

**A ten-year review:
the Closing the
Gap Strategy and
Recommendations
for Reset**

2018



CLOSETHE**GAP**



Acknowledgements

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Cover photograph: Shutterstock (NORTHERN TERRITORY, AUSTRALIA – APRIL 29 2009: A portrait of two young aboriginal girls in Arnhem Land, Northern Territory, Australia)

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Aboriginal and Torres Strait Islander people should be aware that this document may contain images or names of people who have since passed away.

A ten-year review: the Closing the Gap Strategy and Recommendations for Reset

Executive Summary and Recommendations

This review assesses the most significant national effort to date to improve Aboriginal and Torres Strait Islander health: the 2008 Council of Australian Governments' (COAG) *Closing the Gap Strategy* with its target to achieve life expectancy (health) equality by 2030. Ten-years after its commencement, it is time to critically reflect on why Australian governments have not yet succeeded in closing the health gap to date, and why they will not succeed by 2030 if the current course continues. In fact, a December 2017 Australian Institute of Health and Welfare report found the mortality and life expectancy gaps are actually widening due to accelerating non-Indigenous population gains in these areas.¹

The COAG *Closing the Gap Strategy* was developed by Australian governments following their signing of the *Close the Gap Statement of Intent* from March 2008 onwards. The *Close the Gap Statement of Intent* is, first, a compact between Australian governments and Aboriginal and Torres Strait Islander peoples. Second, it embodies a human right to health-based blueprint for achieving health equality referred to hereon as the 'close the gap approach'.

The close the gap approach and the *Close the Gap Statement of Intent* is founded on an understanding that population health outcomes are fundamentally the result of underlying structural factors, such as social determinants, institutional racism, the quality of housing, and access to appropriate primary health care. If governments want to improve and sustain the health of any population over time, these elements must be addressed. What this means is that sustainable improvements to the health of a population will ultimately depend on the quantum, quality, coherence and coordination of the health system and other governments' **inputs in these areas**. The close the gap approach then is founded on an evidence-based understanding that health outcomes will sustainably improve on a population basis if there are sufficient, purposeful and effective inputs to address these underlying factors.

This does not mean that funding should be pulled from *Closing the Gap Strategy* elements such as addressing preventable, chronic and communicable diseases and child and maternal health. Indeed, there is an obligation to address these, including risk behaviours (such as smoking) within a rights-based approach. However, policy makers should not take their eyes off the 'main game': sustainable long-term improvement to the health of Aboriginal and Torres Strait Islander peoples by addressing the underlying structural factors – treating the causes rather than focusing on symptoms.



Journey Together – CLOSE THE GAP

The Horizon breaks, a new day dawns.

We journey together across Country, guided by our Ancestors we are connected.

Smooth rock, freshwater rises, this land restores us, we are healed, saltwater cleanses.

Navigation by the stars, Culture is strong ceremony is performed. We come together and celebrate as one.

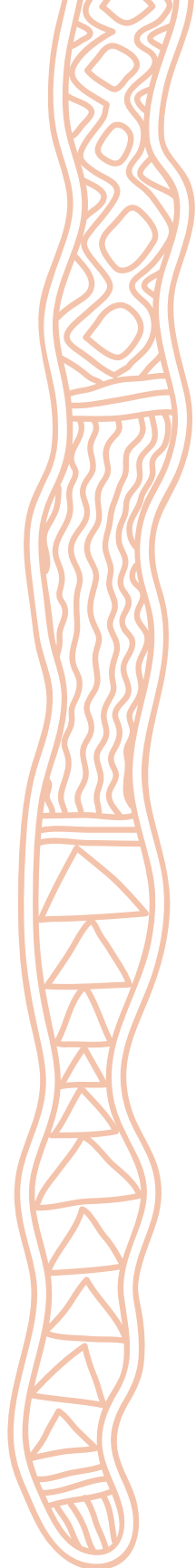
Journey Together – Close the Gap: Artwork explained

The diamond shaped patterned pathway represents the journey from different country, cultures, customs and nations throughout Australia traveling as one.

Lines represent tracks, the arch shapes represent the challenges faced on the journey. The dots represent the people, they come together for change, for equality and self determination.

The zig-zag lines towards the centre represents a weave which symbolises bringing Indigenous and non-Indigenous people closer together.

The central motif represents people seated as equals in discussions on how to Close the Gap on all health issues for Aboriginal and Torres Strait Islander Peoples. This motif also symbolises the sun representing a celebration and a new day.



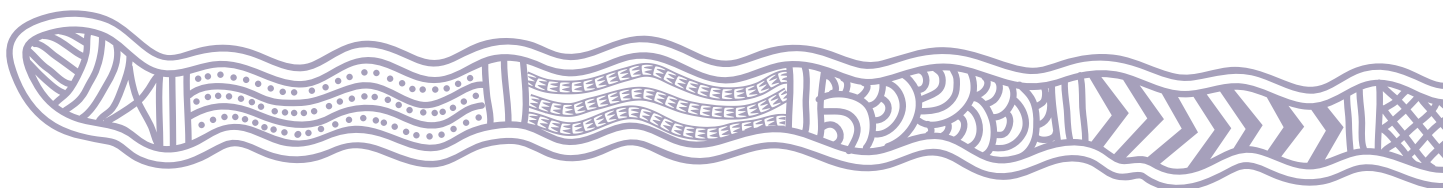
Indeed, without this additional focus, responses to chronic and communicable diseases are likely to be unsustainable, a metaphorical ‘band aid’, rather than resulting in permanent health gains and, ultimately, Aboriginal and Torres Strait Islander life expectancy equality in 2030 and beyond.

The close the gap approach and the *Close the Gap Statement of Intent* also incorporate the Federal Government-supported United Nations Declaration on the Rights of Indigenous Peoples (the Declaration) articulation of the right to health as it applies to Indigenous peoples. In short, this requires governments to respect Indigenous peoples’ right to self-determination in efforts to improve their health. At the national level, this means Aboriginal and Torres Strait Islander-government partnerships in health planning. At the community level, it means community governance and control of health services. In other words, to ‘get the inputs right’, investment must be guided into the kinds of services, health infrastructure and other responses as determined by Aboriginal and Torres Strait Islander health leaders and communities.

This review’s major findings are:

- First, the *Close the Gap Statement of Intent* (and close the gap approach) has to date only been partially and incoherently implemented via the *Closing the Gap Strategy*:
 - An effective health equality plan was not in place until the release of the *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan* in 2015 – which has never been funded. The complementary *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017-2023* needs an implementation plan and funding as appropriate. There is still yet to be a national plan to address housing and health infrastructure, and social determinants were not connected to health planning until recently and still lack sufficient resources.
 - The *Closing the Gap Strategy* focus on child and maternal health and addressing chronic disease and risk factors – such as smoking through the Tackling Indigenous Smoking Program – are welcomed and should be sustained. However, there was no complementary systematic focus on building primary health service capacity according to need, particularly through the Aboriginal Community Controlled Health Services and truly shifting Aboriginal and Torres Strait Islander health to a preventive footing rather than responding ‘after the event’ to health crisis.
- Second, the *Closing the Gap Strategy* – a 25-year program – was effectively abandoned after five-years and so cannot be said to have been anything but partially implemented in itself. This is because the ‘architecture’ to support the *Closing the Gap Strategy* (national approach, national leadership, funding agreements) had unraveled by 2014-2015.
- Third, a refreshed *Closing the Gap Strategy* requires a reset which re-builds the requisite ‘architecture’ (national approach, national leadership, outcome-orientated funding agreements). National priorities like addressing Aboriginal and Torres Strait Islander health inequality have not gone away, are getting worse, and more than ever require a national response. Without a recommitment to such ‘architecture’, the nation is now in a situation where the closing the gap targets will measure nothing but the collective failure of Australian governments to work together and to stay the course.

- Fourth, a refreshed *Closing the Gap Strategy* must be founded on implementing the existing *Close the Gap Statement of Intent* commitments. In the past ten years, Australian governments have behaved as if the *Close the Gap Statement of Intent* was of little relevance to the *Closing the Gap Strategy* when in fact it should have fundamentally informed it. It is time to align the two. A refreshed *Closing the Gap Strategy* must focus on delivering equality of opportunity in relation to health goods and services, especially primary health care, according to need and in relation to health infrastructure (an adequate and capable health workforce, housing, food, water). This should be in addition to the focus on maternal and infant health, chronic disease and other health needs. The social determinants of health inequality (income, education, racism) also must be addressed at a fundamental level.
- Fifth, there is a ‘funding myth’ about Aboriginal and Torres Strait Islander health – indeed in many Indigenous Affairs areas – that must be confronted as it impedes progress. That is the idea of dedicated health expenditure being a waste of taxpayer funds. Yet, if Australian governments are serious about achieving Aboriginal and Torres Strait Islander health equality within a generation, a refreshed *Closing the Gap Strategy* must include commitments to realistic and equitable levels of investment (indexed according to need). Higher spending on Aboriginal and Torres Strait Islander health should hardly be a surprise. Spending on the elderly, for example, is higher than on the young because everyone understands the elderly have greater health needs. Likewise, **the Aboriginal and Torres Strait Islander population have, on average, 2.3 times the disease burden of non-Indigenous people.**² Yet on a per person basis, Australian government health expenditure was \$1.38 per Aboriginal and Torres Strait Islander person for every \$1.00 spent per non-Indigenous person in 2013-14.³ So, for the duration of the *Closing the Gap Strategy* Australian government expenditure was not commensurate with these substantially greater and more complex health needs. This remains the case. Because non-Indigenous Australians rely significantly on private health insurance and private health providers to meet much of their health needs, in addition to government support, the overall situation for Aboriginal and Torres Strait Islander health can be characterised as ‘systemic’ or ‘market failure’. Private sources will not make up the shortfall. Australian government ‘market intervention’ – increased expenditure directed as indicated in the recommendations below – is required to address this. The *Close the Gap Campaign* believes no Australian government can preside over widening mortality and life expectancy gaps and, yet, maintain targets to close these gaps without additional funding. Indeed, the Campaign believes the position of Australian governments is absolutely untenable in that regard.



In considering these findings, the Close the Gap Campaign are clear that the *Close the Gap Statement of Intent* remains a current, powerful and coherent guide to achieving Aboriginal and Torres Strait Islander health equality, and to the refreshment of the *Closing the Gap Strategy* in 2018. Accordingly, this review recommends that:

Recommendation 1: the ‘refreshed’ Closing the Gap Strategy is co-designed with Aboriginal and Torres Strait Islander health leaders and includes community consultations. This requires a tripartite negotiation process with Aboriginal and Torres Strait Islander health leaders, and the Federal and State and Territory governments. Time must be allowed for this process. Further, Australian governments must be accountable to Aboriginal and Torres Strait Islander people for its effective implementation.

Recommendation 2: to underpin the *Closing the Gap Strategy* refresh, Australian governments reinvigorate the ‘architecture’ required for a national approach to addressing Aboriginal and Torres Strait Islander health equality. This architecture includes: a national agreement, Federal leadership, and national funding agreements that require the development of jurisdictional implementation plans and clear accountability for implementation. This includes by reporting against national and state/territory targets.

Recommendation 3: the *Closing the Gap Strategy* elements such as maternal and infant health programs and the focus on chronic disease (including the Tackling Indigenous Smoking program) are maintained and expanded in a refreshed *Closing the Gap Strategy*.

Along with Recommendation 2, a priority focus of the ‘refreshed’ Closing the Gap Strategy is on delivering equality of opportunity in relation to health goods and services and in relation to health infrastructure (housing, food, water). The social determinants of health inequality (income, education, racism) must also be addressed at a far more fundamental level than before. This includes through the following recommendations:

Recommendation 4: the current *Closing the Gap Strategy* health targets are maintained, but complemented by targets or reporting on the inputs to those health targets. These input targets or measures should be agreed by Aboriginal and Torres Strait Islander health leaders and Australian governments as a part of the *Closing the Gap Strategy* refresh process and include:

- Expenditure, including aggregate amounts and in relation to specific underlying factors as below;
- Primary health care services, with preference given to Aboriginal Community Controlled Health Services, and a guarantee across all health services of culturally safe care;
- The identified elements that address institutional racism in the health system;
- Health workforce, particularly the numbers of Aboriginal and Torres Strait Islander people trained and employed at all levels, including senior levels, of the health workforce; and
- Health enabling infrastructure, particularly housing.

Recommendation 5: the *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan* is costed and fully funded by the Federal government, and future iterations are more directly linked to the commitments of the *Close the Gap Statement of Intent*; and, an implementation plan for the complementary *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* is developed, costed and implemented by the end of 2018 in partnership with Aboriginal and Torres Strait Islander health leaders and communities. This will include:

- (a) A five-year national plan to identify and fill health service gaps funded from the 2018-2019 Federal budget onwards and with a service provider preference for Aboriginal Community Controlled Health Services (ACCHSs). This includes provision for the greater development of ACCHS's satellite and outreach services.
- (b) Aboriginal and Torres Strait Islander health leadership, Federal, State and Territory agreements clarifying roles, responsibilities and funding commitments at the jurisdictional level.
- (c) Aboriginal and Torres Strait Islander health leadership, Primary Health Network and Federal agreements clarifying roles, responsibilities and funding commitments at the regional level.

Recommendation 6: an overarching health infrastructure and housing plan to secure Aboriginal and Torres Strait Islander Peoples equality in these areas, to support the attainment of life expectancy and health equality by 2030, is developed, costed and implemented by the end of 2018.

Focus on 2017: Why have we arrived where we are with efforts to close the gap?

Over the decade since 2008, Aboriginal and Torres Strait Islander affairs have experienced discontinuity and uncertainty. Regular changes to the administration and quantum of funding, shifting policy approaches and arrangements within, between and from government, cuts to services, and a revolving door of Prime Ministers, Indigenous Affairs Minister and senior bureaucrats have all but halted the steady progress hoped for by First Peoples.

After the initial funding commitments made for the Closing the Gap Strategy, via the National Indigenous Reform Agreement (NIRA) and the supporting National Partnership Agreements (NPAs) – the Strategy was effectively abandoned with the extensive cuts (over \$530 million) made to the Indigenous Affairs portfolio in the 2014 Federal Budget. A new competitive tendering process for services to apply for funding grants was introduced, creating enormous upheaval and led to uncertainty, lost continuity, and eroded engagement between Aboriginal and Torres Strait Islander organisations and government.

Government expenditure at all levels has not been commensurate with the substantially greater and more complex health needs of Aboriginal and Torres Strait Islander peoples. Of the investments made, in many cases it has been invested in the wrong areas, focussing more on tertiary than primary care, mainstream rather than Aboriginal Community Controlled Health Services, or been exhausted by the administrative costs of government departments.

It is unsurprising in this environment that governments have not been able to make real in-roads into closing the gap in health equality and life expectancy for Australia's First Peoples.

Despite this, Aboriginal and Torres Strait Islander community controlled health services continue to account for much of the gains made in health equality. Similarly, the small but growing Aboriginal and Torres Strait Islander health workforce continues to improve access and approaches to addressing First Peoples' health.

It is the duty of all Australian governments to build upon and support what is working. Closing the Gap is an agreed national priority, and hundreds of thousands of Australians have joined the Campaign, calling upon governments to work with First Peoples to ensure they can enjoy long and healthy lives. It is the particular responsibility of the Federal Government to ensure that the effort will be sustained, with effective, collaborative leadership and coordination with State and Territory governments to meet this national priority.

The recently released Productivity Commission 2017 Indigenous Expenditure Report noted that direct expenditure has actually dropped to 18 per cent from 22.5 per cent when the Statement of Intent was signed in 2008.⁴ The Report also illustrated that expenditure on Aboriginal and Torres Strait Islander people is heavily skewed toward the costs of reacting to the outcomes of disadvantage rather than investments to reduce or overcome disadvantage.

Furthermore, the 2017 Indigenous Expenditure Report states that to 'know the direct impact of expenditure on the outcomes' requires a cost benefit analysis.

The Close the Gap Campaign agrees and believes that far greater effort should be spent on working with First Peoples on the approaches that can be shown to work, especially those that address the root causes of poor health, and direct investment to them. To date, the Close the Gap Campaign is not aware of any long-term cost benefit analysis, nor comprehensive evaluation of the last 10 years of closing the gap by government. This is a failure of accountability and good governance by the Federal Government.

We note the work of the National Health Leadership Forum and the Redfern Statement Alliance offers some hope to better collaboration with Government. These senior Aboriginal and Torres Strait Islander leaders provide considered, expert and collective advice to Government.

The last 12 months...

In the 2017 *Closing the Gap Report* to Parliament, the Prime Minister announced that the Council of Australian Governments (COAG) would be looking to review and refresh the *Closing the Gap Strategy* and that the Productivity Commission would be expanded to include an Indigenous Commissioner 'to lead on the Commission's work of policy evaluation'.⁵

One year later, there has been no announcement about the appointment of an Indigenous Commissioner to the Productivity Commission. The Close the Gap Campaign expects the Federal Government to appoint the commissioner as a matter of urgency, and that the commissioner is an Aboriginal and/or Torres Strait Islander person.

The Government's 'refresh' process for the *Closing the Gap Strategy* has been maligned with rushed and poor engagement with Aboriginal and Torres Strait Islander leaders and communities. The refresh process has lacked clarity and appears to be promoting an agenda based on views within government that have involved virtually no engagement with First Peoples in their development.

The government preference for internalising policy development, where policy is produced in government bureaucracies with minimal input, will need to be a relic of the past if we are to start meeting closing the gap targets. This will mean prioritising approaches that deliver better health and wellbeing outcomes even if this means relaxing government operational and management control, especially if there is no compelling evidence that the continuation of such control will ensure improved outcomes.

Emblematic of the gap between the rhetoric of partnership and the reality, the Federal Government failed to grasp the opportunity presented by Aboriginal and Torres Strait Islander people with the proposal of the *Uluru Statement from the Heart*. The elements of the *Uluru Statement* go to the core of achieving a refreshed *Closing the Gap Strategy* that is genuinely co-designed. The *Uluru Statement* made three core proposals:

1. An Aboriginal and Torres Strait Islander Voice enshrined in the Constitution;
2. A Makarrata Commission to oversee agreement making between Governments and Aboriginal and Torres Strait Islander peoples; and
3. Truth-telling about our history, led by the Makarrata Commission.⁶

The rejection of the *Uluru Statement* has been compounded by issues with the Refresh process, rumours of additional funding cuts to Indigenous remote housing programs and the devastating findings in the *Royal Commission into the Protection and Detention of Children in the Northern Territory* and the *Royal Commission into Institutional Responses to Child Sexual Abuse*.

Encouragingly, and despite government inertia, there are numerous positive examples of Aboriginal and Torres Strait Islander peoples and communities working effectively to deliver the solutions to the challenges posed.

Given the dreadful record of the trajectory towards closing the gap, 2018 is a critical year for Aboriginal and Torres Strait Islander affairs. We have quite simply reached a fork in the road for how Australia tackles the entrenched inequalities and disparities in health and wellbeing for First Peoples.

We are just two years off being halfway towards the generational deadline to close the gap that was called for in the seminal 2005 Social Justice Report. Aboriginal and Torres Strait Islander people and the nation cannot afford further missteps or apathy from governments if we are to meet the target that we have set as a national priority.

In this review, the Campaign's analysis of the first 10 years of *Closing the Gap Strategy* has identified the key challenges and opportunities that must be addressed in order to deliver on the national commitment to 'close the gap' by 2030.



Embargoed until
1pm, Thursday
11 February
2010

Shadow report

On the Australian Government's progress towards closing the gap in life expectancy between Indigenous and non-Indigenous Australians

A Close the Gap Steering Committee for Indigenous Health Equality report
February 2010



Shadow report

On Australian governments' progress towards closing the gap in life expectancy between Indigenous and non-Indigenous Australians

Close the Gap Campaign Steering Committee
February 2011



Shadow Report 2012

On Australian governments' progress towards closing the gap in life expectancy between Indigenous and non-Indigenous Australians

Close the Gap
Campaign Steering
Committee



Shadow Report 2013

On Australian governments' progress towards closing the gap in life expectancy between Indigenous and non-Indigenous Australians



Progress and priorities report 2014



Progress and priorities report 2015

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Progress and priorities report 2016



Progress and priorities report 2017

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1 The close the gap approach, the Close the Gap Statement of Intent and the Closing the Gap Strategy

In 2006, 'close the gap' entered the Australian political lexicon as the marker of a new approach to improving Indigenous health and reducing disadvantage and was taken up by the members of the Close the Gap Campaign for Indigenous Health Equality.

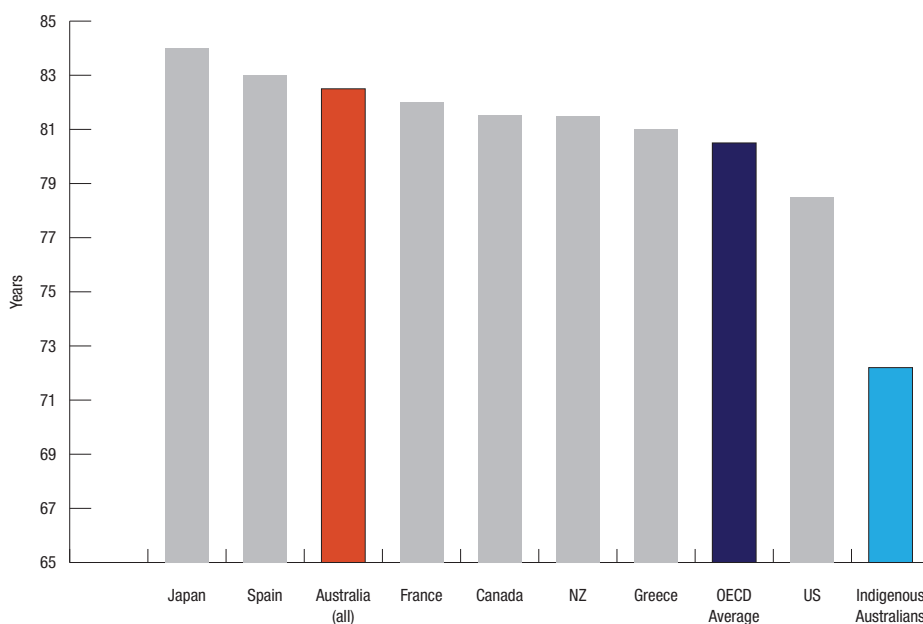
Close the gap is an approach based on Australia's obligations under the right to health. This is not a 'right to be healthy' but has a foundation premise that a nation state's core business includes providing opportunities to be healthy to its population by ensuring two fundamental inputs:

- First, by providing access to health goods, services and facilities, especially primary health care services, to prevent ill-health, or in the event of ill-health.
- Second, by providing housing, essential services, water and food supply of a standard to support good health.⁷

Critically, the focus on the right to health is on health *inputs* with the evidence-based expectation that by ensuring good health infrastructure and access to health goods, services and facilities, health outcomes will improve.

By the right to health, a nation state should also ensure equality of opportunity among its population groups in relation to these health inputs.

Average life expectancy at birth (2015) – selected OECD countries



Further, by Article 2 of the UN *International Covenant on Economic, Social and Cultural Rights* 1966, the prescribed remedy where inequality of opportunity exists is that a nation state is required to progressively realise such through *deliberate, concrete and targeted steps* – planning and implementation.⁸ This planning involves three steps:

- The ‘gap’ between the advantaged and disadvantaged population is quantified.
- The level of opportunity enjoyed by the advantaged population is adopted as a target for the disadvantaged population.
- Over a reasonable and set period of time, the level of opportunity of the disadvantaged population (taken as a baseline) is progressively raised to reach the target level. In that way, the gap is closed.

Finally, human rights law requires that a range of determinants of ill-health that are human rights subject matters are addressed. Many are specifically covered by the ‘health infrastructure’ concept: housing, health literacy, essential services, healthy food and water. Others are broader. For example, it has long been recognised that health broadly improves with improved socioeconomic standards, income, employment, education and so on.⁹ Underlining these factors in Australia is inherent issues of institutional racism which restrict many Aboriginal and Torres Strait Islanders from receiving better healthcare outcomes, securing long-term employment or gaining meaningful and appropriate education.

The commitments of the Close the Gap Statement of Intent

The Federal Governments’ commitment to the close the gap approach was linked to the broader Reconciliation movement and a ‘re-setting’ of the relationship between Australian governments and Indigenous peoples, as stated by Prime Minister Rudd in the *Apology to Australia’s Indigenous Peoples* made on the 13th of February 2008, and included in the Preamble to the *Close the Gap Statement of Intent* (see page 13).

The 2008 ‘new partnership’ approach was cemented by two agreements, the *National Indigenous Reform Agreement* (NIRA) and the *Close the Gap Statement of Intent*, signed on the 20th of March 2008 by the Prime Minister, ministers and the leaders of other main national-level political parties as a compact. Over the following two years (2008-2010), the Governments and Opposition parties in Victoria, Western Australia, the Australian Capital Territory, New South Wales and South Australia also signed the *Close the Gap Statement of Intent*.¹⁰

But what exactly do the nine *Close the Gap Statement of Intent* commitments commit Australian governments to do? Broadly, they fall into three process commitments and three subject matter commitments. (See matrix on page 14).

Establishing the Closing the Gap Strategy

At the 20 December 2007 Council of Australia Governments (COAG) meeting, and under Federal Government leadership, Australian governments agreed to adopt a new national, intergovernmental approach to addressing Indigenous health equality and disadvantage. The initial agreement included six national equality targets including to life expectancy equality by 2030 and reductions in child mortality (<5 years).¹¹

A COAG Working Group on Indigenous Reform was established to progress COAG’s initial agreement. This would go on to develop the National Indigenous Reform Agreement (NIRA) and other elements in the *Closing the Gap Strategy*.

The *Close the Gap Statement of Intent* was a compact with, and a set of commitments to, Aboriginal and Torres Strait Islander people made by Australian governments. The NIRA on the other hand was an intergovernmental agreement that would come into effect on 1 June 2009. The NIRA set out to change the way the Federal, States and Territories worked together in Indigenous Affairs. It established the Federal Government as the primary funder and driver of efforts to achieve Aboriginal and Torres Strait Islander health equality and other equality-based efforts in employment and education.¹² This shift towards greater Federal Government leadership was also signified by the June 2009 appointment of the first Federal Government Minister of Indigenous Health to oversee the closing the gap efforts pertaining to health.

CLOSE THE GAP

Indigenous Health Equality Summit

CANBERRA, MARCH 20, 2008

PREAMBLE

Our challenge for the future is to embrace a new partnership between Indigenous and non-Indigenous Australians. The core of this partnership for the future is closing the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities. This new partnership on closing the gap will set concrete targets for the future: within a decade to halve the widening gap in literacy, numeracy and employment outcomes and opportunities for Indigenous children, within a decade to halve the appalling gap in infant mortality rates between indigenous and non-indigenous children and, within a generation, to close the equally appalling 17-year life gap between Indigenous and non-Indigenous when it comes to overall life expectancy.

Prime Minister Kevin Rudd, Apology to Australia's Indigenous Peoples, 13 February 2008

This is a statement of intent – between the Government of Australia and the Aboriginal and Torres Strait Islander Peoples of Australia, supported by non-Indigenous Australians and Aboriginal and Torres Strait Islander and non-Indigenous health organizations – to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by year 2030.

We share a determination to close the fundamental divide between the health outcomes and life expectancy of the Aboriginal and Torres Strait Islander peoples of Australia and non-Indigenous Australians.

We are committed to ensuring that Aboriginal and Torres Strait Islander peoples have equal life chances to all other Australians.

We are committed to working towards ensuring Aboriginal and Torres Strait Islander peoples have access to health services that are equal in standard to those enjoyed by other Australians and enjoy living conditions that support their social, emotional and cultural well-being.

We recognise that specific measures are needed to improve Aboriginal and Torres Strait Islander peoples' access to health services. Crucial to ensuring equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery and control of these services.

ACCORDINGLY WE COMMIT:

- To developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-indigenous Australians by 2030.
- To ensuring primary health care services and health infrastructure for Aboriginal and Torres Strait Islander peoples which are capable of bridging the gaps in health standards by 2018.
- To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs
- To working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples.
- To building on the evidence base and supporting what works in Aboriginal and Torres Strait Islander health, and relevant international experience.
- To supporting and developing Aboriginal and Torres Strait Islander community controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.
- To achieving improved access to, and outcomes from, mainstream services for Aboriginal and Torres Strait Islander peoples.
- To respect and promote the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable and good quality.
- To measure, monitor, and report on our joint efforts, in accordance with benchmarks and targets, to ensure that we are progressively realising our shared ambitions.

WE ARE: SIGNATURES



Representative of the Australian Government


Congress of Aboriginal and Torres Strait Islander Nurses


Indigenous Dentists Association of Australia


National Aboriginal Community Controlled Health Organisation


Australian Indigenous Doctors Association


Aboriginal and Torres Strait Islander Social Justice Commissioner.
Human Rights and Equal Opportunity Commission

The Close the Gap Statement of Intent commitments arranged as a matrix

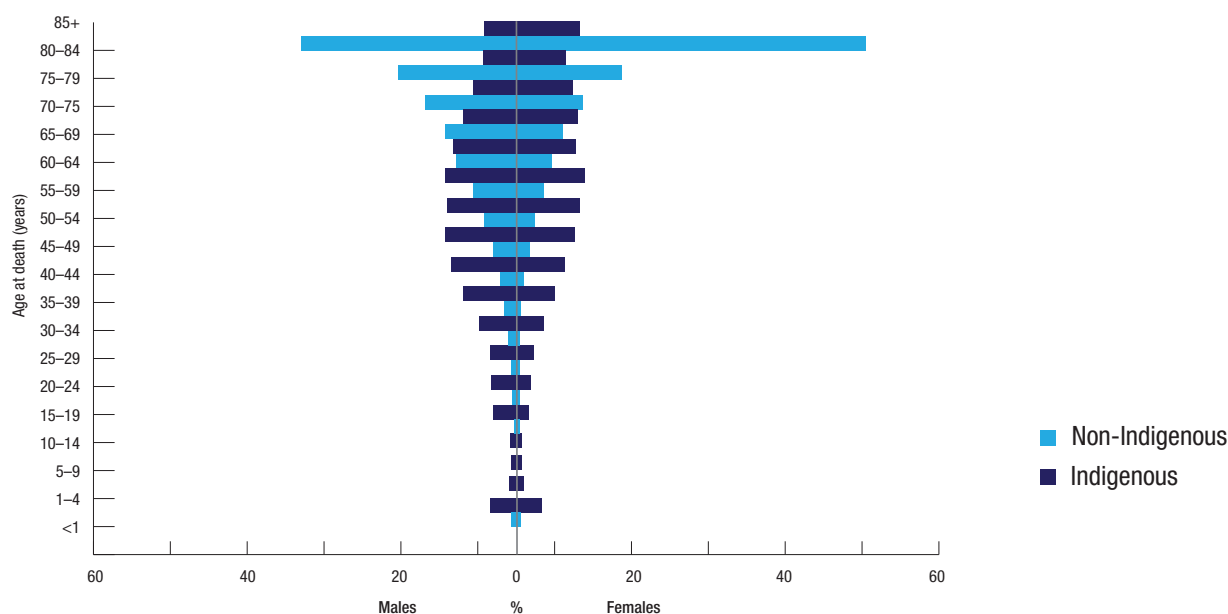
PROCESS COMMITMENTS		
EVIDENCE BASED-PLANNING FOR PROGRESSIVE REALISATION OF RIGHT TO HEALTH SUBJECT MATTERS...	... IN PARTNERSHIP WITH INDIGENOUS PEOPLE	... WITH TARGETS AND ACCOUNTABILITY FOR IMPLEMENTATION
<p>To developing a comprehensive, long-term plan of action, that is targeted to need, evidence-based and capable of addressing the existing inequities in health services, in order to achieve equality of health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non- Indigenous Australians by 2030.</p> <p>To building on the evidence base and supporting what works in Aboriginal and Torres Strait Islander health, and relevant international experience.</p>	<p>To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.</p>	<p>To measure, monitor, and report on our joint efforts, in accordance with benchmarks and targets, to ensure that we are progressively realising our shared ambitions.</p>

SUBJECT MATTER COMMITMENTS		
HEALTH SERVICES	HEALTH INFRASTRUCTURE	SOCIAL DETERMINANTS
<p>To ensuring primary health care services... for Aboriginal and Torres Strait Islander peoples which are capable of bridging the gap in health standards by 2018.</p> <p>To respect and promote the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available, appropriate, accessible, affordable, and of good quality.</p> <p>ABORIGINAL COMMUNITY CONTROLLED HEALTH SERVICES</p> <p>To supporting and developing Aboriginal and Torres Strait Islander community-controlled health services in urban, rural and remote areas in order to achieve lasting improvements in Aboriginal and Torres Strait Islander health and wellbeing.</p> <p>MAINSTREAM HEALTH SERVICES</p> <p>To achieving improved access to, and outcomes from, mainstream services for Aboriginal and Torres Strait Islander peoples.</p>	<p>To ensuring... health infrastructure for Aboriginal and Torres Strait Islander peoples which are capable of bridging the gap in health standards by 2018.</p>	<p>To working collectively to systematically address the social determinants that impact on achieving health equality for Aboriginal and Torres Strait Islander peoples.</p>

The NIRA marked the beginning of a nationally coordinated approach to Indigenous Affairs. It set out respective roles, objectives, outcomes, outputs, performance measures and benchmarks of the governmental parties. It required governments to be accountable for progress and report against specified indicators on an annual basis, disaggregated by Indigenous and non-Indigenous status. And their progress was to be independently assessed by a COAG Reform Council.¹³

The NIRA was ‘fueled’ or implemented by national partnership funding agreements (NPAs) to which almost six billion dollars of new investment was committed. For health, the most significant was the \$1.6 billion over four years *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* 2009-2013. The Federal Government contribution (about half) was under the Indigenous Chronic Disease Package that focused on: tackling chronic disease risk factors; earlier detection, improved management and follow up of chronic diseases in primary health care; and expanding the Aboriginal and Torres Strait Islander health workforce and increasing the capability of the health workforce to deliver effective care.¹⁴ Important to health also was the \$564 million/ six years *National Partnership Agreement on Indigenous Early Childhood Development* (NPAIECD) that included a significant focus on child and maternal health.¹⁵

Distribution of reported Indigenous and non-Indigenous deaths by age and sex, Australia, 2011–2015



Source: Australian Institute of Health and Welfare.

In relation to health infrastructure, the ten-year \$1.9bn *National Partnership Agreement on Remote Indigenous Housing* (NPARIH) was the primary funding vehicle to improve remote Indigenous housing. The NPARIH established the Federal Government as the major funder of remote Indigenous housing, with State and the Northern Territory governments responsible for service delivery against a set of agreed objectives in remote communities. In particular, the NPARIH sought to reduce severe overcrowding by increasing the supply of new houses and improving the condition of existing houses, and ensuring rental houses were well maintained and managed.¹⁶

The NIRA included a *National Integrated Strategy for Closing the Gap in Indigenous Disadvantage* that featured a ‘building block’ approach that recognised that improvements in any building block subject matter would contribute to improvements in the others. The building blocks were: Early Childhood; Schooling; Health; Healthy Homes; Safe Communities; Economic Participation; and Governance and Leadership and these were supported by other NPAs.¹⁷

Finally, a broader COAG Reform Agenda encompassing seven areas of work (of which Indigenous reform was but one) was established over 2007-08 underpinned by a new *Intergovernmental Agreement on Federal Financial Relations* that began on 1 January 2009.¹⁸

The COAG Reform Agenda eventually included, in addition to the NIRA and the NPAs discussed above, an array of frameworks, plans, national partnerships and national partnership agreements. Each of these, to varying degrees, was intended to address Aboriginal and Torres Strait Islander disadvantage.



2 The unravelling of the Closing the Gap Strategy

Government decides not to align approaches with the commitments of the Close the Gap Statement of Intent

As noted, the *Close the Gap Statement of Intent* embodied a 're-setting' of the relationship between Australian governments and Aboriginal and Torres Strait Islander peoples to one based on partnership. Likewise, the NIRA includes *Service Delivery Principles for Indigenous Australians*. This purported that '*engagement with Indigenous men, women and children and communities should be central to the design and delivery of programs and services.*'¹⁹

It was somewhat ironic then that the NIRA and the *Closing the Gap Strategy* was agreed by Australian governments without any significant Aboriginal and Torres Strait Islander engagement, let alone partnership. This was not for lack of choice. Partners could have included the Indigenous health planning forums at the state and territory level that had been operational since the late 1990s, the Close the Gap Campaign Steering Committee (with its significant Aboriginal and Torres Strait Islander health leadership and expertise), or the then recently appointed (and now defunct) National Indigenous Health Equality Council (NIHEC) which was formed in July 2008 to advise the then Federal Government Minister for Health and Ageing.

It soon became clear that a comprehensive national plan to achieve health equality by 2030 was not a COAG priority. In the inaugural 2010 *Close the Gap Shadow Report* (and subsequent reports), the Close the Gap Campaign noted this while critiquing the adequacy of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013* (NSFATSIH) as a health equality plan.²⁰ However, the NSFATSIH remained in place until 30 June 2013. Further, despite the launch of the *National Aboriginal and Torres Strait Islander Health Plan* in 2013, this was actually a Framework, and an implementation plan was not available until 2015. Moreover, the Implementation Plan was the framework of a plan rather than a real implementation plan and lacked the fundamentals, most notably a service gap analysis or concrete action to fill the service gaps, budget or workforce provision. The Implementation Plan is still to address social determinants.

The missed opportunities for equality based planning in the opening years of the *Closing the Gap Strategy* undermined its potential longer-term impact. In particular, and contrary to the *Close the Gap Statement of Intent* commitments, Australian governments seemed reluctant to invest in Aboriginal Community Controlled Health Services (ACCHS). Where investments have been made, via programs such as the Tackling Indigenous Smoking (TIS) program, there is considerable and additional reporting burdens place on local health services. Further, despite TIS labelled as a national program, there are many regions without funded organisations delivering services (for example regional areas including Tiwi Islands, Torres Strait Islands).

The effectively 'plan-less' period from 2008 – 2015 was also marked by the 2009 lapsing of the first *National Strategic Framework on Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* without any replacement until 2017. This was the much-needed strategic response to Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing intended to complement the physical health-focused NSFATSIH (until 2013) and the NATSIHP and its subsequent implementation component.²¹



What planning did take place was narrowly focused on implementing the NIRA through jurisdictional Overarching Bilateral Indigenous Plans and the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes* (NPACTGIHO) including with state and territory level Aboriginal and Torres Strait Islander health planning forums.

But to start with, the main content of NPACTGIHO and other NPA programs was pre-determined and not open to change. Even when concerns were raised, for example by the ACCHS about the 'Indigenous Outreach Worker' component of the NPACTGIHO and its potential impacts on Aboriginal Health Workers, these concerns were ignored.²²

As an Indigenous stakeholder commented in our 2010 Report:

*This is how Government has functioned for years when working on Aboriginal issues, it just so happens now that we are dealing with a substantial amount of money and hence there is greater potential for wastage based on poor ideas.*²³

What this also meant, in effect, was that the subject matter commitments of *Close the Gap Statement of Intent* were not prioritised as might have been expected. In particular, as the Close the Gap Campaign Steering Committee would call for over many years, there was no systematic plan to progressively realise the capacity of the ACCHS according to need, let alone in relation to housing, health infrastructure and social determinants.



Text Box 1: The need for policy continuity identified

Despite significant process concerns with the first round of health and other NPAs, there was cause for optimism and reason to expect policy continuity at least in broad terms, (and, to align the *Closing the Gap Strategy* with the *Close the Gap Statement of Intent* over time):

- A 2013 Federal Department of Health and Ageing evaluation of the NPACTGIHO reported that it was too early to assess health outcomes resulting from it. However, the NPA had been designed based on available evidence of what works. As such, 'we [Australian governments] can expect that, if maintained, [it] will lead to improvements in health outcomes. Given this, it will be important that all governments maintain their commitment to the increased investment in health initiated under the NPA'. The evaluation recommended that: *All governments should continue their current commitments to improving Indigenous health outcomes, including their current commitments under this NPA, acknowledging that real change will not be seen in four years.*²⁴
- Urbis Young evaluated the NPAIECD in 2014. It found that *longer-term outcomes sought by NPAIECD investments were not expected to show change in the period of the evaluation. However, ... while definitive client outcomes data for NPA IECD investments is limited, stakeholders have consistently reported visible gains are being made that are attributable to NPAIECD efforts. It is highly likely that the investments are making a positive difference to the lives of Aboriginal and Torres Strait Islander children, families and communities.* Urbis Young recommended that: *Investment in early childhood development as a key investment in longer-term health, development and well-being' outcomes should retain prominence within ongoing strategies to 'close the gap'.*²⁵
- A mid-term (2012-13) evaluation of the NPARIH reported that targets for capital works and Indigenous employment have been exceeded, and that inroads were being made into reducing severe overcrowding in locations where there has been NPARIH investment. However, that: *coming from a historically low base in most jurisdictions, continuing the momentum of capital works delivery and embedding the comprehensive property and tenancy management reforms, which are critical to underpin long-term sustainability and help address severe overcrowding, are challenging issues... Other challenges are longer term and will be most critical post 2018, the final year of the NPARIH. Across jurisdictions, those involved in NPARIH implementation have noted in the context of this review the need for ongoing collaborative policy effort between governments to determine next steps.*²⁶ Over the years, the NPARIH was recalibrated twice to become the Remote Indigenous Housing Strategy (RIHS). A November 2016 evaluation of the RIHS while noting significant progress also found that continuity was needed. It estimated an additional 5,500 homes are required by 2028 to reduce levels of overcrowding in remote areas to acceptable levels. Half of the additional need is in the Northern Territory alone.²⁷ Further, it warned that *without further investment in this area, improvement will be lost, and the \$5.4 billion investment will have been wasted.*²⁸

In sum, the *Closing the Gap Strategy* had significant merits attempting to address chronic disease, child and maternal health and other areas, and were recognised in the evaluations. These must continue to be supported in a refreshed Strategy. Alongside the lack of continuity, the main criticism this review makes is that the Strategy did not include a complementary set of programs to systematically address (i.e. by progressive realisation) the underlying causes of Aboriginal and Torres Strait Islander health inequality (primary health care and so on).

Addressing the underlying causes (the social determinants) requires a high degree of cross-portfolio purpose and collaboration, as these factors are both mutually supporting and inter-dependent. The lack of progress against targets raises questions about whether there has been sufficient cross-portfolio commitment to Closing the Gap. The imperative of portfolio-based ministerial responsibility, accountability and budget rules may present not only a complex coordination task but serves to work against agendas that require cross-cutting, whole-of-government approaches and commitment.

Yet despite the positive evaluation findings, a background of misinformed criticism began to undermine the credibility of the *Closing the Gap Strategy*, as discussed in Text Box 2.





Text Box 2: A background of misguided criticism

In the NPA evaluations discussed above, it was underscored that significant health outcomes could not be expected within 3 – 4 years of NPA implementation because of the time taken to implement initiatives; for the initiatives to result in changes to health outcomes; and or data to become available to measure these changes. It contained a useful illustration of this time lag, reproduced as Diagram 1 below.

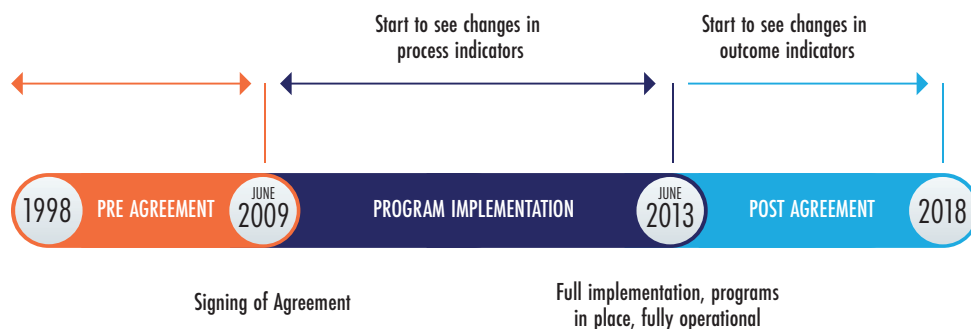


Diagram 1: The time lag between implementation and changes in health outcomes²⁹

Yet despite this, a consistent focus of government and the media critics has been on the lack of measurable short-term high-level health outcomes against the closing the gap health targets. This has been used to characterise the *Closing the Gap Strategy* as failing, as a gross waste of taxpayers' money, and to undermine its credibility. Unfortunately, similar limitations apply to governments' budgetary construct and processes, which focus on the 3 to 4 year forward estimate periods. These timespans incorporate the set-up costs associated with initiatives, but are generally too short to factor in the anticipated 'returns' associated with improved health (either in health directly or due to increased employment related revenue and so on). This presents a structural bias in the Budget against policy and investment designed to deliver long-term improvements.

In response, the Close the Gap Campaign has noted that the *Closing the Gap Strategy*, and indeed the close the gap approach, is not an exercise in 'target practice' for its own sake – but must be understood as an effort to build strong and sustainable foundations (health goods and services, health infrastructure and social determinants) that will result in improved health outcomes and equality, over time. But few have listened. Instead, and with lessening support from Australian governments, the *Closing the Gap Strategy* has effectively come undone, as discussed below.



National partnership agreements are discontinued

The NPA evaluations discussed have all stressed the need for policy continuity while identifying areas whereby the NPAs could be improved. This included improving national level governance through reform to the NIRA.³⁰ But rather than the Federal Government responding to the NPA evaluations by adapting the NPAs, and strengthening its role within the NIRA and *Closing the Gap Strategy* – perhaps demanding greater accountability from the States and Territories – it has effectively abandoned the *Closing the Gap Strategy*.

By late June 2013, with NPAGTGIHO days from expiring, urgent calls were made by the then Federal Government Indigenous Health Minister for a number of State and Territory governments to commit to a renewed NPAGTGIHO. The Minister's call echoed those of the Close the Gap Campaign Steering Committee.

At that point, the Federal Government had committed an additional \$700+ million to a renewed NPAGTGIHO, but the States and Territories were mostly not at the table. And overarching national health reform was being implemented (at that point the Medicare Locals were barely two years old). This situation would persist until the August 2013 when a federal election was called and the government changed the following month. At that point, then National Aboriginal Community Controlled Health Organisation (NACCHO) Chair, Justin Mohammed said:

*We're only at the beginning of the journey to close the gap in life expectancy by 2030. We can't turn back now because closing the gap needs long-term commitment and policy continuity. Aboriginal and Torres Strait Islander health in our hands is having an impact and we must keep supporting our people to deliver their own health outcomes.*³¹

Yet continuity did not occur. In December 2013, COAG formally decided not to renew the NPACTGIHO.³² And in June 2014 the NPAIECD was allowed to lapse without being replaced.³³ These were intended to be replaced by bilateral Federal-jurisdictional agreements, effectively ending a national approach, but even these were not completed.

Another change to the management of primary health care was the decision to replace Medicare Locals in July 2015 with geographically much larger Primary Health Networks, responsible for commissioning wide-ranging primary health care service delivery from service providers. As noted in the 2017 Close the Gap Campaign Report, the Government did not make any provision for ACCHS to be represented on PHN Boards, their Clinical Councils or their Community Advisory Committees. NACCHO noted:

*...a serious concern... was the automatic transfer of scores of millions of dollars in Aboriginal and Torres Strait Islander "health programme grant funds" from Medicare Locals to Primary Health Networks for PHNs to distribute without any public guidelines to protect probity, ensure fairness, and encourage value for money or consultation with the ACCHS Sector.*³⁴

Further, within a year, important elements of the Closing the Gap Strategy including NIHEC (then NATSIHEC), the position of Minister for Indigenous Health (although revived in 2016), the COAG Reform Council and the Closing the Gap Clearinghouse would be discontinued.

The effective abandonment of Federal Government leadership and its funding role placed a significantly greater onus of responsibility for Indigenous health on the States and Territories at a time when many of them had been, or were at the time, cutting health spending: notably, in Queensland,³⁵ New South Wales³⁶ and South Australia.³⁷ Meanwhile, the Federal Government's 2014-15 budget included cuts to the successful Tackling Indigenous Smoking program and to Aboriginal and Torres Strait Islander primary health care. Compounding the situation, cuts to mainstream health and other social services led to further pressure on remaining (targeted and mainstream) services.

Yet the annual Prime Minister's Closing the Gap reports to Parliament would continue as if nothing had changed, with accompanying dismay at the lack of progress along with the misinformed criticisms discussed in Text Box 1 above. By 2014-15, the *Closing the Gap Strategy* as a coherent, national response to Indigenous disadvantage was effectively over. This salient point passed most critics by.

Partnership and planning occurs too late

In November 2011, work to replace the NSFATSIH by its expiration in July 2013 began. From the start, the development of the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (NATSIHP) was framed as an implementation of the *Close the Gap Statement of Intent* to planning in partnership with Aboriginal and Torres Strait Islander peoples, including the agreement of accountability mechanisms.³⁸

Unlike the development of the *Closing the Gap Strategy* itself, the NATSIHP was developed by a Stakeholder Advisory Group (SAG) to the Federal Government Minister for Indigenous Health and the Department of Health and Ageing that embodied a planning partnership between the Federal Government and Aboriginal and Torres Strait Islander health leaders and that was complemented by a community consultation process. The SAG also worked with NATSIHEC and the National Health Leadership Forum (NHLF) in their own right as consultative fora.

The NATSIHP, however, while stressing its role within the national effort to achieve the closing the gap targets made no claim to be a national plan ('national' in the title referring to the fact that it applied to the Federal Government). And while nominally a plan, the NATSIHP was in fact a framework requiring the development of three-yearly implementation plans to be the true drivers of change.

From mid-2014 through to October 2015, the NHLF and the Federal Government led by the Rural Health Minister again worked in partnership to develop the first *National Aboriginal and Torres Strait Islander Health Plan Implementation Plan 2013-2023* (Implementation Plan).

The Implementation Plan contains 106 deliverables across seven domains. From the perspective of the right to health and the *Closing the Gap Statement of Intent*, it is of significance that Strategy 1A requires of the Federal Government a systematic process to meeting primary health care needs through the expansion of ACCHS as well as in Strategy 1B that focuses on making mainstream services more accessible.³⁹

The Implementation Plan also contains a commitment from the Federal Government to formalise partnership arrangements and provide a forum for governments to work in partnership with Aboriginal and Torres Strait Islander health leaders to review, assess and guide action under the Implementation Plan. This occurred with the establishment of an Implementation Plan Advisory Group (IPAG) in September 2016. And useful work has been undertaken by the IPAG particularly in relation to the development of the second Implementation Plan due in late 2018 but what was needed was funding and actual implementation of the first NATSIHP that already existed rather than losing more time on developing a second plan. Further, in late 2016 the Federal Government established a cross-portfolio working group to work intensively for six months to drive the development of a Whole-Of-Government plan to address the social and cultural determinants of health. IPAG community and sector consultations informed this work.





Further planning would, eventually, take place within the mental health space following the lapsing of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004–2009*. Given the major contribution of mental health issues to Aboriginal and Torres Strait Islander health inequality,⁴⁰ this was a particularly important development. Both the NATSIHP and the subsequent Implementation Plan acknowledge the need for complementary mental health strategic documents to the NATSIHP.⁴¹ *The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (NSF) was launched in October 2017.⁴² This followed a three-year development process overseen by the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG), and that included community consultation processes. ATSIMHSPAG is a ministerial appointed body of majority Aboriginal and Torres Strait Islander mental health experts.

The legacy of six years (from 2011–2017) of working effectively in partnership to develop robust, strengths based, culturally focused physical and mental health equality frameworks (and an implementation plan in the case of the NATSIHP) is a major outcome from the *Closing the Gap Strategy*. It has also been the major vehicle for *Close the Gap Statement of Intent* implementation. But it has been a patchy and frustrating process also.

Critically, the NATSIHP and NSF were intended to be critical parts of the *Closing the Gap Strategy* even as the *Closing the Gap Strategy* itself was being undermined, and in a rapidly changing mainstream health policy environment. In particular, the NATSIHP was clearly developed under the expectation that the NPACTGIHO would be renewed and provide the 'fuel' needed for the Implementation Plan. But by the time the Implementation Plan was released in 2015, the entire *Closing the Gap Strategy* had effectively unraveled and there was no clear resourcing strategy to power implementation. Further, the renewed NSF is a framework and requires an implementation plan and resources to be operationalised.

The programmatic elements of the Closing the Gap Strategy are dispersed

The discontinuation of the *Closing the Gap Strategy*'s effective demise involved the dispersal of some of the elements of the Strategy. The Federal Government's Indigenous Australian's Health Programme (IAHP) began on 1 July 2014 and was delivered through the Indigenous Health Division of the Department of Health. This became the repository of the NPACTGIHO Indigenous Chronic Disease Package (renamed the Aboriginal and Torres Strait Islander Chronic Disease Fund). It includes the Stronger Futures in the Northern Territory health program.

Base funding for Indigenous specific and culturally appropriate primary health care services – primarily delivered through ACCHSs and other suitably qualified providers – and including the *Healthy for Life* program – was folded into the IAHP. In 2015, a capital works funding stream was also added.

Apart from the IAHP, the Federal Government continues to provide general practitioner health checks for Aboriginal and Torres Strait Islander people under the Medicare Benefits Schedule (MBS), along with follow-on care and incentive payments for improved chronic disease management, and cheaper medicines through the Pharmaceutical Benefits Schedule.

IAHP promotional material suggests that it is intended to 'align' with the NATSIHP Implementation Plan⁴³ but it is not doing so in any systematic way. Alongside this, the States and Territories have developed their own strategic responses to Indigenous health. These too are usually stated to support the aims of the *Closing the Gap Strategy*.⁴⁴

In relation to social determinants at the national level, the Indigenous Affairs priorities of the Federal Government were recalibrated in 2014 as 'getting children to school; getting adults to work; and building safer Indigenous communities'. The Indigenous Advancement Strategy (IAS) became the vehicle for delivering these objectives. The IAS consolidated more than 150 individual programmes and activities, many previously components of the NPAs, into five broad-based program streams coordinated from the Department of the Prime Minister and Cabinet. Funding through the IAS was based on a competitive tendering process, moving more towards a supply (rather than demand) driven approach to investment decisions.

The IAS was, however, connected to the NATSIHP Implementation Plan as the vehicle to address social determinants of health for Aboriginal and Torres Strait Islander people.

Like the *Closing the Gap Strategy*, the IAS was developed with minimal input from Aboriginal and Torres Strait Islander people, apart from the Prime Minister's appointed Indigenous Advisory Council. Yet the changes were huge, affecting about 1,440 organisations and 3,000 funding contracts, causing disruption to community-based organisations, including many with the emerging capability and local credibility to address deep issues and on a sustainable basis. Unsurprisingly, implementation was unwieldy and subject to significant controversy.⁴⁵

The *Closing the Gap Strategy* and the IAS are only tenuously connected by the maintenance and use of the closing the gap targets in IAS programs, and the continuity of some elements of the NPAs (often re-branded) through the IAS.





The Close the Gap Strategy remains in name only

In practice, the *Closing the Gap Strategy* persists in name only with the closing the gap targets being used to measure 'national progress' being pursued by fragmented jurisdictional efforts, with no national leadership. It is almost a full retreat. A return to a past when policy documents like the *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013* could state:

Provision of financial resources to implement the Strategic Framework will depend on fiscal management strategies and competing funding priorities as determined by each jurisdiction's budget processes.⁴⁶

Yet the national issue of Aboriginal and Torres Strait Islander health inequality has not gone away and requires a national response. Without the 'architecture' needed for such an approach (national agreement, national leadership and national funding agreements), the nation is now in a situation where the closing the gap targets will measure nothing but the collective failure of Australian governments to work together and to stay the course.

Reflecting on the past ten years, it's timely to recall one of the main findings of the *Remote Indigenous Housing Strategy* evaluation. This reported that efforts were complicated:

by multiple objectives, poor governance and constantly changing policy settings. Both Commonwealth and jurisdiction officials consulted by the [evaluation team] noted the distractions caused by constant renegotiations to the agreement which... hampered efforts to focus on best practice.⁴⁷

But such an observation could just as easily have been made about the *Closing the Gap Strategy* overall.

In the Introduction, the *Close the Gap Statement of Intent* was presented as a matrix with the commitments arranged under three process and three subject matter areas. We close this Chapter by summarising progress against implementation in a report card format.

Close the Gap Statement of Intent Implementation Report Card

PROCESS COMMITMENTS		
EVIDENCE BASED-PLANNING FOR PROGRESSIVE REALISATION OF RIGHT TO HEALTH SUBJECT MATTERS...	... IN PARTNERSHIP WITH INDIGENOUS PEOPLE	... WITH TARGETS AND ACCOUNTABILITY FOR IMPLEMENTATION
<ul style="list-style-type: none"> Up until the 2015 NATSIHP Implementation Plan, there was, in effect, no plan in the Indigenous health space (NATSIHP was only a Framework that needed a substantial implementation plan). The Implementation Plan is a robust plan but no resources attach to it. Piecemeal implementation is occurring incidentally through the IAHP. The Mental Health and SEWB Framework is robust but needs an implementation plan and resources strategy. Health infrastructure planning is still required. 	<ul style="list-style-type: none"> Closing the Gap Strategy was not developed on a basis of partnership. The establishment of the SAG and then IPAG in 2016 formalised a health planning partnership between the Federal Government and Aboriginal and Torres Strait Islander peoples at the national level. The Aboriginal and Torres Strait Islander Health Forums provide a mechanism for jurisdictional planning fora and have a generally good track record. The capacity of PHNs to plan in partnership with Indigenous communities and ACCHSs is not clear. 	<ul style="list-style-type: none"> The COAG closing the gap targets have been useful for focusing government attention and, to a degree, effort. The NATSIHP Implementation Plan contains 20 health goals or targets. There has been little attention paid to input and equality of opportunity targets including expenditure targets.

SUBJECT MATTER COMMITMENTS		
HEALTH SERVICES	HEALTH INFRASTRUCTURE	SOCIAL DETERMINANTS
<ul style="list-style-type: none"> There has been far too little progress in the fundamental task of identifying and filling service gaps More funding and workforce required to make a significant difference to PHC. While ACCHS have seen some additional funding through the <i>Closing the Gap Strategy</i>, there have been missed opportunities to support their expansion as significant funds have gone to mainstream services without good reason. Significant barriers in mainstream services remain for Indigenous people, including long-term structural and institutional racism. Strategies 1A and 1B of the NATSIHP Implementation Plan provide a systematic approach to achieving equality of opportunity in relation to ACCHSs and mainstream health services but require implementation 	<ul style="list-style-type: none"> Significant resources have been invested and improvements have been reported. However, continuity in, and more, funding and stability in policy is needed if these improvements are to be sustainable, and able to support and be leveraged to promote important cross-sector and other partnerships and service capacity. A dedicated health infrastructure plan is urgently needed if preventable admissions and deaths are to be drastically reduced. 	<ul style="list-style-type: none"> While significant attention has been paid to employment and education a greater breadth of determinants including racism and their connection to health should be better integrated in to the NATSIHP Implementation Plan. More focus than the IAS is needed and this may eventuate through the second Implementation Plan development process. The recognition of the contribution cultural determinants and culture can make to health has been recognised but implementation policy and resources towards these components remains a challenge.



3

Resetting the Closing the Gap Strategy

First, the *Closing the Gap Strategy* must be reset by building the requisite ‘architecture’ needed for such a national approach (national agreement, national leadership, funding agreements). National issues like Aboriginal and Torres Strait Islander health inequality have not gone away and require a national response. Without a recommitment to such architecture, the nation is now in a situation where the closing the gap targets will measure nothing but the collective failure of Australian governments to work together and to stay the course.


Critically, the reset *Closing the Gap Strategy* must be co-designed with Aboriginal and Torres Strait Islander people, and involve a tripartite partnership between Aboriginal and Torres Strait Islander health leaders, the Federal, and State and Territory governments. It must not involve government replicating mistakes of the past 10 years where policy was designed in isolation by government departments in Canberra.

Recommendation 1: the ‘refreshed’ Closing the Gap Strategy is co-designed with Aboriginal and Torres Strait Islander health leaders and includes community consultations. This requires a tripartite negotiation process with Aboriginal and Torres Strait Islander health leaders, and the Federal and State and Territory governments. Time must be allowed for this process. Further, Australian governments must be accountable to Aboriginal and Torres Strait Islander people for its effective implementation.

Recommendation 2: to underpin the Closing the Gap Strategy refresh, Australian governments reinvigorate the ‘architecture’ required for a national approach to addressing Aboriginal and Torres Strait Islander health equality. This architecture includes: a national agreement, Federal leadership, and national funding agreements that require the development of jurisdictional implementation plans and clear accountability for implementation. This includes by reporting against national and state/territory targets.

The elements of the *Closing the Gap Strategy* that have been evaluated as successful (see previous Chapter) should be maintained and expanded. Further evaluation activity should have appropriate timeframes, include a strong focus on impact, and includes assessment of how multiple and various initiatives serve to improve overall wellbeing (rather than take only a narrow program-centric approach).





Recommendation 3: the Closing the Gap Strategy elements such as maternal and infant health programs and the focus on chronic disease (including the Tackling Indigenous Smoking program) are maintained and expanded in a refreshed Closing the Gap Strategy.

By the *Close the Gap Statement of Intent*, the main focus of efforts towards health equality should be on inputs relating to the underlying causes of Aboriginal and Torres Strait Islander health inequality. In fact, from the start the Close the Gap Campaign has called for greater attention to inputs and even the development of closing the gap input targets in relation to these areas.

As discussed, the two major inputs to achieve sustainable improvements to the health of any population are health goods and services (and particularly primary health care) and health infrastructure (including housing). Significant attention to social determinants must also be given.

A broad but telling measure of such inputs is expenditure. In this part of the review the focus is on health services, not health infrastructure spending. And as noted in the *Aboriginal and Torres Strait Islander Health Performance Framework*:

A basic principle of equity is that health expenditure should reflect the relative needs for health services. Health expenditure for population groups with higher levels of need should be proportionately higher. A broad assessment of how well this principle is implemented is provided by comparing differentials in health status with differences in per capita health expenditure.⁴⁸

In other words, equality of opportunity must be related to need noting that Aboriginal and Torres Strait Islander people have between two and three times the health needs of non-Indigenous people. Higher spending on Aboriginal and Torres Strait Islander health should hardly be a surprise. Spending on the elderly, for example, is higher than on the young because everyone understands the elderly have greater health needs.

Yet while data shows increased expenditure associated with the *Closing the Gap Strategy* it does not show anything close to a two or three times magnitude per capita increase needed to meet the burden of inequality. Detailed expenditure data is available for 2013-14. On a per person basis, average health expenditure was \$1.38 per Aboriginal and Torres Strait Islander person for every \$1.00 spent per non-Indigenous person.⁴⁹ From 2010-11 to 2014-15, Australian governments' health expenditure per Aboriginal and Torres Strait Islander person grew by 23 per cent.⁵⁰ So, for the duration of the *Closing the Gap Strategy* Australian government expenditure was not commensurate with Aboriginal and Torres Strait Islander peoples' substantially greater and more complex health needs.

Further, the recently released Productivity Commission's 2017 Indigenous Expenditure Report provided a series of raw figures relating to the Federal, State and Territory government expenditure over the previous year. As a breakdown of estimated overall expenditure on Aboriginal and Torres Strait Islander peoples (i.e. 100 per cent), 18 per cent is dedicated spending (i.e. intended specifically for Aboriginal and Torres Strait Islander peoples) and 82 per cent is mainstream expenditure. The Report noted that direct expenditure has actually dropped from 22.5 per cent since 2008, the year the *Close the Gap Statement of Intent* was signed.⁵¹ The Report also found that expenditure on Aboriginal and Torres Strait Islander people is heavily skewed towards reacting to disadvantage rather than addressing the fundamental causes of disadvantage.

And there is still tremendous waste evident in the health system overall whilst an ongoing and relative lack of spending on Indigenous primary health care. In 2013-14, primary health care expenditure on medical services, including those paid through the MBS, was \$271 per Aboriginal and Torres Strait Islander person compared with \$302 per non-Indigenous person. A difference of about 11 per cent.⁵² Per person expenditure on pharmaceuticals in the primary care sector was also much lower for Aboriginal and Torres Strait Islander peoples (\$471 versus \$741).

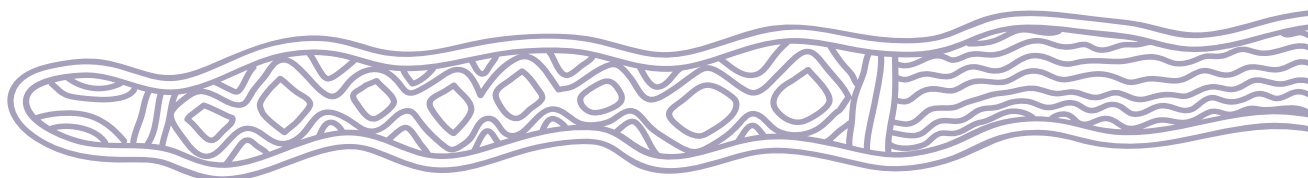
In contrast, for Aboriginal and Torres Strait Islander people, expenditure on hospitals was six times expenditure for medical services (e.g. MBS services provided by a medical practitioner) compared with 2 times for non-Indigenous people.⁵³ These figures point to the fundamental issue that lack of access to primary health care is contributing to serious health conditions and more costly (but often avoidable) interventions.

Because non-Indigenous Australians rely significantly on private health insurance and private health providers to meet much of their health needs, in addition to government support, the overall situation for Aboriginal and Torres Strait Islander health can be characterised as ‘system’ or ‘market failure’. Private sources will not make up the shortfall. Australian government intervention – increased expenditure directed as indicated in the recommendations – is required to address this.

While funding levels for Indigenous health care is expected to grow over the next four years, it will not be of the magnitude to support equality of opportunity in relation to the underlying matters that will make a long term, sustainable and positive difference to Aboriginal and Torres Strait Islander health – primary health care and health infrastructure.⁵⁴ And significant opportunities to increase expenditure will remain locked in the hospital system when it could instead support expanded ACCHS or other services.

Recommendation 4: the current Closing the Gap Strategy health targets are maintained, but complemented by targets or reporting on the inputs to those health targets. These input targets or measures should be agreed by Aboriginal and Torres Strait Islander health leaders and Australian governments as a part of the Closing the Gap Strategy refresh process and include:

- Expenditure, including aggregate amounts and in relation to specific underlying factors as below;
- Primary health care services, with preference given to Aboriginal Community Controlled Health Services, and a guarantee across all health services of culturally safe care;
- The identified elements that address institutional racism in the health system;
- Health workforce, particularly the numbers of Aboriginal and Torres Strait Islander people trained and employed at all levels, including senior levels, of the health workforce; and
- Health enabling infrastructure, particularly housing.





Recommendation 5: the National Aboriginal and Torres Strait Islander Health Plan Implementation Plan is costed and fully funded by the Federal government, and future iterations are more directly linked to the commitments of the Close the Gap Statement of Intent; and, an implementation plan for the complementary National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 is developed, costed and implemented by the end of 2018 in partnership with Aboriginal and Torres Strait Islander health leaders and communities. This will include:

- (a) A five-year national plan to identify and fill health service gaps funded from the 2018-2019 Federal budget onwards and with a service provider preference for Aboriginal Community Controlled Health Services (ACCHSs). This includes provision for the greater development of ACCHS's satellite and outreach services.
- (b) Aboriginal and Torres Strait Islander health leadership, Federal, State and Territory agreements clarifying roles, responsibilities and funding commitments at the jurisdictional level.
- (c) Aboriginal and Torres Strait Islander health leadership, Primary Health Network and Federal agreements clarifying roles, responsibilities and funding commitments at the regional level.

Of particular concern, the NATSIHP Implementation Plan remains largely unimplemented. As noted by the Federal Government in 2017 about the former:

There are 106 deliverables included in the current Implementation Plan, reflecting progress that is expected to be achieved by 2018 as well as planned for 2023. Against the 2018 Implementation Plan deliverables, key achievements to date have included the release of the AHMAC endorsed Australian National Diabetes Strategy and the AHMAC Cultural Respect Framework, improved access to antenatal and post-natal care through the expansion of the Better Start to Life initiative and the roll out of regional grants under the Tackling Indigenous Smoking program.⁵⁵

While the above achievements are welcome, they do not tackle the fundamental requirement to identify and fill the service gaps. What is required is a costing of implementation followed by allocations and operationalisation itself. This is particularly so in relation to Strategies 1A and 1B which would amount to a systematic approach to expanding ACCHS according to need, and otherwise ensuring mainstream health services were accessible, in accordance with the commitments in the *Close the Gap Statement of Intent*.

Similarly, the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* requires an implementation component, costing and operationalisation.

Recommendation 6: That the implementation and ongoing delivery of the National Aboriginal and Torres Strait Islander Health Plan Implementation Plan is costed and fully funded, and future iterations are more directly linked to the commitments of the Close the Gap Statement of Intent; and, an implementation plan for the complementary National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 is developed, costed and implemented by the end of 2018.

Finally, we are yet to see any sort of national progressive realisation planning around health infrastructure. This is despite the Remote Indigenous Housing Strategy evaluation recommending the development of a comprehensive 'health infrastructure' plan that would:

*link and develop plans for infrastructure and housing together, under town and community planning principles. Plans should include housing-related infrastructure in parallel with housing delivery, and coordinate municipal and essential services requirements and infrastructure needs including the need for new land development or upgrades of essential services. Plans should be completed to the same quality standard as applies for urban environments. Such planning would also coordinate effort between governments and avoid duplication and waste.*⁵⁶

Recommendation 7: an overarching health infrastructure and housing plan to secure Aboriginal and Torres Strait Islander Peoples equality in these areas, to support the attainment of life expectancy and health equality by 2030, is developed, costed and implemented by the end of 2018.





4

Conclusion

The agreement to focus on the appalling health inequality of Aboriginal and Torres Strait Islander people through a nationally coordinated, funded, and Federal Government-led approach was a watershed change to the way government had done business prior to 2008. The *Close the Gap Statement of Intent* was a response to calls by Aboriginal and Torres Strait Islander people and supporters that a country as wealthy as Australia was readily capable of solving the enormous health equality gap between First Peoples, who represent just under 3 per cent of the population, and other Australians. The Statement was predicated on government working with Aboriginal and Torres Strait Islander peoples, based on realisation of their right to health and appropriate services to support better health outcomes.

We as a nation have for several years now been at risk of failing to address the national priority we have set for ourselves of addressing this most fundamental of rights. While the approach has all but fallen apart, with the right settings and right approach to co-designing a new and reset Strategy. With Aboriginal and Torres Strait Islander people inherently embedded in leading, designing and implementing these efforts, we can start to meet the challenge of health inequality, and live up to the ideals that all Australians have a fundamental right to health.



Endnotes

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