request 6: Characteristics of the organisation to lead data development under the Agreement

- The IUIH Network supports the establishment of an organisation to lead data development under the National Agreement (recommendation 1).
- Such an organisation would be Indigenous-led and governed, committed to data development to support Indigenous data sovereignty and be accountable to the community.
- The organisation must have a clear mandate to direct government agencies at a national and jurisdiction level to enhance data collection and reporting.

Information Request 7: Performance reporting tools – Dashboard and annual data compilation report

- The IUIH Network recognises the importance of *the Closing The Gap Annual Data Compilation Report* (ADCR) and Dashboard as public accountability tools against closing the gap targets.
- To enhance the usefulness of these tools, the IUIH Network would suggest the ADCR and the Dashboard provide data according to regionality across all indicators and that the National Agreement, and consequently the ADCR and Dashboard, be expanded to include measures and targets on Health Adjusted Life Expectancy (HALE), mental health, aged care and disability.

Information Request 8: Quality of implementation plans and annual reports

- The IUIH Network reflects that for ACCOs, our obligation is to the community, and our First Nations communities are better at holding us to account than any other mechanism.
- Strengthening accountability directly back to the community through regional or community (as appropriate) implementation plans, annual reports and annual meetings between the community and both levels of government and government agency executives may be the most effective way of seeing substantive and meaningful improvements in the quality and relevance of implementation plans and annual reports.

Information Request 9: Independent mechanism in the broader landscape

- The IUIH Network recognises the importance of independent accountability mechanisms and reaffirms that the best accountability mechanism is the community.
- Any independent accountability mechanism must have a strong connection to the community directly and to ACCOs and not overshadow the importance of robust, community-led governance that advocates for local community needs.

Information Request 10: Senior leader or leadership group to drive change in the public sector

- Key tasks for the senior leaders or leadership group should include frequent engagement with the community and ACCOs and identifying opportunities to transition service delivery to ACCOs and transition funding to regional community-controlled commissioning organisations.

Information Request 11: Specific accountability mechanisms

- The IUIH Network agrees that sector regulators, such as commissioners and ombudspersons, are important functions but rarely work well for Aboriginal and Torres Strait Islander communities.
- A stronger relationship between sector regulators and ACCOs would be beneficial to ensure that regulators have a better understanding and appreciation of the work of ACCOs and vice versa.
- ACCOs could also be a valuable conduit for regulators to raise awareness and build trust around their roles and functions in the community.

Summary of the IUIH Network's Response to Draft Recommendations

Draft Recommendation 1: Appointing an organisation to lead data development under the Agreement

The IUIH Network supports appointing an organisation or entity with dedicated resourcing and staffing to lead data development.

As per the IUIH Network response to information request 6, such an organisation should be Indigenous-led and governed, be committed to data development to support Indigenous data sovereignty and be accountable back to the community.

The organisation must have a clear mandate to direct government agencies at a national and jurisdiction level to enhance data collection and reporting.

Draft Recommendation 2: Designating a senior leader or leadership group to drive jurisdiction-wide change

The IUIH Network supports designating a senior leader or leadership group to drive jurisdiction-wide change within the public sector.

As per the IUIH Network response to information request 10, the senior leaders or leadership groups should be tasked with frequent engagement with the community and ACCOs and identification of opportunities to transition regional commissioning and service delivery functions to ACCOs.

Draft Recommendation 3: Embed responsibility for improving cultural capability and relationships with Aboriginal and Torres Strait Islander people into public sector employment requirements

The IUIH Network supports draft recommendation 3 and notes that one way for senior public sector employees to demonstrate they have upheld the principles of the National Agreement is to increase investment in the ACCO sector, including for regional commissioning and service delivery, and to improve data sharing at a regional and local level.

Draft Recommendation 4: Central agencies leading changes to Cabinet, Budget, funding and contracting processes

IUIH supports draft recommendation 4 and suggests consideration be given to:

- Ensuring that any requirement on government agencies to self-assess Cabinet, Budget, funding and contracting arrangements against the National Agreement priorities and commitments does not become a superficial 'tick-and-flick' box or paragraph in Cabinet, Budget and other briefing materials.

- State and Commonwealth budget processes mandate proactive engagement with the ACCO sector, including at a local level, to enable timely submission of budget priorities from the sector and budgets that are responsive to differing regional community and funding needs and priorities.

Draft Recommendation 5: Include a statement on Closing the Gap in government agencies' annual reports

The IUIH Network supports draft recommendation 5 and suggests that the recommendation be strengthened by requiring that the annual reports of government agencies specifically report on the following:

- The number of ACCOs funded by the agencies (existing commitment)
- The quantum of investment through ACCO, and where relevant to the agency, is broken down by Indigenous-specific and mainstream program investment.
- The proportion of Indigenous-specific program investment flowing to ACCOs.

Understanding investment by agency/portfolio and at a regional level assists ACCOs, such as the IUIH Network, in understanding sector investment and growth opportunities.

Draft Recommendation 6: Publish all the documents developed under the Agreement

The IUIH Network supports draft recommendation 6 with no further suggestions.

Submission

Response to Information Requests

Information Request 1: Effectiveness of policy partnerships

Key messages from the IUIH Network:

The IUIH Network experiences daily the policy barriers impacting the lives of the mob in our region. The progress of national policy partnerships has been slow and largely invisible. These partnerships need a stronger connection to the community-controlled sector.

Shared decision-making needs to occur at the lowest level possible, and there needs to be greater focus on how to effect this in urban areas where most Aboriginal and Torres Strait Islander people live. Support is required to expand urban place-based partnerships under the National Agreement.

The IUIH Network would welcome specific resourcing to ACCOs to support strategic engagement with government, to contribute to or lead national, jurisdictional, regional, and local policy partnerships, and to sustain engagement and accountability to our community.

Shared decision-making should not just occur at Indigenous-specific, national policy partnerships or through place-based partnerships under the National Agreement, but at whole-of-population ('mainstream') partnerships where the weight of advice from the community-controlled sector should be equivalent to the disadvantage experienced by Aboriginal and Torres Strait Islander people.

Importantly, to ensure ACCOs can participate as equal partners, resourcing should support ACCOs in obtaining independent advice or expertise of the type that is readily available within government agencies.

Are adequate support structures (such as resourcing and sufficient timeframes to provide views) in place to enable the participation of Aboriginal and Torres Strait Islander people and organisations? What else would help to support participation?

The National Agreement proclaims a 'full and genuine partnership' between governments and Aboriginal and Torres Strait Islander people in policy-making that impacts the lives of Indigenous people. Priority Reform 1 – Formal partnerships and shared decision-making - commits governments to establish five new policy partnerships in the areas of:

- Justice
- Social and emotional wellbeing
- Housing
- Early childhood care and development
- Aboriginal and Torres Strait Islander languages.

The IUIH Network supports the Commission's observation that work on the policy partnerships to date has been patchy and slow. Despite the first four of these policy partnerships closely aligning with the IUIH Network's significant service delivery footprint in SEQ and broader, we have not yet been directly approached for input into these partnerships.

The IUIH Network would expect these policy partnerships to connect with local and regional ACCOs to ensure their work is informed from the ground up. While these policy partnerships may have been behind some of the recent requests for information from the National Aboriginal Community Controlled Health Organisation (NACCHO) to its ATSICCHO member base, this has not been made explicit, raising concerns that there is a lack of transparency and substantive action in progressing the policy partnerships.

The Community-Controlled sector is an inseparable part of and represents the community. ACCOs must be able to participate in policy partnerships directly or through ACCO representative bodies on these partnerships. Ideally, policy partnerships would be established at regional levels and be led by the community-controlled sector.

To be able to participate in partnerships as equal partners to government ACCOs require resourcing that could be used to: 1) support additional staff or free up existing staff to participate in or lead partnerships; 2) maintain engagement with and accountability to community; and 3) enable access to independent advice or expertise of the type that is readily available within government agencies.

How do policy partnerships build accountability into their structure and governance?

For policy partnerships to build accountability in their structure and governance, they must be more visible to the community and the community-controlled sector. This can be achieved by having an online presence; publicly reporting on actions, activities and decisions; and having a transparent and accessible mechanism for advice, input and feedback from the community-controlled sector and the broader community.

Are the policy partnerships the right mechanism to address change across the five sectors? Are there other mechanisms that would be more effective?

Priority Reform 1 is about building the structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with the government. In the experience of the IUIH Network, government attempts at shared-decision making have been limited by:

- Governments come to the community for feedback on pre-determined priorities, models, programs or plans rather than with a genuine commitment to shared decision-making.
- Governments rarely fund ACCOs to fully participate in shared decision-making.
- Insufficient funding or time is provided to undertake the breadth of community engagement activities required beyond mere consultation.

The IUIH Network recognises that national policy partnerships involving Aboriginal and Torres Strait Islander people in decision-making are important and can be effective in driving policy reform at a system level. However, high-level partnerships at a national level are somewhat removed from the unique circumstances and priorities at regional, place-based levels.

Due to the diverse nature of Aboriginal and Torres Strait Islander communities across Australia, regional representation is crucial to ensure governments hear and respond to differing regional priorities. Community-controlled organisations, like IUIH, play a vital role in decision-making, as they provide a stethoscope to the heartbeat of the community they represent and can provide insight into the system-level policy issues that impact the day-to-day lives of Aboriginal and Torres Strait Islander peoples.

There should be greater emphasis through the National Agreement on supporting regional and local partnerships relevant to the priorities of the region or community and on community engagement led by the community-controlled sector.

In alignment with the National Agreement, the community-controlled sector must be supported to lead and/or participate in local partnerships catering to regional needs and priorities. As previously mentioned, to be able to participate in partnerships as equal partners to government ACCOs require resourcing that could be used to 1) support additional staff or free up existing staff to participate in or lead partnerships; 2) maintain engagement with and accountability to community; and 3) enable access to independent advice or expertise of the type that is readily available within government agencies.

The SEQ First Nations Health Equity (FNHE) partnership (Box 1) is an example of a regional, system-focused partnership that is led by the IUIH Network, receives a modest amount of resourcing from the State government, and is building mechanisms for input from and accountability to community.

Box 1: SEQ First Nations Health Equity

In 2021, the IUIH Network CEOs took leadership in facilitating a regional response to the *National Close the Gap Agreement (2020)* and the *Queensland First Nations Health Equity Framework (2021).* It established an executive-level partnership with SEQ Hospital and Health Services (HHSs), Children's Health Queensland (CHQ), Mater Health and the SEQ Primary Health Networks (PHNs).

In July 2021, SEQ stakeholders met and agreed to a networked, regional and accelerated approach to achieve health equity for Aboriginal and Torres Strait Islander people by 2031. A Statement of Commitment, signed in November 2021, outlined a collective agreement to close the gap in SEQ. In March 2022, the *South East Queensland First Nations Health Equity Strategy 2021-31* (Regional Strategy) was developed and endorsed by all partner organisations.

The Regional Strategy enhances existing service delivery partnerships in SEQ to create a more accessible, connected, and responsive health system. It aims to strengthen targeted services and programs for First Nations people, enhance the role of the ATSICCHO sector, improve cultural safety, and eliminate institutional racism.

The SEQ FNHE is a living document reviewed every three years to reflect emerging policies, priorities and opportunities. Supported by strong evidence, it uses the *South East Queensland Close the Gap Health Performance Monitoring and Reporting Framework* to track progress. New initiatives are added as appropriate, informed by data, needs assessments and community input. Progress is monitored, and results will be reported back to the community every two years.

The Strategy, its implementation and future refreshes are informed by local needs analyses, identification of service gaps and continuous ATSICCHO-led community engagement through the *South East Queensland Aboriginal and Torres Strait Islander Community Engagement Strategy*. This ongoing dialogue captures community views, aspirations, and health system experiences, shaping reform directions over the next decade to ensure they are driven by the voices of First Nations people.

The Strategy is supporting system-level reform, including exploring opportunities to direct mainstream Activity Based Funding to sub-acute healthcare delivered in the community-controlled setting, and has seen additional investment flow to the IUIH Network to provide culturally responsive and coordinated health care that may have otherwise been directed to mainstream services.

IUIH receives a small grant from the HHSs to support secretariat functions for the SEQ FNHE partnership and key activities, such as coordinating an annual SEQ FNHE Conference.

The IUIH Network notes the place-based partnership committed to under the National Agreement is an opportunity to address local priorities. The IUIH Network supports the expansion of place-based partnerships as an opportunity for shared decision-making at the lowest level possible to the people that the decisions impact. The IUIH Network also urges a greater focus on place-based partnerships in urban areas.

There is a common misconception that the gap in socio-economic circumstances we see at a national level can largely be explained by the poor conditions in remote communities.[vi] To date, government funding and program responses to the National Agreement have an elevated emphasis on remote service delivery initiatives under the rationale that remote Indigenous populations experience more significant rates of disadvantage than urban Indigenous populations, against most health and social indicators.[vii] However, the majority (66.2%) of Aboriginal and Torres Strait Islander people live in major cities and inner regional areas,[viii] and 56% of the total burden of disease is in urban areas.[ix]

There remains a 7.9-year Life Expectancy gap for Indigenous Australians in Major Cities.[x] This clearly demonstrates that proximity to mainstream health and related services has not resulted in health equity for the urban Indigenous population. While urban First Nations people may be near a broad range of mainstream services, they have poorer access to culturally appropriate health services.[xi] Consequently, closing the gap will not be possible without significant attention to the health and wellbeing of urban Indigenous Australians. This imperative will only increase in the coming years as urban areas experience the fastest rates of Indigenous population growth. Between the 2016 and 2021 census counts, urban Indigenous populations grew at a pace almost four times that of non-urban areas (32.4% increase in urban areas, compared to 8.9% increase in non-urban areas).[xii] Australian Bureau of Statistics (ABS) population projections indicate this trend will continue.[xiii]

The IUIH Network acknowledges the 'thematic' partnerships between governments and the community-controlled sector referenced in the National Agreement. Thematic partnerships at a jurisdictional level are equally important, and Queensland has previously had an active and successful Aboriginal and Torres Strait Islander Health Partnership operating at State and regional levels, underpinned by Agreements signed by Australian and Queensland health ministers and the Queensland peak body for ATSICCHOs. Ministerial commitment and active participation from senior executives within government agencies are essential to the success of these partnerships. However, thematic partnerships can only have limited effect if they focus only on Indigenous-specific policy and investment.

In the health sector, the most significant opportunities for Closing the Gap exist in leveraging 'mainstream' and system-wide policy and funding mechanisms. There are many health partnerships, not explicitly related to the National Agreement, where policy and funding decisions are made at a system-level that have a significant impact on access to services and the health and wellbeing outcomes of Aboriginal and Torres Strait Islander peoples but where the community-controlled sector has no real opportunity to provide input or advice. Where the sector does have a seat at the table, there is typically a significant power imbalance, which might be reflected in a lack of resourcing to support participation, a lack of access to information, data or expertise compared to others at the table, or the dominance of mainstream voices and perspectives. There needs to be genuine mechanisms for the community-controlled sector to participate in 'mainstream' system-level partnerships as equal partners where the weight of advice and opinion of the community-controlled sector is equivalent to the disadvantage experienced by Aboriginal and Torres Strait Islander people.

Information Request 2: Shifting service delivery to Aboriginal community-controlled organisations (ACCOs)

Key Messages from the IUIH Network:

Increasing investment in ACCOs has been slow and not at the pace required to achieve the close the gap targets. Transparent and measurable reporting of the investment available and the investment transitioning at a regional level to ACCOs is needed (see also response to recommendation 5).

Increasing investment in ACCOs must be accompanied by adequate additional funding to build organisational capacity and to meet the actual cost of delivering services and programs in an integrated, culturally appropriate and wholistic manner.

As has been repeatedly demonstrated and acknowledged in the National Agreement, ACCOs are best placed to deliver services and programs in line with the community-identified needs and priorities.

Government procurement processes need to recognise ACCOs as preferred providers and 'best value for money' for government-funded services to Aboriginal and Torres Strait Islander people.

The design of funding programs and associated contracts need to give ACCOs control over defining service and program outcomes and be sufficiently flexible to meet community needs and respond to changing priorities.

Through the National Agreement, Commonwealth and State and Territory Governments should commit to regional community-controlled commissioning arrangements at a whole-of-systems level.

At a minimum, Commonwealth and State and Territory Governments should transition needs assessment, priority setting and service planning responsibilities, such as those currently undertaken by Primary Health Networks and Queensland Hospital and Health Services, to ACCOs.

[What are] some examples of good practice in transferring service delivery from mainstream organisations to ACCOs?

As noted by the Productivity Commission, through the National Agreement, all governments have agreed that community control is an act of self-determination and that services delivered by community-controlled organisations generally achieve better results and are often preferred over mainstream services.

The IUIH Network agrees with the Productivity Commission's observations that current actions do not sufficiently support ACCOs, missing opportunities for governments to learn and improve policy and program and service design. Although there have been some shifts towards ACCOs providing more services, the pace is slow, and the demand for culturally safe services remains unmet, particularly in urban areas.

There needs to be greater transparency of the investment through ACCOs, by region, by government agency, and broken down by Indigenous-specific program investment and mainstream program investment. Current reporting tends to provide a global view. However, an understanding

of investment by agency, by region, and by investment type assists ACCOs, such as IUIH, to identify opportunities for sector investment and growth (see also comments on recommendation 5).

To increase investment in community-controlled health services in SEQ, the IUIH Network has focused on evidence-based service planning and advocacy efforts directly with governments and mainstream health service providers. IUIH Network has been able to increase access to culturally responsive health care through shared care partnerships with public and private mainstream health services (Box 2). Under these models, IUIH Network coordinates the client's healthcare journey and delivers culturally appropriate, integrated and wholistic community-based health and social services and the mainstream health service provides the medical specialist and hospital-based care.

Box 2. Improving health outcomes through Community-Controlled Shared Care in SEQ

Birthing in Our Communities (BiOC)

IUIH's BiOC program delivers a unique model of Indigenous-led maternity care that provides comprehensive and culturally informed maternal and infant health services for Aboriginal and Torres Strait Islander families. BiOC is a holistic, strengths-based approach to maternal-infant health care, in which an Indigenous Family Support Worker, continuity of midwifery care, and wrap-around social support are provided to our mums and their families.

From an innovative pilot program self-funded by IUIH through self-generated Medicare Benefits Scheme (MBS) income, BiOC now operations from four locations. BiOC is a partnership with mainstream public and private health services (Mater Health Services, My Midwives, and Metro South Hospital and Health Service) who contribute midwifery and obstetric care within an Indigenous-led model of care.

BiOC has proven to perform better than standard care on a range of national maternity indicators and has closed the gap in preterm births and birth weights. In addition, the program has been demonstrated to cost less than standard care.[xiv]

IUIH Cataract Surgery Pathway

The IUIH Cataract Surgery Pathway addresses the need for system-wide improvements for Aboriginal and Torres Strait Islander eye health. The Pathway has been designed to embody IUIH's values of providing holistic primary care services with a continuum into tertiary care for Aboriginal and Torres Strait Islander people in SEQ. The IUIH Cataract Surgery Pathway partners with Metro South HHS, Mater Springfield Hospital and a private ophthalmology team at 'Infinite Vision'.

The Pathway begins when clients access IUIH's in-house optometrists for diagnosis and referral and is completed when the client returns to this point for post-operative care. IUIH staff provide wrap-around support throughout the entire loop and alleviate socio-economic barriers to care, such as transport and health literacy. The Pathway involves a culturally safe process of explaining clinical information in a yarn-based format, assisting with hospital paperwork, attending hospital surgical days to liaise with surgical and hospital staff, and telehealth consultations following surgery until return to face-to-face care in the clinic.

The system-wide changes brought about by the IUIH Cataract Surgery Pathway have successfully reduced wait times, increased chances of care completion and streamlined multiple health points to improve client satisfaction and their relationship with the health system. Since its commencement in 2015, the Pathway has successfully supported 378 clients through 618 operations, with many people having both eyes operated.

Box 2. Continued…

Urban Respiratory Outreach Clinic (UROC)

UROC is a partnership between IUIH and Metro North Hospital and Health Service (HHS) to provide specialist respiratory outreach clinics to Aboriginal and Torres Strait Islander adults in a culturally safe and respectful environment.

The service was set up to decrease preventable hospital readmission, as it was identified that 4.5% of total Metro North HHS respiratory hospitalisations were Indigenous, and 20% of Indigenous admissions were readmitted within 28 days of discharge.

The program commenced in October 2022, servicing clients referred for specialist respiratory services in the Moreton Bay region. Through the program, the Metro North specialist respiratory clinical team provide a fortnightly specialist respiratory services clinic, and clients are connected to IUIH rehabilitation and exercise programs for ongoing management. IUIH provides transport to all clients who require it to ensure they can attend appointments.

In the experience of the IUIH Network, regional partnerships are an important part of increasing investment in ACCOs. Through the SEQ First Nation Health Equity (FNHE) Strategy,[xv] SEQ Hospital and Health Services, Primary Health Networks and the Mater Health Service have committed to priority areas of effort that increase investment in and access to community-controlled health services through the IUIH Network (Box 3). In 2023, through the SEQ FNHE partnership, the IUIH Network was able to leverage around $6 million in funding for the establishment or expansion of a range of services, including dental care, cancer screening and youth care coordination (Box 3).

Box 3. SEQ First Nations Health Equity Strategy: A commitment to increasing community-controlled service delivery.

Through the SEQ First Nation Health Equity Strategy (the Strategy), SEQ Hospital and Health Services, Primary Health Networks and the Mater Health Service have committed to focused effort in areas aligning with the National Closing the Gap Agreement and the Queensland Health Equity Framework.

Eight (8) of the priority areas under the Strategy specifically relate to “Building the Community Controlled Sector”:

- Priority area 2.5: Harness opportunities to expand First Nations primary healthcare services across the region.
- Priority area 2.6: Implement culturally appropriate health promotion and prevention initiatives across SEQ.
- Priority area 3.4: Supporting community-controlled models of service delivery that integrate early childhood clinical therapies and learning.
- Priority area 4.6: Design and establish community-controlled suicide prevention and aftercare services that are culturally and clinically informed.
- Priority area 4.7: Design and establish a regional community-controlled specialist mental health service for people with mild to moderate mental health needs that have strong referral pathways into and partnerships with acute mental health services.
- Priority area 5.2: Improve integrated care by strengthening hospital discharge processes.
- Priority area 5.3: Transition appropriate community-based HHS services to the CCHS sector where possible and as guided by local co-design and service capacity.
- Priority area 5.4: Work with Queensland Health’s Healthcare Purchasing and System Performance Division to identify opportunities for commissioning/purchasing First Nations services and programs from the CCHSs sector.

Connected Community Pathways (CCP)

Queensland Health’s CCP initiative is a $67.5 million mainstream initiative that funds Queensland Hospital and Health Services to provide timely and appropriate access to care that is as close to home as possible, where clinically appropriate; reduce the demand in the hospital setting; and strengthen sustainable partnerships with the primary and/or community care sector.

In 2023-2024, through the governance of the SEQ First Nations Health Equity Strategy, the SEQ Hospitals and Health Services – Children’s Health Queensland, Gold Coast, Metro North, Metro South, and West Moreton – each partnered with IUIH to make a submission that specifically increased investment in community-controlled health services through the IUIH Network.

As a result, around $6 million will come to the IUIH Network to deliver:

- Cancer Screening and care integration and coordination
- Dental services
- Early intervention pathways for young people (10-17 years)
- Integrated specialist cardiology clinics within community-controlled clinics.
- Improved access to specialist pain management services.
- Public Health partnerships.

Through this process the IUIH Network played a significant role in identifying priorities and defining program scope and outcomes.

[What are] the risks to the sustainability of ACCOs from simply 'lifting and shifting' mainstream services into ACCO delivery?

Since its establishment in 2009 as the 'backbone' organisation for the regional Network, IUIH has focused on building the skills, capability, expertise and governance and operational structures within IUIH and the IUIH Network organisations to deliver sustainable growth in community-controlled health service delivery across the region. Through our experience, the IUIH Network recognises two key risks associated with 'lifting and shifting' services to ACCOs.

Firstly, there is the risk to organisational stability and viability. Any transfer of services should be accompanied by a capacity assessment and investment that ensures the organisation's operational governance, systems and processes can absorb an increase in service delivery. This includes adequate investment in 'back of house' enabling functions, including administration, IT, HR and data systems and ensuring organisations are adequately resourced to build or attract the executive leadership required to lead growing organisations.

The second risk arises because the services being 'lifted and shifted' are often grossly underfunded and not delivered in a culturally appropriate model in the first place. Consequently, ACCOs must invest significant effort in integrating and reorienting these services (and potentially staff) to a community-controlled and culturally responsive environment. Therefore, the lifting and shifting of services must be accompanied by additional funding that accurately reflects the actual costs of providing integrated, 'whole-of-system' culturally appropriate care and allows flexibility to align services with local needs.

[What are your views on] putting obligations for governments into service delivery contracts, such as requirements for governments to provide data to ACCOs to enable them to design and deliver services that best meet the priorities and needs of service users

At face value, placing obligations on the government to share data in service delivery contracts with ACCOs would be a positive step forward but it would also require a parallel shift from "short, insecure and inflexible funding contracts"[xvi].

Typically, government procurement processes – solicited and unsolicited – require organisations to have the service planning and design done already. As such, access to data is often needed before entering into a service delivery contract. Where data is made available publicly or through tender processes, it typically lacks disaggregation for the Indigenous population or at a regional or local level that is useful to inform service planning and design. In the health sector, access to data is further complicated with responsibilities for data generation, collection and reporting sitting across different levels of government and across multiple sectors – public, private, and non-government.

Another concern is that the current narrow and rigid approach to government contracting would mean contractual terms would be applied that limit the use of the data. Governments might conditionally share data through service delivery, restricting its use solely for informing services under the contract, potentially limiting its value for informing the ACCO's broader service planning and delivery or even informing ongoing funding.

In some contexts, data-sharing obligations within service delivery contracts may be useful. For example, for the IUIH Network, access to monthly emergency department presentation data,

outpatient and elective surgery waiting list data and hospital admission data would be useful across a range of service deliver contracts related to shared care.

However, the IUIH Network suggests some options that may be more useful than tying data sharing to specific service delivery contracts. These options are not necessarily mutually exclusive.

Option 1: ACCOs to lead regional needs assessment, priority setting and service planning for the Aboriginal and Torres Strait Islander population.

In the health sector, both Primary Health Networks and Hospital and Health Services are required by the Australian and Queensland governments, respectively, to do whole of population local area needs assessments and service planning for their geographic areas. Both processes are incomplete in terms of access to data, engagement with Aboriginal and Torres Strait Islander communities lacks depth, and the needs of the Aboriginal and Torres Strait Islander communities are largely subsumed within broader population priorities.

An alternative approach could be for both levels of government to contract with ACCOs at a regional or local level specifically to undertake needs assessment, priority setting and service planning. This contract would be separate from specific contracts for service delivery and would be a long-term contract with obligations on both levels of government to provide sufficiently disaggregated data. In SEQ, IUIH would be well-placed to undertake this work.

Option 2: A national data repository

Relying on contractual data-sharing obligations from governments may not adequately support ACCOs. Instead, the continuous sharing of meaningful data – as defined by Aboriginal and Torres Strait Islander communities - by governments in an accessible format within a national data repository, such as the Data Clearing House, would be beneficial. Further details on data sharing are discussed under Information Request 4 below.

[What is] the extent to which, in transferring service delivery from mainstream organisations to ACCOs, governments are reforming the way that services are contracted, funded, delivered, reported against and evaluated?

IUIH agrees with the Commission's observations that government approaches to contracting ACCOs must change. The slowly increasing investment in ACCOs lacks substantial changes in contracting, funding, and evaluation that would empower ACCOs to close the gap.

The Commission notes, and IUIH concurs that ACCO funding is often rigid, specific, and unresponsive to local needs. Resourcing for reporting or evaluation, or the development of more appropriate ways of measuring or reporting on outputs and outcomes, is rare.

While some policy areas within a government department may have good knowledge and accountability against the National Agreement, this is rarely understood in the more 'corporate' areas of government departments, such as procurement or contract management areas. Government departments are also bound by very rigid procurement policies and processes. While some chief procurement officers or similar executive roles may be open to an approach more aligned with the National Agreement, this does not translate to a change in practice with the contract management and compliance officers who implement contracting arrangements. ACCOs, therefore,

need greater control over service planning, design and delivery underpinned by more flexible governments' procurement policies and processes for effective outcomes.

ACCOs need greater autonomy in shaping and executing services to align with community needs and evolving priorities. The onus is on governments transitioning from a mere transactional mindset in contracting to a more cooperative one, collaborating with ACCOs and local communities to establish service goals and outcomes.

IUIH actively advocates for such funding reforms, especially in the aged care sector (Box 4) and in system-level regional, community-controlled commissioning.

Box 4. Aged Care Funding Arrangements

Indigenous Elders, wherever they live, are all entitled to have access to the service supports of the Aged Care System and to participate in those service supports delivered to them.

There is a critical need for improved flexibility in entry-level in-home aged care, as well as the necessary integration of primary health care services with aged care service supports delivered in the home, both at entry level and for more complex cases.

In remote and very remote areas, the Australian Government'sNational Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) supports community-based hostel accommodation and other aged care services for Indigenous Elders. There is no similar offering to NATSIFSACP available in major cities and 'inner regional centres despite urban Indigenous Elders experiencing lower access rates to their Indigenous counterparts in remote and very remote areas or non-Indigenous elderly across the board.

There is a growing need to adapt the 'rural and remote' Multi-Purpose Program and the NATSIFACP to urban environments where there are significant residential populations of Aboriginal and Torres Strait Islander elderly but for whom the mainstream urban aged care model does not meet needs.

An opportunity to reform the way services are contracted is to shift, where possible and appropriate, away from grant funding agreements to fee-for-service (activity-based) contracts for ACCOs. Fee-for-service funding contracts offer distinct advantages for ACCOs. They provide a more sustainable and predictable revenue stream, enabling ACCOs to plan and invest in long-term initiatives.

Such arrangements foster a culture of accountability, as services are remunerated based on actual deliverables, promoting efficiency and effectiveness in service provision. In addition, fee-for-service arrangements empower ACCO services by emphasising their role as valued providers capable of generating revenue through their essential services. This shift in funding methodology supports self-determination and self-sufficiency, allowing ACCOs to exert greater control over their operations and tailor services to the specific needs of their communities.

Regional Community-controlled commissioning

Contestability has failed to deliver outcomes for Indigenous people but remains the dominant approach of governments to rolling out investment in Aboriginal and Torres Strait Islander services. While some procurement approaches appropriately preference funding to ACCOs, the overall approach is often inflexible and fails to respond adequately to the needs and priorities of local communities.

The Commonwealth government uses high-level commissioning arrangements, predominantly leveraging the Primary Health Networks (PHN) and, increasingly, NACCHO, to roll out Indigenous-specific health funding. State government health funding is primarily directed to hospital care and commissioned predominantly through Hospital and Health Services, with some funding rolled out to the non-government sector through contestability approaches for siloed program investments.

The transition of Indigenous funding to national Indigenous-bodies to undertake 'commissioning' simply replicates the top-down, 'one-size fits all', centralised commissioning or procurement approaches of governments. Government commitments to reform commissioning must be accelerated, applied at a systems level, not a program level, and progressed through regional ACCOs. Although the Strengthening Medicare Taskforce Report recommended piloting ACCO-led regional commissioning approaches,[xvii] IUIH notes minimal government progress.

Good commissioning practice is about more than just procuring (contracting) services; it includes working with communities to identify community needs and priorities, planning and procuring services, undertaking market development to meet these needs, and evaluating and reporting outcomes. Progressing commissioning at a regional (sub-state/territory level) recognises and leverages the distinctive and unique opportunities and benefits of regional-scale capacity and capability while retaining the connection to local communities.

A unified commissioning framework, guided by the United Nations Declaration on the Rights of Indigenous Peoples,[xviii] and anchored in the principles that outcomes for Aboriginal and Torres Strait Islander people flourish under Indigenous control and that cultural competency and safety and whole-of-system integration are paramount in assessing the value of programs and services for Aboriginal and Torres Strait Islander peoples is notably absent.

The IUIH Network advocates for a stronger commitment through the National Agreement regional, community-controlled, population-based healthcare commissioning, focusing investment, wherever possible and appropriate, through well-governed and accountable ACCOs.

The IUIH Network would argue that community-controlled commissioning is a meaningful act of self-determination, with the government relinquishing decision-making to Aboriginal and Torres Strait Islander people. This is usefully reflected in the following Closing the Gap spectrum of engagement behaviours, developed by the Closing the Gap Coalition of Peak Organisations and incorporated in the *Agreement to Implement the Social and Emotional Wellbeing Policy Partnership.*[xix]

Less power → *More power*

Abuse	Ignore	Tokenise	Consult	Involve	Collaborate	Partner	Relinquish
Communities are actively harmed by government, or government manipulates community to do certain things.	Communities are not involved at all by government who makes decisions on their own, but without direct or intentional harm to the community	Communities are used in a limited way and are usually procured for a service (i.e., welcome to Country),or asked to contribute for free but are not actively involved.	Aboriginal and Torres Strait Islander people are asked for their views and some of these views may be incorporated into the final product, but they do not have a say in the design of the process or the outcome.	Aboriginal and Torrs Strait Islander people are more actively involved throughout the process and advice taken on board to iterate the project. There may be formal structures like an advisory in place. Remuneration for time may also be present.	There is more exchange of knowledge and ideas. Aboriginal and Torres Strait Islander parties share some decision-making and say over process and outcomes. Power is still not equal, but there may be some transfer of resources.	Governments and Aboriginal and Torres Strait Islande people come together as equal parties to share decision-making through all stages. Even within partnering approaches there will be weaker and stronger forms of partnership.	Governments relinquish their power and hand over full decision-making to Aboriginal and Torres Strait Islander people. The community may decide if they want to collaborate, partner or involve government in their decision-making processes, but they are fully self-determined.
Harmful practice- should not be engaging this way			Good beginnings for a more productive relationship of engagement			Best practice engagement	

Information Request 3: Transformation of government organisations

Key Messages from the IUIH Network:

ACCOs are well positioned to support government organisations to address institutionalised racism and to change organisational cultures, priorities, and ways of operating, as demonstrated through the SEQ First Nation Health Strategy, which includes IUIH leading development of an anti-racism campaign to be rolled out across the Hospital and Health Services in SEQ.

The IUIH Network notes that the Commission has a strong preference that this information requested in relation to transforming government organisations be provided by individual government organisations as public submissions to this review.

The IUIH Network would like to note that a benefit of regional partnerships is the opportunity for ACCOs to engage directly with the leaders of government organisations, build a positive relationship, and have honest conversations about experiences of institutionalised racism at all levels.

The SEQ First Nations Health Strategy includes, as a key priority, actively eliminating racial discrimination and institutional racism within [mainstream] services. Key actions under this priority include ensuring Aboriginal and Torres Strait Islander voices are present in corporate and clinical governance and decision-making; developing a regional cultural protocol guideline for SEQ; and implementing a regional anti-racism campaign, primarily targeted at raising awareness of experiences of racism in the Hospital and Health Service towards Aboriginal and Torres Strait Islander patients but also Aboriginal and Torres Strait Islander colleagues. IUIH has been engaged by the Hospital and Health Service to lead the development of the anti-racism campaign.

Information Request 4: Indigenous data sovereignty and Priority Reform 4

Key Messages from the IUIH Network:

The IUIH Network strongly agrees that there has been a lack of progress against Priority Reform 4 – Shared Access to Data and Information at a Regional Level. The IUIH Networksupports clarifying Indigenous data sovereignty as the objective of this priority reform.

However, clarifying data sovereignty as the objective should not impede an accelerated effort by governments to ensure that data currently collected on services provided to Aboriginal and Torres Strait Islander people can be reported (disaggregated) by Indigenous status and for consistent geographical regions using the Australian Statistical Geography Standard. This work is still required as part of a commitment to and transition to Indigenous data sovereignty.

What are the substantive differences between the way Priority Reform 4 is currently described in the National Agreement on Closing the Gap and an explicit reference to Indigenous data sovereignty as the objective of Priority Reform 4?

The IUIH Network agrees with the Commission's observation that overall, there has not been a large-scale change in how governments share data, undertake data-related activities or interact with Indigenous people on data-related issues.

The Commission's draft report considers whether the lack of progress is due to uncertainty as to whether Indigenous data sovereignty is the objective of this reform.

The IUIH Network advocates for Indigenous data sovereignty, giving Indigenous communities control over their data from creation to use. Indigenous data refers to information or knowledge about or affecting Indigenous peoples, collectively or individually.[xx] Data sovereignty is expressed through Indigenous data governance, in that Indigenous people decide what, how and why data is collected, accessed and used.[xxi]

The IUIH Network has long understood that having control over what data is collected and how and why is critical to the foundation of a culturally sensitive, effective, and empowering healthcare system for Aboriginal and Torres Strait Islander communities. This sovereignty ensures that information on the health and wellbeing of our communities is treated with the utmost respect, in line with our cultural values.

By shifting to an approach of Indigenous data sovereignty, communities are empowered to dictate the terms of research, data collection, and analysis to ensure they align with our cultural values, priorities, and aspirations. This approach fosters collaboration, yields accurate insights, and supports closing the health gap. Data sovereignty helps ACCOs tailor services, maintain trust, and advocate for informed policies.

Effective data sovereignty requires government-facilitated data linkages, combining datasets for a comprehensive view of a population. This practice is essential in healthcare and social services to improve care delivery and community support. Matching and linking datasets allow information integration across different sources to create a more comprehensive dataset. Linked datasets contain a broader array of information about the population being studied and, therefore, a more complete picture of their healthcare needs, demographics and social circumstances. With access to this data, ACCOs are better equipped to design and implement more targeted and effective healthcare and support services.

However, regardless of whether Indigenous data sovereignty is the objective of priority reform 4, IUIH calls for significant reform to improve data sharing between governments and ACCOs. Improvements to data collection, disaggregation and sharing are required on a journey to Indigenous data sovereignty.

Governments and mainstream health services have a wealth of information about Aboriginal and Torres Strait Islander people. However, despite this vast information on Aboriginal and Torres Strait Islander people, critical data for ACCOs is often delayed, infrequent, or inaccessible. Breast Cancer screening data would be a good example of this.

When available, data presentation lacks clarity and consistency, often not aligning with regional geographic structures, such as the Australian Statistical Geography Standard, that are useful for planning services for regional or local populations. For example, there is a complete lack of health and social services outcome and activity/output data available (at no cost) at a regional level (below the State level), and very little of the available regional data is disaggregated by Indigenous status. Health data that is reported at a regional level is typically conveyed according to government regional structures, such as PHN footprint, Hospital and Health Service (HHS) / Local Health Network (LHN) footprint, and Child Safety region.

There are very few examples of where data is readily available and presented in a way ACCOs can use. One example of well-presented data is the Australian Institute of Health and Welfare's (AIHW) Indigenous Health Checks and Follow-ups Dashboard, which enables data to be disaggregated at various geographic levels – including Statistical Area Level 4 and by PHN boundaries - making it useful for both service planning and advocacy to government.[xxii] More data presented in this manner would better support ACCOs and Indigenous communities in making informed decisions.

Issues concerning Indigenous data sovereignty and data collection and reporting are interrelated with performance reporting obligations set by governments, which often lack measures suitable for ACCOs. For example, Indigenous Key Performance Indicators (KPIs) in government-funded programs are often limited to specific areas of service delivery, thereby failing to capture the holistic view of health and wellbeing held by IUIH and our First Nations communities. This means that the benefits of ACCO's best practices, such as IUIH's integrated, wrap-around model of care, are often not showcased to governments, which can be detrimental to policy and program evaluation, transfer of services to ACCOs and the renewal of funding agreements.

Health and social data, whether to be used for priority setting, service planning or accountability, must be standardised, related to outcomes, easy to understand and applied to continually drive best practices.

Information Request 5: Legislative and policy change to support Priority Reform 4

Key Messages from the IUIH Network:

The experience of the IUIH Network is that barriers to data sharing tend to be academic and technical rather than genuine legislative barriers.

The IUIH Network supports legislative and/or policy change to enable the sharing of data with Aboriginal and Torres Strait Islander communities and ACCOs. However, the IUIH Network notes these changes would need to be communicated clearly and repeatedly within government agencies. The onus must not be on communities and ACCOs to educate public servants and to advocate and agitate where data is not forthcoming.

What, if any, legislative or policy barriers are preventing governments from sharing data with Aboriginal and Torres Strait Islander people and organisations, or giving Aboriginal and Torres Strait Islander people more control over how data about them is governed?

In the IUIH Network's experience, governments are reluctant to share the data they hold. However, in the health context, the issues around data sharing are rarely a genuine legislative barrier.

The barriers to data sharing tend to be:

- Lack of clarity over the purpose of data sharing – for example, for direct patient care, service planning, or research – and the relevant best practice about patient confidentiality and consent.

- Data experts in government advise against data sharing due to concerns over the accuracy, validity or robustness of the data, which relies on patients/clients being asked to identify and

loses statistical integrity as it is disaggregated into smaller geographic populations. These arguments are technical and academic, play into the risk-averse policy and political context, and are rarely solution-oriented (in many cases, valid statistical solutions can be found to the concerns of data experts).

- Data is not collected by Indigenous status – staff collecting data are not confident in asking for identifying information and/or the data repository does not have a field for identification.
- Existing systems are not set up to disaggregate or report the data by Indigenous status or at a regional level, which is useful for ACCOs. Many of the health systems from which data is drawn are patient management systems designed to support clinicians in delivering direct patient care and not intended to support service planning or reporting. Similar issues exist in other social service contexts, such as child protection.
- Government departments do not prioritise configuring or reconfiguring systems to enable useful reporting for Aboriginal and Torres Strait Islander populations. Configuring or reconfiguring systems comes at a cost, and while the direct return on investment to the government might be small, the benefit for Aboriginal and Torres Strait Islander Australians and closing the gap would be significant.

Through the SEQ FNHE Strategy, the IUIH Network and its partners are actively working to improve data sharing and access to health and social determinant data at a level useful to inform system-level service planning and reform, noting that this is a work in progress and has required IUIH to purchase Indigenous data at an SEQ regional level – potentially an issue that could be overcome if Indigenous data sovereignty was the aim of priority reform 4.

To tackle barriers obstructing data sharing by governments, IUIH would support changes being made across all relevant legislation – or through specific legislation – to include a general requirement for all government-collected data to be able to be reported by Indigenous status and by the Australian Statistical Geography Standard.

An interim improvement could be amendments to the Service Delivery Statements of relevant portfolios (e.g. health, child safety, disability, education, etc.) to ensure that all data is reported by Indigenous status, where it is not already. This could also be required of the annual reports of relevant government departments or statutory bodies.

Such changes must occur in consultation with Aboriginal and Torres Strait Islander stakeholders. If government departments are required to change data systems to meet obligatory reporting requirements, it makes way for discussion and opportunities for broader changes around data in line with Indigenous data sovereignty, such as setting up or changing systems to collect data that is more meaningful for Aboriginal and Torres Strait Islander communities.

Importantly, any commitment or legislative change to enhance data sharing and Indigenous data sovereignty must be well communicated across government to public servants. All too often, the experience of the IUIH Network is that the onus is on ACCOs to agitate, advocate, negotiate and find solutions to overcome barriers to data sharing.

Information Request 6: Characteristics of the organisation to lead data development under the Agreement

Key Messages from the IUIH Network:

The IUIH Network supports the establishment of an organisation to lead data development under the National Agreement (recommendation 1).

Such an organisation would be Indigenous-led and governed, committed to data development to support Indigenous data sovereignty and be accountable to the community.

The organisation must have a clear mandate to direct government agencies at a national and jurisdiction level to enhance data collection and reporting.

If an organisation (such as an independent research centre, government department, independent government agency or a unit within a department or agency) were appointed to lead data development work to track progress under the Agreement (as per draft recommendation 1), what governance structure would ensure it has the authority and capability to deliver?

The IUIH Network supports the Productivity Commission's draft recommendation 1 to appoint an entity with adequate resources and expertise to lead data development and that options for this organisation span from independent research centres to government units.

The IUIH Network would advocate that, consistent with Indigenous data sovereignty and self-determination, this organisation should be Indigenous-led, Indigenous-governed, and accountable back to the community.

The scope of work of the organisation must be clearly defined. For example, would the entity only be responsible for leading work on data required to report against the National Agreement indicators or would the organisation have scope to ensure that all sectors and systems can better report Indigenous data of any type? This is important to clarify, as different data types (outcome, output, activity) are useful for different purposes. For example, Health Adjusted Life Expectancy (HALE), morbidity and mortality rates may be helpful outcome indicators; however, they are slow to shift. In contrast, presentations to emergency departments, hospital admissions and 715 health checks may be more immediate indicators of need, demand, and proxy indicators for health outcomes.

If the scope of the organisation is to enable Indigenous data sovereignty, it must have the mandate and capacity to work with Aboriginal and Torres Strait Islander communities to identify the data that is meaningful for them and the expertise to bring that data collection to reality. This would include the authority to lead the work and direct other government entities to make changes to the way they collect and report data. Without this power, mainstream systems will neglect the entity's directives.

Regarding governance, IUIH recommends the organisation reports directly to the government or through an independent national mechanism. The Joint Council on Closing the Gap has the potential for this function; however, the independence and expertise of the Australian Digital Council could make it a better fit. Given the wide-reaching implications of Indigenous data sharing and Indigenous data sovereignty, the National Cabinet and its Ministerial Councils must prioritise this.

Information Request 7: Performance reporting tools – Dashboard and annual data compilation report

Key Messages from the IUIH Network:

The IUIH Network recognises the importance of the closing the gap Annual Data Compilation Report (ADCR) and Dashboard as tools of public accountability against the closing the gap targets.

To enhance the usefulness of these tools, the IUIH Network would suggest the ADCR and the Dashboard provide data according to regionality across all indicators and that the National Agreement, and consequently the ADCR and Dashboard, be expanded to include measures and targets on Health Adjusted Life Expectancy (HALE), mental health, aged care and disability.

The Commission is seeking further information on how the performance reporting tools in the Agreement (namely the Dashboard and annual data compilation report (ADCR)) are currently being used and how they could be improved.

The Annual Data Compilation Report (ADCR) and Dashboard track the National Agreement's Priority Reforms. The Dashboard offers the latest data on targets and indicators, while the ADCR gives a snapshot of this data. The IUIH Network sees potential in these tools but finds them currently lacking in data depth – with much data still under development – and a complete lack of regional disaggregation.

As such, these tools have some value to the IUIH Network as a point of reference in strategic policy and advocacy to government but are of little use for meaningful engagement with the community or for service planning or design.

As noted by the Commission, it may be necessary to amend the National Agreement over time and re-evaluate the targets and indicators. IUIH strongly agrees and calls for the inclusion of targets and indicators on Health Adjusted Life Expectancy (HALE), mental health, aged care and disability in the National Agreement and associated performance reporting.

Health-Adjusted Life Expectancy (HALE)

The life expectancy gap is one of the current targets under the National Agreement (closing the life expectancy gap by 2031). The Productivity Commission's Annual Data Compilation Report 2022 highlighted that this target is not on track to be met.[xxiii]

Although it is an important health indicator, life expectancy does not give any indication of the quality of life being experienced; it is based on the quantity of life. A measurement that considers life expectancy data and the impact of ill health in a population is health-adjusted life expectancy or 'HALE'. HALE refers to the number of years lived without reduced functioning (including decreased mobility and the decline in the functioning of body systems) due to ill health and is, therefore, an indicator of both quantity and quality of life. Measuring the impact of ill health is particularly important in the context of the close correlation between poor health and the impact on education and employment outcomes. In recognition of the above, Queensland Health regularly reports against the HALE measure under its close the gap agenda.[xxiv] As expected, because disease and injury are considered, the average HALE is lower than life expectancy.

IUIH contends that reducing premature mortality is not enough if people are going to live longer but in states of ill health and disability. In 2018, Indigenous Australians lost 239,942 years due to premature death or living with disease or injury.[xxv] In the context of closing the gap, the inclusion of HALE is therefore considered a better measure to use, as it provides a more holistic understanding of whether people are spending more years in good health or more years living with illness.

Mental Health

Mental and substance use disorders are a key concern for our Mob. Socio-economic outcome area 14 of the National Agreement is that 'Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing'. The National Agreement uses the Indigenous suicide rate as a wellbeing metric, but this does not capture the full complexity of wellbeing.

IUIH contends that to advance the social and emotional wellbeing of our communities, the National Agreement must incorporate specific targets on mental health and substance misuse. These conditions are leading contributors to the Indigenous burden of disease, accounting for a substantial 23% of the total disease burden and almost half (42%) of the non-fatal burden. They also stand as the largest contributors to the health gap at 20%.[xxvi] Notably, the impact of mental health is even more pronounced in urban areas, where its prevalence is disproportionately higher among the Indigenous population compared to remote areas. In urban settings, mental health and substance use disorders contribute 25% of the total burden, compared to 18% in non-urban areas.[xxvii] Despite having greater needs, First Nations people have lower-than-expected access to mental health services and professionals.[xxviii] ATSICCHOs report that the most significant service deficits relate to mental health services.[xxix]

Meeting the National Agreement targets will require simultaneous action to address chronic disease and mental illness in Aboriginal and Torres Strait Islander families and communities. Aboriginal and Torres Strait Islander peoples embrace a holistic concept of health, which inextricably links mental and physical health within a broader concept of social and emotional wellbeing. In a whole-of-life view, social and emotional wellbeing recognises the interconnectedness of physical wellbeing with spiritual and cultural factors, especially a fundamental connection to the land, community and traditions, as vital to maintaining a person's wellbeing.xxx

Current funding and commissioning arrangements are not supporting efficient and effective mental health, Social and Emotional Wellbeing (SEWB) and substance use service responses for Indigenous people. This is primarily due to fragmented responsibilities spread across government agencies, as well as mainstream commissioning arrangements and decisions that do not align with community-led solutions. It underscores the imperative for mental health and substance use to be comprehensively integrated into the National Agreement targets, reflecting their substantial impacts on the lives of Aboriginal and Torres Strait Islander peoples.

Aged Care

The March 2021 Royal Commission into Aged Care Quality and Safety (Royal Commission) Final Report set out a blueprint for long-advocated transformational change in Indigenous aged care. This will require dramatic increases in the percentage of eligible Indigenous population (50+) receiving aged care. However, governments have made little progress in committing to the Royal Commission's recommendations for Indigenous Elders.

The IUIH Network also calls on the Australian Government to honour its own National Agreement commitments, which directly underpin the Royal Commission recommendations. These

commitments oblige the government to give Indigenous people the resources to take control of their own services, their lives, and their futures. This includes a priority commitment to ramp up the numbers of Indigenous providers and to ensure the voices of Indigenous people have as much weight as the government in all decisions affecting them.

The IUIH Network recommends that the government set annual access targets, monitor them as part of the National Agreement, and allocate additional, discrete and flexible funding to meet these targets outside mainstream competitive rounds.

Disability

The IUIH's strategic priority to deliver a broader range of social health programs includes a focus on the National Insurance Disability Scheme (NDIS) rollout to ensure that the design and implementation of this scheme supports Indigenous people having culturally appropriate access to services – particularly in relation to the SEQ region.

The NDIS has the potential to significantly enhance choice and control for disabled persons through customising and personalising annual Service Plans to reflect individual goals. However, systemic design flaws in the National Disability Insurance Agency's (NDIA) Indigenous investment and engagement strategies put this potential at risk for Indigenous clients. In particular, functional and siloed constraints inherent in the current NDIS model present barriers to culturally appropriate access to and navigation of the NDIS, including concerning community/region-specific and tailored support from Local Area Coordination (LAC) services. While the evidence supports Indigenous community-controlled organisations as being best placed to address these barriers, this is currently not being supported by the NDIA – an approach that is also misaligned with the principles of the National Agreement.

IUIH, therefore, recommends the inclusion of Indigenous-specific NDIS access and disability targets in the National Agreement and into all NDIS programs. IUIH also recommends publishing of more granular NDIS Indigenous access and plan data at the NDIS Service Area Level.

Information Request 8: Quality of implementation plans and annual reports

Key Messages from the IUIH Network:

The IUIH Network reflects that for ACCOs, our obligation is to the community, and our communities are better at holding us to account than any other mechanism.

Strengthening accountability directly back to the community, through regional or community (as appropriate) implementation plans, annual reports and annual meetings between the community andboth levels of government and government agency executives, may be the most effective way of seeing substantive and meaningful improvements in the quality and relevance of implementation plans and annual reports.

The Commission is seeking further information on how to improve the quality of governments' implementation plans and annual reports, and what is needed for governments to prepare the plans and reports according to the agreed criteria. Could this include a function for an external group (such as the independent mechanism) to assess adherence to the criteria?

The IUIH Network acknowledges that implementation plans against the National Agreement are made with good intentions. However, they lack details, specific targets, and clarity around how the activities will be measured or how they will contribute to the priority reforms. Currently, there is a disconnect between the actions of the implementation plans and how they contribute to the socio-economic outcomes of the Agreement. They reflect a 'business as usual' approach by governments.

The Productivity Commission suggests an external group to assess adherence to the criteria for Implementation Plans and annual reports outlined in the National Agreement. The IUIH Network reflects that for ACCOs our obligation is to the community, and our communities are better at holding us to account than any other mechanism.

Given the intent of the National Agreement, the IUIH Network suggests that rather than another independent group or entity for accountability being established, the accountability be directly to the community. Consideration could be given to implementation plans and annual reports being developed at regional or community levels (as appropriate), including input from ACCOs, with Ministers from both levels of government, along with government agency executives, required to meet with and be accountable to the Aboriginal and Torres Strait Islander community, annually.

Information Request 9: Independent mechanism in the broader landscape

Key Messages from the IUIH Network:

The IUIH Network recognises the importance of independent accountability mechanisms and reaffirms that the best accountability mechanism is the community.

Any independent accountability mechanism must have a strong connection to the community directly and to ACCOs and not overshadow the importance of robust, community-led governance that advocates for local community needs.

The Agreement provides for an independent mechanism that will drive accountability by supporting, monitoring, and reporting on governments' transformations (Priority Reform 3). The Commission is seeking further information on

- *What are the essential features of the independent mechanism?*
- *What levers should the independent mechanism have to enable it to hold governments to account?*
- *Should the independent mechanism have a broader role – beyond Priority Reform 3 – so that it can drive accountability for progress towards all of the Priority Reforms in the Agreement?*
- *How could the independent mechanism improve the timeliness of accountability?*
- *How should the independent mechanism be situated with respect to the new and emerging Aboriginal and Torres Strait Islander bodies (such as the proposed Voice to the Australian Parliament and Government, state and territory representative bodies, Voices to State Parliaments, treaty processes, and justice commissions)? Is a stand-alone independent mechanism still required?*
- *What role should the independent mechanism play in reviewing and/or approving Closing the Gap implementation plans and annual reports?*

The IUIH Network acknowledges the potential benefits of an independent mechanism. However, this should not overshadow the importance of robust, community-led governance that advocates for local community needs.

Despite the Agreement underscoring the need for structural change in how governments collaborate with Aboriginal and Torres Strait Islander people, this has not been realised, and government-led engagement approaches continue to fall short of desired outcomes.

Transformative progress in closing the gap will only be achieved when it is spearheaded by organisations founded 'by the community, for the community'. These entities stand distinguished by community-driven accountability and not government priorities.

Information Request 10: Senior leader or leadership group to drive change in the public sector

Key Messages from the IUIH Network:

Key tasks for the senior leaders or leadership group, should include frequent engagement with community and ACCOs, and identifying opportunities to transition service delivery to ACCOs and transition funding to regional community-controlled commissioning organisations.

Which senior leader or leadership group should be tasked with promoting and embedding changes to public sector systems and culture, in order to improve cultural capability and relationships with Aboriginal and Torres Strait Islander people and to eliminate institutional racism throughout the public sector? What tasks should they be assigned (see draft recommendation 2)?

Recognising that the public sector is best placed to respond to this information request, the IUIH Network does not have a strong view on who should be assigned as the senior leaders or leadership group responsible for promoting and embedding changes to public sector systems and culture.

Key tasks for the senior leaders or leadership group should include frequent engagement with community and ACCOs, and identifying opportunities to transition to regional commissioning and service delivery functions to ACCOs.

As noted in information request 3, addressing institutional racism can also be achieved through partnerships between ACCOs and governments or mainstream services, such as the SEQ First Nations Health Equity partnership.

A clear mechanism to reduce institutional racism and to improve the relationship between Aboriginal and Torres Strait Islander people and the public sector system is for the public sector to recognise self-determination by accelerating transition of commissioning and service delivery for Aboriginal and Torres Strait Islander communities to ACCOs.

Information Request 11: Specific accountability mechanisms

Key Messages from the IUIH Network:

The IUIH Network agrees that sector regulators, such as commissioners and ombudspersons, are important functions but rarely work well for Aboriginal and Torres Strait Islander communities.

A stronger relationship between sector regulators and ACCOs would be beneficial to ensure that regulators have a better understanding and appreciation of the work of ACCOs and vice versa.

ACCOs could also be a valuable conduit for regulators to raise awareness and build trust around their roles and functions in the community.

Response to recommendations

Draft Recommendation 1: Appointing an organisation to lead data development under the Agreement

The IUIH Network supports appointing an organisation or entity with dedicated resourcing and staffing to lead data development.

As per the IUIH Network response to information request 6, such an organisation should be Indigenous-led and governed, be committed to data development to support Indigenous data sovereignty and be accountable back to the community.

The organisation must have a clear mandate to direct government agencies at a national and jurisdiction level to enhance data collection and reporting.

Draft Recommendation 2: Designating a senior leader or leadership group to drive jurisdiction-wide change

The IUIH Network supports designating a senior leader or leadership group to drive jurisdiction-wide change within the public sector.

As per the IUIH Network response to information request 10, the senior leaders or leadership groups should be tasked with frequent engagement with the community and ACCOs and identification of opportunities to transition commissioning and service delivery functions to ACCOs.

Draft Recommendation 3: Embed responsibility for improving cultural capability and relationships with Aboriginal and Torres Strait Islander people into public sector employment requirements

The IUIH Network supports draft recommendation 3, the employment requirement that all public sector CEOs, executives and employees are required to continually demonstrate how they have sought to:

- Improve their cultural capability.
- Develop relationships with Aboriginal and Torres Strait Islander people.

- Identify and eliminate institutional racism.
- Support the principles outlined in the National Agreement on Closing the Gap.

IUIH Network notes that one way to demonstrate how they have supported the principles of the National Agreement is to increase investment in the ACCO sector, including for regional commissioning and for service delivery, and to improve data sharing at a regional and local level.

Draft Recommendation 4: Central agencies leading changes to Cabinet, Budget, funding and contracting processes

The IUIH Network supports draft recommendation 4 and suggests consideration be given to the following:

- Ensuring that any requirement on government agencies to self-assess Cabinet, Budget, funding and contracting arrangements against the National Agreement priorities does not become a superficial 'tick-and-flick' box or paragraph in Cabinet, Budget and other briefing materials.

  A strategy to manage this through the Cabinet process could be by including an assessment against the National Agreement priorities in the proactive release materials that support Cabinet papers.

- Implementing dedicated "Closing the Gap" Cabinet meetings, where they don't already exist, and an annual dedicated Closing the Gap National Cabinet meeting to enhance government-wide action and collaboration on the National Agreement and Priority Reforms.

- State and Commonwealth budget processes mandating proactive engagement with the ACCO sector through not only the Coalition of Peaks membership but also jurisdictional ACCO peaks and local and regional ACCOs to enable timely submission of budget priorities from the sector, and budgets that are responsive to differing regional funding needs and priorities.

Draft Recommendation 5: Include a statement on Closing the Gap in government agencies' annual reports

The IUIH Network supports draft recommendation 5, including that agency annual reports, at a minimum, include:

- how each of the Priority Reforms has been implemented in the agency
- how the agency has contributed to relevant socio-economic outcomes
- how the agency tracks the outcomes it achieves for Aboriginal and Torres Strait Islander people
- how did the agency assess the effectiveness of each of the above actions?

The IUIH Network suggests that the Productivity Commission's recommendation 5 is strengthened by requiring that the annual reports of government agencies specifically report on:

- The number of ACCOs funded by the agencies (existing commitment)
- The quantum of investment through ACCO, and where relevant to the agency, is broken down by Indigenous-specific program investment and mainstream program investment.
- The proportion of Indigenous-specific program investment flowing to ACCOs.

We recognise that National, State and Territory Closing the Gap annual reports should be reporting on a number of ACCOs funded (clause 118) and that jurisdictions should be reviewing and identifying current spending and reprioritisation opportunities to Aboriginal and Torres Strait Islander organisations (clause 113), but this tends to provide a global view.

Understanding investment by agency/portfolio and at a regional level assists ACCOs, such as the IUIH Network, in understanding sector investment and growth opportunities.

Additionally, this is a mechanism to hold agencies to account for Priority Reform Area 2 – Building the community-controlled sector and ensuring their portfolio Indigenous-specific investment is, wherever possible, being delivered to the community by the community.

The IUIH Network also suggests that the requirements set out in draft recommendation 5 also be required of relevant statutory agencies and bodies. For instance, In the Queensland health sector, this includes but is not limited to:

- Hospital and Health Services (or Local Health Networks in other jurisdictions).
- Health Ombudsman.
- Mental Health Commission.
- Health and Wellbeing Queensland.

Australian Government examples would include but not be limited to:

- Australian Institute of Health and Welfare (AIHW);
- Australian Commission on Safety and Quality in Healthcare; and
- The National Disability Insurance Agency (NDIA).

Draft Recommendation 6: Publish all the documents developed under the Agreement

The IUIH Network supports draft recommendation 6 with no further suggestions.

Attachments

Attachment A – IUIH Network and Clinics

Caboolture
Morayfield
Deception Bay
Margate
Strathpine
Northgate
Wynnum
Minjerribah (North Stradbroke Island)
Woolloongabba
Capalaba
Ipswich
Logan
Laidley
Goodna
Loganlea
Browns Plains
Coomera
Miami
Bilinga

[i] Australian Bureau of Statistics (ABS) Census counts with addition of the ABS estimate of Indigenous population undercounts (17.5% in 2016, 17.4% in 2021).
[ii] Institute of Urban Indigenous Health (2022), *Institute for Urban Indigenous Health Ltd Annual Report 2021-2022*.
[iii] S Kildea, Y Gao, S Hickey et al (2021) Effect of a Birthing on Country service redesign on maternal and neonatal health outcomes for First Nations Australians: a prospective, non-randomised, interventional trial, *The Lancet Global Health* 9(5):e651–e659; S Kildea, Y Gao, S Hickey et al (2019) Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia, *EClinicalMedicine* 12(1):43–51; Y Gao, Y Roe, A Chadha et al (2023) Birthing on country service compared to standard care for First Nations Australians: a cost-effectiveness analysis from a health system perspective, *The Lancet Regional Health - Western Pacific* 34(1):1-13.
[iv] Institute of Urban Indigenous Health (2022), *Institute for Urban Indigenous Health Ltd Annual Report 2021-2022*.
[v] Institute of Urban Indigenous Health (2021) *South East Queensland First Nations Health Equity Strategy.* Accessed at: https://www.iuih.org.au/strategic-documents/corporate-documents/south-east-queensland-first-nations-health-equity-strategy/?layout=default
[vi] N Biddle (2009) Same Suburbs, Different Worlds: Comparing Indigenous and non-Indigenous outcomes in city suburbs and large regional towns, *People and Place* 17(2):56-63.
[vii] Note that when referring to 'urban', this submission includes the ABS remoteness categories of Major Cities and Inner Regional areas. 'Non-urban' includes ABS remoteness categories of Outer Regional, Remote and Very Remote areas.
[viii] Australian Bureau of Statistics (30 June 2021) *Estimates of Aboriginal and Torres Strait Islander Australians: Remoteness Area.* Accessed at: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/census-population-and-housing-counts-aboriginal-and-torres-strait-islander-australians/latest-release#remoteness-areas
[ix] Proportion of total burden (Disability Adjusted Life Years), n=139,902 in urban areas, n=109,753 in non-urban areas. Australian Institute of Health and Welfare (2022) *Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018,* Data Table S10.10. Accessed at: https://www.aihw.gov.au/reports/burden-of-disease/illness-death-indigenous-2018/data
[x] Australian Bureau of Statistics (2015-2017) *Life Tables for Aboriginal and Torres Strait Islander Australians.* Accessed at: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-life-expectancy-estimates/latest-release#cite-window1
[xi] L Turner, A Albers, A Carson et al (2019) Building a regional health ecosystem: a case study of the Institute for Urban Indigenous Health and its System of Care, *Australian Journal of Primary Health* 25(5):424-429.
[xii] Australian Bureau of Statistics (June 2016) *Estimated resident Aboriginal and Torres Strait Islander Australians,* Estimated resident Aboriginal and Torres Strait Islander, non-Indigenous and total populations, states and territories, Remoteness areas – 3- June 2016*.* Accessed at: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/jun-2016 ; Australian Bureau of Statistics (June 2021) *Estimates of Aboriginal and Torres Strait Islander Australians,* Table 3: Estimated resident Aboriginal and Torres Strait Islander, non-Indigenous and total populations, states and territories, Remoteness Areas – 30 June 2021. Accessed at: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release#remoteness-areas
[xiii] Australian Bureau of Statistics (2006-2031) *Estimates and Projections, Aboriginal and Torres Strait Islander Australians.* Accessed at: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-and-projections-aboriginal-and-torres-strait-islander-australians/latest-release
[xiv] S Kildea, Y Gao, S Hickey et al (2021) Effect of a Birthing on Country service redesign on maternal and neonatal health outcomes for First Nations Australians: a prospective, non-randomised, interventional trial, *The Lancet Global Health* 9(5):e651–e659; S Kildea, Y Gao, S Hickey et al (2019) Reducing preterm birth amongst Aboriginal and Torres Strait Islander babies: A prospective cohort study, Brisbane, Australia, *EClinicalMedicine* 12(1):43–51; Y Gao, Y Roe, A Chadha et al (2023) Birthing on country service compared to standard care for First Nations Australians: a cost-effectiveness analysis from a health system perspective, *The Lancet Regional Health - Western Pacific* 34(1):1-13.
[xv] Institute of Urban Indigenous Health (2021) *South East Queensland First Nations Health Equity Strategy.* Accessed at: https://www.iuih.org.au/strategic-documents/corporate-documents/south-east-queensland-first-nations-health-equity-strategy/?layout=default
[xvi] Australian Government Productivity Commission (2023) *Review of the National Agreement on Closing the Gap: Draft Report,* pg. 42. Accessed at: https://www.pc.gov.au/inquiries/current/closing-the-gap-review/draft
[xvii] Australian Government Department of Health and Aged Care (2022) *Strengthening Medicare Taskforce Report: December 2022*. Accessed at: https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf
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[xix] Australian Government Department of Health and Aged Care (2023) *Agreement to Implement the Social and Emotional Wellbeing Policy Partnership.* Accessed at: https://www.health.gov.au/resources/publications/agreement-to-implement-the-social-and-emotional-wellbeing-policy-partnership?language=en

[xx] Lowitja Institute (2021), *Research Pathways: Information Sheet Series, Indigenous Data Governance and Sovereignty*. Accessed at: https://www.lowitja.org.au/icms_docs/328550_data-governance-and-sovereignty.pdf
[xxi] Ibid.
[xxii] Australian Institute of Health and Welfare (2022) *Indigenous health checks and follow-ups.* Accessed at: https://www.aihw.gov.au/reports/indigenous-australians/indigenous-health-checks-follow-ups/contents/rate-of-health-checks/geographic-variation
[xxiii] Australian Government Productivity Commission (2023) *Closing the Gap: Annual Data Compilation Report July 2023.* Accessed at: https://www.pc.gov.au/closing-the-gap-data/annual-data-report
[xxiv] Queensland Government (2023) *The health of Queenslanders: Report of the Chief Health Officer* Queensland. Accessed at: https://www.choreport.health.qld.gov.au/ ; See also, Queensland Government (2010) *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033: Policy and Accountability Framework.* Accessed at: https://www.health.qld.gov.au/_data/assets/pdf_file/0030/159852/making_tracks_pol.pdf
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[xxviii] Queensland Health (2016) *Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021*. Accessed at: https://www.health.qld.gov.au/_data/assets/pdf_file/0030/460893/qhatsi-mental-health-strategy.pdf
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