Joint Report on the Review
of the
National Partnership Agreement on
Closing the Gap in Indigenous Health Outcomes

March 2013

Report prepared by the Department of Health and Ageing
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## Abbreviations

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<th>Descriptions</th>
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<tbody>
<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
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<tr>
<td>AHMAC</td>
<td>Australian Health Ministers’ Advisory Council</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>ATSIHPF</td>
<td>Aboriginal and Torres Strait Islander Health Performance Framework</td>
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<tr>
<td>CO</td>
<td>Central Office (Department of Health and Ageing)</td>
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<td>COAG</td>
<td>Council of Australian Governments</td>
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<td>DoHA</td>
<td>Department of Health and Ageing (Australian Government)</td>
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<td>ICDP</td>
<td>Indigenous Chronic Disease Package</td>
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<td>IHPFs</td>
<td>Indigenous Health Partnership Forums</td>
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<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<td>NHA</td>
<td>National Healthcare Agreement</td>
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<td>NIRA</td>
<td>National Indigenous Reform Agreement</td>
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<td>NPA</td>
<td>National Partnership Agreement</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>NT</td>
<td>Northern Territory</td>
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<td>OATSIH</td>
<td>Office for Aboriginal and Torres Strait Islander Health</td>
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<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<tr>
<td>PIP</td>
<td>Practice Incentives Program</td>
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<td>Qld</td>
<td>Queensland</td>
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<td>SA</td>
<td>South Australia</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmissible Infections</td>
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<tr>
<td>STOs</td>
<td>State and Territory Offices (Department of Health and Ageing)</td>
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<td>Tas</td>
<td>Tasmania</td>
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<td>Vic</td>
<td>Victoria</td>
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<td>WA</td>
<td>Western Australia</td>
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Executive Summary

Background

The purpose of this report is to provide a review of the effectiveness, efficiency and appropriateness of the first three years of the National Partnership Agreement (NPA) on Closing the Gap in Indigenous Health Outcomes (2009-10 to 2011-12).

The total investment by all Australian governments under the NPA is $1.58 billion. Of this, $805.5 million is funded through the Australian Government, and $771.5 million from state and territory governments.¹ The NPA complements and adds to existing Indigenous health funding from all governments.

The review has been undertaken collaboratively by the Commonwealth, states and territories through the Community Care and Population Health Principal Committee (CCPHPC) of the Australian Health Ministers’ Advisory Council (AHMAC).

Assessing the impact of implementation of the NPA on health outcomes was, and will continue to be, difficult for a number of reasons:

- The time taken to implement initiatives, for the initiatives to result in changes to health outcomes, and for data to become available to measure these changes
- The need for long-term sustainable improvements across all aspects of people's lives
- The difficulty of isolating and assessing the contribution of this NPA on a set of broad, population-level performance indicators².

Effectiveness of the National Partnership Agreement

2.1 Outcomes

Based on the evidence collected, it is too early to make an assessment of the extent to which the NPA has achieved its intended outcomes in terms of improvements to Indigenous health outcomes. This relates both to the time it takes to achieve improvements in health outcomes and to lag times in data collection and reporting.

However, activities under the NPA have been designed based on available evidence of what works and we can expect that, if maintained, they 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.

¹ National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, November 2008, page 13
² Australian Institute of Health and Welfare (AIHW), Supporting Analysis for the Review of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, December 2012, pages 43-44
2.2 Outputs

Under the NPA, all Australian governments have implemented, or are currently implementing, an extensive range of activities to improve Indigenous health outcomes and contribute to closing the gap in life expectancy. Commonwealth, state and territory government implementation plans and annual progress reports document a total of 325 activities undertaken as part of the NPA.

The NPA has resulted in a large increase in funding for, and focus on, provision of health services to Indigenous Australians. Analysis conducted by the Australian Institute of Health and Welfare (AIHW) to support this review notes that governments have implemented a number of actions/initiatives relating to the performance benchmarks and there are also some early indicators of improved access to health care.

2.3 Performance monitoring and reporting

The review found that the performance monitoring and reporting arrangements of the NPA are overly complex, and that there is no clear line of sight between indicators, benchmarks, outputs and outcomes. The requirement for annual progress reporting is appropriate, but would have been more effective had there been agreement on a standard format and minimum content requirements. Reporting should also be consistent with existing reporting frameworks such as the Health Performance Framework and the data governance arrangements detailed in the National Health Information Agreement and the NIRA.

While there is scope for substantial improvement in the performance monitoring and reporting arrangements, they have allowed for an assessment of progress under the NPA, and all governments have made good progress against the performance benchmarks. Reporting has been mostly qualitative in nature and describes the significant number of new initiatives being undertaken under the NPA.

2.4 Governance Arrangements

The NPA did not include a strong focus on national level governance. The Standing Council on Health through AHMAC is responsible for the NPA and all governments submitted annual reports through the AHMAC process for endorsement by health ministers and forwarding to COAG. However this structure did not deliver a shared ownership and commitment to active management of the NPA as a whole among officials with responsibility for implementing the NPA.

Efficiency of the National Partnership Agreement

3.1 Progress against Performance Benchmarks

There has been good progress in the implementation of initiatives and activities by all governments, particularly in the second and third years of the NPA. Each government prepared an implementation plan and delivered annual reports that addressed their implementation plan. Most performance benchmarks were reported on most of the time, and the annual reports reflect the

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3 Tasmania did not provide a report in 2009-10 as its Implementation Plan had only just been completed
significant amount of work undertaken by governments to implement activities designed to improve Indigenous health outcomes.
3.2 Roles and Responsibilities

Information provided through the annual progress reports and input to the review suggests that all governments have fulfilled their roles and responsibilities under the NPA. Financial information provided as part of this review showed that not all financial commitments were met by some governments (noting that two did not provide financial information) as there were some underspends, particularly for the priority area Primary health care that can deliver. These were largely related to delays due to workforce recruitment and service capacity issues.

Appropriateness of the National Partnership Agreement

The NPA is a major plank within the National Indigenous Reform Agreement (NIRA) dedicated to achieving the first of the closing the gap targets - to close the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation. In this context, the review notes the need for continuing and sustainable improvements to the health system to support efforts to closing the gap in health outcomes.

The funding mechanism under the NPA reflects the focus on all governments making improvements in those parts of the health system for which they have responsibility and has supported the development of targeted initiatives in each jurisdiction. However, time-limited commitments by some governments do not match with the long-term, generational nature of the objectives and outcomes being sought through the NPA.

Given the relative newness of many of the activities under the NPA, the lack of certainty about ongoing funding in some jurisdictions, and the potential to drive improvements through improved coordination, there would be benefit in seeking further intergovernmental arrangements to close the gap in Indigenous health outcomes. This will enable a continued focus on these activities to ensure they embedded into the health system and drive long term population level improvements in health outcomes.

Recommendations

Recommendation 1

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. Any changes to the current activities should be based on evidence of what works in improving Indigenous health outcomes.

Recommendation 2

Performance indicators and benchmarks for any future arrangements should be informed by the AIHW analysis to ensure accurate National reporting.

Recommendation 3

Any future arrangements should include a standardised reporting template to improve the consistency and completeness of reporting against existing performance indicators and benchmarks outlined in the HHPF and NIRA and improve comparability of data across governments.
Recommendation 4
Any future arrangements to close the gap Indigenous health outcomes should include provision for a senior level officials group to guide and coordinate planning and implementation of activities, share information, identify gaps and strategies to address them, develop linkages and shared approaches, and ensure implementation arrangements are complementary. Terms of Reference for this group will be clearly defined and agreed.

Recommendation 5
That governments consider further intergovernmental arrangements to close the gap in Indigenous health outcomes to allow time to embed the current activities into the health system.

Recommendation 6
All governments should review the range of initiatives being implemented to ensure any gaps in service delivery are identified and addressed both within and across governments.

Recommendation 7
All governments should continue to ensure that initiatives are regularly evaluated, key learnings are shared and disseminated and that this information informs the design or modification of implementation arrangements.
1. Background

1.1 Policy context

Closing the Gap is a commitment by all Australian governments to improve the lives of Indigenous Australians, and in particular provide a better future for Indigenous children, by addressing the key issues associated with the life expectancy gap between Indigenous and non-Indigenous Australians.

In October 2008 the Council of Australian Governments (COAG) set six targets to close the gap between Indigenous and non-Indigenous Australians. These are:

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

COAG, through the National Indigenous Reform Agreement (NIRA) committed $4.6 billion over 10 years to drive fundamental reforms in remote housing, health, early childhood development, jobs and improvements in remote service delivery. The NIRA forms the overarching agreement for a range of initiatives and performance measures to Close the Gap.

Closing the Gap requires long term concerted action on a number of fronts, both in health and in those areas that address the social determinants of health. The NIRA commits all governments to this long term goal and recognises the need to review and update the agreement on a regular basis. COAG last updated the NIRA in September 2012.

The COAG Reform Council reports to COAG on the performance of the Commonwealth and the states and territories in achieving the outcomes and performance benchmarks specified in National Agreements.

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4 COAG, Communique: COAG Meeting 2 October 2008
5 COAG, National Indigenous Reform Agreement (Closing the Gap), 2008
6 COAG, National Indigenous Reform Agreement (Closing the Gap), September 2012
7 http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf
1.2 National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (the NPA) was agreed in November 2008 and has five objectives:

(a) Preventive health: to reduce the factors that contribute to chronic disease through: effective anti-smoking campaigns; and integrated alcohol, drug and mental health services.
(b) Primary health care: to significantly expand access to and coordination of comprehensive, culturally secure primary health care, allied health services and related services.
(c) Hospital and hospital-related care: to deliver better clinical outcomes through quality, culturally secure hospital and hospital-related services that include rehabilitation, allied health care and transition care case management.
(d) Patient experiences: to ensure access by Aboriginal and Torres Strait Islander people to comprehensive and co-ordinated health care, provided by a culturally competent health workforce within a broader health system that is accountable for Indigenous health needs, in genuine partnership with the people and communities they target; and to build service reach and influence to re-engage the most vulnerable Indigenous people into mainstream and targeted health services.
(e) Sustainability: to increase the number of Aboriginal and Torres Strait Islander people in the health workforce, reform and improve the supply of the health workforce generally including the adoption of complementary workplace reforms, create sustainable program and funding models, measure performance and ensure that services are responsive both to national targets and local community needs.

The NPA contributes to achieving the first of the Closing the Gap targets – to close the life expectancy gap between Indigenous and non-Indigenous Australians within a generation. The term of the Agreement is from 1 July 2009 to 30 June 2013.

The NPA focuses on five key initiatives or priority areas to achieve the objectives. Each initiative is linked to expected outputs, outcomes and performance benchmarks. Appendix 1 provides an overview of these objectives, mapped against the initiatives, outputs, outcomes and performance benchmarks as articulated in the NPA.

Governments committed a total of $1.58 billion to the NPA over the four years of its operation. Of this, $805.5 million was committed by the Australian Government, and $771.5 million by state and territory Governments. All funding for the NPA was Commonwealth Own Purpose Expenditure (COPE) and State Own Purpose Expenditure (SOPE). The NPA complements and builds on existing funding for Indigenous health in each jurisdiction.

As part of achieving the objectives, the NPA lists the following priorities:

- Tackling smoking, the single biggest killer of Indigenous Australians
- Healthy transition to adulthood

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9 National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, November 2008, pages 6-7
• Making Indigenous health everyone’s business
• Primary health care services that can deliver
• Fixing the gaps and improving the patient journey.10

The NPA also identifies a range of expected outcomes, outputs, performance benchmarks and indicators to measure progress towards closing the gap. Unfortunately, these do not align neatly to each other, making the task of assessing progress difficult.

The NPA required implementation plans to be developed and to reflect an integrated approach between governments and be informed by engagement with Indigenous Australians.

The NPA provides that the Commonwealth, states and territories will each provide a detailed report on an annual basis to the Australian Health Ministers’ Advisory Council and Aboriginal and Torres Strait Islander organisations against the benchmarks and timelines, as detailed in their implementation plans. Reports against these benchmarks are to provide a summary of activity in relation to the agreed outputs to complement national reporting against the performance benchmarks and indicators in the NPA.11

Oversight of the NPA is the responsibility of the Standing Council on Health (SCoH), formerly the Australian Health Ministers Conference, through AHMAC.12

1.3 Terms of Reference

1.3.1 Purpose

The purpose of the review was to assess the effectiveness, efficiency and appropriateness of the NPA, based on information from the first three years of the NPA’s implementation (2009-10 to 2011-12). The review also canvasses options for future efforts to close the gap in health outcomes following the expiry of the NPA in June 2013.

The review has been conducted in accordance with the Terms of Reference agreed by the AHMAC Community Care and Population Health Principal Committee (CCPHPC) (see below) and consistent with the Standing Council on Federal Financial Relations A Short Guide to Reviewing National Partnerships (available at: http://www.federalfinancialrelations.gov.au/content/guidelines/Short-Guide_review_dec_12.pdf). The full Terms of Reference are included at Appendix 4.

1.3.2 Scope

Key questions for the review are outlined in the Terms of Review and form the basis of this report:

1. Effectiveness:
   a. Have the NPA’s outcomes and outputs been achieved? The review will assess the progress made by the Commonwealth, States and Territories in respect of outputs delivered under the NPA as a proxy for outcomes where data are unavailable.

10 Ibid, page 13
11 National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, November 2008, page 13
12 National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, November 2008, page 12
b. To what extent did the performance monitoring and reporting aspects of the NPA support the assessment of the NPA’s outcomes/outputs?

2. Efficiency:
   a. How well has progress tracked against performance benchmarks?
   b. To what extent have the parties to the NPA fulfilled their agreed roles and responsibilities, including financial contributions?
   c. Were the performance indicators and benchmarks adequate for assessing if the outcomes/outputs have been met?

3. Appropriateness:
   a. Is there a need for further reform or service delivery improvement?
   b. Is the funding mechanism appropriate?
   c. Is there an ongoing need for an NPA?

1.3.3 Timeframe

The review was conducted during the period September 2012 to February 2013.

1.4 Method

The review was undertaken collaboratively by the Commonwealth, States and Territories through the Community Care and Population Health Principle Committee. The Commonwealth, on behalf of all Australian governments, commissioned the Australian Institute of Health and Welfare (AIHW) to collect and analyse qualitative and quantitative data and prepare detailed analysis of performance against the NPA outputs and outcomes. All governments provided input through a data collection instrument developed by the AIHW for this purpose. The AIHW work has been produced as a separate technical background paper to inform the review report. This report was drafted by the Commonwealth based on input provided by all governments.

Information to inform the review was sourced from:

- The NPA and jurisdictional Implementation Plans;
- Reports against the Aboriginal and Torres Strait Islander Health Performance Framework (ATSIHPF);
- 2009-10, 2010-11 and 2011-12 annual progress reports from all governments against the NPA Implementation Plans
- Related Commonwealth, state and territory evaluations/reviews.
- Additional information provided by the parties to the NPA.

This report examined a range of other documents and resources, including the AIHW’s technical background paper titled *Supporting Analysis for the Review of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*, state, territory and Commonwealth government websites, COAG and jurisdictional reports, and implementation plans. A full Bibliography is at Appendix 2.
1.5 Limitations

There are significant challenges in measuring changes in health outcomes and attributing them to specific health system interventions. These issues are common across the health system and relate to factors such as the complexity of the health system and the fact that improving health outcomes is also dependent on making improvements in the social determinants of health, such as education, housing and employment.

The AIHW analysis notes that assessing the impact of implementation of the NPA since 2009 on health outcomes was, and will continue to be, difficult for a number of reasons, namely:

- Lead times, from when the policy is announced to when initiatives are actually being implemented on the ground.
- Lag times, from when the policy is implemented to when change can be expected in health outcomes; and between when the changes in outcomes occur and when data to measure those changes are available.
- Improving health outcomes, such as chronic disease mortality, requires long-term sustainable improvements across all aspects of people's lives and for this reason there may not be improvement in short or medium timeframes.
- The NPA is one of many initiatives by Commonwealth, state and territory governments aimed at improving Indigenous health outcomes and assessing the contribution of this single NPA on a set of broad, population-level performance indicators is difficult.

Figure 1 below shows the estimated timeframes for program implementation, and when changes in outcomes for process and outcome indicators in the NPA can expect to be seen.

![Figure 1: Timeframes for program implementation and expected changes in health outcomes under the NPA](image)

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13 Australian Institute of Health and Welfare (AIHW), Supporting Analysis for the Review of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, December 2012, pages 43-44
A further difficulty in determining the effectiveness of the initiatives under the NPA is the availability of data relating to the relevant outcomes. While data are available for most of the medium to longer term outcomes, there is little in the way of good quality data that could measure improved intermediate health outcomes that would indicate whether we are on track to achieve the longer term outcomes.

Finally, the structure of the performance framework in the NPA is complex and lacks a clear line of sight between the priority areas, outcomes, outputs, performance indicators and benchmarks. This is reflected in jurisdictional implementation plans and annual progress reports where information does not always align to the outcomes, outputs, performance benchmarks and performance indicators for each of the health outcomes in the NPA. This has made it difficult for the review team to identify what and when planned activities had been implemented and compare performance across governments. A standardised reporting template for annual reports may have reduced complexity and assisted governments with reporting.

Given the challenges outlined above, it is not yet possible to infer a direct relationship between the NPA and any improvements in health outcomes for Aboriginal and Torres Strait Islander peoples since 1 July 2009. It is possible, however, to assess the outputs – that is – the agreed implementation activities undertaken as a result of the NPA. The contributions of these outputs towards closing the gap in Indigenous health outcomes will become measurable in future years as data of sufficient quality becomes available.

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14 Australian Institute of Health and Welfare (AIHW), Supporting Analysis for the Review of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, December 2012
2. Effectiveness of the National Partnership Agreement

This chapter considers the extent to which the NPA’s outcomes and outputs have been achieved, noting that the focus will be on outputs as a proxy for outcomes where outcome data are not available. The chapter will also consider the extent to which the NPA’s performance monitoring and reporting arrangements supported assessment of outcomes and outputs, and the effectiveness of the governance arrangements in supporting their delivery.

2.1 Outcomes

As outlined in the Limitations section of the Background chapter, it is too early to make an assessment of the extent to which the NPA has achieved its intended outcomes in terms of improvements to Indigenous health outcomes. This relates both to the time it takes to achieve improvements in health outcomes and to lag times in data collection and reporting.

However, activities under the NPA have been designed based on available evidence of what works and we can expect that, if maintained, they 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 commenced under the NPA.

In areas where there is limited evidence of what works, such as effective approaches to health promotion in Indigenous populations, it will be critical to at least maintain the current investment and invest in evaluation activities in order to collect information and make assessments about the effectiveness of these approaches.

Table 1 below lists the key performance indicators in the NPA for which some data are currently available, and notes where we can already assess whether or not there has been progress. The table clearly indicates that for the majority of the outcomes it is too early to be able make an assessment.

Table 1: Performance indicators and measures to assess progress against objectives and outcomes in the NPA

<table>
<thead>
<tr>
<th>Objective (section 14)</th>
<th>Initiative (section 15)</th>
<th>Performance indicators (section 22)</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative health</td>
<td>Tackle smoking</td>
<td>Incidence/prevalence of important</td>
<td>Too early to tell</td>
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<td></td>
<td>Healthy transition to</td>
<td>preventable diseases and injury</td>
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<td></td>
<td>adulthood</td>
<td>(Leading causes mortality; chronic</td>
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<td></td>
<td>Making Indigenous</td>
<td>disease mortality)</td>
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<td></td>
<td>health everyone’s</td>
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<td></td>
<td>business</td>
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<td></td>
<td>Risk factor prevalence</td>
<td></td>
<td>Too early to tell</td>
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<td></td>
<td>Proportion of babies</td>
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<td>Too early to tell</td>
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<td>born of low birth</td>
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<td></td>
<td>weight</td>
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<td></td>
<td>Immunisation rates</td>
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<td>↑ Increase</td>
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<tr>
<td></td>
<td>for vaccines in the</td>
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<td></td>
<td>national schedule</td>
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<td></td>
<td>Cancer screening rates</td>
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<td></td>
<td>(breast, bowel, cervical)</td>
<td></td>
<td>Breast/bowel - No change detected</td>
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<tr>
<td></td>
<td>Number of women with</td>
<td></td>
<td></td>
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<td></td>
<td>at least one antenatal</td>
<td></td>
<td>Cervical - too early to tell</td>
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<tr>
<td></td>
<td>visit in the first</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>trimester of pregnancy</td>
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</table>

15 Australian Institute of Health and Welfare (AIHW), Supporting Analysis for the Review of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, December 2012
<table>
<thead>
<tr>
<th>Objective (section 14)</th>
<th>Initiative (section 15)</th>
<th>Performance indicators (section 22)</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco smoking during pregnancy</td>
<td>Too early to tell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social and emotional well-being</td>
<td>Too early to tell</td>
<td></td>
<td></td>
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<tr>
<td>Prevalence of tobacco related diseases (cardiovascular disease, respiratory disease, lung cancer)</td>
<td>Too early to tell</td>
<td></td>
<td></td>
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<tr>
<td>Hospitalisation rates for tobacco-related diseases (lung cancer, cardiovascular disease, respiratory)</td>
<td>Too early to tell</td>
<td></td>
<td></td>
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<tr>
<td>Mortality rates for tobacco-related diseases</td>
<td>Too early to tell</td>
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<td></td>
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<tr>
<td>Notification rates of chlamydia, syphilis, gonorrhoea and hepatitis C</td>
<td>Too early to tell</td>
<td></td>
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<tr>
<td>Hospitalisation rates for injury and assault</td>
<td>Too early to tell</td>
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<tr>
<td>Hospitalisation rates for Indigenous males for major causes of ill-health</td>
<td>Too early to tell</td>
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<tr>
<td>Primary health care</td>
<td>Primary health care services that can deliver</td>
<td>Access to GPs, dental and primary health care professionals</td>
<td>Too early to tell</td>
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<tr>
<td>Rate of MBS health checks for Indigenous Australians aged 0-14 years, 15-54 years and 55 years and over</td>
<td>↑ Increase</td>
<td></td>
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</tr>
<tr>
<td>Life expectancy (including gap between Indigenous &amp; non-Indigenous)</td>
<td>Too early to tell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant/young child mortality rate (incl. gap between Indigenous and non-Indigenous)</td>
<td>Too early to tell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potentially avoidable deaths</td>
<td>Too early to tell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selected potentially preventable hospitalisations</td>
<td>Too early to tell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic disease management</td>
<td>↑ Increase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• GP management plans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Team care arrangements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting times for services</td>
<td>Elective surgery: ↓ Decrease in SA, Tas &amp; NT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Waiting times elective surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency department waiting times (proportion of patients treated within national benchmarks)</td>
<td>Emergency department waiting times: ↑ Increase in SA and NT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of Aboriginal and Torres Strait Islander primary health care services accredited</td>
<td>↑ Increase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous primary health care services providing discharge planning and follow-up and referral</td>
<td>No clear pattern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of MBS services claimed – total and allied health</td>
<td>↑ Increase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital and hospital related care</td>
<td>Fixing the gaps and improving the patient journey</td>
<td>Unplanned/unexpected readmissions within 28 days of surgical admissions</td>
<td>No clear pattern (small numbers)</td>
</tr>
<tr>
<td>Survival of people diagnosed with cancer (5 year relative rate).</td>
<td>Too early to tell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rates of discharge from hospital against medical advice</td>
<td>No change detected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average length of stay in hospital for Indigenous persons</td>
<td>No change detected in most jurisdictions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of Indigenous persons reporting going to the same GP or Aboriginal medical service</td>
<td>Too early to tell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient experiences</td>
<td>Fixing the gaps and improving the patient journey</td>
<td>Access to services by type of service compared to need.</td>
<td>Too early to tell</td>
</tr>
<tr>
<td>Barriers to accessing care.</td>
<td>Too early to tell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sustainability</td>
<td>Primary health care services</td>
<td>Indigenous Australians in the health workforce.</td>
<td>Too early to tell</td>
</tr>
<tr>
<td>Expenditure on health services (including mainstream</td>
<td>Too early to tell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective (section 14)</td>
<td>Initiative (section 15)</td>
<td>Performance indicators (section 22)</td>
<td>Progress</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------</td>
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<td>----------</td>
</tr>
<tr>
<td>that can deliver</td>
<td>versus Indigenous -specific)</td>
<td>Appalachian and Torres Strait Islander people in tertiary education for health related disciplines (focus on completions).</td>
<td>↑ Increase</td>
</tr>
<tr>
<td>Recruitment and retention</td>
<td></td>
<td>No change detected</td>
<td></td>
</tr>
</tbody>
</table>
Recommendation 1.
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. Any changes to the current activities should be based on evidence of what works in improving Indigenous health outcomes.

2.2 Outputs

Under the NPA, all Australian governments have implemented, or are currently implementing, an extensive range of activities to improve Indigenous health outcomes and contribute to closing the gap in life expectancy. Commonwealth, state and territory government implementation plans and annual progress reports document a total of 325 activities undertaken as part of the NPA.

The NPA has resulted in a large increase in funding for, and focus on, provision of health services to Indigenous Australians. The AIHW analysis notes that governments have implemented a number of actions/initiatives relating to the performance benchmarks and there are also some early indicators of improved access to care (listed in Table 1, above).

A high-level overview of governments’ outputs under the NPA for each of the five priority areas is presented below.

2.2.1 Tackling smoking, the single biggest killer of Indigenous Australians

Activity to reduce smoking was undertaken by all governments over the course of the first three years of the NPA. Key activities included:

− Social marketing campaigns at national, state and local levels developed in consultation with Aboriginal and Torres Strait Islander communities and/or sporting codes
− A focus on the benefits of a smoke-free lifestyle after feedback from Aboriginal and Torres Strait Islander people about the inappropriateness of negative approaches
− Nicotine replacement therapy was subsidised through the PBS co-payment measure
− Improved cultural appropriateness of smoking cessation services, including resources in Aboriginal languages and the development of a Quit for New Life program for pregnant Indigenous women and their families.

2.2.2 Providing a healthy transition to adulthood

Activities reported in this priority area were generally inter-related, making it difficult to apportion them to individual output areas. This was reflected in the jurisdictional reports, with some governments not reporting against particular outputs and reporting multiple activities against others. The Commonwealth did not implement activities under this priority and therefore did not report on progress.

Activity was reported in the areas of social and emotional wellbeing, in particular mental health. In the area of juvenile justice, initiatives targeted diverting young Aboriginal and Torres Strait Islander people away from the justice system into other support services, more effectively reintegrating them into the community following detention and improving family support services. Programs
addressing substance abuse to help reduce negative and anti-social behaviours, and avoid contact with the justice system were also implemented by a number of governments.

2.2.3 Making Indigenous health everyone’s business

There was a high level of diversity in activities under this priority area, including programs in maternal and infant health, dental care, optometry, housing, family violence and child protection/sexual abuse. The Commonwealth did not implement activities under this priority and therefore did not report on progress.

Many of the activities reported under this priority area were also relevant to the Healthy transition to adulthood priority area, and some governments noted that the two priority areas could have been combined. A number of governments funded innovative programs addressing the social determinants of health, broadening the contribution to improving Indigenous health outcomes to non-health related sectors. Programs implemented under this priority area included:

– Programs for families with complex needs were introduced by most governments, some of which included work to improve the cultural appropriateness of services for Indigenous children and their families
– Multi-sector funding programs and a multi-sector Aboriginal health conference
– South Australia funded the recruitment and training of Aboriginal environmental health workers under this output.

2.2.4 Primary health care that can deliver

Governments have implemented numerous activities under this priority area, mainly in relation to chronic disease detection and management, through the introduction of multidisciplinary care, enhanced screening, programs for various chronic diseases, and quality improvement programs. Activities included:

– The Commonwealth introduced the Practice Incentives Program Indigenous Health Initiative (PIP-IHI) to improve the identification of Aboriginal and Torres Strait Islander people in primary health care, improve the cultural awareness of health professionals in general practice, and improve management of chronic disease
– SA Health made a commitment to reorient services to improve access to comprehensive primary health care for Aboriginal South Australians through a collaborative approach to planning and service delivery at state, regional and sub-regional levels. This approach aims to maximise the reach of services, address gaps in services and be flexible to best respond to local Community needs and circumstances through development of sustainable and efficient operational models of health care.
– Detection and management of chronic disease through the introduction of multidisciplinary care (Commonwealth, NSW, Qld, Tas), enhanced screening (NSW) and other programs for various chronic diseases (Qld, WA and NT).
– Victoria invested in capacity-building for Aboriginal Community Controlled Health Organisation workforce and governance, and in improving partnerships with mainstream providers.
Key outputs under this priority area included:

- Since the introduction of the NPA, over 340 extra health professionals and 150 new case managers/ Aboriginal Liaison Officers have been appointed to work in Indigenous health.
- In the NT, educational resources about elective surgery waiting lists have been developed to explain the hospital system to Aboriginal patients, and a culturally appropriate health literacy tool has also been developed.
- Aboriginal Liaison Officers and Indigenous staff were used by most governments to assist Indigenous patients to navigate the health care system.
- NSW implemented a program to reduce unplanned hospital re-admissions by following up Aboriginal patients with a chronic disease within 2 working days of discharge from hospital. To support this program, additional funding was provided to each Local Health District to employ dedicated follow-up officers.
- In Victoria there has been significant strengthening between Aboriginal Community Controlled Health Organisations and universal services leading to improved access and coordination of services, and extensive cultural competency training. A number of state-wide clinical improvement projects have been implemented and are currently being evaluated.

2.3 Performance monitoring and reporting

This section of the paper considers the extent to which the performance monitoring and reporting aspects of the NPA supported the assessment of the NPA’s outcomes and outputs.

Governments’ views on the effectiveness of the performance monitoring arrangements under the NPA were split, with around half reporting that they were ineffective and half reporting that they were satisfied with the arrangements.

The review found that the performance monitoring and reporting arrangements of the NPA are overly complex, and that there is no clear line of sight between indicators, benchmarks, outputs and outcomes. The requirement for annual progress reporting is appropriate, but would have been more effective had there been agreement on a standard format and minimum content requirements.

While there is scope for substantial improvement in the performance monitoring and reporting arrangements, they have allowed for an assessment of progress under the NPA, and all governments have made good progress against the performance benchmarks. Reporting has been mostly qualitative in nature and describes the significant number of new initiatives being undertaken under the NPA.

2.3.1 Performance indicators and benchmarks

The performance monitoring framework outlined in the NPA was included to support the assessment of its outcomes and outputs. However the complex array of 5 objectives, 5 priority
areas, 20 outcomes, 20 outputs, 19 performance benchmarks and a total of 31 performance indicators, many of which do not align with each other, limits its effectiveness.16

Whilst it is too early for reporting against most of the performance indicators, the AIHW’s supporting analysis includes an assessment of whether they will be adequate to measure progress against all of the objectives and outcomes. The analysis notes that there is not always a clear line of sight from performance indicators and benchmarks to health objectives or outcomes. In addition, there are data limitations for some performance indicators, including availability, accuracy, comparability and timeliness. Some indicators have not been adequately specified and are difficult to report against.

The AIHW’s analysis suggests that the current performance benchmarks should be reviewed for their relevance and measurability and that any new benchmarks should have clear timeframes for when they are to be achieved and be based on the SMART (specific, measurable, achievable, relevant and timeframe) criteria. The AIHW’s analysis proposes a set of revised indicators that could be used in future intergovernmental arrangements to close the gap in Indigenous health outcomes and noted that these are reported in the National Indigenous Reform Agreement, the National Healthcare Agreement, and the Aboriginal and Torres Strait Islander Health Performance Framework.

2.3.2 Reporting arrangements

The NPA committed each jurisdiction to preparing an implementation plan based on the performance benchmarks in the NPA, that reflected the integrated approach between governments, and was informed by engagement with Aboriginal and Torres Strait Islander organisations and communities17. The information provided in these implementation plans varied but generally included information about initiatives to be implemented, how progress would be measured, provision for evaluation, reporting and risk management arrangements.

The NPA requires that all governments report annually on progress. However there was no agreement on a standardised reporting template for these reports and governments reported their activities in a variety of ways, using largely qualitative data. Only two governments used the performance benchmarks as a basis for reporting. This meant that reporting was not consistent across governments.

Governments’ reporting against the performance benchmarks increased over time, with quantitative benchmarks being reported on less frequently than the qualitative benchmarks. For example, some governments could not report quantitative data against particular performance benchmarks such as the percentage of Aboriginal and Torres Strait Islander people participating in rehabilitation programs intended to reduce hospitalisation of people with chronic disease. However, these governments did report activity associated with the priority area or output associated with that benchmark. The lack of a clear reporting framework in the NPA in combination

16 Australian Institute of Health and Welfare (AIHW), Supporting Analysis for the Review of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, December 2012, page 107
17 National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, November 2008, pp 9-12
with the lack of a reporting template contributed to the uneven reporting against performance benchmarks.

**Recommendation 2**
Performance indicators and benchmarks for any future arrangements should be informed by the AIHW analysis prepared for this review to ensure accurate National reporting.

**Recommendation 3**
Any future arrangements should include a standardised reporting template to improve the consistency and completeness of reporting against existing performance indicators and benchmarks outlined in the HPF and NIRA and improve comparability of data across governments.

### 2.4 Governance Arrangements

This section considers the extent to which the NPA’s governance arrangements supported delivery of the outcomes and outputs.

The NPA did not include a strong focus on national level governance. The Standing Council on Health through AHMAC is responsible for the NPA and all governments submitted annual reports through the AHMAC process for endorsement by health ministers and forwarding to COAG. However this structure did not deliver shared ownership and commitment to active management of the NPA as a whole among senior and mid-level officials with responsibility for implementing the NPA.

DoHA commissioned a review by KPMG in 2011 to assess the effectiveness of the coordination mechanisms associated with the NPA. The review was based on interviews with Commonwealth, state and territory government officials. The findings of this review are summarised below:

- Early cross-jurisdictional coordination of the development of detailed implementation plans was impeded by the confidential nature of the budget processes during the program design phase (both Commonwealth and jurisdictional).
- The single most important coordination mechanism for NPA activities has been through the Indigenous Health Partnership Forums (IHPFs).
- Interviewees commented that the NPA was a great opportunity to improve coordination of Commonwealth, and state / territory activities but in practice most activities continued to be implemented through parallel processes rather than as a partnership.
- While AHMAC has broad responsibility for governance of the NPA, there has been no operational governance structure, and no formal committee or structure to coordinate between governments and share information and learnings.

Comments provided by all governments as part of the review of the NPA confirmed these findings and reflected the desirability of strengthening governance and coordination arrangements under any future arrangements.

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18 Tasmania did not provide a report in 2009-10 as its Implementation Plan had only just been completed.
The separate jurisdictional processes for deciding on activities to be implemented under the NPA allowed each jurisdiction to consider how to improve those elements of the health system for which it was responsible. However, committing to these activities without reference to what other governments were doing (particularly between states/territories and the Commonwealth) has resulted in missed opportunities to consider:

- complementary activities in important areas of co-investment such as tackling smoking
- how to improve the patient journey between primary, secondary and tertiary services
- shared approaches to evaluation and building the evidence base.

There were some examples of improvements to enhance cooperation between services such as a conference in SA, co-funded with the Commonwealth, that was held to facilitate the coordination of services funded through the NPA and other Indigenous-specific services.

**Recommendation 4**

Any future arrangements to close the gap Indigenous health outcomes should include provision for a senior level officials group to guide and coordinate planning and implementation of activities, share information, identify gaps and strategies to address them, develop linkages and shared approaches, and ensure implementation arrangements are complementary. This group should be supported by clearly defined and agreed terms of reference.
3. Efficiency of the National Partnership Agreement

The Terms of Reference state that efficiency is to be reviewed by assessing how well progress was tracked against performance benchmarks, whether the parties to the NPA fulfilled their agreed roles and responsibilities (including financial commitments), and whether the performance benchmarks and indicators were adequate for assessing if the outcomes and outputs have been met.

3.1 Progress against Performance Benchmarks

There has been good progress in the implementation of initiatives and activities by all governments, particularly in the second and third years of the NPA. Each jurisdiction prepared an implementation plan and delivered annual reports that addressed their implementation plan. Most performance benchmarks were reported on most of the time, and the annual reports reflect the significant amount of work undertaken by governments to implement activities designed to improve Indigenous health outcomes.

A more detailed discussion of the appropriateness of the performance benchmarks for reporting progress is provided at Section 2.3.

3.2 Fulfilling Roles and Responsibilities

The key requirements for governments under the NPA were that they produce and share implementation plans, implement the activities in these implementation plans, including engaging Indigenous organisations in both planning and delivery, and provide a detailed report annually to each jurisdiction and Aboriginal and Torres Strait Islander organisations. Financial reporting was not required under the NPA.

Information provided through the annual progress reports and governments’ input to the review suggests that all governments have fulfilled their roles and responsibilities under the NPA. Financial information provided as part of this review showed that not all financial commitments were met by some governments (noting that three jurisdictions did not provide financial information) as there were some underspends, particularly for the priority area Primary health care that can deliver. These are largely related to delays due to workforce recruitment and service capacity issues. The review did not collect information on whether all governments fulfilled the requirement to report annually to Aboriginal and Torres Strait Islander organisations.

3.3 Adequacy of Performance Benchmarks and Performance Indicators

The analysis undertaken by the AIHW of the performance benchmarks and performance indicators included in the NPA indicates some design flaws. The rationale for the linkages between benchmarks and indicators is not always clear and some are not able to be reported against as there are no sources of data. This presented challenges in assessing whether the NPA’s outcomes and outputs were achieved.

Few governments reported against quantitative benchmarks, such as number of hospital readmissions of Aboriginal and Torres Strait Islander people. Any future intergovernmental
arrangements to close the gap in Indigenous health outcomes should select a specific sub-set of quantitative indicators that can be reported against accurately and consistently and monitor these over time to measure improvements.

The enhancements to the NIRA agreed in September 2012 clearly articulate benchmark measures, and includes a commitment to review and revise performance reporting and data quality for all six building blocks to the NIRA, including health\textsuperscript{19}.

\textsuperscript{19} COAG, National Indigenous Reform Agreement (Closing the Gap), September 2012
4. Appropriateness of the National Partnership Agreement

This chapter considers whether there is a need for further reform or service delivery improvement, the appropriateness of the funding mechanisms under the NPA, and whether there is a need for a further NPA.

The appropriateness of the NPA needs to be considered in the context of governments’ overarching objectives. This NPA is a major plank within the NIRA dedicated to achieving the first of the closing the gap targets - to close the gap in life expectancy between Indigenous and non-Indigenous Australians within a generation. Improving health outcomes takes time as well as resources, and this is reflected in the generational nature of the target.

It is also important to remember that the NPA does not stand alone. It is only one plank within the NIRA, and governments have made a range of other commitments, both in health and addressing the social determinants of health. In addition, activity under the NPA builds on the existing health service delivery system.

National Partnership Agreements sit under the Federal Financial Framework and are defined as:

“An agreement defining the objectives, outputs and performance benchmarks related to the delivery of specified projects, to facilitate reforms or to reward those jurisdictions that deliver on national reforms or achieve service delivery improvements.”20

National Partnership Payments are generally associated with transfer payments from the Commonwealth to state / territory governments. They are guided by a number of principles that are articulated in the Intergovernmental Agreement on Federal Financial Relations. Of particular relevance to this NPA, they should be designed to drive specific reforms and be linked to national objectives or expenditure priorities. Thus, an assessment of the need for further reform forms part of the assessment of whether there is a need for a further NPA.

4.1 Is there a need for further reform?

The Aboriginal and Torres Strait Islander Health Performance Framework reports provide a biannual assessment of the performance of the health system in addressing the needs of Indigenous Australians. The 2012 report notes that while there have been improvements in health system performance there are still continuing challenges, particularly in areas such as access to care and health workforce.

As noted earlier in this report, all governments have made substantial progress in implementing a large number of initiatives designed to improve the performance of the health system and delivery of improved Indigenous health outcomes. However, based on governments’ feedback and the review team assessment, it is clear that there is significant variation in the extent to which these initiatives are sustainable and have been incorporated into the framework of the health system. In some areas this is simply because of the time it takes to bed down significant change in complex

20 Intergovernmental Agreement on Federal Financial Relations, pA1
systems. In other areas the lack of ongoing funding has impacted implementation, particularly in initiatives that are dependent on recruitment and retention of additional staff.

It is also important to consider the contribution of the separate components. The NPA as a whole will only be effective in driving improved outcomes if the component activities are effectively contributing to improved health outcomes. All governments based their planning on the best available evidence; however there are areas where the evidence is limited. While some governments included comprehensive evaluation activities in their implementation plans this did not occur in all governments. It will be important that evaluation findings can be shared and contribute to the design of programs going forward.

Future activities and any future arrangements, should include a strong focus on effective evaluation from the start to allow an assessment of their effectiveness in improving health outcomes. Effort should also be focused on identifying any service delivery gaps and opportunities for improvement, particularly linkages and boundary issues between Commonwealth and state/territory programs and responsibilities.

4.2 Is the funding mechanism appropriate?

Under the NPA each jurisdiction committed own-purpose funding to activities under the agreed priority areas. This contrasts with NPAs that include transfer payments to state/territory governments.

The absence of transfer payments in this NPA reflects the focus on all governments making improvements in those parts of the health system for which they have responsibility and has supported the development of targeted initiatives in each jurisdiction.

The Commonwealth and some states/territories committed ongoing funds to their activities under the NPA whereas other states/territories made time-limited commitments with no guarantee of continued support beyond the expiry of the NPA on 30 June 2013.

Where commitments are time-limited it has been more difficult to embed system reform, and those states have been more likely to report concerns about sustainability. More importantly, time-limited commitments do not match with the long-term, generational nature of the objectives and outcomes being sought through the NPA.

4.3 Ongoing need for the National Partnership Agreement

As noted throughout this report, the current NPA has resulted in significant additional funding and activity by all governments. While it is too early to assess whether governments are on track to achieve some of the long term objectives, withdrawal of resources at this stage would be detrimental and slow progress.

Since the introduction of the NPA, a focus on improving Indigenous health has been integrated into a range of key national agreements and partnerships, including:
• National Healthcare Agreement: to improve health outcomes for all Australians and the sustainability of the Australian health system;
• National Disability Agreement: provides the national framework and key areas of reform for the provision of government support to services for people with disabilities;
• National Partnership on Hospital and Health Workforce Reform: to improve health workforce, hospitals and capacity; and
• National Partnership on Preventive Health: reforms to Australia’s efforts in preventing the lifestyle risks that cause chronic disease.

These agreements articulate the objective of maintaining a sustainable health system. This includes improving access to quality and culturally inclusive health care services across the continuum of care, and the prevention, early detection and management of major chronic diseases. The agreements also identify the roles and responsibilities of Australian Government, and state and territory governments in realising those objectives.21

Comprehensive information on expenditure on health services is provided in the Productivity Commission’s series of Indigenous Expenditure Reports, and these will continue to provide valuable information in relation to the objectives of the NPA.

These overarching agreements and performance reporting mechanisms provide an opportunity to integrate, monitor and embed closing the gap investments and initiatives over time. In addition, the Australian Government is developing a National Aboriginal and Torres Strait Islander Health Plan (the Health Plan) in partnership with Aboriginal and Torres Strait Islander people and their representatives, and has invited state and territory governments to participate.

The Health Plan will support the Government’s efforts to close the gap in life expectancy and infant mortality between Aboriginal and Torres Strait Islander people and non-Indigenous people, and will recognise the importance of the social determinants of health in closing the gap.

The review has found general agreement with continuing to address the 5 priority areas of:

• Tackling smoking, the single biggest killer of Indigenous Australians
• Healthy transition to adulthood
• Making Indigenous health everyone’s business
• Primary health care services that can deliver
• Fixing the gaps and improving the patient journey.

A suggestion was made to extend the Tackling Smoking priority to include promoting healthy lifestyles.

However, given the relative newness of many of the activities under the NPA, the lack of certainty about ongoing funding in some jurisdictions, and the potential to drive improvements through

21 Australian Health Ministers’ Advisory Council, Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report, 2012
improved coordination, there would be benefit in seeking further intergovernmental arrangements to close the gap in Indigenous health outcomes. This will enable a continued focus on these activities to ensure they embedded into the health system.

**Recommendation 5**
That governments consider further arrangements to close the gap in Indigenous health outcomes to allow time to embed the current activities into the health system.

**Recommendation 6**
All governments should review the range of initiatives being implemented to ensure any gaps in service delivery are identified and addressed both within and across governments.

**Recommendation 7**
All governments should continue to ensure that initiatives are regularly evaluated, key learnings are shared and disseminated and that this information informs the design or modification of implementation arrangements.
### Appendix 1- The framework of the NPA

Note: developed by cross referencing tables in Clauses 14, 15, 16, 21, 22 and 28 of the NPA on Closing the Gap in Indigenous Health Outcomes

<table>
<thead>
<tr>
<th>Objective (NPA Clause 14)</th>
<th>Initiative (NPA Clause 15)</th>
<th>Expected outcomes (NPA Clause 15)</th>
<th>Expected outputs and responsible jurisdiction (NPA Clause 16)</th>
<th>Performance benchmarks (NPA Clause 21)</th>
<th>Performance Indicators (NPA Clause 22)</th>
<th>Total funding $m (NPA Clause 28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive health</td>
<td>Tackle smoking - the single biggest killer of Indigenous people</td>
<td>Reduced smoking rate Reduced burden of tobacco related disease for Indigenous communities</td>
<td>Social marketing campaigns to reduce smoking-related harms among Aboriginal and Torres Strait Islander peoples (Cwth/S/T) Indigenous specific smoking cessation and support services (Cwth/S/T) Continued regulatory efforts to encourage reduction/cessation in smoking (S/T) Strategies to improve delivery of smoking cessation services, including nicotine replacement therapy (Cwth)</td>
<td>1. Number and key results of culturally secure community education/health promotion/social marketing activities to promote quitting and smoke-free environments 2. Key results of specific evidence based Aboriginal and Torres Strait Islander brief interventions, other smoking cessation and support initiatives offered to individuals 3. Evidence of implementation of regulatory efforts to encourage reduction/cessation in smoking in Aboriginal and Torres Strait Islander people and communities 4. Number of service delivery staff trained to deliver the interventions</td>
<td>Note: Indicators spread across all three Preventive Health initiatives and not necessarily linked to stated initiatives Incidence/prevalence of important preventable diseases and injury Proportion of babies born of low birth weight Teenage birth rate Risk factor prevalence Immunisation rates for vaccines in the national schedule Cancer screening rates (breast, cervical, bowel) Number of women with at least one antenatal visit in the first trimester of pregnancy Additional indicators Tobacco smoking during pregnancy Social and emotional well-being Health promotion</td>
<td>$198.69 m Tackle smoking</td>
</tr>
<tr>
<td>Healthy transition to adulthood</td>
<td>Increased sense of social and emotional wellbeing Reduced uptake of alcohol, tobacco and illicit drugs Reduced rates of sexually transmissible infections</td>
<td>Create/enhance youth outreach networks to support early diagnosis, treatment and advice to at-risk young Aboriginal and Torres Strait Islander peoples (S/T) Expand and integrate mental health and substance use services (S/T)</td>
<td></td>
<td>1. Number of additional health professionals (including drug/alcohol/mental health/outreach teams) recruited and operational in each 6 month period</td>
<td></td>
<td>$116.96 m (*no Commonwealth funding)</td>
</tr>
<tr>
<td>Objective (NPA Clause 14)</td>
<td>Initiative (NPA Clause 15)</td>
<td>Expected outcomes (NPA Clause 15)</td>
<td>Expected outputs and responsible jurisdiction (NPA Clause 16)</td>
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<td>Total funding $m (NPA Clause 28)</td>
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<tr>
<td><strong>Reduced hospitalisations for violence and injury</strong>&lt;br&gt;Reduced excess mortality and morbidity among Aboriginal and Torres Strait Islander men</td>
<td><strong>Making Indigenous health everyone’s business</strong></td>
<td>Improved multi-agency, multi-programme and inter-sectoral collaboration and coordination to meet the needs of Indigenous families and communities&lt;br&gt;Improved access to targeted early detection and intervention programs by high need Indigenous families&lt;br&gt;Reduced waiting times for health services&lt;br&gt;Reduction in early mortality</td>
<td>Expand diversionary activities within the juvenile justice system and provide health and wellbeing checks for young Aboriginal and Torres Strait Islander offenders (S/T)&lt;br&gt;Improve the network of family-based alcohol/drug treatment, rehabilitation and support services (S/T)</td>
<td>Note: Making Indigenous health everyone’s business had no specified performance benchmarks</td>
<td><strong>$52.77 m</strong> (<em>no Commonwealth funding</em>)</td>
<td></td>
</tr>
<tr>
<td><strong>Improved multi-agency, multi-programme and inter-sectoral collaboration and coordination to meet the needs of Indigenous families and communities</strong>&lt;br&gt;Improved access to targeted early detection and intervention programs by high need Indigenous families&lt;br&gt;Reduced waiting times for health services&lt;br&gt;Reduction in early mortality</td>
<td><strong>Primary health care Incorporating Sustainability</strong>&lt;br&gt;<strong>Primary health care services that can deliver</strong>&lt;br&gt;<strong>Implementation of national best practice standards and accreditation processes for Aboriginal and Torres Strait Islander health services delivering primary health care</strong>&lt;br&gt;Increased uptake of MBS-funded primary health care services by Aboriginal and Torres Strait Islander people&lt;br&gt;Improved access to quality primary health care through improved</td>
<td><strong>Introduce minimum service standards for all organisations providing primary health care services to Aboriginal and Torres Strait Islander populations (Cwth/S/T)</strong>&lt;br&gt;&lt;br&gt;Introduce measures that will increase the uptake of MBS-funded primary health care services by Aboriginal and Torres Strait Islander peoples, with approximately 130,000 additional adult health checks being provided over the next four years (Cwth)</td>
<td><strong>1. Number of Indigenous specific health services meeting national minimum standards</strong>&lt;br&gt;<strong>2. Number of Aboriginal and/or Torres Strait Islander people receiving a MBS Adult Health Check</strong>&lt;br&gt;<strong>3. Number of new allied health professionals recruited</strong>&lt;br&gt;<strong>4. Increased effort to refocus own purpose outlays in primary care to prioritise core</strong>&lt;br&gt;<strong>Access to GPs, dental and primary health care professionals</strong>&lt;br&gt;<strong>Proportion of diabetics with HbA1c below 7per cent</strong>&lt;br&gt;<strong>Life expectancy (including gap between Indigenous &amp; non-Indigenous)</strong>&lt;br&gt;<strong>Infant/young child mortality rate (including gap between Indigenous &amp; non-Indigenous)</strong>&lt;br&gt;<strong>Potentially avoidable deaths</strong>&lt;br&gt;<strong>Selected potentially preventable hospitalisations</strong>&lt;br&gt;<strong>Indigenous Australians in the health workforce</strong></td>
<td><strong>$779.75 m</strong></td>
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<td>Objective (NPA Clause 14)</td>
<td>Initiative (NPA Clause 15)</td>
<td>Expected outcomes (NPA Clause 15)</td>
<td>Expected outputs and responsible jurisdiction (NPA Clause 16)</td>
<td>Performance benchmarks (NPA Clause 21)</td>
<td>Performance Indicators (NPA Clause 22)</td>
<td>Total funding $m (NPA Clause 28)</td>
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<td>coordination across the care continuum, particularly for people with chronic diseases and/or complex needs</td>
<td>Fixing the gaps and improving the patient journey</td>
<td>Reduced average length of stay in the long term</td>
<td>Workforce strategies developed in partnership with Aboriginal and Torres Strait Islander communities to improve continuity of care and coordination with health services (Cwth/S/T)</td>
<td>1. Number of new case managers / Indigenous Liaison Officers recruited and operational</td>
<td>Hospital related care</td>
<td>$428.80 m</td>
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<td>Provision of improved cultural security in services, and increased cultural competence of the primary health care workforce</td>
<td>Improved level of engagement between Aboriginal and Torres Strait Islander patients, referred care providers and primary level providers (private or public) to deliver better follow up and referral processes</td>
<td>Improved long term stability in primary provider choice</td>
<td>Strategies to improve the cultural security of services and practice within public hospitals (S/T)</td>
<td>2. Number of culturally secure health education products and services to give Indigenous people skills and understanding of preventive health behaviours, and self-management of some chronic health conditions</td>
<td>Waiting times for services</td>
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<td>Improved care (and sub-acute) systems for Aboriginal and Torres Strait Islander people (S/T)</td>
<td>Improved patient satisfaction with the care and patient journey (based on domains of concern to patients)</td>
<td>Improved access to acute care (and sub-acute) systems for Aboriginal and Torres Strait Islander people (S/T)</td>
<td>3. Key results of strategies to improve cultural security of services and practice within public hospitals</td>
<td>Unplanned/unexpected readmissions within 28 days of surgical admissions</td>
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<td>In-hospital care managers provided to coordinate and follow up care transitions (S/T)</td>
<td>New culturally secure</td>
<td>New culturally secure</td>
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<td>Survival of people diagnosed with cancer (5 year relative rate)</td>
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<td>Rates of services provided for public and private hospitals per 1,000 weighted population by patient type</td>
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<td>Nationally comparative information that indicates levels of patient satisfaction around key aspects of care they received.</td>
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<td>Additional indicators</td>
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<td>Rates of discharge from hospital against medical advice.</td>
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<td>Objective (NPA Clause 14)</td>
<td>Initiative (NPA Clause 15)</td>
<td>Expected outcomes (NPA Clause 15)</td>
<td>Expected outputs and responsible jurisdiction (NPA Clause 16)</td>
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<td>Reduced admissions and incomplete treatments for Aboriginal and Torres Strait Islander patients</td>
<td>transition care services to address issues of social isolation and/or geographic remoteness, language, health literacy and other social factors established (S/T) Transport and accommodation support provided for rural and remote patients and their families (S/T)</td>
<td>4. Increased percentage of Aboriginal and/or Torres Strait Islander people with a chronic disease with a care plan in place 5. Percentage of Aboriginal and Torres Strait Islander people participating in rehabilitation programs intended to reduce hospitalisation of people with chronic disease 6. Increased number of culturally appropriate transition care plans/procedures/best practice guidelines to reduce readmissions by (percentage/proportion) 7. Improved quality of Aboriginal and Torres Strait Islander identification in key vitals and administrative datasets</td>
<td>Access to services by type of servicer compared to need Barriers to accessing care</td>
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</tbody>
</table>
Appendix 2 - Document List

Australian Health Ministers’ Advisory Council, Aboriginal and Torres Strait Islander Health Performance Framework 2012 Report, 2012

Australian Institute of Health and Welfare (AIHW), Supporting Analysis for the Review of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, December 2012

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

Annual Progress Reports against Implementation Plans for each jurisdiction 2011–12. For the Commonwealth, these take the form of the Indigenous Chronic Disease Package (ICDP) annual progress report 2011–12.

COAG, National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, 2008 and 2012


COAG Reform Council, Indigenous Reform 2010–11: Comparing performance across Australia

FaHCSIA, Closing the Gap: Prime Minister’s Report 2012

KPMG, Coordination of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes, Health Practitioner Service Review, January 2011


Urbis, Closing the Gap in Health Outcomes in Victoria: Baseline Report, May 2011
Appendix 3 - Jurisdiction Responses to Appropriateness and Effectiveness Questions

Through the NPA parties have agreed to work in partnership to contribute to closing the gap in health outcomes and achieving key goals as agreed by COAG by implementing initiatives under the following five priority areas:

1. Preventive health: to reduce the factors that contribute to chronic disease through effective anti-smoking campaigns and integrated alcohol, drug and mental health services
2. Primary health care: to significantly expand access to and coordination of comprehensive, culturally secure primary health care, allied health services and related services.
3. Hospital and hospital-related care: to deliver better clinical outcomes through quality, culturally secure hospital and hospital-related services that include rehabilitation, allied health care and transition care case management.
4. Patient experiences: to ensure access by Aboriginal and Torres Strait Islander people to comprehensive and coordinated health care, provided by a culturally competent health workforce within a broader health system that is accountable for Indigenous health needs, in genuine partnership with the people and communities they target and to build service reach and influence to re-engage the most vulnerable Indigenous people into mainstream and targeted health services.
5. Sustainability: to increase the number of Aboriginal and Torres Strait Islander people in the health workforce, reform and improve the supply of the health workforce generally including the adoption of complementary workplace reforms, create sustainable program and funding models, measure performance and ensure that services are responsive both to national targets and local community needs.

Six questions were asked in total, three related to how effective the NPA had been through objectives, performance monitoring and governance arrangements and three related to how appropriate in the future were the objectives, Commonwealth support and a multi-lateral agreement. Tables relating to each question and a summary of the findings have been listed below.
**Effectiveness**

To what extent does your jurisdiction agree that the policy objectives of the Agreement have been achieved?

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<td>Preventive health</td>
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<td>Primary health care</td>
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<td>Hospital and hospital-related care:</td>
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<td>Patient experiences</td>
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<td>Strongly Agree</td>
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<td>Sustainability</td>
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There was universal agreement between governments that the NPA had achieved its objectives in Primary Health Care and Hospital services. There was general agreement that the preventive health and patient experience objectives had been met, however Tasmania was unsure in these areas, and SA disagreed that the patient experience objective had been met. SA was also unsure about the sustainability objective, and mentioned ongoing funding uncertainty which may be one of the contributing factors to this response. The Commonwealth’s response raises issues of concern due to lack of ongoing funding commitments in some States and Territories, placing the gains made at risk and causing barriers to sustaining the national effort at Closing the Gap.

**How effectively do the performance monitoring aspects of the Agreement (eg measures, performance benchmarks, performance indicators) support the assessment of whether the objectives, outcomes and outputs of the Agreement have been achieved?**

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Governments’ views on the effectiveness of the performance monitoring arrangements under the NPA were split, with around half saying that they were ineffective and half reporting that they were satisfied with the arrangements. Tasmania commented that they were ineffective due to the benchmarks being at a population level which meant that the data were of limited usefulness given the small number of Aboriginal and Torres Strait Islander people in Tasmania. Comments from both SA and Commonwealth highlighted that significant lag times can be expected between the delivery of program outputs and reportable improvements in health outcomes.
Did the Agreement’s governance arrangements support delivery of the outcomes/outputs?

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Queensland was the only jurisdiction to find that the NPA governance arrangements supported the delivery of the outcomes/outputs. SA and ACT found the arrangement satisfactory although both felt interaction between State and Commonwealth did not reflect a partnership. WA and Tasmania found the arrangement to be ineffective. WA reported that their program ran parallel with the Commonwealth’s allowing little opportunities for collaboration. The Commonwealth found the arrangement to be satisfactory.

**Appropriateness**

Looking forward, to what extent does your jurisdiction agree the scope of the Agreement’s objectives remain appropriate?

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<td>Hospital and hospital-related care</td>
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<td>Patient experiences</td>
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There is universal agreement between governments that the NPA objectives remain appropriate. Governments report that they have made long term commitment towards change in Aboriginal and Torres Strait Islander health outcomes but acknowledge there is still sustained effort and commitment required.

To what extent does your jurisdiction agree there is an ongoing need for Commonwealth Government activity to meet the objectives of closing the gap in Indigenous health outcomes?

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There was general agreement Commonwealth Government activity is required in order to meet the objectives of closing the gap in Indigenous health outcomes; however WA was unsure in hospital and hospital related care. WA believes in the Commonwealth investment but feels greater effort is required to work in a collaborative manner. The Commonwealth agrees that Government activity is still required. Noting that not all relevant activity will be through this NPA.

**To what extent does your jurisdiction agree a multi-lateral agreement, for example a National Partnership Agreement is required to close the gap in Indigenous health outcomes?**

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There was general agreement between governments that a multi-lateral agreement is required. A partnership is seen to be a crucial component in keeping with current agendas and objectives. Tasmania was unsure due to specific issues for Tasmania, suggesting that a bi-lateral agreement would be more appropriate.

Overall all governments have found the NPA to be effective and appropriate. Improvements in community engagement and cultural competency have increased integrated health service planning and delivery. Areas of concern are due to uncertainty with ongoing funding commitments, lag time between delivery outputs and reportable improvements in health outcomes and communication between State and Territories and the Commonwealth.
Appendix 4 – Terms of Reference

1.1 Background

In November 2008, COAG agreed to a $1.6 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes (the NPA) to specifically address the first of the COAG Closing the Gap targets – to close the gap in life expectancy.

The NPA lists five priority areas:

1. tackling smoking;
2. providing a healthy transition to adulthood;
3. making Indigenous health everyone’s business;
4. delivering effective primary health care services; and
5. better coordinating the patient journey through the health system.

Each jurisdiction has an Implementation Plan that sits under the NPA and is endorsed by the Australian Health Ministers’ Advisory Council (AHMAC) and Health Ministers. The Plans cover the period July 2009 to June 2013. Each jurisdiction reports annually to AHMAC on progress against their Plans, and these reports are provided through the Standing Council on Health to COAG.

The NPA stipulates that the NPA will be reviewed in 2012-13 with regard to progress made by the Parties in respect of achieving the agreed outcomes.

1.2 Purpose of the Review

The purpose of the review is to assess the effectiveness, efficiency and appropriateness of the NPA, based on information from the first three years of the NPA’s implementation (2009-10 to 2011-12).

1.3 Scope of the Review

Questions for the review are:

1. Effectiveness:
   a. Have the NPA’s outcomes and outputs been achieved? The review will assess the progress made by the Commonwealth, states and territories in respect of outputs delivered under the NPA as a proxy for outcomes where data are unavailable.
   b. To what extent did the performance monitoring and reporting aspects of the NPA support assessment of the NPA’s outcomes/outputs?
   c. Did the NPA’s governance arrangements support delivery of the outcomes/outputs?

2. Efficiency:
   a. How well has progress tracked against performance benchmarks?
   b. To what extent have the parties to the NPA fulfilled their agreed roles and responsibilities, including financial contributions?
   c. Were the performance indicators and benchmarks adequate for assessing if the outcomes/outputs have been met?

3. Appropriateness:
   a. Is there a need for further reform or service delivery improvement?
b. Is the funding mechanism appropriate?
c. Is there an ongoing need for an NPA?

1.4 Timeframe

The review will be conducted between September 2012 and December 2012.

1.5 Process for conducting the Review

The review will be undertaken collaboratively by the Commonwealth, states and territories. The final Community Care and Population Health Principal Committee endorsed report will be provided to AHMAC.

A consultant will be contracted to collect and analyse qualitative and quantitative data and prepare a report of performance against the NPA outputs and outcomes. This will be used to inform the final review report which will be prepared collaboratively by the Commonwealth, states and territories.

Information to inform the review will be sourced from:

- The NPA and jurisdictional Implementation Plans;
- Reports against the Aboriginal and Torres Strait Islander Health Performance Framework;
- 2009-10 and 2010-11 annual progress reports from all jurisdictions against the NPA Implementation Plans;
- Related Commonwealth, State and Territory evaluations/reviews;
- Additional information provided by the Parties to the NPA.